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ASSESSING APPROACHES TO DEMAND-SIDE FAMILY PLANNING MEASUREMENT WITH A REPRODUCTIVE JUSTICE AND RIGHTS FRAMEWORK

IUSSP EXPERT GROUP MEETING REPORT, MOMBASA, KENYA

5-7 MARCH 2024

INTERNATIONAL UNION FOR THE SCIENTIFIC STUDY OF POPULATION

INTERNATIONAL UNION FOR THE SCIENTIFIC STUDY OF POPULATION (IUSSP)

Established in 1928 with over 1,800 members from 140 countries is a worldwide association for those interested in population studies. The IUSSP brings together population scientists, professionals, and policymakers from diverse disciplines and backgrounds to address key population issues.

IUSSP Scientific Panel on Rethinking Family Planning Measurement with a Reproductive Justice and Rights Lens has a mandate to engage a diverse pool of researchers, policymakers, and program planners from different regions and countries to critically examine global fertility and family planning indicators to inform improved collection, measurement, assessment, and communication about gaps in family planning programming. Its activities are funded by a grant (INV-055848) from the Bill and Melinda Gates Foundation.

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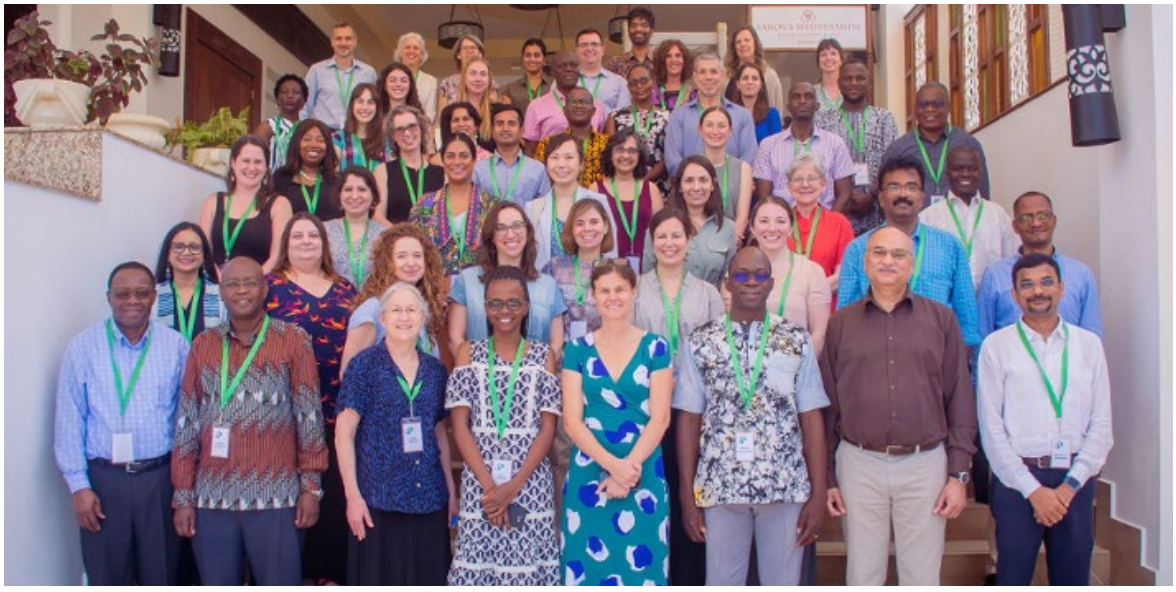
BACKGROUND

International family planning measures, such as contraceptive prevalence, unmet need and demand satisfied, serve as critical indicators for tracking progress and assessing the impacts of family planning policies and programs. Though these population-based measures are widely used and have been for decades, a strong and growing body of research offers compelling critiques, calling for clarified terminology and correct interpretation of current measures, and the development of new measures to capture important aspects of equity and person-centered preferences and behaviors.[1,2]

The International Union for the Scientific Study of Population (IUSSP) Scientific Panel on Rethinking Family Planning Measurement with a Rights and Justice Lens engaged a diverse pool of researchers, policy makers, and program planners from different regions and countries to critically examine global fertility and family planning indicators to inform improved collection, measurement, assessment, and communication about gaps in family planning programming. In May and June 2023, IUSSP hosted two webinars, the first to reflect on the history and current use of demand-side family planning indicators, and the second to explore new directions and frameworks for family planning measurement.

On March 5-7, 2024, IUSSP convened an international expert group meeting in Mombasa, Kenya, on assessing approaches to demand-side family planning measurement with a reproductive rights and justice framework. Over 50 participants attended the three-day workshop, which was supported by the Bill & Melinda Gates Foundation with funds to the IUSSP, and USAID through funds provided to the Data for Impact project. This report is a summary of the discussions. It is presented in the order of the agenda (see Appendix 1 for full agenda). The meeting was organized first around grounding frameworks and then participants examined different methodological approaches to measuring demand side measures, discussed data sources, and engaged with data users. Much of the meeting time was spent on deep discussions that are summarized in the relevant sections.



Participants at the IUSSP Meeting in Mombasa

1 Speizer, I. S., Bremner, J., & Farid, S. (2022). Language and measurement of contraceptive need and making these indicators more meaningful for measuring fertility intentions of women and girls. Global health, science and practice, 10(1), Article e2100450. https://doi.org/10.9745/GHSP-D-21-00450

2 Fabic, M. S. (2022). What do we demand? Responding to the call for precision and definitional agreement in family planning's "demand" and "need" jargon. Global health, science and practice, 10(1), Article e2200030. https://doi.org/10.9745/GHSP-D-22-00030

1.1 WELCOME AND INTRODUCTIONS

Opening Remarks

Jacob Adetunji, Bill & Melinda Gates Foundation: The International Union for the Scientific Study of Population (IUSSP) has the unique ability to bring together expert panels for intellectually stimulating scientific discussions on issues of global importance. This is one of the rewards of being a member of the Union. The theme of this meeting is timely, and the world is waiting for the outcome. The Bill & Melinda Gates Foundation Family Planning Program is evidence-driven and keen on the outcome of this meeting and its implications for programming.

Madeleine Short Fabic, Deputy Director, United States Agency for International Development (USAID) Office of Population and Reproductive Health: USAID has a long history of supporting improved family planning measurement, from the World Fertility Survey beginning in the 1970s to its ongoing leadership of the Demographic and Health Surveys Program and beyond. As we celebrate the 30th anniversary of the International Conference on Population and Development this year, it is imperative to acknowledge how far we have come and recognize how far we still have to go to achieve the program's action. Two ideas will help to maintain focus on measuring complexity better to improve family planning policies and programs: first, what gets measured gets done; and second, not everything that counts can be counted, and not everything that is counted counts.

Mary Ellen Zuppan, Executive Director, IUSSP: With over 2,000 members from 140 countries, IUSSP is the largest international professional association for individuals interested in population studies. It is best known for the International Population Conference (IPC), held every four years, the next of which will be in 2025 in Australia. In between the conferences, IUSSP organizes international scientific panels on various topics to expand knowledge, test new methods and ideas, and advance the discipline. Participants were welcome to submit papers for the 2025 IPC by September 15, 2024. Those not yet members of IUSSP were invited to join the union.

Meeting Objectives

Elizabeth Sully, Principal Research Scientist, Guttmacher Institute

The panel came about because of frustration with how conversations about measurement of family planning were happening, and the need to go beyond critiquing to creating change, with the inclusion of diverse voices. The panel's Steering Committee is co-chaired by Ilene Speizer and Beth Sully. Over 120 submissions were received for the meeting and the panel reviewed all submissions to identify those that best reflected the theme of the workshop.

The IUSSP Panel's objectives are to:

- Engage a broad set of stakeholders to examine strengths and limitations of current family planning indicators;
- Identify and assess new and modified indicators with a rights and justice lens, including identifying opportunities for further testing and validation;
- Collaboratively develop a set of recommendations for what measures to keep, what to eliminate, what to modify, and what to adopt to strengthen family planning measurement; and
- Present and communicate recommendations to inform diverse global family planning stakeholders.

This meeting is part of the second objective, aimed at assessing new indicators and opportunities for further measurement development.

Specifically, the objectives of the Expert Panel meeting in Mombasa were to:

- Convene researchers, program implementers, policymakers, advocates, and other civil society members to examine measures and measurement approaches with a reproductive rights and justice lens.
- Identify measures that can be used to assess family planning progress, opportunities, and gaps in a way that is reflective of individuals' self-identified needs and goals (i.e., person-centered).
- Discuss ways forward to advance global family planning measurement.

Participants' objectives for the meeting

Participants were asked to reflect on what they would like to come out of the meeting. This was done by putting sticky notes on the wall. When reviewing the sticky notes, the participants' objectives could broadly fit into several categories, as listed below.

