GLOBAL LEARNING AGENDA

Expanded Method Choice for Adolescents and Youth

Report on the March 19, 2024, virtual workshop *"Reviewing progress on the Global Learning Agenda for expanded contraceptive method choice for adolescents and youth"*

June 2024

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Contents

List of abbreviations

AGYW: adolescent girls and young women

CHW: community health workers

DMPA-IM: intramuscular depot medroxyprogesterone acetate

DMPA-SC: subcutaneous depot medroxyprogesterone acetate

EC: emergency contraception

FAFC: Full Access, Full Choice project

FP: family planning

HIP: high impact practice

HIV: human immunodeficiency virus

IUD: intrauterine device

LARC: long-acting reversible contraceptive

LGBTQIA+: lesbian, gay, bisexual, transgender, queer, intersex, asexual

LNG-IUS: levonorgestrel intrauterine system

MAYE: meaningful adolescent and youth engagement

PAFP: postabortion family planning

PPFP: postpartum family planning

STI: sexually transmitted infection

VHT: village health teams

WHO: World Health Organization

Part I: Background to the virtual workshop

Global Learning Agenda

Given their large number globally, adolescents and youth are increasingly a focus of family planning (FP) programs and are an important component of the Sustainable Development Goal Target 3.7 that seeks to ensure universal access to sexual and reproductive health services for all. Increased attention to and interest in adolescents and youth in the FP field was evident in the late 2010s, when FP2020 country programs began including commitments specific to reaching young people. At that time the FP field realized it had limited information on how to reach young people to ensure that they have access to a full range of contraceptive methods.

In 2018, during the first year of the Full Access, Full Choice (FAFC) project funded by the Bill & Melinda Gates Foundation, 64 participants representing international organizations, United Nations agencies, donors, university partners, and youth convened for a technical workshop in Washington, DC, on March 6–8. Organized by the FAFC project in collaboration with representatives from the WHO Human Reproduction Programme, FP2020, and the Expanded Method Choice for Youth Working Group, the workshop's objectives were to develop a Global Learning Agenda and prioritize evidence and measurement needs to improve access to and use of an expanded range of FP methods for adolescents and youth.

Attendees participated in facilitated small group discussions on eight learning themes: 1) quality and availability of services, 2) post-pregnancy FP, 3) client satisfaction and acceptability, 4) expanding method choice, 5) young people's needs and choices, 6) program strategies and replication/scale-up, 7) advocacy priorities, and 8) outcome measurement. Each group created and prioritized learning agenda questions and identified potential projects and data sources to answer proposed questions. The workshop ended with a consensus-based prioritization exercise in plenary, and all participants voted on their top two learning agenda questions that could be answered in the short term (addressed now or in the coming two years), medium term (addressed in the next three to five years using forthcoming data), and long term (requires new project or primary data collection). These priority questions, plus all others identified during the workshop, were incorporated into the Global Learning Agenda. The FAFC team subsequently worked with global colleagues to answer several of the learning agenda questions with primary and secondary data.

As a first activity, FAFC developed a definition for "expanded method choice": *Ensuring that all individuals and couples, especially adolescents and youth, have the agency, information, access, and support they need to freely choose and obtain the contraceptive method they prefer in an environment free from bias or stigma*. The Global Learning Agenda developed through this process was also publicly available. Since 2018 significant research has addressed adolescent contraception and expanded method choice; however, progress on the learning agenda has not been tracked. It is not clear to what extent the different questions have been answered, whether the questions are still relevant, and how the questions align with current learning needs in the field of adolescent sexual and reproductive health.

Notably in 2020 the WHO began a process to update the 2011 WHO Guidelines on preventing child marriage and increasing access to and uptake of contraception among adolescents. In June 2023 members of the Guideline Development Group were invited to review and discuss the evidence to inform the updated guidelines. At that meeting participants identified several challenges related to using the research due to the focus of the systematic review on experimental and quasi-experimental study designs. The participants recognized that other evidence that did not meet the WHO review requirements can also inform the field. Consequently the FAFC team undertook rapid scoping reviews to examine the Global Learning Agenda priority questions and encompass a broad range of studies, including experimental, quasi-experimental, observational, and qualitative ones, to help answer key questions around adolescent and youth contraceptive use.

Virtual workshop

Almost six years after the initial global convening and creation of the Global Learning Agenda and in the wake of the WHO's guideline development process, on March 19, 2024, a multi-stakeholder participatory virtual workshop convened to review the current evidence to address the priority Global Learning Agenda questions. The objectives for reviewing the agenda were to: 1) identify priority evidence gaps to inform an updated Global Learning Agenda, 2) work with partners to build buy-in and advocate for investment in the research priorities, and 3) provide guidance to inform stronger study designs to examine programs supporting adolescent and youth contraceptive use. This was a virtual workshop with contributions from the FAFC project, the USAID MOMENTUM Country and Global Leadership project, and the WHO Human Reproduction Programme. In total 136 people registered to participate, and 81 people attended the virtual workshop.

The workshop had three main objectives.

1. **Review of knowledge from rapid scoping reviews related to priority questions in the Global Learning Agenda.** In the fall of 2023 the FAFC conducted rapid scoping reviews of existing evidence surrounding each of the six questions identified as priorities in 2018. The FAFC developed presentations of the findings in collaboration with colleagues with expertise on the topics: David Imbago-Jacome from YIELD Hub, Syeda Nabin Ara Nitu from Save the Children, and Anna Temba from EngenderHealth.
2. **Reflection on findings for the priority questions.** Following the six presentations, participants met in group discussion sessions to share other evidence relevant to the priority learning questions and reflected on which questions have been sufficiently answered and which are important to take forward. The presenters facilitated the sessions and used interactive Mural boards to collect the contributions. These reflections are in Appendix A.
3. **Set the stage for development of an updated Global Learning Agenda.** Building on the FAFC Global Learning Agenda review, the USAID MOMENTUM Country and Global Leadership project, in partnership with the WHO and the Carolina Population Center at the University of North Carolina, will facilitate a process to update the agenda that will focus on adolescent contraceptive access, quality, choice, use, discontinuation, and equity.

Part II: Review of the six priority learning questions

Methodology

The FAFC team conducted a rapid scoping review related to each learning question. We took a slightly different approach to each question, but each review proceeded with the following steps. Using multiple search engines, including Google Scholar, EBSCO, and PubMed, we searched for relevant publications focused on adolescents (ages 10–19), youth (ages 20–24), and/or young people (ages 10–24) as the key population. Because this was a rapid scoping review of six questions to update the knowledge base of the Global Learning Agenda, we focused on the time frame since 2015, although some pertinent earlier articles were also included as essential. We sorted articles by date and relevance and typically focused on the first 100–200 hits. To supplement the peer-reviewed literature that the search engines found, we reviewed High Impact Practice (HIP) briefs and chose applicable articles on each question. Consequently we included gray literature (e.g., project reports and summaries) in addition to peer-reviewed studies. In addition, specifically for the first question on interventions, we targeted key projects focused on social norm change for a comprehensive review of new interventions that the peer-reviewed literature may not have reported yet.

The inclusion criteria required that studies were related to the priority question. We included rigorous study designs (e.g., experimental and quasi-experimental studies), observational studies, and qualitative studies. Because many of the questions concern barriers and facilitators to adolescent and youth contraceptive use (e.g., postpartum or postabortion use, service use, influencers), the most relevant findings came from observational and qualitative studies. We provide additional details on the search approach in the findings for each question below. We list the references for each question in Appendix B.

Summary

The FAFC team undertook a rapid scoping review of each of the six priority research questions (see Box 1 below). In this section we summarize the findings from each of the six reviews and the discussions in the breakout groups related to each specific question.

Box 1: Six priority learning questions from the Global Learning Agenda

SHORT TERM

1. Understanding who is influential (e.g., parents, peers, community members, service providers, etc.) at affecting adolescent and youth adoption and continuation of a family planning method and how does this differ across the young person's life course? How do we intervene programmatically to shift negative community norms at the household, community, and provider levels that pose as barriers to adolescents and youth uptake and continued use of modern contraception?
2. What is the link between expanded method choice and adolescent and youth outcomes such as uptake, discontinuation and switching?

MEDIUM TERM

1. What are the influencing factors- facilitators (e.g., social norms, champions, cultural factors) and barriers (e.g., FP stigma)- that influence the timing of postpartum or post-abortion family planning uptake and method selection among post-pregnancy adolescents and youth?
2. What can we learn from a "pathway" to method choice for adolescents and youth? What drives family planning decisions? What makes an adolescent girl/youth choose a specific method?

LONG TERM

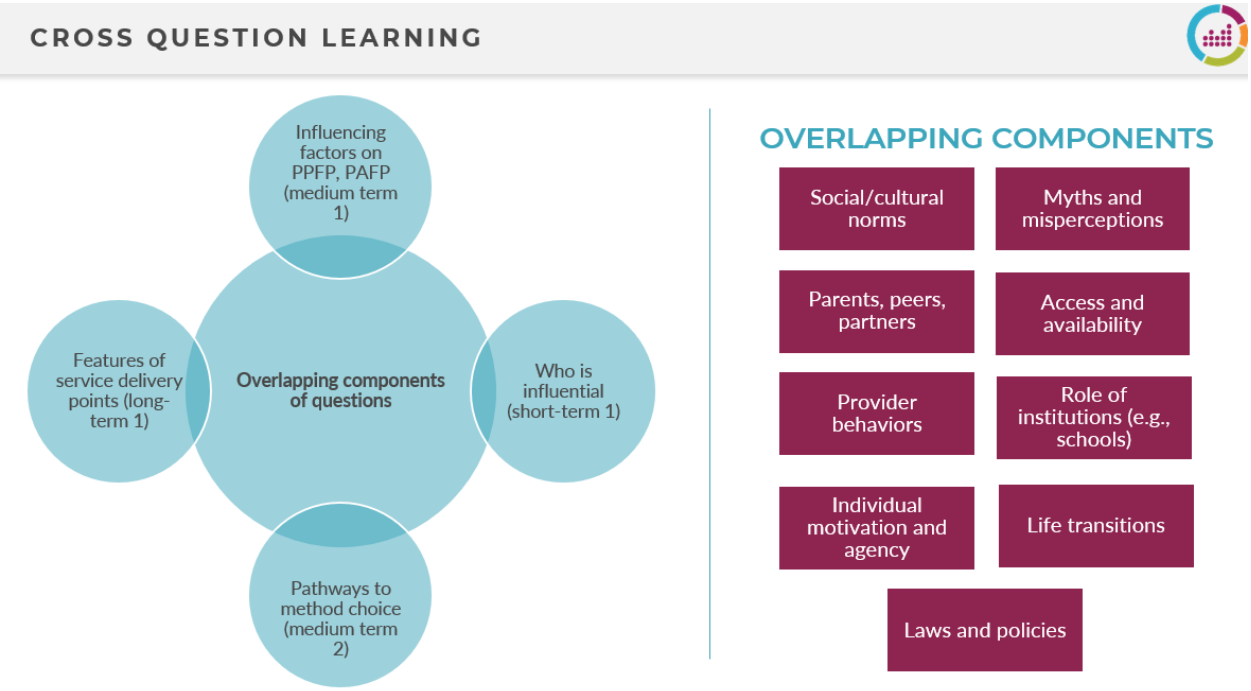
1. What features of service delivery points and/or providers are attractive and important to young people when seeking contraceptive advice and services? And how does this influence method choice?
2. When young people design services, how are they changed? When young people are involved in program design, what is prioritized and how does this lead to improved method choice?