- *Comprehension:* To understand the best measures for demand-side family planning; limitations of current measures; how person-centered approaches to family planning measurements can be incorporated in existing measurements; how new indicators will measure program effectiveness; the perspectives of colleagues, especially from the Global South
- *New indicators:* Discuss new measures and how to operationalize them; identify challenges for proposed measures and how to address them; ensure new indicators are inclusive and reflect individual needs and goals; ensure that new measures are programmatically actionable and acceptable to donors and compatible with the DHS program; reach consensus on terminology in new measures
- *Networking:* Build networks of people working on demand-side family planning measurements; how to measure the potential users central to measurement
- *Learning and sharing:* Share experiences of measurement and new measurement direction in disease contexts; learn latest thinking about capturing reproductive agency and empowerment; learn from research experiences of others; share research findings; share recommendations of the Panel at the upcoming UNFPA expert group meeting on measuring reproductive agency
- *Collaboration:* See how research, M&E, and program implementers can collaborate in developing SMART indicators and identifying new measures for field testing; find new areas of collaboration with other researchers
- *Technology:* Identify measures that can easily be deployed in consumer-facing digital channels; Artificial Intelligence and large language model (LLM) prompts to generate optimally placed family planning intent question; apps where family planning intent can be inferred, measured and incorporated
- *Prioritization:* Ensure that women have access to information on contraceptives; couple perspectives are incorporated; new measurements are relevant to family planning advocacy and fit into the agenda for the post 2030 era
- *Research:* Identify research gaps where funding and/or advocacy are needed; identify new needs to incorporate into DHS surveys

1.2 GROUNDING FRAMEWORKS AND TERMINOLOGY FOR FAMILY PLANNING MEASUREMENT WITH A REPRODUCTIVE RIGHTS AND JUSTICE PERSPECTIVE

Objective: Review and discuss key measurement frameworks and terminology to ground the expert group meeting discussions

1.2.1 Human-Rights Based Family Planning Framework: How can it guide measures of demand? *Karen Hardee, Hardee Associates*

The Holistic Framework for Human Rights-Based Family Planning was developed by the UNFPA and What Works Association and launched in 2023. A support tool was published at the same time for use by country stakeholders to identify gaps in programming. The approach ensures family planning programmes maintain a focus on key relevant human rights-related principles and standards. The human rights principles that apply to family planning include availability, accessibility, acceptability, and quality (AAAQ), non-discrimination and equality, bodily autonomy and agency, informed decision-making, privacy and confidentiality, accountability, and participation. The holistic framework applies these principles at all levels of the programme – individual, service delivery, law and policy, and community. Empowered and satisfied rights holders who can exercise bodily autonomy are at the core of the framework. However, human rights are complex; there is no one indicator – or simple index of – human rights-based family planning. Nevertheless, the focus on human rights principles and standards can sharpen measures of demand.

1.2.2 Reproductive Justice in the Global Context, *Evelyne Opondo, Africa Director, International Center for Research on Women*

The Reproductive Justice Framework is a cross-disciplinary feminist framework founded on the notions of human rights and intersectionality. It upholds the right to bodily autonomy in safe and sustainable communities, safe from state violence and injustice, and recognizes that sexual and reproductive health issues are profoundly social, deeply political, and an arena for oppression of women. It calls attention to women, who are frequently deemed as socially undesirable reproducers or unfit parents, resulting in reproductive injustices. It is fundamentally a framework that helps to critique power within and across the reproductive ecosystem. It recognizes that socio-structural context mediates access to power and resources.
Application of the Reproductive Justice framework in the global context must consider the contraceptive paradox: contraceptives can be a very empowering tool for women, but they can also be used as a tool for oppression. The Reproductive Justice approach recognizes that contraceptive agency is constrained by contextual issues, intersecting inequities such as race or ethnicity, class, and sexuality. It allows us to see how contraceptive agency may be restricted by provider-patient power relations and by age and race-based power relations.

1.2.3 Understanding Reproductive Choice and Agency Using the EMERGE Measurement Framework, *Anita Raj, Executive Director, Newcomb Institute, Tulane University*

Women's choice and agency have long been a focus of sexual and reproductive health and rights, but how do we measure these and what do we want to measure? Choice is about cognition and access and refers to a choice to achieve self-determined fertility goals, choice to use or not to use modern contraceptives, and what contraceptives to use or not to use. Agency is behavior in context, and focuses on efficacy, decision making, and freedom to act. The Evidence-Based Measures of Empowerment for Research of Gender Equality (EMERGE) framework considers reproductive choice and agency using Empowerment Theory, where empowerment is the process of transformation for oppressed individuals and groups to move from critical consciousness to agency to self-determined goal achievement for actualization.

The EMERGE conceptualization allows us to consider choice and behavior in context, and as part of a transformative process through which self-determined goals are achieved. The focus on measurement in family planning remains the individual. The empowerment process is influenced by various elements, including social norms. Understanding collective choice and agency may offer insights into how reproductive health protections are sustained at the community and political levels. This is an area requiring more work. At the same time, while this approach focuses on quantitative measures, qualitative data are often required to understand these processes and ensure that this is an empowerment process.

1.2.4 Centering People's Needs, Values and Preferences in Reproductive Health Measurement,

Christine Dehlendorf, MD, University of California San Francisco

The concept of patient-centered care emerged from the Institute of Medicine in 2001 and was defined as care that is respectful of and responsive to individual patient preferences, needs, and values. It is also defined as a core dimension of quality health care and associated with improved outcomes. For progress towards universal health coverage, the WHO prescribes a shift away from health systems designed around diseases and health institutions towards those designed for people. Subsequently, person-centered measurement means centering what people themselves want, their experiences, preferences and values, rather than reproductive health outcomes driven by public health and funder priorities. Similarly, people who want contraception should not have to demand it but rather know their rights and act on their preferences.
Moving forward, how do we break from the problematic past and reconceptualize what we are doing, how we are measuring it and how we communicate about it? How can we create a measurement ecosystem that has what people themselves want as the foundation? How can a person-centered approach help to push back on instrumentalizing fertility for economic or political purposes?

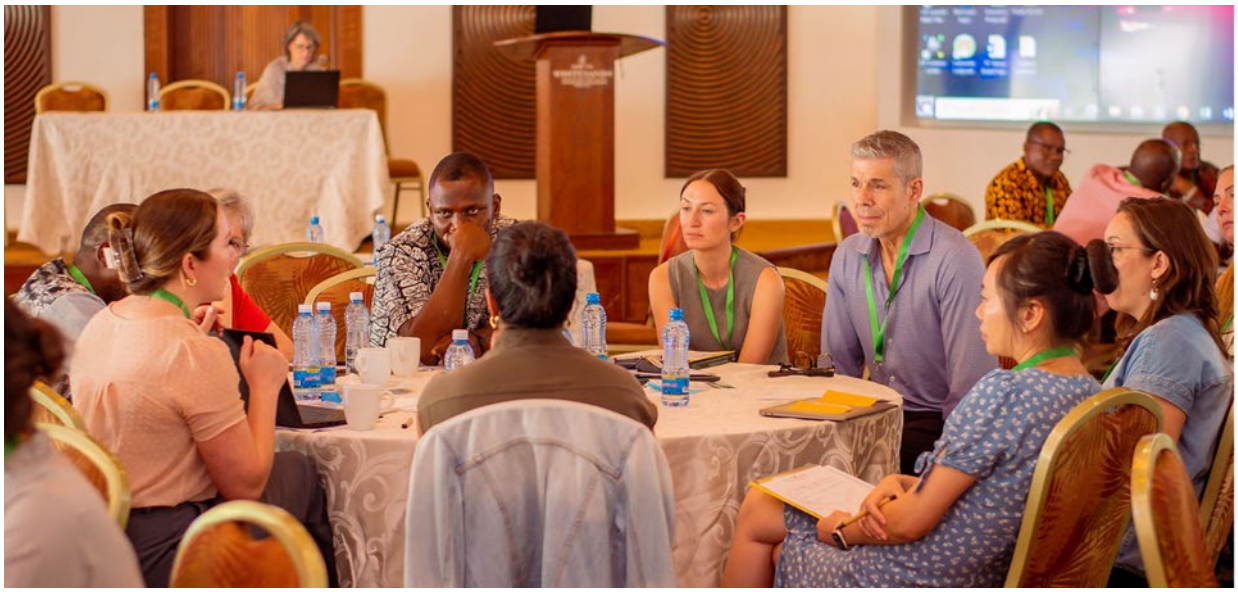
1.2.5 Shared Language and Meaning: Measuring Family Planning-Related Needs and Demand

Madeleine Short Fabic, USAID

One of the initial areas of confusion in family planning jargon is the field's frequent use of economic terms. 'Need' and 'demand', in particular, are frequently misused and misinterpreted. To move the field forward, we must improve language and metrics to describe demand and need, and ensure that the perspective of users, potential users, and non-users are included. Specifically, it is important to reestablish shared meaning and definitions, and to recognize, measure, and understand four types of family planning needs and demands: desire/demand for reproductive autonomy; desire/demand to delay or limit pregnancy; desire/demand for contraception; and desire/demand for a specific contraceptive method. A desire is a wish, a want is a non-essential desire, a need is an essential desire for a necessity that is essential for life, while demand is desire plus ability and willingness to act on that desire.

1.2.6 Overview of Preliminary Findings from Systematic Review of Person-Centered Demand-Side Family Planning Measurement, *Ilene Speizer, Carolina Population Center, University of North Carolina at Chapel Hill and Data for Impact project*

Objectives of the review were to provide a comprehensive picture of measures of family planning desires, needs and intentions; identify when and where non-standard measures were being used; examine whether considerations of equity, rights, justice and person-centeredness were considered in the measures; and provide recommendations to advance person-centered measures for family planning. Research questions sought to find out which person-centered concepts influenced measurement of fertility and family planning preferences; how the concepts have been operationalized in population-based research; how person-centered measurement has advanced global knowledge of fertility and family planning and, what measurement gaps exist and how to address them.
Preliminary findings from 54 selected studies showed a focus on preference-aligned fertility management; the importance of contraceptive autonomy; contraceptive preference measurement as it relates to autonomy; diverse language used in the field; and proposed measurement changes. The next step is data extraction from the studies.



Breakout discussions during IUSSP Mombasa meeting

Comments and Discussions

- *Reproductive autonomy:* It has no age limit. From a person-centered perspective, the care delivery system needs to consider the needs and desires of clients and meet them where they are, irrespective of their context (including developmental stage for adolescents) or circumstances, as well as critical consciousness based on availability and knowledge of their rights. Acknowledge different perspectives of policy stakeholders versus health care providers.
- *Collective versus individual rights:* When it comes to person-centered care, the collective depends on what the individual wants, and how much they want to be part of the collective. The person and the collective are interconnected; we need to think of the individual within the collective. Literacy is important to get a common understanding of the issues.
- *Communal versus individual power:* The ideal is consensus that includes male involvement. For some women it makes sense for men to be involved, for others it does not. Is it about her choice as a woman, or does it include other relationships? Whose right is it? Do women's rights extend to where they infringe on men's rights?
- *Objectivity:* We need individually focused objective measures that honor people's needs, values, and preferences and then respond to them.
- *The place of trust:* Trust is critical, but the healthcare system is not a trusted space for communities because it is focused on goals (such as getting a certain percentage of people on contraceptives, preventing teen pregnancies) rather than the individual and the broader picture of how we are doing in terms of human wellbeing in the context of contraception.
- *Relational aspect:* Choices always take place in the context of relationships and power often reflects decision making. People value consensus and peace in their relationships. How do we frame power in a relational way? Is it being captured in our current frameworks?
- *Male engagement:* The focus needs to be on measures, rather than engagement, measures about men and how to go about it within a person-centered based framework.
- *Reproductive justice:* Research coming out of the US is increasingly focused on reproductive justice. It has not been widely adopted in Africa, or anywhere else outside the US, but those who know about it find it more acceptable than the rights framework. There is a negative connotation to the word 'rights', which is seen as a western principle. Reproduction is also a controversial area, but the justice framework is more accepted. This framework allows capturing of data on the ground for effective change. The challenge is how to invest in it and customize it for use outside the US.
- *Collective understanding*: Vocabulary determines preferences and measurement, so there must be internal consensus. Consensus on vocabulary needs to focus on definitions such as agency, empowerment, and access.

1.3 INTENTION TO USE AS AN INDICATOR OF DEMAND FOR FAMILY PLANNING

Objective: Review and discuss new research on intention to use as an indicator of demand for family planning

1.3.1 A Review of The Evidence on Intention to Use Contraception to Inform Conversations on Person-Centered Measures, *Victoria Boydell, Institute of Women's Health at the University College London*

Demand is measured in two ways: unmet need and intention to use, the latter of which gauges a woman's directly expressed desire to use contraception. Intention signals the end of a deliberation process about what actions one will perform and how much one is willing to put effort into achieving the desired outcome. According to behavioral science, intention is most likely to predict voluntary behavior when compared with variables such as attitudes, norms, and self-efficacy.

There is little evidence on intention to use and contraception adoption. The study set out to map the extent and nature of available evidence on intention to use and found 112 papers combining survey instruments and behavioral theory. In nine out of ten sites in a multi-country study, intention to use within a year was significantly associated with subsequent adoption, while in eight out of ten sites, unmet need for spacing or limiting was not associated with adoption. There is strong evidence, therefore, of a positive relationship between the intention to use contraception and using contraception in the future. When asked, women know what they need and want. However, we lack a standard definition of intention to use, and need to sharpen its definition.

1.3.2 Among Women Who Intend to Use Contraception, Who Fulfills and Who Does Not?
Simon Kibira, Makerere University School of Public Health

There is interest in new measures of demand for contraception that improve on unmet need. Intention to use is an improved measure of demand for family planning as it is more person-centered and has stronger predictive utility. However, longitudinal studies show that there are women who say that they intend to use but do not subsequently use. The questions to be answered are: Who fulfils intention to use and who does not? Are there correlates of adoption of preferred methods? And can continued non-use of contraception be explained by changes in fertility and contraceptive intentions?
The study was done in Kenya, Uganda, and Burkina Faso. Findings were that 59% of women in Kenya adopted preferred contraception, 48.6% in Uganda and 34.7% in Burkina Faso. Characteristics that predict fulfilment and intention include education level, prior use of family planning, timing-based intention, and partner support. Three-quarters of non-users stated the same fertility intentions at baseline and follow up. Most non-use is due to reduced need for contraception (rather than an access issue), for postpartum reasons or reduced sex. The study had limitations, including the fact that it did not account for adoption or discontinuation between baseline and follow-up, and the research questions were purely descriptive, not hypothesis-testing.

1.3.3 Association Between Intention, Contraceptive Use and Contraceptive Self-Efficacy in Premarital Relationships among Adolescents in Rajasthan, *AJ Francis Zavier, Population Research Centre, Gandhigram, Tamil Nadu, India*

Contraceptive self-efficacy (CSE) measures the strength of adolescents' conviction that they could use or demand contraception in sexual relationships. Evidence indicates that adolescents are not likely to use contraception based only on the knowledge and availability of contraceptive information and methods. Instead, motivation and willingness are necessary to translate knowledge into action. The study examined the association between intention, contraceptive use, and contraceptive self-efficacy among adolescents and how it translates into behavior change. A sample of 1,386 boys and 1,784 unmarried adolescent girls (13-19 years) from 88 villages in Rajasthan, India, were interviewed for a baseline survey in September and October 2019. About 17% of boys and 16% of girls reported engaging in premarital sex in the previous year. Multivariate logistic regression results showed that adolescents with high CSE were more likely to use contraception in premarital sex. To improve CSE among adolescents, interventions to build their agency through sexual education programs are needed.

Discussant: Jacob Adetunji, Bill & Melinda Gates Foundation

Intention to use is a complex construct. Literature has a vast view of what it is, making it difficult to summarize any findings. If we are going to adopt intention to use as a standard indicator for family planning, then we need to begin to think about how to operationalize it. It is noteworthy that 'unmet need', which used to be a favorite family planning indicator, went through iterations, and was refined to what it currently is. The Bill & Melinda Gates Foundation is keen on intention to use as a way of approximating demand. But what about those who do not intend to use? When we create demand, how do we keep track of the people we reach to see whether they become users?

Comments and Discussions

- *Value of intention to use:* The Bill & Melinda Gates Foundation's shift towards intention to use is not abandonment of the Modern Contraceptive Prevalence Rate (mCPR). It is useful as a predictive, person-centered measure of demand. It also avoids the controversial rights issue. Testing and experimentation are ongoing with the intention of expanding and scaling up. Where it works, it stays.
- *Timing of interviews:* If questions are asked repeatedly, a respondent is either likely to give the answers the interviewer wants so that the questioning can stop, or to seriously consider getting a contraceptive. Thus, it could be that frequency of questioning influences behavior, which could affect measurement in longitudinal studies.
- *Past learnings:* Data around bias needs consideration, as well as learnings from similar studies, such as on the use of tobacco.
- *Purpose of measurement:* Any measure will have a purpose, but it is important to realize that it cannot solve all problems. Thus, intention to use may not be able to address the patient-provider relationship, or policy making. This is just a starting point, and there is room for multiple measures.
- *Strength of intention:* Further elaboration is needed on how to measure the strength or weakness of intention to use, starting from intent to use to starting to use.
- *Choice of method:* The choices of women who were pregnant and had intention to use family planning postpartum could be influenced by health workers. It would also be prudent to capture use of traditional methods as this can be considered intention to use.
- *Question on intention to use in DHS:* Would it be an improvement to make it time bound? Does it facilitate person-centeredness? Do we need to open it up to all? Who wants to know what, from this measure, and how do we use it?

1.3.4 Implications of Intention to Use for Measurement and Programming: Pragmatic and Incremental Improvement, or Unhelpful Repurposing of an Existing Measure?

Intention to use is becoming increasingly prominent as an outcome indicator for family planning and a proxy for modern contraceptive use and demand. It is person-centered, self-described from a woman's perspective, and is already familiar to many of the gatekeepers. The purpose of the session was to ground the discussions on intention to use. Participants were divided into four groups to discuss what intention to use measures, for whom the measurement is being done, data requirements for measurement of intention to use, and its implications on family planning programming.

Group 1: Definitions of intention to use.

- The group defined intent to use as a measure of latent demand to replace unmet need. It is a demonstrated correlate of contraceptive use, but questions remain about whether it gives person-centered outcomes and reflects supply. For DHS data, the question of intent to use is only asked of those who do not use contraception. It is important to identify who is being missed and to reach underserved populations.
- The goal of using intent to use as an indicator should be to reduce adolescent fertility rates, delay first birth, increase contraceptives provided, and establish the number of people served. It should be a denominator for contraceptive use. It could also be about funder goals – for reporting purposes.
- Questions about intention to use should include both traditional and modern methods (unless they are for predicting supply); should be asked of both men and women; and should be broadened to include intent towards a preferred behavior.
- The language of 'intent' may not always be viewed the same way across cultures and countries.
- Intent to use is advantageous because it is able to directly assess women or men and it is better than unmet need as a measure of demand. It works well as a market approach if contraceptive use is the target. But questions still exist about whether it will generate demand and whether it can be used more broadly to understand behavior.
- It is a useful measure but not a replacement or a higher-level value measure. We cannot gain enough information from this simple question to help guide supply and demand solutions. Social desirability is a concern and also the fact that it does not account for person-centered reproductive goals.
- There are more people with unmet need than with intent to use. With intent to use, many people or groups would be lost, including those who are ambivalent or do not consider contraception an option.
- How do you assess intent and behavior if it is not a longitudinal cohort? Would it have value in cross-sectional surveys?
- Intent to use is an important but insufficient measurement. It is self-reported but not necessarily person-centered and does not consider gender dynamics. It focuses on the individual and does not recognize systemic issues such as the supply side of family planning. It is valuable within a set of measures but not as a single measure. It is a band aid solution, but it can be the cure where other measures are not available.

Group 2: For whom should we measure intention to use?

- The current measure focuses on women who are not currently using a modern contraceptive method. Expanding to other groups in part depends on how the question is defined; and how the information gathered will be used.
- The measure seemed to implicitly assume that respondents had reasonably detailed knowledge about contraception already. But for those with limited knowledge, the measure is somewhat meaningless.
- Expanding to other groups: extending the measurement to all women, including current users, would require changing the question slightly to focus on intention to continue using contraception more broadly and continuing using a specific method. Expanding to men would help contextualize women's behavior, but justification in terms of men's sexual and reproductive health was less clear. The question might need to be framed as 'do you or your partner intend to use' as men's methods are so limited.
- People that the measure currently misses include the most vulnerable, such as those living with disabilities. The measure also requires that the person can conceptualize using those methods.
- Refine the question and make it more specific, ask about intentions for the next time they have sex, rather than the broad way it is asked currently.

Group 3: Critical thinking about intention to use – definition, timeframe, implementation, and tracking.