Crosscutting findings

We found common themes across the six priority learning questions and reflect them here in the presentation summaries. Recognizing the overlapping themes, the virtual workshop participants began by briefly discussing relevant overlaps in the findings (see Figure 1). Notably, four of the questions seek to understand facilitators and barriers and/or who is influential in adolescent and youth contraceptive decision-making: short-term question 1 on who is influential in adolescent and youth contraceptive decision-making; medium-term question 1 on influencing factors on postpartum and postabortion FP use; medium-term question 2 on pathways to method choice; and

long-term question 1 on attractive features of service delivery points for adolescents and youth. For these four questions, evidence shows that social and cultural norms; myths and misperceptions; parents, peers, and partners; access and availability of FP services and methods; provider behaviors; the roles of institutions; individual motivation and agency; life transitions; and laws and policies are often important components that affect adolescent and youth FP use. These overlapping components also highlight the many lenses and approaches to take into account when considering adolescent and youth contraceptive use and method choice overall.

Figure 1. Overlapping components and findings across four of the research questions

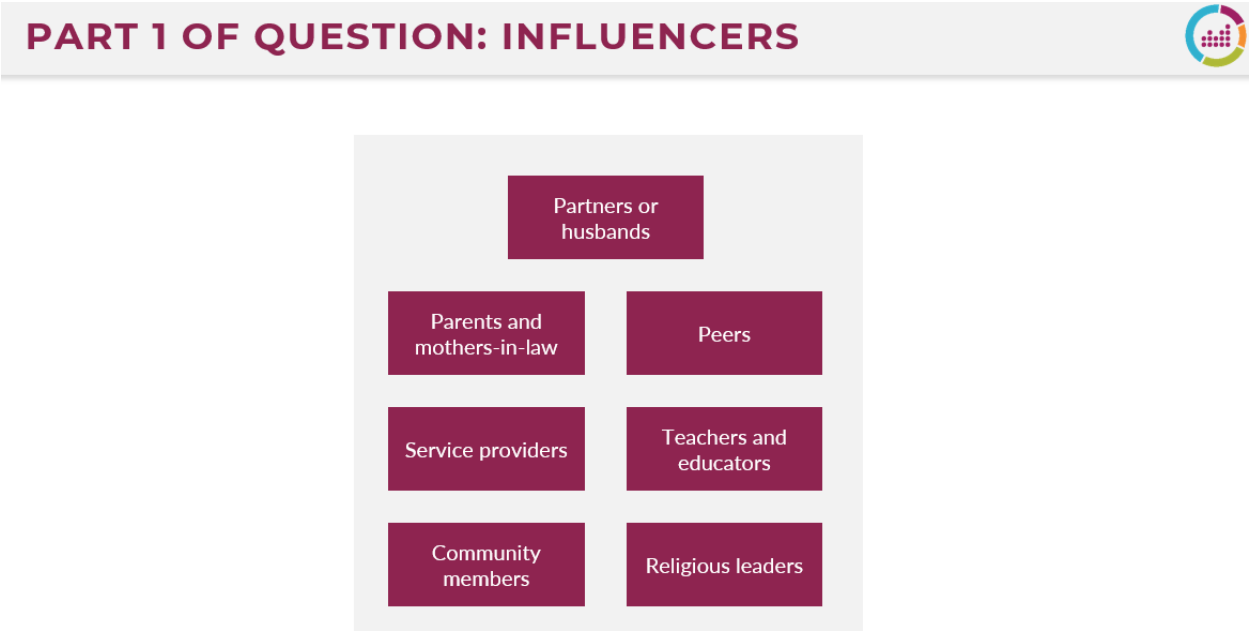


Results of the rapid scoping review by question

Short-Term Question 1: Who is influential (e.g., parents, peers, community members, service providers, etc.) at affecting adolescent and youth adoption and continuation of a FP method and how does this differ across the young person's life course? How do we intervene programmatically to shift negative community norms at the household, community, and provider levels that pose as barriers to adolescents and youth uptake and continued use of modern contraceptives?

This learning question has two parts: 1) who are the influencers in adolescent and youth FP use, and 2) what is known about programs that aim to affect norms (of influencers). The scoping review included 187 articles, most of which address the first part of the question about influencers. Therefore to supplement the review we undertook a few targeted searches on the Social Norms Learning Collaborative website, papers and reports from the Passages Project, and a literature search that specifically looked at social norm interventions. This secondary search identified programs that address social norm changes at multiple levels. Figure 2 summarizes the main findings.

Figure 2. Influencers on adolescent and youth adoption and continuation of FP



The first part of this question addresses influencers of young people's decision-making about contraceptive use. The main influencers follow.

- **Partners/husbands** can increase or decrease FP use depending on their attitudes, which might be related to religious or other cultural beliefs.
- **Parents and mothers-in-law** may positively or negatively influence FP use among adolescent girls and young women (AGYW) by providing knowledge and information about FP or restricting this information. Also they may or may not give consent for use if that is a requirement for access to services.

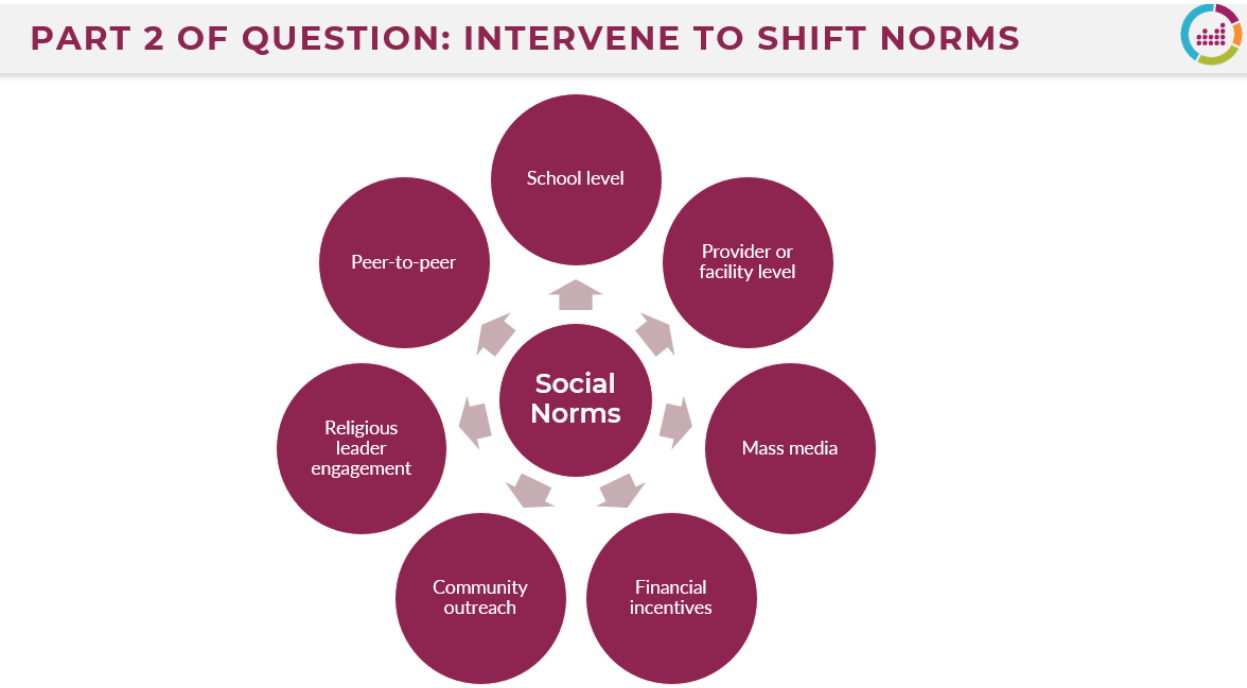
- **Peers** can be a source of information and methods. The information can be positive, negative, correct, or incorrect. Peers can also be a source of peer pressure. AGYW may develop fears about their reputations among their peers or in their communities if their FP use (or a pregnancy) becomes public.
- **Service providers** may be a trusted source of information, counseling, and methods, and a positive provider experience can lead to FP use. Married adolescents named health workers as more influential than unmarried adolescents. Service providers may also be a negative influence if they have a bias toward adolescent and youth sex, contraceptive use, or specific methods. Service providers also may not know how to provide services to adolescents and youth, and a lack of youth friendliness can affect access, adoption, and continuation.
- **Teachers and educators** can be trusted resources for information, but they might also be judgmental. They are more important for younger adolescents than for those who are out of high school.
- **Community members** exert a collective influence through cultural and religious norms that may or may not support the use of a method. Norms around age at marriage, nonmarital sex, contraceptive use, fertility, and childbearing all play a role in influencing adolescents and youth.
- **Religious leaders** are among the influential community members.