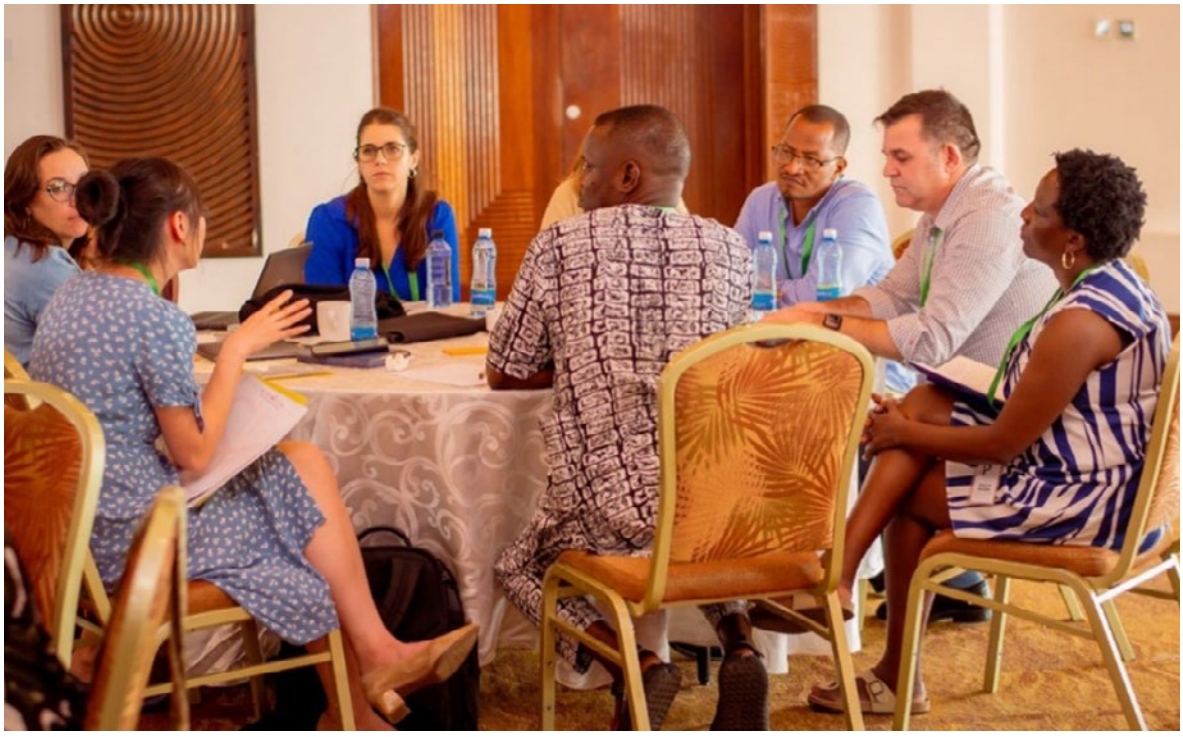
- What is measured gets done. What about the ones who don't show up?
- How is intention to use tracked when it increases as a result of education and information?
- Intention to use is a more appropriate measure for programmatic decisions but there is concern about the person-centered continuum and whether it represents desire.
- Intention to use should be time bound, maybe for one year – then look at access, demand, and availability – and what services should be available for the person who demonstrates intention.
- What about current users and their intention to continue using or not to use?
- How can intention to use be assessed? Should it be consistent, or can it change? At what point in time is it being captured?
- Are women able to articulate intention, and how? What is the context of lack of intention to use? Should intention to use be the one measure that defines program success or can programs have different objectives?
- Aggregate population level (country level) may not be very informative. What is informative is how many are fulfilling the intention – or not fulfilling the intention, and capturing this over time.
- Learnings from fertility intention and preferences should inform intent to use.

Group 4: Programmatic implications on intention to use.

- The group noted that there may be alternatives that are better for programs than intent to use. Its appeal, however, is that it is a better predictor of future contraceptive use and provides an avenue to discuss demand. Several questions were raised:
- Is intention to use the target, and if so, is it person-centered? Does it matter how it is used and why?
- Do we want programs to increase or improve intention to use? What is our target and what do we want all people to have?
- Is it a numerator – what is the percentage of people who intend to use out of the whole population – or a denominator – how well are we meeting the demand of people wanting to use contraception?
- It is a population measure – not an individual level one, but does it seek to solve the same problem as unmet need.
- What is a person-centered measure for access? What is contraceptive agency?
- People have the agency and rights to change their minds. How does intention to use align with free and informed choice?

"There's no such thing as a single-issue struggle because we do not live single-issue lives."

Audre Lorde



Breakout discussions during IUSSP Mombasa meeting

2.1 WELCOME AND DAY 1 RECAP

Irene Casique provided a summary of the presentations and discussions from Day 1 and introduced the plans for Day 2. She also welcomed inputs and observations from participants.

2.2 MEASUREMENT OF CONTRACEPTIVE METHOD PREFERENCE

Objective: Review and discuss new research on the measurement of contraceptive preferences.

Method preference is one of the fundamental issues in person-centered care. It relates to several considerations among potential contraceptive users including effectiveness, satisfaction, autonomy, and method continuation. But how do quantitative method preference measures work in contexts where there are limited methods available?

2.2.1 Meeting Preferences for Specific Methods: An Overdue Indicator of Need for and Quality of Care, *Kristen Lagasse Burke, University of Texas at Austin*

Measuring preferences by asking people what contraceptive method they want to use and, among those with discordant use and preferences, why they are not using their preferred method is a direct, person-centered way to evaluate unmet need for contraception. The argument for studying preferences is that 1) the prevalence of satisfied preferences offers an indicator of reproductive autonomy, 2) using a non-preferred method has cross-sectional and longitudinal associations with other reproductive outcomes like contraceptive continuation and undesired pregnancy, and 3) measuring method-specific preferences and the extent to which they are satisfied can be used to identify opportunities to improve care in a targeted way (e.g., we can tell when use exceeds demand and vice versa).
Recommendations: In survey data collection efforts, collect information on individuals' preferred method of contraception and why it is currently not being used. Use this data to estimate prevalence of non-preferred use, demand for specific methods, common mismatches between method use and preferences, barriers by method type, and variation across sociodemographic groups. We should invest in the thoughtful development of survey items to measure these concepts through cognitive interviewing and field testing to ensure that we are measuring what we want to measure and consider how to balance context-specific and universal measures. Also, we should think expansively about whose preferences should be measured. Widespread adoption of just two survey items that focus on contraceptive preferences and reasons for non-preferred use can bring key health indicators into closer alignment with the needs of people.

2.2.2 How Do We Measure Contraceptive Method Preferences? Evidence From a Scoping Review, *Carolina Cardona, Johns Hopkins Bloomberg School of Public Health*

There is limited knowledge about contraceptive preferences, such as their influence on contraceptive behavior, how they are most accurately measured, what percentage of women are using their preferred method and to what extent these preferences change over time. It is important to study them not only because they relate to sexual and reproductive health, which is a human right, but because they are directly linked to patient-centered care and have limited substitution. There are two ways of measuring preference in the Consumer Theory: one is stated preference, which measures preferred attributes of specific goods, and the other is revealed preferences, which are driven by quantity and price.

From 1,400 articles, the study's restriction criteria yielded 49 articles. In the direct approach, which was used in 18 of the studies, respondents were asked about their preferred contraceptive methods,

prospectively and retrospectively, while in the indirect approach, used in 34 studies, women were asked about the attributes of their preferred contraceptive methods, classified across 19 different categories. The review showed that we need to improve our understanding of contraceptive preferences and ask ourselves some questions: Do preferences have impacts on sexual and reproductive health behavior? Are we measuring the correct contraceptive attributes? Is it easier or more accurate to ask about contraceptive attributes or about contraceptive methods?

Discussant – *Lonkila Moussa Zan, Institut Supérieur des Sciences de la Population (ISSP), Université de Ouagadougou*

In both articles, there is a notable gap for data from developing countries. Preferences are not stable and evolve with everyday knowledge and experience. Thus, measuring the stability of preferences, considering the context and highlighting the main determinants of stability, change and fulfilment is crucial. In addition to measuring preferences longitudinally, measuring them cross-sectionally can inform the quality of use and monitor improvement over time based on their main determinants. A question for the two presenters: Among all the questions about measuring preferences, which ones would you recommend be used?

Comments and Discussions

- *Non-preferred use:* As we work towards a more person-centered approach, we need to consider reasons for non-preferred method use. Beyond contraceptive use, there are other more or less modifiable reasons for non-preferred contraceptive use. Many people are not using their preferred methods because they do not want to go to the doctor for one reason or another, because of contraindications, or lack of motivation. We need to look into these access barriers.
- *Discordance:* Mapping from attributes to methods is important. A woman might have a good understanding of what she is looking for in a method, but not enough knowledge of the actual method. A systemic review is needed to show to what extent there is discordance between the attributes they prefer and the methods they are actually using.
- *Range of options:* Thinking about family planning more broadly, women should be asked whether they are thinking about contraception as opposed to another method such as abortion or abstinence. The frame of reference across alternatives is important for making comparisons.
- *Timing:* The timing of questions to measure preference could be an indicator of quality of care, rather than just development of a population-level measure. If women are asked about preference upon exit, they can also be asked why they did not receive their preferred method, and whether it has to do with incorrect or biased clinical judgment.
- *Shaping preferences:* Research about what meditates preference, who is changing preferences and why, can help with understanding where preferences come from and what they are shaped by.
- *Power of perception:* Perceived attributes can shape preference, whether or not they are factual. There have been studies that looked at people's perceptions of attributes and how that shapes preferred method use. A participant mentioned a study in Malawi that found that if a woman perceived that a method had no side effects, did not influence menstruation, had no potential impact on a future pregnancy and was easy to use covertly, then she preferred the method. Sometimes people might prefer several attributes and those might not align with an actual real method.
- *Context and access:* Proposing preferences as an indicator inches us towards person-centered care. But contraceptive preference is not the be-all end-all measure. There are many factors related to context and access that do not influence preference. Answers like 'I don't know' or 'I do not want to use a method' are important to acknowledge.
- *Universal measures versus specific measures:* There should be some universal measures, but also specific measures tailored to context.
- *Limitations:* Available methods are limited, focusing on women's bodies. It is important to acknowledge that all methods come with a compromise.

2.2.3 Are Contraceptive Method Preferences Stable? Measuring Change in Preferred Methods Among Kenyan Women, *Peter Gichangi, Technical University of Mombasa and Performance Monitoring for Action (PMA)*

Presentations and discussion during IUSSP Mombasa meeting

Contraceptive preferences are important for reproductive outcomes, such as contraceptive continuation and pregnancy, but current measures are inadequate, assuming that contraceptive users are using a method they want, and not taking into consideration preference changes over time. Measuring contraceptive preferences could improve the assessment of the quality of family planning services and elevate contraceptive autonomy. However, there is limited or no information about changes in contraceptive preferences. The objective of the study was to assess the consistency of contraceptive preferences conditional on consistency of usage and to identify demand- and supply-side factors and life events associated with the consistency of these preferences.

Three rounds of longitudinal data were collected one year apart between 2019 and 2021 in Kenya, from 1,594 non-user segments from 1,130 women and 4,224 user segments from 2,534 women. Measures used were contraceptive preferences (direct questions) and covariates (demand, supply, life events, and demographic and socioeconomic data). Results showed that women change their contraceptive preferences, but it is not possible to tell whether it is due to the framing of the question or contraceptive behavior. An increase in the number of contraceptive methods ever heard of is associated with stable contraceptive preferences. Women in monogamous relationships are less likely to change their contraceptive preferences, while life events are positively associated with changes in contraceptive preferences.

2.2.4 Contraceptive Method Preference-Use Discordance in Kigoma, Tanzania: Results from a Population-Based Survey of Reproductive Age Women, *Sarah Huber-Krum, Center for Disease Control and Prevention (CDC)*

Understanding contraceptive preferences is important because preference-use discordance is predictive of other important reproductive outcomes. Information about preferred methods can help inform family planning interventions. At the same time, discordance may be an indicator of reproductive autonomy. The study was set in Kigoma in rural Tanzania, where women have higher fertility than the rest of the country and receive less ante-natal care. This was part of a larger survey by the government to find ways of preventing maternal and perinatal mortality. Research objectives

were to assess the prevalence of contraceptive preference-use discordance among contraceptive users; to analyze the sociodemographic and health access factors associated with discordance among contraceptive users; and to describe reported barriers to preferred method use among women not using their preferred contraceptive method.

The study used data from a cross-sectional, representative household survey of reproductive age women conducted in 2018. About 13% of women were not using their preferred contraceptive methods. Discordance was low compared to past studies as most non-users who preferred to use a method in the future were not using because they were not sexually active. A primary barrier to using preferred methods was fear of side effects, but some women also reported healthcare-related factors. It was found that perceived quality of care may have prevented some women from using their preferred method, and that knowledge of potential side effects might help women use their preferred methods.

Discussant: *Moazzam Ali, WHO*

A key observation highlighted in both papers was women's fear of a method, fear of side effects, and fear of surgery, a pointer to the quality of counseling services. A study done in Senegal found that only 18% of women were given basic information on how to use a method, its side effects, and when to come back. Counseling is therefore an area that needs emphasis because it helps in determining preferences. It is also clear that a reasonable percentage of women were using implants, which could have been driven by policy or donor priorities, giving women little room for choice. This too, needs looking into.

Comments and Discussions

- *Discordance and preference change:* If people were discontinuing or not using contraception, that would be a challenge. But switching between methods and discordance are signs of person-centered care, autonomy and choice. Similarly, preference change, as opposed to stable preference, points to empowerment.
- *Use of language:* Questions for users and non-users are significantly different but they need to be more specific. Non-users were asked if they preferred to be using a method in the future, but the question was confusing because some of them were not having sex.
- *Preference versus intention to use:* A question to ask non-users would be: 'Do you perceive yourself to have a need for contraception. If so, what method do you prefer to use?'
- *Covert use:* Qualitative data found that covert use is a perceived attribute, different for each person, and influenced the use of a preferred method. In reality, all methods could be used covertly, depending on one's context and perception.
- *Focus on relationships:* Choices take place within relationships, but we do not focus on them, therefore we are missing some measures. Challenges in measuring the intention to use contraceptives include issues around social desirability bias, lack of contextual understanding and ethical implications. There is need for a standard definition of intention to use, its purpose, and with the awareness that it excludes some populations, build something new from the recognition of those limitations. The Human Rights Framework for Family Planning needs to be updated with the latest principles and standards.
- *Method satisfaction:* It is important to note that clients may say they want a particular method, but really what they mean is they want the method without its side effects. Thus, not using the method does not reflect an unmet need for that method. Method satisfaction is important: we should care about whether people are satisfied with their experiences in the moment.
- *Mapping approach:* There are concerns about the mapping approach because people perceive things differently and relative importance of different method considerations is very hard to understand and predict. It is also noteworthy that research in places such as the US has shown that there are methods that align with many people's preferences.

- *Reproductive age:* Age of puberty and sexual debut have declined. The WHO sets reproductive age at 15-49 years, but it is important to look at ages 10-14, particularly in terms of limitations around provider bias towards unmarried adolescents and how that impacts their contraception preferences, their decisions to use or not use, or even go to the provider or not.
- *Preference by gender:* An explicit set of questions needs to be used to measure men's and women's contraceptive needs and preferences. The goal of the Kigoma study was maternal health in Tanzania. A participant mentioned a study done in Malawi where men's and women's preferences did not match. Men struggle answering questions about preferences, so questions for them would need to be much more explicit.
- *National population surveys:* There is a lot of complexity around questions asked in national population surveys, either because of language used or the objective of questions. Considering how the various studies have asked different sets of questions to capture the specific method preference is critical.

2.3 INTEGRATING METHOD PREFERENCE INTO NEW MEASURES OF FAMILY PLANNING DEMAND

Objective: To review and discuss new research on integrating method preference into new measures of family planning demand.

2.3.1 Measuring Unmet Need for Contraception Using a Person-Centered Algorithm: An Application With a Community-Based Sample of Rohingya Women in Bangladesh, *Octavia Mulhem, Guttmacher Institute*

Nearly 750,000 Rohingya people who were displaced from Myanmar in 2017 depend on humanitarian aid for education, food, clean water, and health care. Contraceptive use in the camps is well documented, but less is known about the unmet need for contraception among Rohingya women. The unmet need measure quantifies the gap between women's fertility intentions and their contraceptive behavior and is a key indicator used by NGOs to design family planning programs. The objectives of the study were to measure unmet need for contraception among Rohingya women using a person-centered algorithm that accounts for contraceptive desires among users and non-users; and to critically examine the standard measure while suggesting an approach for incorporating contraceptive desires in measures of unmet need.

The survey was fielded in September-November 2022, with 1,173 respondents. Measurement of unmet need was based on the contraceptive desires of respondents as opposed to inferring need based on an externally perceived misalignment between contraceptive behaviors and fertility intentions, enabling interpretation of unmet need for contraception specifically as an unmet need. The findings supported evidence that unmet need existed among current users in the form of method dissatisfaction; this approach may help inform policies and improve contraceptive service delivery and educational programs in the camps. In the wider context of the measurement of unmet need, this analysis emphasizes the limitations of using fertility intentions, combined with contraceptive use, as an indicator in measures of contraceptive need. The findings showed how the addition of a small set of questions in quantitative research instruments can generate nuanced differences in measures of unmet need.

2.3.2 Preference-Aligned Fertility Management Among Married Girls in Northern Nigeria: Assessing New Measures of Contraceptive Autonomy, *Claire Rothschild, Population Services International*

In 2020, Leigh Senderowicz made a call to 'redefine' how we measure success in family planning, shifting from indicators focused on contraceptive use to contraceptive autonomy, or concordance between what a person wants and what they have, regardless of contraceptive use status. In response, Kesley Holt and her colleagues developed the preference-aligned fertility management (PFM) approach to measuring concordance between desire and practice. A person is said to be practicing PFM if their current use aligns with their desired use and they want to be using the method type that they are. The study assessed PFM among a cohort of 1,101 married adolescent girls aged 15-19 who were accessing public health facilities supported by a program implemented by PSI and a consortium of partners.

Three-and-a-half months after method initiation, prevalence of modified PFM was 97%. Incorporating method dissatisfaction decreased PFM to 93%. Correlates of PFM and satisfaction-adjusted PFM at three-and-a-half months were examined. Among participants using contraceptives at three-and-a-half months, significant differences were observed in method type by PFM; this ranged from 92-97% across waves, with 20% not practicing PFM in the first wave. The study showed that PFM is a straightforward and actionable metric of program success. Discordant contraceptive use and desire were prevalent in this cohort. Results demonstrated viability of PFM for routine program monitoring and evaluation; as a measure of program 'success'; and as an endpoint for longitudinal cohort studies.

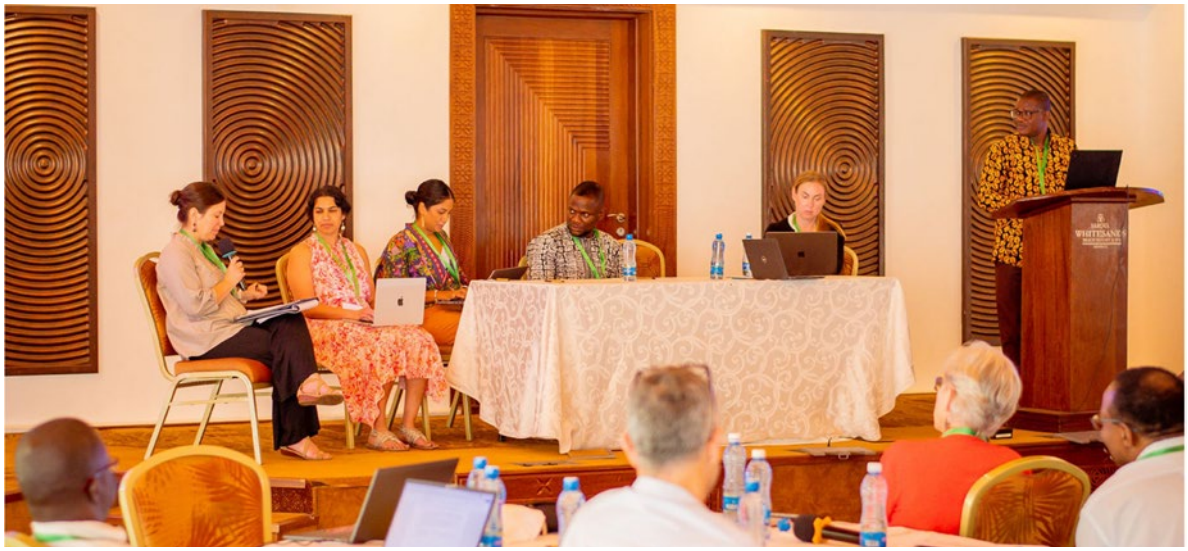
2.3.3 Validation of the Preference-Aligned Fertility Management Index in Uganda and Nigeria, *Kelsey Holt, University of California at San Francisco*

Preference-aligned fertility management (PFM) is the use or non-use of contraception that aligns with one's current preference. It is measured by asking whether the person wants to use contraception and whether they are using it, and whether the current method is desired. The approach also calls for acceptance of traditional contraception methods such as withdrawal, long-acting reversible contraception, periodic use, and preference not to use as good alternatives. We need to trust people and be respectful of their circumstances and preferences.