Some influencers can be more or less effective over the life course, and that can vary depending on an adolescent or young person's marital status or parity and whether or not the adolescent or youth is in or out of school. Additionally the lack of control or coercion over decisions that some young people experience may make some groups more influential. As discussed above, many of the findings for this question overlap with those for three of the other priority learning questions.

The second part of this learning question considers how to effectively intervene to shift social norms that act as barriers to adolescents' and youths' uptake and continued use of contraceptives. This was deemed a short-term question in 2018 because many programs were looking at norm change at that time. Indeed considerable evidence defines social and gender norm concepts, supports implementers to identify social norms that influence priority outcomes, and evaluates social norm change programs for adolescents and youth. This evidence contributes to the consensus in the global community that social norm interventions are a good practice. However, the evidence does not yet (and may never) fully answer the question of how to intervene programmatically to shift negative norms for several key reasons. First, norm change is a highly contextual process and will always vary based on priority outcomes, populations, and contexts, making it difficult to reach universal conclusions. Second, the published evidence finds that multicomponent programs have successfully shifted norms that act as barriers to uptake of contraception for adolescents and youths. But because those programs are multicomponent, it is difficult to determine which components are the most important or if all components are essential. Our review did find that programs that aim to shift social norms use a variety of mechanisms, including schools, providers/services, mass media, digital media, community dialogue, home visits, peer outreach, and/or mass events in communities, as Figure 3 illustrates. Finally, measurement of social norms is still novel, and norm change is not always measured similarly or at the level of an intervention. Aspects that remain to be answered include the following.

- What interventions effectively lead to norm change in specific populations and contexts? Are the impacts of those interventions sustained beyond the life of the intervention?
- What are we measuring to capture norm change? What types of measures should be used, and among whom are we measuring norm change?
- How do changing norms lead to long-term changes in behavioral or other outcomes?

Figure 3. Intervention mechanisms to shift social norms

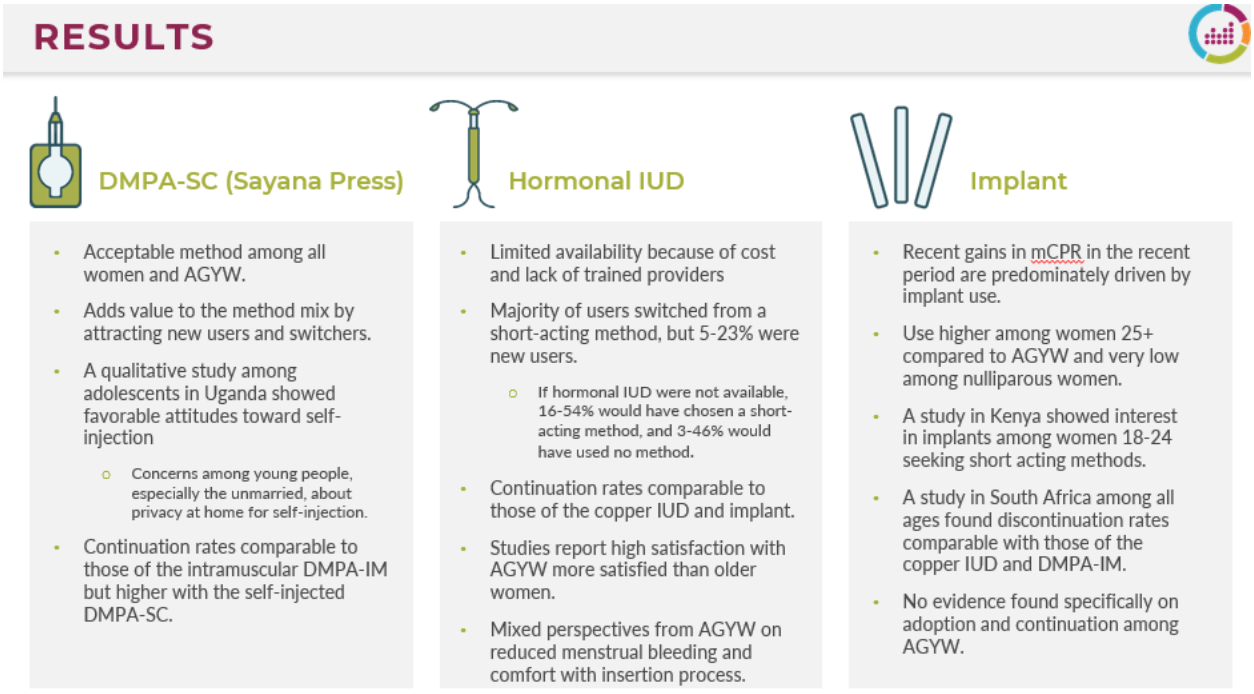


The breakout group on this topic focused on: 1) to what degree the question has been answered, 2) whether we are missing other bodies of work, 3) what questions should we be asking given that social norm change is typically part of a multicomponent program, and 4) what are the implementation research questions we should be asking about social norm interventions. The discussion was richest around what questions we should be asking. The participants raised the importance of considering context for social norm interventions and not treating adolescents and youth as a homogenous group. Participants also discussed identifying what the core components of social norm interventions are given that they are typically part of multicomponent programming. Further, an important issue was the intensity needed to change social norms at multiple levels (e.g., partner, family, and community). Another interesting point was to consider leveraging positive social norms to support strengthening the enabling environment. Other points participants raised are on pages 26-30 in Appendix A.

Short Term Question 2: What is the link between expanded method choice and adolescent and youth outcomes, such as uptake, discontinuation, and switching?

This question originally evolved out of the acknowledgment of earlier evidence showing that when an additional method is added to the method mix or an existing method becomes available to a larger percentage of the population, overall contraceptive use increases by 4–8 percentage points.[1] Recently the focus is increasingly on reproductive justice and rights. Thus development of new and accessible methods can meet the needs of young women better and address their concerns about side effects or their preferences for specific attributes (e.g., not coital dependent, nonhormonal, etc.). This review focused on how the introduction of new methods affects contraceptive use, specifically among adolescents and youth. We looked at three methods: the self-injectable subcutaneous depot medroxyprogesterone acetate (DMPA-SC), such as Sayana Press; the hormonal intrauterine device (IUD), also known as the levonorgestrel intrauterine system (LNG-IUS); and the implant. The review examined evidence around the acceptability of these methods, who adopts them, whether users are switching from other methods, and their continuation rates among adolescents and youth. Few studies specifically reported adolescent and youth acceptability and use, and those that did focused primarily on the DMPA-SC. Our review included 26 papers on the DMPA-SC, 17 papers on the hormonal IUD, and 8 on the implant. The main findings are summarized below.

Figure 4. Method introduction for the DMPA-SC, the hormonal IUD, and the implant



Many studies have established the DMPA-SC's acceptability among women of all ages and that its use has been increasing among married and unmarried women. An increasing percentage of young women also have been adopting the method. In pilot studies over 40% of new doses were given to women under 25 years old.[2] DMPA-SC also adds value to the method mix by attracting new users in addition to attracting women to switch from the intramuscular depot medroxyprogesterone acetate

[1] Ross, J., & Stover, J., 2013.

[2] Stout, A., et al., 2018.

(DMPA-IM) injected by a clinician. Several studies show high rates of new users adopting DMPA-SC. In a study using population-based data from Burkina Faso and Uganda, DMPA-SC was the first method used by a majority of users of all ages.[3] Those women who did switch to DMPA-SC generally changed from a less effective method.[4] A noteworthy attribute of DMPA-SC is the ability to self-inject it, but initially there was uncertain about the acceptability of self-injection, particularly among younger women. At this point the feasibility and acceptability of self-injection for DMPA-SC has been well documented for all ages, and evidence shows that adolescents also have favorable attitudes toward self-injection. However, adolescents raised concerns about privacy at home with self-injection, especially for those who are unmarried. Continuation rates are comparable to those of DMPA-IM but have been seen to be higher when self-injected, especially among women 18–24 years old compared to older women.

Availability of the hormonal IUD is limited in low- and middle-income countries due to cost and a lack of trained providers. Evidence shows a potential for the hormonal IUD to attract new users as 5–23% of users are new,[5] but it largely appeals to women who want to switch from a short-acting method to a longer-acting one. Continuation and satisfaction rates for the hormonal IUD are comparable to those of other long-acting reversible contraceptives (LARCs). One study found that women under 25 years old were more satisfied with the method than older women.[6] Among adolescents, reduced menstrual bleeding was seen as both a positive and a negative side effect, and they shared mixed perspectives about their comfort with the insertion process. Overall most hormonal IUD users are married, older than 25, and have children, but the method has the potential to appeal to younger users. In Madagascar and Kenya a notable minority of users are under 25 years old.[7] The Hormonal IUD Access Group was created to gather governments, donors, researchers, and other stakeholders together to collaborate to expand hormonal IUD access in low- and middle-income countries. The group developed its own learning agenda, and in 2022 Rademacher and colleagues published a paper summarizing their key findings.[8]

It is notable that overall increases in contraceptive use have been attributed to increases in implant use. Overall, implant use is higher among women over 25 years old with low use among nulliparous women. However, a study in Kenya showed interest in implants among women 18–24 years old, and those who adopted the implant had higher continuation rates than those who chose a short-acting method. A study in South Africa found implant discontinuation rates were comparable with those of the copper IUD and injectables. Our rapid scoping review did not find evidence specifically on adoption and continuation of the implant among AGYW.

The breakout group on this topic focused on: 1) to what degree the question has been answered, 2) whether we are missing other bodies of work, 3) what questions should we ask next to build on this evidence, and 4) how can studies on new methods better include adolescents and youths. In the

[3] Anglewicz, P., et al., 2021.

[4] Anglewicz , P., et al., 2021.

[5] Rademacher, K. H., et al., 2022.

[6] Danna, K., et al., 2022.

[7] Rademacher, K. H., et al., 2022.

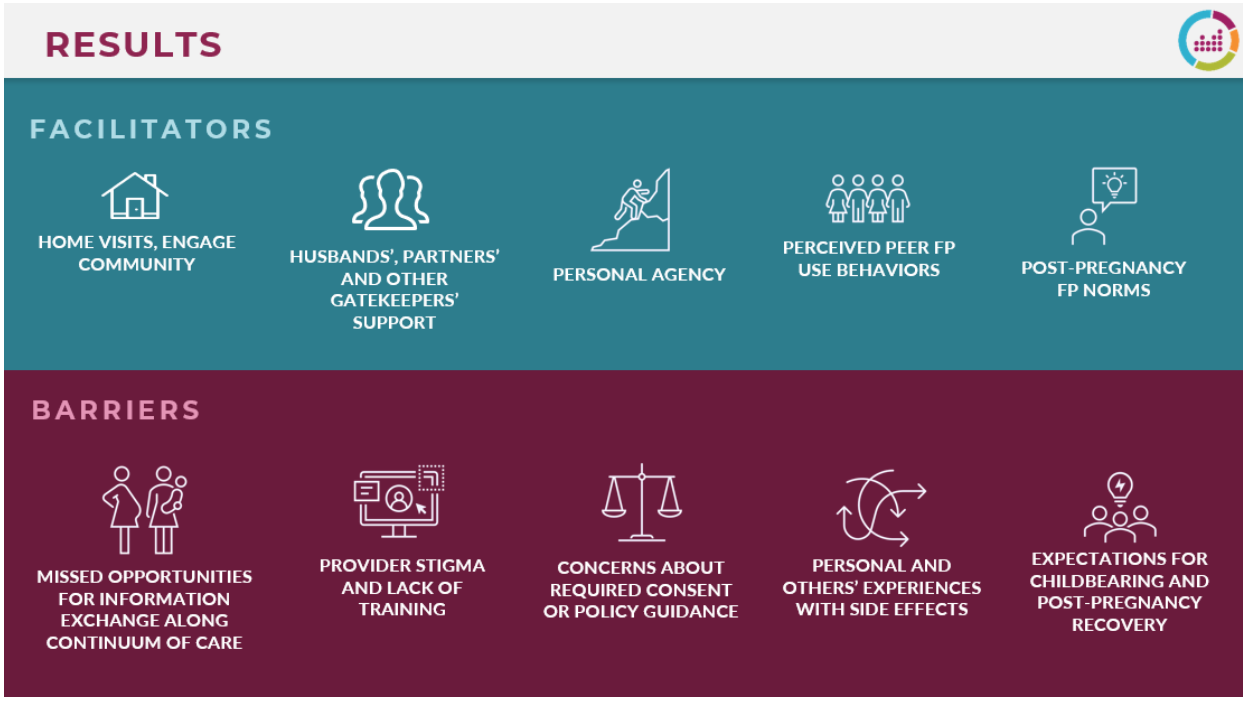
[8] Rademacher, K. H., et al., 2022.

discussions it was apparent that participants felt that while acceptability of the methods among adolescents and youth has been demonstrated, more information is needed on adolescent and youth adoption and continuation. In addition participants made the point that adolescents and youth are not homogenous, therefore we need studies among different groups by marital status, parity, and other variables. Further, discontinuation is not a negative outcome among adolescents and youth since they are at a time in their lives when they should be testing new methods and may have evolving fertility and FP desires and intentions. Finally, participants raised the importance of ensuring that removal services are available, including adolescents and youth, when new methods are introduced. More input from the participants is on pages 31-35 in Appendix A.

> **Medium Term Question 1:** What are the influencing factors—facilitators (e.g., social norms, champions, cultural factors) and barriers (e.g., FP stigma)—that influence the timing of postpartum or postabortion family planning uptake and method selection among post-pregnancy adolescents and youth?

This review examined new evidence since 2015 on facilitators and barriers to postpartum FP (PPFP) and postabortion FP (PAFP) for adolescents and youth. We reviewed the FP HIP briefs Immediate Postpartum Family Planning and Postabortion Family Planning and their reference lists and undertook a Google Scholar search of relevant articles. The evidence in our scoping review included 28 studies and programs focused on postpartum (n = 20) or postabortion (n = 8) contraceptive use. About half of the postpartum studies were adolescent- or youth-specific, whereas only a third of the postabortion ones were. We included the evidence from all ages because many of the influencing factors were the same for women of all ages, adolescents, and youth. The evidence came from a variety of country contexts and included qualitative and quantitative data. The main findings are summarized below.

Figure 5. Facilitators and barriers to adolescent and youth postpartum and postabortion FP use



We identified numerous barriers and facilitators associated with PPFP and PAFP. Some of the key facilitators to PPFP and PAFP use can also be barriers, for example, husbands, partners, and families can serve as both barriers and facilitators to use. We found facilitators and barriers at the institutional, community, interpersonal, and individual levels. Findings related to facilitators and barriers are useful for designing and testing multicomponent interventions to address these factors.

The facilitators identified include the following.

- **Home visits and community engagement** ensure that approaches are tailored to the context (rural/urban) and sphere of influence of young pregnant women or first-time mothers.
- **Husbands, partners, and other gatekeepers, including mothers-in-law and other family members,** are important influencers who affect a young pregnant or postpartum woman's decision-making on contraceptive use.
- **Personal agency** in young women leads them to be more likely to use FP in the postpartum and postabortion periods. In some contexts young married women have more comfort/agency to use FP, whereas in other contexts young married and pregnant women lack the agency to make these decisions (i.e., decision-making power rests with their husbands).
- **Perceived peer FP use behaviors** influence young people's own behaviors, as with contraceptive use at first sex and last sex and current use. We found perceived norms and behaviors of peers are associated with PPFP intentions and peers are a key source for information on FP (positive and negative) among young people.
- **Post-pregnancy FP norms** influence young women's PPFP use. For women of all ages, perceived norms are more important than sociodemographic characteristics. A woman's perceptions of the community's approval of PPFP use is more predictive of PPFP intentions than the perceived approval of people in her network.

The barriers identified include the following.

- **Missed opportunities for information exchange exist along the continuum of care**, such as times of antenatal care, institutional delivery, postnatal care, and immunization services. More discussion of FP along the care continuum is linked with greater PPFP use (i.e., a discussion with a provider is a facilitator).
- **Provider stigma and lack of training** are common with adolescent and youth contraceptive use (not just PPFP or PAFP). Provider stigma toward young pregnant women (married and unmarried) affects postpartum and postabortion care. Young women also experience stigma toward specific methods considered not appropriate for them (e.g., injectables and/or LARCs) and a lack of privacy and confidential services.
- **Concerns about required consent or policy guidance** emerge when providers lack guidance at the facility level on the provision of services to young and unmarried clients. For women of all ages, providers may require the consent of the husband/partner for PPFP provision or think consent is required at their facility.
- **Personal and others' experiences with side effects** are important barriers to adolescents', youths', and all women's contraceptive use. Personal or peer experiences with

and myths and misperceptions about side effects can discourage FP use in the postpartum or postabortion period.

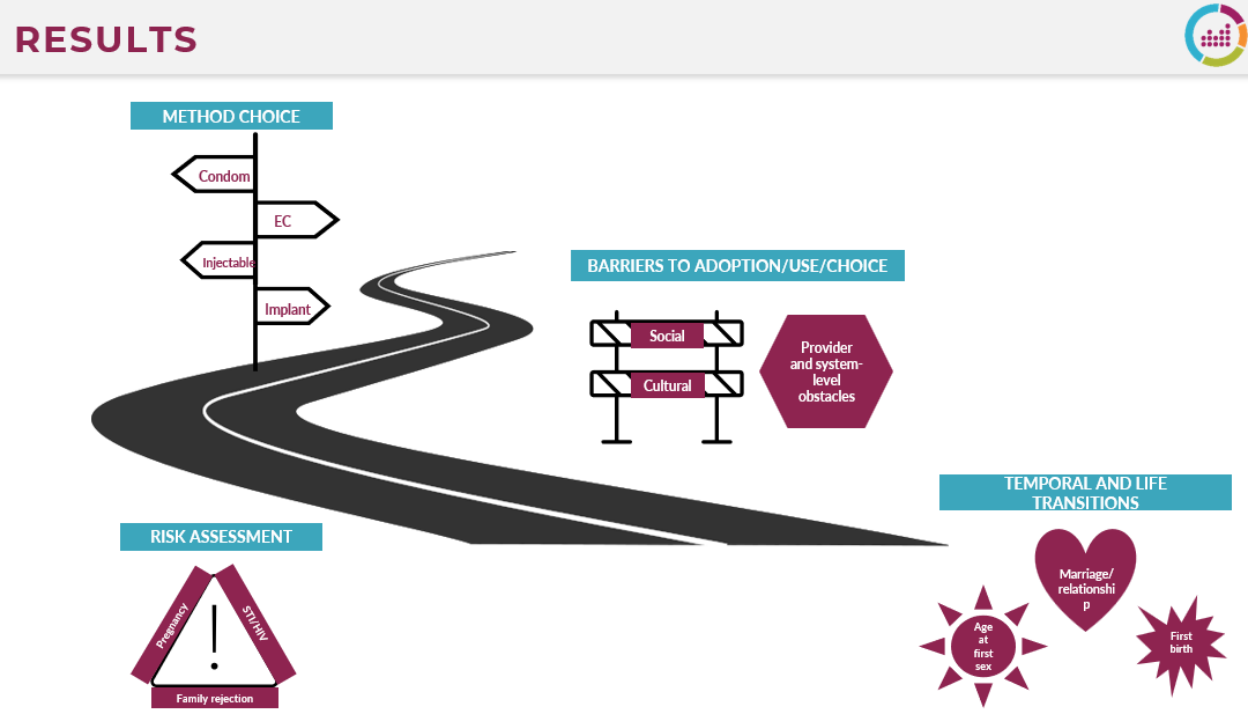
- **Expectations for childbearing and post-pregnancy recovery**, such as social pressures for immediate birth post marriage for young women or negative beliefs about the acceptability of contraceptive use postpartum for women of all ages influence FP use. In addition beliefs that unmarried young women should not be having sex may lead to early marriage and early pregnancy.

The breakout group on this topic focused on: 1) to what degree the question has been answered, 2) whether we are missing other bodies of work, 3) what questions should we ask next to build on this body of evidence, and 4) how is this information used to influence programs and policies. Participants pointed out that while evidence exists, it does not necessarily examine married and unmarried pregnant women separately, and they would have different barriers and facilitators. Further, we need to consider transitions in the postpartum period from the lactational amenorrhea method to more effective methods among young women. Finally, participants discussed the stigma around abortion and PAFP and the need to examine it separately from PPFP barriers and facilitators. Other issues raised are on pages 36-40 in Appendix A.