Data were collected from 2,417 users and non-users in Uganda, and 580 female contraceptive users in Nigeria. PFM was measured by country and contraception status; by comparing unmet need and PFM; developing a nomological network and hypothesized framework of interrelationships between PMF and other constructs; and bivariate logistic regression analyses predicting the odds of PFM associated with variables from the nomological network. There was evidence of construct validity of the PFM index in Uganda and Nigeria, providing opportunity for further research. In conclusion, measuring PFM requires adding minimal new survey questions. Additionally, PFM can be used in tandem with other measures.

Discussant: Mahesh Karra
How are the proposed measures leading us to the objectives of this meeting? Conceptually, is this index a measure of unmet need for family planning or unmet need for contraception? Inclusion of women who stated wanting or not wanting to use a method is a fundamental premise underlying unmet need for family planning. If this is a different measure, then one would ask whether understanding unmet need for family planning is still important or relevant, and whether understanding unmet need for contraception is enough. Family planning is not equal to contraception. Contraception is one means of family planning and fertility regulation, while family planning includes other means of fertility regulation, such as abstinence and abortion.

The studies showed that contraceptive use is not a measure of demand, autonomy, and well-being, and that balance is needed between what is conceptually ideal and what is empirically feasible. Capturing latent demand by asking "Do you want to use a method?" is seen as an elicited unconstrained demand for contraception at the present time. In addition, identifying an unconstrained demand from the constraints and constraint-induced demand that women face at the time when the question is asked raises serious risks of ex-post rationalization biases, hypothetical framing biases, cognitive anchoring, and reference dependence. It is not valid to assume that one can reasonably answer such questions when faced with these risks. Indeed, we put too much weight on demand questions. Honest responses to biased questions equals biased answers. It is also important to note that agency and autonomy are not the same things; agency is much more complicated. To be person-centered relates more closely to autonomy, while to be preference-centered relates more to agency.



Presentations and discussion during IUSSP Mombasa meeting

Comments and Discussions

- *Holistic approach:* The reason the index was called preference-aligned fertility management and not preference-aligned contraceptive use is because it was meant to be a more holistic construct.
- *Satisfaction measure:* Of the overall sample, 3% no longer wanted to be using the method they were using at that point, which is a high discordance at 15 weeks post method initiation. It will be important to understand where the variability is coming from – from passive to promoter – and to see how that is applicable and generalizable.
- *Contraception for non-pregnancy reasons:* We need to be clear that what we are talking about is fertility management, which can include things other than contraception, which is pregnancy prevention. There is a range of options for management of things like menstrual regulation, peri-menopausal symptom and fibroids, other than the commodities for pregnancy prevention. Thus, saying that people are using contraception for non-pregnancy prevention is confusing the narrative. However, it is also true that perimenopausal women need contraception before they actually get into menopause. There is therefore a need to look at women as comprehensive beings without separating between use of contraception for different needs.
- *Trust:* We need to trust people and the answers they give. Just because there are changes over time does not mean that there is anything wrong. People have different behaviors and what they said first remains valid. There is also a need to improve how questions are asked, how they are sequenced, and the exact wording of the questions.

- *Needs versus choice:* It is important to weigh self-defined needs versus full and informed choice. Satisfaction with a method could be tied to satisfaction with the service where the method is provided. In fact, people may be quite happy with their utility management in a context with very little informed choice. Intention to use could be helpful in overcoming this tension.
- *Real world context:* Rethinking the demand side of measures provides an opportunity to move the measurement discussion forward at both the individual level and also as part of a more concrete, ecological measurement framework that supports person-centeredness in a programmatic and real world context.
- Environmental context: In the context of the Rohingya, more than 50% wanted less children when coming to Bangladesh. This could vary with the changes in their circumstances. Personal preferences and environment would need to come into play in measurement.

2.4 NEW MEASURES OF DEMAND, CHOICE, AND USE

Objective: Review and discuss new research on other measures of family planning demand, choice, and use.

2.4.1 Capturing the Dynamic Nature of Choice: Development of a Measure of Contraceptive Hesitancy in Cameroon and Kenya, *Lotus McDougal, Agency for All*

There is an important gap within existing measures that is a connection between the desire for contraception and demand. Women and men feel varying degrees of hesitancy about using contraception to meet their reproductive goals. The spectrum of this certainty or uncertainty is critical to better understanding of contraceptive demand and behavior. Drawing from lessons learned from immunization research and measurement efforts to understand vaccine hesitancy, this study focused on the degree of willingness or unwillingness to use a contraceptive when pregnancy was not desired using the 5 Cs – confidence, calculation, constraints, complacency, and collective responsibility – framework. The study adopts definitions used in the vaccine studies for testing in qualitative research carried out in four sites in Kenya and Cameroon.

Confidence (perceived trust in contraceptive safety and effectiveness) is related primarily to contraceptive safety and side effects, and experiences with health services and providers. Calculation (thinking, questioning, and information seeking) is related to direct and indirect experiences that are influential to participants' assessments of a contraceptive method, premised on specific goals. Constraints (perceived structural, social, and psychological factors) were identified as health service access and contraceptive method availability in Cameroon, financial affordability in Kenya, and partner engagement in both countries. For complacency (perception that one is not at risk of pregnancy), perception depended on the participants' life stages and reproductive goals, while collective responsibility (motivation to engage in contraceptive-related behavior for the benefit of others) focused on immediate family. A major takeaway from the formative research was that contraceptive hesitancy has the potential to be an important tool to measure and promote choice and agency and to strengthen quality of person-centered family planning programs.

2.4.2 Revising the Definition of 'Demand Satisfied for Family Planning': A Cross-Sectional Study to Explore Incorporating Person-Centered Constructs of Demand, Choice and Satisfaction, *Jewel Gausman, Guttmacher Institute*

The study was part of a larger project to validate a subset of core upstream indicators prioritized by global stakeholders. 'Demand satisfied for family planning' is a key indicator to measure universal access to sexual and reproductive health services. It is constructed from a series of standard

questions rather than through a direct expression, counter to the principles of person-centered care. The study aimed to assess the construct validity of the standard measure of demand-satisfied by iteratively comparing it to alternative definitions that incorporate personal intent to use a method, decisional autonomy, and satisfaction, where construct validity refers to the accuracy of the operationalization of a concept or phenomenon.

The cross-sectional study was done in Argentina, India, and Ghana, working with 1,440 women in each country aged 15-49 from October 2020-June 2021. Specific questions were asked relating to demand, choice, and satisfaction. The results showed that the standard definition of demand satisfied may overestimate the constructs of intent, choice, and satisfaction among women. The definition misses contraceptive demand among important population sub-groups, including adolescents and post-partum women, while the addition of decisional autonomy (choice) into the construct causes the largest declines in demand satisfied.

2.4.3 Predicting Unintended Pregnancy Rates Through Contraceptive Information Deprivation in Nigeria: Evidence from Nigeria DHS and Google Trends in 2018, *Tosin Olajide Oni, Obafemi Awolowo University*

Contraceptive prevalence rate has often been used as an index of the achievement of women's family planning needs, but unintended pregnancies have not reduced in many settings despite recorded improvement in contraceptive prevalence, thus other measures of met need are required. We cannot talk about preferences when women do not have information about contraception options. Indeed, the amount of information that people have about contraception may be a better predictor of the occurrence of unintended pregnancies. It is known that women of low socioeconomic status are more vulnerable to unintended pregnancies, but how contraceptive information deprivation influences the pregnancies has not been widely investigated.

Data was sourced from the Nigeria Demographic and Health Survey for 2018 from 22,021 sexually active women aged 15-35 years. The study also used Google Trends data. The study looked at the proportion of women who were poor, unmarried, unemployed, and educated below secondary level, did not understand the ovulatory cycle, and lacked information on contraceptive methods and sources. An insignificant influence of information needs was noted, likely due to sharp differences in internet access. Nevertheless, the search pointed to the type of contraceptive information women need to achieve their family planning goals. Thus, the number of women in communities who are informed about contraception should be adopted as an important measure in meeting family planning program objectives.