Medium Term Question 2: What can we learn from a "pathway" to method choice for adolescents and youths? What drives family planning decisions? What makes an adolescent girl/youth choose a specific method?

This question about pathways to method choice among young people encompasses a number of areas that relate to adoption of a method, barriers to contraceptive use, and barriers to receiving a method of choice. As this is a broad question, for the scoping review we decided to focus on adolescent and youth decision-making, timing of adoption, and method choice. We searched Google Scholar and PubMed using key terms related to method choice, pathway, FP, decision-making, and adolescents and youth. The review also included FAFC papers on the topic. Lastly the team reviewed the HIP brief Knowledge, Beliefs, Attitudes, Self-efficacy for relevant resources. In total we found 121 articles, 38 of which were excluded as not applicable, and examined the remaining 83 in greater depth. Figure 6 summarizes the main findings.

Figure 6. Factors that influence adolescents and youths along the pathway to method choice



Numerous key factors influence adolescent and youth decision-making about contraceptive adoption, contraceptive continuation, and method choice. These factors fit into four broad categories: 1) temporal and life transitions, 2) risk assessment, 3) barriers to adoption/use, and 4) method choice.

The temporal and life transition factors include age at first sex (and relationship status at first sex), marriage and relationship status, and experience of a first birth. For example, a young woman who is having early or nonmarital sex (or first sex) is likely to choose a different method (e.g., condom or emergency contraception [EC]) than a young woman whose first use is after her marriage or first birth (e.g., injection or injectable).

Some young women, particularly those who are not yet in a union, choose whether or not to use a method and which method to use (including abortion) based on their risk assessment of pregnancy, sexually transmitted infection/human immunodeficiency virus (STI/HIV), and the response from their families. This risk assessment is closely tied to the social and cultural barriers these young people feel to having premarital/nonmarital sex. Each factor influences decisions about sexual activity, about whether to use a contraceptive method, and about what method to use. Additionally some young women worry about side effects, which might influence their decisions whether to use FP and which method to use.

Social and cultural barriers also influence young married women's decision-making, especially when they are expected to have a birth immediately following marriage. These social and cultural barriers are also found at the provider level when providers impose restrictions on young people's use based on their own personal perspectives. Additional barriers include gaps in knowledge about

methods or access to methods among young women (married and unmarried) and other system-level obstacles.

All these factors influence decisions concerning the timing of adoption, which method is chosen at first use, continuation, and switching. Specific method choices are also influenced by method features and related desires, knowledge of contraceptive methods, preference for traditional methods, frequency of sexual activity, source options/preferences, partner influences, location, income, social and relationship influences, and age.

Pathways are useful to learn about method choice influences as there are different patterns and influences at different stages of life. One analysis of trajectories of young women's use reported[9] that some women use a short-acting method at first or early sex. Others who first use a method after a first birth are more likely to adopt an injectable or a LARC, which reflects their increased access to these methods following a birth. Many of these influences and their prioritization may vary over the life course. Information on trajectories can be useful in designing programs for adolescents and youth. For example, program decisions may vary depending on whether the target is young unmarried girls or postpartum young women.

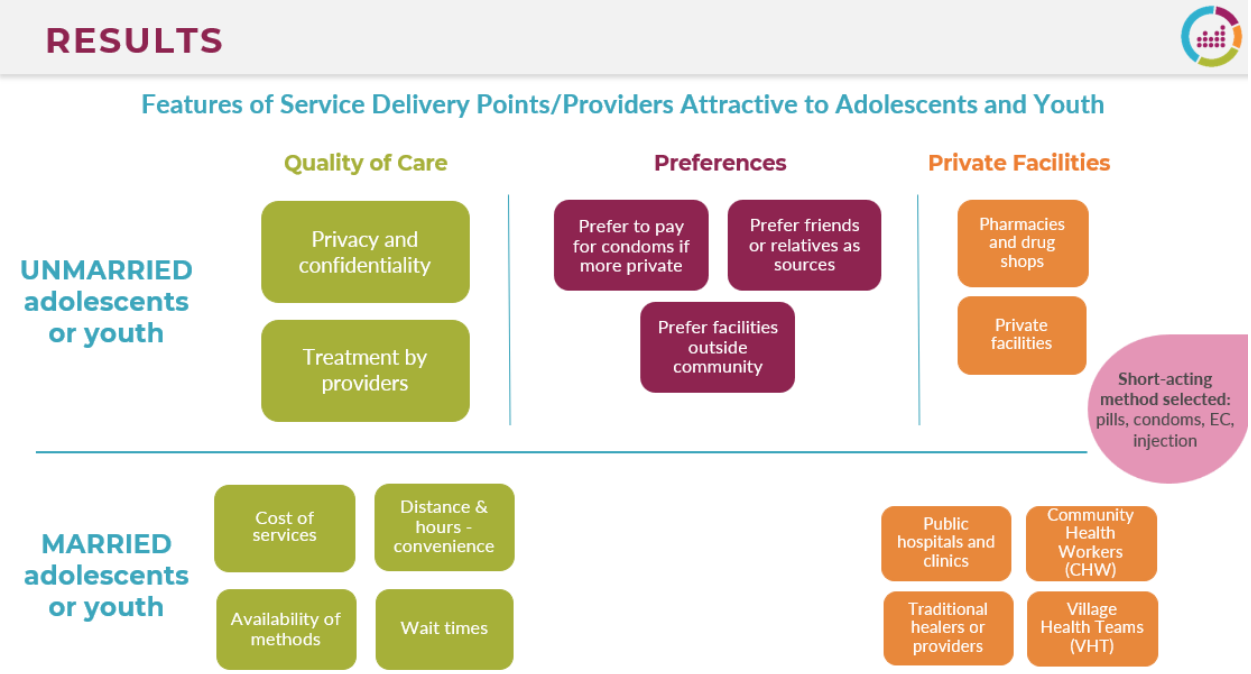
The breakout group on this topic focused on: 1) to what degree the question has been answered, 2) whether we are missing other bodies of work, 3) what these lessons around pathways to method choice mean for programming, and 4) how does (or how can) evidence around pathways to method choice influence program and policy design. During the discussion participants again raised the issues of adolescents and youth being a heterogenous group and the need to consider how these pathways vary across different contexts and among different groups of young people by marital status, parity, education, and so on. Participants noted that these pathways may also reflect access to methods and the acceptability of various sources. Further, the participants highlighted that the discussion of pathways to method choice ignores that some young people may be dissatisfied with their current method, thus current use does not reflect full choice. Additional participant input is on pages 41-45 in Appendix A.

Long Term Question 1: What features of service delivery points and/or providers are attractive and important to young people when seeking contraceptive advice and services? And how does this influence method choice?

The rapid scoping review for this question began with a number of FAFC papers related to the features of service delivery points and providers and the HIP briefs Adolescent-Responsive Contraceptive Services, Community Health Workers (CHW), and Pharmacies and Drug Shops and their references. We reviewed similar articles and searched PubMed with relevant search terms. In total we reviewed 530 titles and abstracts, resulting in 31 articles of interest that included qualitative, quantitative, mix-method studies and reviews. Figure 7 summarizes the main findings.

[9] Calhoun, L. M., Mandal, M., et al., 2022.

Figure 7. Features of service delivery points and providers that are attractive to adolescents and youths by marital status



Adolescents and youths value privacy and confidentiality as important aspects of service quality. In some contexts adolescents and youth have chosen pharmacies, drug shops, and private facilities due to perceived privacy and confidentiality at these service delivery points. Adolescents and youth are also concerned about poor treatment by providers, and these fears or their experiences with poor treatment may cause them not to visit a facility. Positive provider behaviors, such as a friendly and helpful demeanor and trustworthiness, along with provider competency in communicating contraceptive effectiveness and side effects are important to adolescents and youth. The preferred features and characteristics of service delivery points and providers varied among adolescents and youth based on marital status and pregnancy experience. The service delivery points adolescents and youth choose influence the method of contraception they may ultimately use. For example, when young people choose pharmacies or drug shops because of concerns around privacy and confidentiality, they often have access to only short-acting methods. Many other service delivery point characteristics, including method availability and provider counseling processes, also influence the methods adolescents use.

The breakout group on this topic focused on: 1) to what degree the question has been answered, 2) whether we are missing other bodies of work, 3) what questions should we ask next to build on this body of evidence, and 4) how would we examine this question differently if adoption/continuation were the outcome. Participants acknowledged that when services are targeted to young women they often leave out male youth who may also have sexual and reproductive health needs. In addition they mentioned that lesbian, gay, bisexual, transgender, queer, intersex, asexual (LGBTQIA+) youth are often not considered a part of adolescent and youth sexual and reproductive health programs. A deep discussion centered on the importance of pharmacies as they provide the relevant privacy and confidentiality young people desire and considered whether the pharmacy

model attractive to young people can be adapted for the public sector. Additional points raised are on pages 46-50 in Appendix A.

Long Term Question 2: When young people design services, how are they changed? When young people are involved in program design, what is prioritized and how does this lead to improved method choice?

The rapid scoping review for this question began with the HIP strategic planning guide Meaningful Adolescent and Youth Engagement and Partnership in Sexual and Reproductive Health Programming, which defines "meaningful adolescent and youth engagement" (MAYE) and partnership as an "inclusive, intentional, mutually-respectful partnership between adolescents, youth, and adults, whereby power is shared, respective contributions are valued, and young people's ideas, perspectives, skills, and strengths are integrated into the design and delivery of programs, strategies, policies, funding mechanisms, and organizations that affect their lives and their communities, countries, and the world."

An initial search of Google Scholar and PubMed using such terms as "engaged," "design," "involve," and "leader" among others resulted in 57 studies. We included 39 of those studies in the final scoping review. The identified publications included qualitative and quantitative studies and focused on adolescents and/or youth. Most focused on young people's engagement in the design phase with less focus on how this relates to outcomes.