2.4.4 How It Was and How It Should Be: Moving Towards a Better Measurement of Contraceptive Prevalence Among Unmarried Women, *Apoorva Jadhav, USAID*

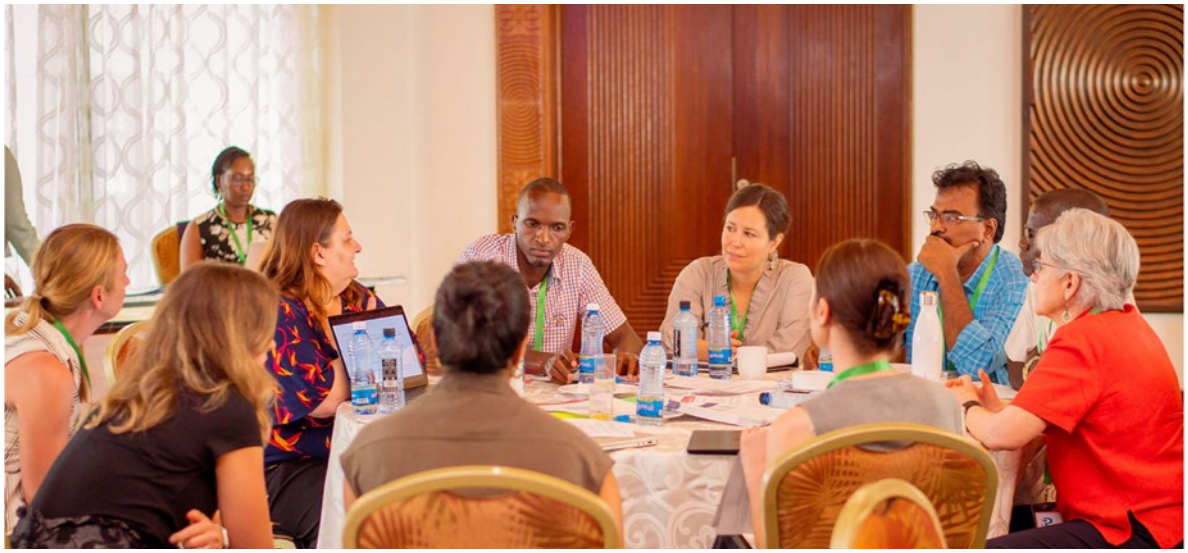
Contraceptive prevalence has been a central indicator to understanding the impact of family planning programs. Looking at women only, there are inconsistencies in calculation based on marital status. Varying approaches to measuring sexual recency among unmarried women result in different contraceptive preference and unmet need estimates, with potentially significant policy and programming ramifications, including the ongoing conversation on rethinking family planning measurement with a reproductive justice and rights lens, and a focus on youth.

The study used DHS data to draw comparisons among the three measures of contraceptive use and different thresholds of sexual recency (for both married and unmarried women) to determine the sensitivity of a composite measure and consider the utility of each measure. It found that the standard way that contraceptive prevalence is calculated works well for married women, while for

unmarried women study authors recommended using a composite measure. And while there is a tremendous benefit in expanding measurement approaches to capture reproductive agency and justice, it is also important to ensure that existing measures can be assessed and modified to understand the reality of individuals' lived experiences.

Discussant: Nirali Chakraborty, Metrics for Management

We need agreement around denominators for global standards and we need measurement approaches that are applicable across countries. We also need to decide whether married and unmarried women will be treated the same way, and whether they will be asked questions about their demand or if that will be inferred from the measure. For questions about current use or desire to use 'right now', there is some benefit to allowing respondents to have a bit of choice in their own interpretation of the question while providing guidance. The measures hold promise, but there is a need to provide consistency and decide which ones are more easily scalable and which ones might be helpful for local resource allocation or for national policy.



Breakout discussions during IUSSP Mombasa meeting

Comments and Discussions

- *Constraints:* The domains are really broad and have the potential to make unwieldy measures with too many questions. They are being refined for testing when field work continues, and there will be further testing over time to look at dynamic stability and stability over the course of a year. This is probably going to be more directly useful for social behavior change programming.
- *Certainty and uncertainty:* It is ok to be uncertain, and there are other reasons beyond information that cause uncertainty. Indifference and ambivalence will be in the middle of the spectrum. Social norms are a different layer. We are not trying to account for ambivalence but to measure it and understand what is contributing to it along the spectrum of hesitancy, certainty to uncertainty.
- *Discrepancy:* What drives the reported discrepancy is related to who is counted in the numerator and denominator. Though the suggested question was not to get what married versus unmarried women were reporting, traditional measures were being underreported, and we found a layer of nuance as to who was underreporting what. Bell and colleagues found that current users are more likely to report permanent methods or implants as opposed to coital-dependent methods.

- *Literacy:* A lot of sexual literacy programming among unmarried men and women does not talk about sexual recency, yet many among the growing young populations in many countries are already having sex. Instead, information for these cohorts is about issues such as menstrual hygiene and management. Programming is catching up to reality, however, and beginning to do more for unmarried men and women with regards to sexual literacy.
- *Life course:* As we think broader conceptually about person-centered measures, it is important to keep life course issues in perspective. A person may be married or unmarried earlier or later in life or may want to have a child after school or later. It is important to think about these at the individual level while recognizing that it is not feasible to have a measure for every group.

2.5 DISCUSSION ON DATA SOURCES, NEW DATA INSIGHTS AND MEASURES, AND OTHER INNOVATIONS

The objective of the session was to discuss the role of different data sources in supporting family planning measurement innovations, new data insights and measures, and other innovations in the field of data.

Each of the facilitators listed below gave a brief presentation on their topic to help frame the subsequent breakout group discussions. Rich conversations were had in the breakout groups as reported in section 2.6.

Breakout group topics:

- Experiences from PMA on piloting new measures using panel data with Fred Makumbi
- Innovations in DHS data with Kerry MacQuarrie
- New analyses and measures using DHS data with Jeffrey Edmeades
- Modeling approaches to improve person-centeredness in measures with Marita Zimmerman
- Real-time digital data insights – experience from Nivi with Ben Bellows

2.6 GROUP FEEDBACK: INNOVATIONS IN DATA

Real-Time Digital Data Insights: Experience from Nivi – *facilitated by Ben Bellows*

Chatbots represent a unique opportunity to strengthen demand-side family planning measurement with a reproductive justice and rights framework. Person-centered metrics reflecting behavior change, healthcare experiences, and health outcomes can be derived from users engaging with chatbots. In this session, one platform, Nivi, was highlighted in order to deepen understanding of chatbots potential roles in supporting rights-based sexual and reproductive health metrics. Nivi is a WhatsApp chatbot platform, rooted in artificial intelligence and behavioral science, that enables private and public organizations to reach, understand, and serve individuals on reproductive, maternal, and primary health journeys. It is designed to support individuals' personal health goals, empowering individuals to engage with health topics at their own pace, deepening awareness, strengthening activation, and supporting action. It has the potential to provide feedback loops, facilitate continuous engagement with clients, create insights on consumer behavior, test survey questions, and conduct rapid data collection at scale.

In the use case presented, Nivi supported the development and deployment of a women's cancer insurance product in Kenya based on a three-stage approach: insights, innovations design, and behavior change impact. Each stage involved person-centered feedback and input ensuring a rights-based approach in shaping the health system.

The group session concluded by comparing the features of Nivi's insights to DHS and PMA surveys that measure population-level reproductive health behaviors and outcomes. Features such as reporting frequency (DHS every 5 years; PMA annually; Nivi monthly), sampling design, margin of error, cost, and other attributes were presented in two slides. Centering regularly collected FP metrics on individual experience and health outcomes is only recently possible. Chatbots like Nivi represent an opportunity to measure demand-side family planning outcomes from the perspective of the individual, which aligns well with a reproductive justice and rights framework.

Modeling Approaches to Improve Person-Centeredness in Measures – *facilitated by Marita Zimmerman*

The group was presented with an agent-based model that has many different components that basically go through the cascade of decision-making from changes in state of pregnancy to non-pregnancy, sexual activity to not, contraceptive use to not, and then incorporating other features of individual decision making, heterogeneity by empowerment, and to simulate and parameterize different scenarios calibrated on country level data from a wide variety of sources. Currently the model has been calibrated in Kenya, Senegal, and Ethiopia. It is open source and Python-based. However, it requires a lot of data from different sources and inputs, including country data, PMA, longitudinal data, and DHS. A question that arises is how policymakers and practitioners can test different scenarios and what inputs are necessary for that. And from the conceptual and research-oriented side, what are the assumptions behind the modeling and which ones are we using for parameterizing different relationships with data that is feeding into it.

New Analyses and Data using DHS Data – *facilitated by Jeffrey Edmeades*

The group focused on the question of contraceptive decision making, asking who makes the final decision on whether or not to use contraception and whose opinion matters the most. They felt that it was an important addition because it captured agency more accurately and helped unpack joint decision-making. There has been no analysis, but recommendations have been made to study associations with contraception. The major concerns were that it is not going to be easy to understand if there's a situation with multiple partners and not having a regular partner. Furthermore, it is predicated on the idea that the woman and her partner are the primary decision makers.

The group was of the opinion that when asked about who has the final say, the woman would say it was a joint decision even if that is not the case. An additional question could be asked about who would make the decision if there was a disagreement, and the answer would provide an understanding of the dynamics in the relationship. Things may be different in an African or Asian context than in the north, so care should be taken when incorporating changes to make them region specific, or even country specific.

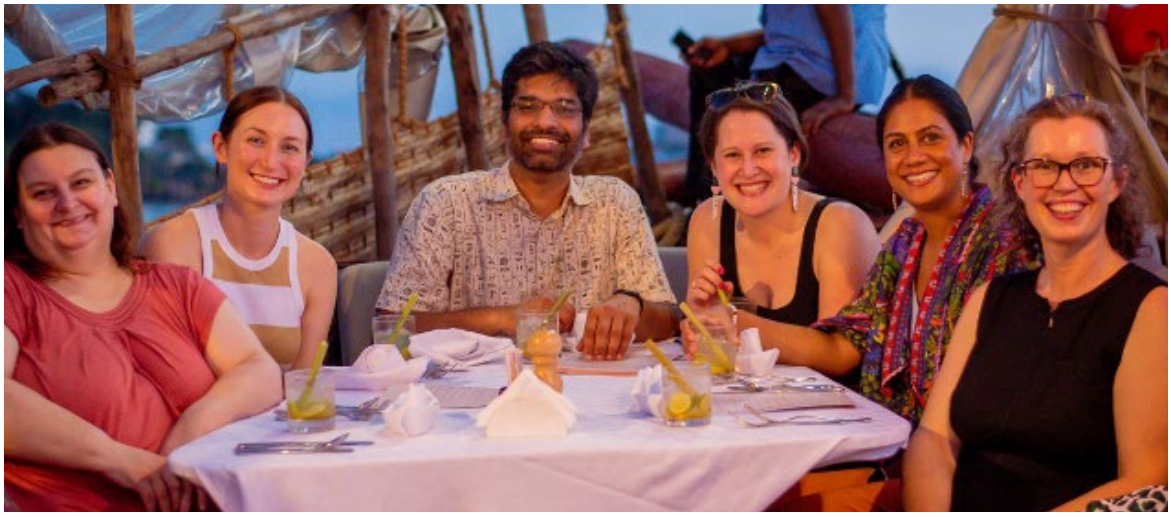
Group members were particularly looking forward to quality of care and respectful care, not from a reference point of having used the old version, but more of an opportunity for moving forward and particularly looking at ways to link Service Provision Assessment (SPA) data with DHS data. One of the challenges that emerged was non-standardized implementation of questions and surveys, where countries decide, for instance, not to incorporate some of the core questions, or not to implement a SPA in a given year.