As discussed above, the WHO has been in the process of updating the Adolescent Contraceptive Guidelines for 2024. The WHO guidelines ask, "Does meaningful engagement of adolescents in the design, implementation, and/or monitoring of programmes increase adolescents' new or continued use of a modern contraceptive method and/or their contraceptive method of choice?" Notably, the WHO review only focused on adolescents, whereas our scoping review included both adolescents and youth.

The evidence review for the WHO guidelines focused on quasi-experimental designs or randomized control trials. Given that the quantity and strength of the evidence were not sufficient for a strong recommendation but the consensus that interventions that include meaningful youth engagement confer more benefits than harms, the WHO Guideline Development Group proposed a good practice statement in the draft guidelines: "Adolescents should be meaningfully engaged in the design, implementation and/or monitoring of programs."

The FAFC review included a broader range of articles and found that it is possible for programs to meaningfully engage adolescent and youth participation to help make programs more culturally appropriate to the target audience. That said, we identified barriers to adolescent and youth engagement, including concerns about confidentiality, cultural taboos, and culturally appropriate communication mechanisms.[10] Gaps remain in understanding the degree to which engagement is "meaningful," outcomes related to MAYE, the most appropriate ways to engage young people, and

[10] Lassi, Z. S., et al., 2022.

whether the engagement contributes to improved outcomes related to contraceptive method use and choice.

Evidence from studies that engaged youth in community-based research to identify barriers to health seeking broadly (i.e., not focused on sexual and reproductive health) showed that young people were able to collect the data and design relevant interventions and research studies based on their findings. This type of adolescent and youth engagement in research and programs improved the programs' responsiveness to youth needs and preferences and supports the development of more culturally appropriate research and programming. While we lack evidence of the impacts of engaging adolescents and youth at all phases of the design, implementation, and evaluation process, this research suggests that young people can be meaningfully engaged throughout the process, including during the research and evaluation stages.

The breakout group on this topic focused on: 1) to what degree the question has been answered, 2) whether we are missing other bodies of work, 3) what questions should we ask next to build on this body of evidence, and 4) what is needed to have answers to these questions in the next three to five years. Participants agreed that we lack enough evidence to understand how MAYE affects sexual and reproductive outcomes. As with some of the other questions, participants acknowledged that MAYE might need to differ depending on which types of adolescents and youth we wish to engage (e.g., married/unmarried, nulliparous/parous). Participants also discussed the need to engage male youth in sexual and reproductive health programming. Additional issues raised are on pages 51-55 in Appendix A.

Part III: Moving forward with an updated Global Learning Agenda

A key objective of the virtual workshop was to set the stage for the development of an updated Global Learning Agenda. This new iteration of the learning agenda will have a broader scope than the original one, which focused on expanded method choice among adolescents and youth, and will encompass adolescent contraception access, choice, quality, and equity. An updated learning agenda that identifies a common set of questions will encourage the adolescent and sexual and reproductive health community to work together to advance the field, reduce duplication of effort, and consolidate resources for priority questions.

All six priority questions discussed during the virtual workshop generated an impressive amount of evidence and learning. Notably they produced a strong understanding of what and who are the influences, influencers, and drivers for adolescents and youth as they decide to seek services, what services they seek, and from where they seek them.

Looking forward to what questions should be included in the updated learning agenda, a few themes for further learning emerged across the six breakout discussions.

- **Adolescents and youth are a heterogenous group.** Future programs and research need to better distinguish programming approaches and results by marital status, parity, age (particularly for younger adolescents), sexual and gender identity, and disability status. In addition more work is needed in key underserved geographies and contexts, such as emergencies.
- **Data disaggregation is essential.** Data on young people need to be collected and presented in a manner that disaggregates by age group, sex, marital status, and parity if feasible. PPFP and PAFP also need to be examined separately.
- **Priority learning questions that examine boys and young men as contraceptive users are needed.** The analyses of the six priority questions included boys and young men as influencers, but none of the questions explicitly examined their own needs, preferences, and desires.
- **It is important to consider contraceptive access and method choice along the life course.** Young people have different needs over the life course. Therefore contraceptive adoption, switching, and discontinuation are part of a normal process because they may reflect diverse attributes of methods pertinent at different phases of the life course.
- **Measures of adolescent and youth contraceptive use, needs, wants, and desires need to be more person-centered.** With an increasing focus on supporting adolescents' and youths' access to and use of contraception when or if they so desire, new measures are needed to assess their preferences for a method (or not), their satisfaction with a method, if they are using, and if they are using with full, informed, and free choice.
- **Studies need to assess the impact of MAYE on relevant outcomes.** Engaging young people in program cocreation has made excellent progress. The time is right to evaluate if and how this cocreation leads to improved (or not) outcomes and the processes that are most effective for positive change.

- **Process evaluations and implementation research are needed to understand how to make effective strategies for adolescents and youth sustainable and scalable.** To date many pilot programs have shown evidence related to adolescent and youth contraceptive use. Now is the time to identify core components related to fidelity and replication of effective adolescent and youth programs that can be sustained and scaled beyond the small pilot setting.
- **Studies that assess the success of novel service delivery strategies that meet privacy and confidentiality desires of adolescents and youth are needed.** Some young people prefer to obtain FP methods at pharmacies or in the private sector because of privacy and confidentiality. Future studies should test novel approaches (e.g., digital health, self-care) that meet these service delivery preferences.
- **We need to identify the essential elements of interventions to shift social norms.** Effective norm-changing interventions are targeted to specific communities and are often part of multicomponent programs. Identifying essential elements of these programs for future norm-changing programs can importantly inform social norm change interventions globally.

Some of the crosscutting themes from all the discussion groups are summarized above. The full list of discussion inputs from the breakout group Mural boards is in Appendix A.

As a next step the USAID MOMENTUM Country and Global Leadership project will lead the development of an updated Global Learning Agenda. A diverse advisory group will create criteria to guide the prioritization of learning questions. Next this advisory group will distribute a survey to gather input and ideas for learning questions to be included in the updated learning agenda. The advisory group will then use the results of the survey to develop a consolidated list of questions and will hold virtual consultations to discuss and refine the proposed learning agenda questions. Finally, the advisory group will score the final group of questions to determine which final learning questions will form the updated Global Learning Agenda.

Appendix A. Mural Boards

(SEE NEXT PAGE)

Appendix A. Mural Board Discussion Questions

Following the six presentations, participants divided into breakout group discussion sessions that the presenters facilitated to delve deeper into each learning question. FAFC asked participants to share other evidence they were aware of that responds to any of the priority learning questions and reflect on which questions have been sufficiently answered and which are important to take forward. The breakout groups were interactive, and we used Mural boards to gather contributions. This appendix shares the questions discussed in each group and the contributions from participants on the Mural boards.

Each group addressed four discussion questions, which are displayed at the top of each page. The discussion questions in green are questions common across all six learning questions, and the questions in maroon are specific to that learning question.

Participants' comments, questions, and resources follow. The comments in bold are ones multiple participants deemed important, indicated by adding a "thumbs up" to the comment.

Short Term Question 1 Mural Board Responses

Who is influential (e.g., parents, peers, community members, service providers, etc.) at affecting adolescent and youth adoption and continuation of an FP method, and how does this differ across a young person's life course? How do we intervene programmatically to shift negative community norms at the household, community, and provider levels that pose ~~as~~ barriers to adolescent~~s~~ and youth uptake and continued use of modern contraception?

To what degree has this question been answered; which parts remain to be answered?

- The community piece has not yet been answered and is a difficult one. Goes against our “traditional” research question, rarely ties back to outcomes due to issues with attribution; needs longitudinal research to really illustrate change over time.
- Some progress on who is influential, but still gaps around the second part of the question.
- **The second question needs investment (from donors!) in longer term research, but we as a field need to do better at identifying intermediate signals of norms change, since this kind of change does take a while.**
- Measurements of social norms are challenging.
- Questions should start with policy goal in mind (involvement of government).
- Influence of social media.

Are there bodies of work that are missing for answering this question?

- **Research/publications/gray literature on social norms diagnosis using standardized tools (SNET, SNAP, etc.).**
- Work in the abortion sector on addressing stigma using Values Clarification for Action and Transformation (VCAT) and “Providers Share Workshop” can also be useful.
- A lot of work in the humanitarian sector exists, but it is not specific to FP.
- This resource isn’t focused on norms but does link social behavior change (SBC) interventions to attitudes and communication and then to contraceptive use.
- Need to think about intersectoral health promotion.
- There is still a general lack of understanding of social norm shifting as different from SBC. Many programs lean heavily on SBC as a sole component to social norm shifting, when it is only one piece.
- Different social norms outcomes in different health areas.
- Passages did a series of consultations on this in 2019 and published a white paper on how to bring together the SBC and social norms worlds.

What questions should we ask next to build on this body of evidence?

- How can we tackle online misinformation on SRH?
- Can anything be learned in short term research re: shifting community norms and if yes, how can we make this a mandatory component to all research?
- **Is it really the norms that are different from context to context or how deeply they are felt and how they are actualized? Let's be specific to what it is that we want to influence. Often many norms are quite similar from context to context (unmarried adolescent sex is taboo, youth struggle to talk with their parents, etc.).**
- **What are the core components of social norm change interventions? Need rigorous evidence on this, e.g., through adaptive trial designs.**
- Need to talk about PRINCIPLES of SBC, as the programmatic interventions need to vary.
- How can we examine and shift norms ethically (in partnership with communities)?
- Which influencers are most important to engage for which norms for which adolescent or youth populations?
- **What level of intensity is required at different levels (partner, family, community) to shift norms?**
- Passages Project provides helpful guidance on components of norms-shifting interventions; new social norms HIP brief is also a helpful resource.
    - Need more clarity on what these core components are.
- How can we be more precise about adapting existing findings to new contexts; how can we know if an intervention that worked in X geography will be expected to will work in Y geography?
- We may need to start our social norm work "at home" in that our work with other sectors often illuminates negative social norms held among our collaborators, or at least many do not support positive social norms re: ASRH. This can make cross-sectoral work a challenge. This includes our education, workforce development, and humanitarian colleagues.
- Leveraging positive existing social norms – not just seeing them as always a barrier but also as positive opportunities to create enabling supportive environments for healthy adolescents.
    - **Are there positive norms that we can build on/leverage?**
- How can governments effectively work to address social norms?
- **Are there other intermediate 'signals' of norms change that we can use to both learn from and use to support further investment in longer term research?**
    - Yes! The Social Norms Collaborative published a Guidance note on this.
- How do we get norms shifting out of the "exclusively research" space and into implementation such as service delivery programming?
- **We need to consider who conducts, analyzes, and disseminates community norm research (e.g. local research organizations).**

How is this information used to influence program and policies?

- Understanding misinformation and its effects can lead to a regulatory response.
- Not quite sure if community norms have had much success in policy formulation/changes. However, policies are not always enough and need to consider issues related to implementation (e.g., child and early first marriages and unions (CEFMU), female genital mutilation (FGM)).
- Work that tries to shift social norms around adolescent pregnancy, premarital use of contraception, etc. often are politically polarizing and can be challenging to get consensus on in some contexts.

Short Term Question 2 Mural Board Responses

What is the link between expanded method choice and adolescent and youth outcomes, such as uptake, discontinuation, and switching?

To what degree has this question been answered; which parts remain to be answered?

- **Not well answered yet due to challenges of longitudinal research.**
- Generally answered and we see more countries adopting more options.
- **The question has been answered, but for a snapshot in time as the field is ever evolving…we have to find a way to continue to ask it.**
- I think the question has been answered to some extent, but I think we need more on how adolescents make their choices.
- **Acceptability for adolescents and youth has been answered, but outcome data on uptake compared to adult women is needed, especially for implant/IUD in LMICs.**
- **Really do not know enough about younger adolescents. Most research ends up being 18+ (or under 25, in many cases) which does not always capture younger adolescents.**
- **Differs by category of adolescents (married, unmarried, etc.).**
- More can be learned about continuation and switching. Particularly linking with menstrual health management and bleeding changes, in how that impacts girls' lives.
- **The question has been answered. But reasons for switching and discontinuation sometimes go beyond side effects. There may be other social issues related to access and fear of becoming infertile.**
- We should also consider a young person's agency and resilience in making these decisions.
- **Does the review consider/capture whether the contraceptive method introduction employed specific strategies to ensure access for adolescents? Method introduction is complex, so that may not always be an intentional component.**
- Discontinuation in Northern Nigeria is linked to religious and social norms for Muslim girls due to bleeding (side effects of hormonal methods).
- Discontinuation in Solomon Islands in the Pacific is linked to social norms about fidelity and thus no need when husband is engaged in manual labor abroad.

Are there bodies of work that are missing for answering this question?

- Consider looking at new evidence from HIV prevention/PrEP (Catalyst study) which also examines method choice for AGYW.
- There is some evidence on switching from DMPA SC in Nigeria done in the private and public sector that you may want to check in terms of predictors for continuation. Available here & here.
- **I wonder if we should question discontinuation as an issue for adolescents. Being provocative here, but I would think that young women and girls should be encouraged to explore different methods, cycle through them and find out what methods suit them under what circumstances. Adolescence and youth is a period of rapid change and it seems to me that contraception should change along with other circumstances. Maybe research should consider alternative indicators of agency and choice than looking at discontinuation.**
- To what extent are national policies restricting access to new methods for adolescents and youth.
- Barriers to uptake/access of new methods for adolescents and youth from the provider side.
- In addition to choice of contraceptive methods, perhaps research should explore choice in channels of accessing methods and whether expanding these channels also influences expanded use and switching in a way that empowers/provides greater agency to adolescents. We know adolescents frequently prefer private channels or those that tend to their needs more carefully.
- Are self care interventions more enabling for youth method continuation and uptake?
- Frequency of sex and multiple partners are missing pieces of information. Are we assuming serial monogamy?

What questions should we ask next to build on this body of evidence?

- More data needed on implants, since use is high, but we don't have evidence on adoption and continuation among AGYW.
- **Do we know enough about availability of removal services for IUDs and implants to understand factors that are underpinning continuation? In many settings there are barriers to removal that need to be understood and addressed.**
- Continuation and switching.
- **Access to implant removal services and approaches to encourage switching.**
- **I think we tend to assume that switching, stopping, etc. are negative outcomes. I would also like to see more work on the positive side or "good reasons" such as desiring pregnancy, changes in relationship status.**
- Continuation, discontinuation, and switching (how is this captured in HMIS records).
- Do adolescents really understand about duration of use/mechanisms of action – and how to switch when needed?
- What it takes for adaptation of these methods in country method mix.
- Are adolescents more open to trying self-care options, including self-removal of IUDs, or use of digital tools (either methods or tools to augment their self-management of contraceptive use or telehealth to obtain prescriptions in settings where those are required).
- How can contraceptive services be further tailored to meet the specific needs of adolescents and youth, considering factors like confidentiality, provider interaction, and logistical barriers?
- We should also consider a young person's agency and resilience in making these decisions.
- **Do we have enough information about method choice, continuation, switching among AGYW with different characteristics (i.e., nulliparous vs parity one, single vs. partnered)?**
- Further disaggregated data – that is not based on age alone. Based on social and behavioral aspect (adolescents and youth are heterogenous and their method choice is based on much more than age).
- **Many of the studies asked why they chose the method but focused on features of the method – I think a part that's missing is how these methods are addressing their contraceptive needs at that point in time.**
- **Do not think we can divorce social/cultural norms in our research any longer. How can this be incorporated in a way that provides solutions to motivate uptake, continuation, etc.?**
- **With arrival of PrEP, need to study method choice holistically (FP & HIV prevention choices).**
- Need to know more about service delivery that is most impactful to uptake, discontinuation, etc. For example, combined services with HIV, MCHN, or with cross-sectoral/multi-sectoral programming.
- Impact of hormonal FP provision on iron deficiency (and related health and educational outcomes).
- DMPA with adolescents: there have been concerns about bone density and return to fertility. How does this affect national level adoption of Sayana Press, additional evidence on safety.

How can studies on new methods better include or address the needs of AGYW?

- **We have new methods being introduced (Caya Diaphram) but not sure if they are helpful due to uptake research to date.**
- I think we need more on male partner perspectives for new methods. Especially with some promise of male methods.
- Need more use of person-centered measures (beyond uptake) that take into account fertility intentions and if adolescents and youth received the method of their choice.
- **Exploring the link between person-centered counseling and care and age specific contraceptive indicators. Most of the counseling studies are somewhat older and may not factor age (though maybe this is not true).**
    - To design programs for adolescents we need to use more and more the human centered approach, to elicit participation.
- Even for married adolescents, questions around fear of STIs/HIV infection should be included re: use of a method that is not a barrier method. Do they have fears? The ECCO study taught us there are high infection and reinfection rates of those on LARCs.

Medium Term Question 1 Mural Board Responses

What are the influencing factors—facilitators (e.g., social norms, champions, cultural factors) and barriers (e.g., FP stigma)—that influence the timing of postpartum FP or postabortion FP uptake and method selection among post-pregnancy adolescents and youth?

To what degree has this question been answered; which parts remain to be answered?

- The role of community-based PPFP efforts still requires further evidence.
- At least in Ethiopia, a major challenge with PPFP is just that clients aren't asked if they want a method post-birth. There is an opportunity to strengthen adherence to the PPFP HIP!
- Re: Personal Agency as a facilitator to post-partum adoption – to what extent can/do positive youth development (PYD) interventions support and/or drive adoption? (Can we show this longer-term causal link, make the case for this broader strategic investment.)
  - Relatedly, role of PYD intervention around agency to support continuation post PPFP adoption.
- Other challenges we've seen (specific to PPFP for adolescents) in Ethiopia and Nigeria include – worries about how FP will affect breastfeeding, feeling coerced into FP after birth, a desire to use LAM for the first six months (and then no follow-up to transition to a different method later).
  - Though aren't these concerns for non-AGYW as well?
  - **Very likely, although these specifically came out from insight gathering work done only with adolescents in Ethiopia and Nigeria under the A360 project.**
- While there is significant evidence on PPFP, but what about the transition to long-term FP use? The field has remaining questions on that.
- To what degree do AGYW access any type of health services postabortion in order to give them access to PAFP?

Are there bodies of work that are missing for answering this question?

- We have a paper under review looking at a dose response effect of integrating counseling at multiple contacts along the continuum of care. Unfortunately, there were few adolescents in our sample which didn't allow for separate analysis by age.
- **I'd like to understand how PPFP and post-abortion FP use differs among married vs. unmarried girls (where expectations about future fertility might be quite different).**
  - Further info re: PPFP adoption among primiparous vs multiparous AGYW?
  - And I was also thinking about expectations of future sexual activity. Once an unmarried girl has already had 1 child, should she be expected to "know better" and not make the same mistake again – and does that translate to support for FP use or expectations to abstain from sex?
- How could we better leverage other HIPs like FP/immunization for PPFP to decrease the likelihood of missed opportunities along the continuum of care?
- **It would be good to answer PAFP and PPFP separately if we can. I think the populations are different.**
- **There is a large body of work about stigma and post-abortion care and the specific needs of adolescents. It would be good to tease our PPFP and PAFP findings separately as there are likely differences in influencers.**
- Building on a previous comment: wording means quite a bit. Would "post-pregnancy FP" be more inclusive and less stigma-producing?

What questions should we be asking given that social norm change is typically part of a multicomponent program?

- High need for research around ensuring more systematic integration of PPFP/PAFP within maternal and child health and postabortion care services. What works to influence providers and provider teams to maintain high rates of integration? (Of course this is not necessarily a social norm area, more provider behavior change.)
- **Social norm change is important no matter what – do we need to disaggregate the stand-alone impact of social norms?**
  - Except when there are pressures to generate lean interventions (absent of social norm change components?). This data might be helpful to advocate for the complex intervention design that's necessary to bring about upstream change.
- The recent Africa Faith and FP meeting had a healthy debate about the role of faith leaders in ASRH. There may be space for more work specifically about dialogues between adolescents and faith leaders and how to do this meaningfully, in ways that protect adolescent agency, and succeed in faith leaders being more supportive to ASRH, PPFP/PAFP is perhaps more palatable for faith communities?

What are the implementation research questions we should be asking about social norms?

- Adolescents have unrealistic expectations about being able to practice abstinence after an abortion. Perhaps there are innovative approaches like gamification to combat this? (Again, not a social norm approach specifically.)
- **When we think about sustainable scale, who is best placed to take forward social norm change work – is it MOHs? How can they be supported to do this work better?**
  - **What are the contextual factors that enable local ownership and sustainability of social norm change interventions' implementation over time?**
- As social norms are so context-specific, is scale the desired outcome for all norm shifting programming?
- What role does the capacity (of local actors) for adaptation (and contextualization) play in enabling meaningful impact of social norm change interventions at large scale?
- I find it counter productive to measure single or lean component interventions – what about changing the frame to be how can we better understand the potential contribution of individual components in larger more comprehensive programs and what compromises are we willing to make?

Medium Term Question 2 Mural Board Responses

What can we learn from a “pathway” to method choice for adolescents and youth? What drives family planning decisions? What makes an adolescent/youth choose a specific method?

To what degree has this question been answered; which parts remain to be answered?

- Significant literature that tells us the factors along the way to method choice for adolescents – drivers/considerations seem to be well documented.
- To a good degree.
- Still need for studies in different contexts.
- The pathways question is interesting and even if there is one paper, it may be good to repeat it in various contexts. Insights from such studies could inform programming strategies in novel ways.

Are there bodies of work that are missing for answering this question?

- Did the question look at what service points/channels adolescents primarily use to access and how that impacts choice?
- Did this question/review include youths' attitudes/preference towards specific types of methods or method attributes?
- There is a need for context-specific evidence.
- Yes, issues such as resources that may also determine which method one gets especially in African countries as well as stock out of commodities.
- **How do we assess 'choice' in the context of social norms and pressure – how does that influence one's perception of what is available to them vs. what is acceptable for them to use?**
- **Adolescents are not homogeneous group – wondering if pathways were assessed from these different perspectives?**
- Pathways don't reveal method discontent, non-use and unprotected sex, safe or unsafe abortions, journey to use for unmarried adolescents should look different than married women.

What do these lessons around pathways to method choice mean for programming?

- **Married and unmarried adolescents and youth should be targeted separately.**
- Should we be implementing programs to different life course groups?
- That programming will be challenging because there are so many different influences on method choice across the life course. There will need to be targeting to different segments.
- There is need to really consider why the young people choose particular methods and ensure that the methods are available as well as talking about some of the side effects that they may experience and how to deal with that.
- How can we meet the needs of sexually active younger adolescents in a way that acknowledges their evolving capacities?

How does (or how can) evidence around pathways to method choice influence program and policy design?

- Need to continue advocacy for addressing any potential restrictions practiced at all levels of the health system and in the private sector.
- **Would be interesting to understand what intervention points should be prioritized to promote method choice – there are many places along the pathway where one could intervene, where should we focus?**
- Coming up with policies that ensure full access to a full range of commodities is important. Having a component of a program that supports knowledge and awareness and service provision for some of the programs especially those targeting vulnerable communities will support broader access to all.

Long Term Question 1 Mural Board Responses

What features of service delivery points and/or providers are attractive and important to young people seeking contraceptive advice and services? How do they influence method choice?

To what degree has this question been answered; which parts remain to be answered?

- Not so much - provision of services alone is not enough to get the adolescents in the room.
- We could add having youth friendly centres where the young people can be free to access services without fear of stigma and of course having young service providers who can relate to the needs of the young people.

Are there bodies of work that are missing for answering this question?

- The research is heavily focused on young women and girls, is there value in expanding focus to males.
- **Are there unique challenges that are faced by sexual and gender minorities needing access to services and how can these be overcome?**
- Progressive policies that allow access to the services without restrictions and unnecessary barriers.

What questions should we ask next to build on this body of evidence?

- How supportive are laws/policies regarding distribution and what advocacy is needed?
- We know a lot about what young people want. How do we support scale-up, including policy and guidelines that support privacy and other aspects that respond to youth needs?
- Need to think about sustainability, as often results suggest that AGYW are more comfortable outside of government health systems.
- How do we meet the preferences of young people while ensuring sustainability?
- **How do we balance making service delivery points attractive with issues around scale and sustainability?**
- **How can the appealing features of pharmacies be adopted by health centers?**
- **What about younger adolescents specifically that face the most stigma and have the least choice for access?**
- **One area that really isn't integrated within SRH services is a link to protection for gender-based violence: how can this be better integrated for adolescents who may be particularly at risk?**
- How can FP service delivery points be made more attractive to male clients?
- Capacity of the providers in pharmacies.
- Some providers such as private pharmacies may be attractive because of privacy, but may provide less information to their clients – how do we improve this?
- Can long term methods be safely and effectively offered in pharmacies?
- Looking at quality of care and experience of care/preferences together.
- Thinking about integration with other services, including HIV.
- Is FP counseling in the immediate post-partum period associated with increased uptake for adolescents and young women?
- Adolescents with disability and service preference.
- How can service delivery points (SDP) be improved to be more likely to be used by adolescents – do these need to be physical sites or can we think of SDP as virtual? What are issues of consent and protection that need to be thought of if SDP are digital?

How would we examine this question differently if adoption/continuation were the outcome?

- Pharmacies and drug shops might be important entry points, so how does this relate to continuation? Are adolescents/youth later choosing to access LARCs elsewhere?
- Address some of the side effects they experience as a result of contraceptive use to ensure optimal adoption and continuation.

Long Term Question 2 Mural Board Responses

When young people design services, how are the services changed? When young people are involved in program design, what do they prioritize? How does this lead to improved method choice?

To what degree has this question been answered; which parts remain to be answered?

- Depends if married or unmarried.
- **Little information available on how meaningful adolescent and youth engagement (MAYE) affects OUTCOMES.**
  - **Need to segment – not all adolescents and youth are alike. Explore MAYE of very young adolescents, married/unmarried, postpartum/parenting, etc.**
- **In my opinion, I don't think this question has been adequately answered.**
- Need more guidance in order to answer these questions.
- Need to connect with other groups who are doing the same work/learning.
- The world/field has changed a lot in regards to youth participation, it's always evolving.
- Can't "hurry up" and meaningfully engage youth, it takes time and resources – need clear understanding of what time/resources are required.

Are there bodies of work that are missing for answering this question?

- There is a large body of evidence on how child participation influences programs/services – can we borrow from this?
- There are a lot of human centered design (HCD) projects – as they engaged youth/adolescents, how did they measure engagement and their changes over time?
  - NOTE: Opportunity to engage the HCD Exchange group to explore this topic.
- Need to disaggregate info that we have on different groups of adolescents (married v. unmarried, racial groups, very young adolescents, etc.).
- Level of participation and involvement of youth who are at school vs. not.
- Method-specific preferences - ideal preferences vs. how do they make tradeoffs in deciding on a method?
- Forced/coerced sex – how does this impact our learning on this?
- Engagement of young men – assumption that FP is the woman's responsibility/she will know what to do, he doesn't need to know – how does this affect women's choices? How can we effectively engage young men in this discussion?
- Important to deliver evidence/guidance on *how to measure/assess* when MAYE has happened.

What questions should we ask next to build on this body of evidence? How would you reframe the questions?

- What does “meaningful” engagement mean? Are there standard definitions that implementers can use to help measure this concept?
- We should be asking young people whether they feel they’ve been meaningfully engaged.
- How do we establish accountability mechanisms for youth engagement?
- I think we also need to ask WHICH ADOLESCENTS AND YOUTH are involved in program design – is it those who are the most available/interested, or those who are representative of the group we want to reach?

What is needed to have answers to these questions in the next 3-5 years?

- Better/more investment in research on how MAYE approaches affect service platforms/design and health outcomes.
- Guidance to develop simple/streamlined monitoring tools that can capture this information (without the need for resource-intensive research studies).
- Multi-stakeholder platforms.
  - Need to consider adolescent and youth (AY) in all their diversity and engage relevant AY for project/research goals.
- Need to be more than just designing interventions, but partnerships with youth need to be maintained throughout implementation, especially with climate change.
- Clear funding and clear mandates for meaningful partnerships with young people beyond just program design.
- More advances in technology of contraception – both for unintended pregnancy prevention and STI prevention.
- More involvement of married young women who want to space births.
- Better engagement of private sector/pharmacies in advancing this work (not just formal health systems).
- Using evidence generated by young people themselves.

Appendix B. References for the scoping reviews for the six priority questions

Priority Learning Question	Pages
Short Term 1: Who is influential (e.g., parents, peers, community members, service providers, etc.) at affecting adolescent and youth adoption and continuation of an FP method, and how does this differ across a young person's life course? How do we intervene programmatically to shift negative community norms at the household, community, and provider levels that pose barriers to adolescent and youth uptake and continued use of modern contraception?	**57-76**
Short Term 2: What is the link between expanded method choice and adolescent and youth outcomes, such as uptake, discontinuation, and switching?	**77-82**
Medium Term 1: What are the influencing factors—facilitators (e.g., social norms, champions, cultural factors) and barriers (e.g., FP stigma)—that influence the timing of postpartum or postabortion FP uptake and method selection among post-pregnancy adolescents and youth?	**83-85**
Medium Term 2: What can we learn from a "pathway" to method choice for adolescents and youths? What drives FP decisions? What makes an adolescent/youth choose a specific method?	**86-94**
Long Term 1: What features of service delivery points and/or providers are attractive and important to young people seeking contraceptive advice and services? How do they influence method choice?	**95-97**
Long Term 2: When young people design services, how are they changed? When young people are involved in program design, what is prioritized and how does this lead to improved method choice?	**98-101**

Short Term 1

Who is influential (e.g., parents, peers, community members, service providers, etc.) at affecting adolescent and youth adoption and continuation of an FP method, and how does this differ across the young person's life course? How do we intervene programmatically to shift negative community norms at the household, community, and provider levels that pose barriers to adolescent and youth uptake and continued use of modern contraception?

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Short Term 2

What is the link between expanded method choice and adolescent and youth outcomes, such as uptake, discontinuation, and switching?

DMPA-SC

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Hormonal IUD

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Long Term 1

What features of service delivery points and/or providers are attractive and important to young people seeking contraceptive advice and services? How do they influence method choice?

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Long Term 2

When young people design services, how are they changed? When young people are involved in program design, what is prioritized and how does this lead to improved method choice?

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