Experience from Performance Monitoring for Action (PMA) on Piloting New Measures using Panel Data – *facilitated by Fred Makumbi*

The group explored how to engage the PMA to ask new questions while ensuring that data quality remains high and supports person-centered measurement. The group observed that the presence of a resident enumerator in the community led to positive outcomes but could also be a source of bias. Training of the resident enumerators was one way of ensuring that the quality of data remained high, while frequent comparisons with the DHS ensured consistency of the data collected. The resident enumerator could also be used as a resource to help draw out learnings from the community over time.

The flexibility of the PMA can facilitate testing or randomization of new questions and even wording of the questions, whereas the DHS is a little rigid. Program-specific indicators for interventions within countries try to contextualize and respond to what is needed on the ground rather than blanket response, especially given the short inter-survey periods.

"Sexual and reproductive lives are not lived in a socio-political vacuum."
Morison T. 2021



Wednesday night group dinner on the Tamarind Dhow

3.1 REVIEW DAY 3 AGENDA

Abdoul-Moumouni Nouhou walked us through a summary of where we have been and what we hope to get out of Day 3, the last day, of the meeting.

3.2 NEW RESEARCH ON CONTRACEPTIVE AND REPRODUCTIVE AUTONOMY AND AGENCY

Objective: Review and discuss new research on reproductive autonomy and agency.

3.2.1 Measuring Women's Contraceptive Decision-Making and Enabling Legal Frameworks: Outcomes of a Multi-Stakeholder Policy Consultation, *Jennie Greany, UNFPA*

UNFPA has a revised Strategy for Family Planning 2022 that is tightly linked to the conversation about family planning measures through a reproductive justice and human rights lens. Multi-stakeholder consultation in 2023 recognized that the focus of most people in the family planning sector is centered on health, not rights and policy. The consultation was around enabling legal frameworks for women's contraceptive decision-making, resulting in the addition of two indicators to the Sustainable Development Goal (SDG) framework – SDG 5.6.1 and SDG 5.6.2 – which measure the legal and regulatory framework for sexual and reproductive health and rights, as well as women's reproductive decision-making.

Discussions about data brought out the need for more indicators, with more granular measurements; more inclusive questions; more variety and nuance in questions; more ways to assess content; and greater clarity on frequency of measurement. There is also a need for data that are simple and easy to understand, packaged for different audiences and useful for policy change and advocacy (just because you can measure it does not mean you should). Discussions led to identifying the need for a comprehensive framework of reproductive agency post-2030 that has clear definitions and terminology, is people-centered and human rights-based, and includes in-depth and more detailed questions, methodology, and funding.

3.2.2 Agency in Family Planning: A Scoping Review of the Conceptualization and Measurement of Agency in Low- and Middle-Income Countries, *Francine Wood, Agency for All*

Agency is important for women to make informed decisions about their reproductive lives and assert control over their reproductive choices. It sits within the empowerment process and involves capacity, action, and resistance. Individuals, couples, communities, and organizations can all have agency.

The aim of the study was to find out how agency has been conceptualized across contexts and domains of global health and well-being through a scoping review on measurement of agency in family planning research within low- and middle-income countries. In the 72 articles identified as suitable for the review, there was minimal focus on marginalized populations, while discussion of agency was primarily at the individual level. None of the measures reviewed included all three constructs – Can, Act, and Resist – of determining agency: the Can construct focuses on self-efficacy and explores self-esteem and perceived control over the action; the Act construct focuses on measuring decision making in households, finances, and specific family planning domains; and the Resist construct seeks to determine whether the woman is able to continue the action despite the opposition she may face. The scoping review revealed that there was limited psychometric evaluation of measures and limited focus on the Resist construct; discussion of interpersonal, community, and organizational agency were underrepresented; and there was need to broaden the focus beyond contraceptive use.

3.2.3 Family Planning Self-Efficacy (FPSE) as a Measure of Reproductive Agency: Findings from Bihar, India, *Nandita Bhan, Jindal School of Public Health*

The work originated from an India-based grant to the Center on Gender Equity and Health at UC San Diego to develop measures to unpack the demand-side determinants and the user journey, especially among young and low-parity women. The gaps in understanding reproductive agency were identified as lack of clear conceptual clarity and consensus on defining reproductive agency; limited understanding of main decision-making measures; lack of contextual nuances and field-based insights for family planning programming; and need for greater dialogue between research and implementation science.

A landscaping review demonstrated notable gaps and the need to develop new measures, hence development of FPSE through partners in India. Items were developed, refined, and tested, first in Uttar Pradesh and later in Bihar. Nine items were eventually identified, falling into main categories: self-efficacy to access and discuss contraceptive use, and self-efficacy to use contraception in the face of resistance. Almost 74% of women felt high self-efficacy to discuss family planning with their partners, but only 12% felt self-efficacy to use, which was relevant for programming policy. The implication of the findings for family planning programs is a need for male engagement to translate discussion into use, while strengthening women's ability to negotiate through gender-transformative family planning programs.

Development and Validation of the ICAN Measure of Contraceptive Agency, *Sneha Challa, University of California, San Francisco*

Innovations for Choice and Autonomy (ICAN) has an innovative Measure of Contraceptive Agency that comprises two different domains: the first is agency in contraceptive decision-making, and the second is agency in acting on contraceptive decisions. These present several opportunities for innovation, including shifting away from equating (overt) contraceptive use with empowerment to acknowledging women's self-defined needs and preferences, which may not include contraceptive use; trying to understand the extent to which people are aware of their rights and societal injustices; incorporating various sources of interference and support beyond a partner; and broadening the scope for universal applicability.

The survey was done among 2,422 contraceptive users and non-users in Uganda and 580 users in Nigeria, all sexually active women of reproductive age. Sub-scale measures were perceived control and consciousness of rights, self-efficacy, knowledge, and coercion. In the end, intentional collaboration and structured item pool development resulted in a comprehensive measure of the internal processes to facilitate contraceptive decisions. It showed that contraceptive agency frameworks can guide programmatic focus on salient agency-related constructs, and that the ICAN Measure of Contraceptive Agency was a robust measure for program evaluation.

Discussant: *Jay Silverman, University of California, San Diego*
Conclusions from the four presentations were that a person-centered, rights-based approach is critical, as well as the need for context and nuance. But what, if any, constructs of men's agency are important to understand and measure? Is agency a more useful person-centered, rights-based outcome relative to intent or preference? Do we have a clear consensus on the definition and components of agency, and is there sufficient data to adequately address agency as a global indicator? Abortion agency and covert use are key forms of resistance, but little has been done about them. Critical consciousness is another important area that needs more work.

Comments and Discussions

- *Broader scope of review:* Where we look dictates what we learn. All reviews presented were limited to English language publications. Unless we broaden our search to include sources of data from non-English speaking countries and the global south, there is information and learning we will be missing. Similarly, preference-aligned measures need to incorporate indicators around self-efficacy to not use contraception and other such actions. Many measures only tend to work for married women, but there is a need to broaden this to a wider population outside of the married context.
- *Efficient measure:* Shorter innovative measures are needed for DHS to look at agency more efficiently through one or two questions. People often use vignettes and attitude tests to measure attributes rather than methods, but this needs more discussion.
- *Strengthening relationship:* Agency and empowerment are inherently relational concepts, but they are not explicitly being framed in that way. The challenge is that a woman's agency and empowerment can be high in one relationship and low in another. The self-efficacy piece might capture that, but we ought to measure more elements of relationship, such as communication, trust, and respect. The relationship between intimate partners is important and central to where decisions are made. Self-efficacy should not be measured for the narrow purpose of contraceptive use, but for the feeling of reproductive freedom and control. (Marital relationships were included in the study but were removed due to pushback during training.)
- *Language and terminology:* Autonomy and agency are sometimes used interchangeably to mean the same thing. Others use intrinsic agency or critical consciousness. Many times, differences in language are brought out by the fact that people are from different disciplines. We struggle to find a common language yet all that is needed is a common understanding. Still, consensus is required in defining concepts for purposes of this objective. Formalization of terminology would provide a point of reference and departure. It is important to understand each other's concepts of agency, but what are we trying to change that women do not have currently, other than what they are being offered by health services?
- *Driving change:* It is important to do more than measurement. We need to measure what is driving change and build it into new indicators. To do this, projects need a theory of change and a conceptual framework.
- *Reinventing the wheel:* In the early 2000s, a framework was created on HIV self-efficacy, agency, and action. There is no need to reinvent the wheel by creating a new one for family planning. The framework was drawn from behavioral literature, which guided how to define terms and steps to follow in translating it into action. Agency is influenced by many things, including norms, but we have not looked enough at how they interact with agency. How can we use these measures to understand the role of norms? We need to think about reproductive empowerment rather than reproductive agency. There is over 30 years of feminist history defining these terms within the broader context of empowerment.
- *Autonomy:* Decision making was the key autonomy question for the FP2020 Working Group, and it still is. We seem to be stuck because we want only one or two questions. But what does it mean and in what direction is it heading?
- *Male involvement:* There is very little work on the agency of men and boys, but what constructs of men's agency are important to understand? It is important to ensure that as men become involved, girls and women are not disenfranchised.

"Where we look dictates what we learn"

From a meeting participant

3.3 ENGAGING DATA USERS IN MEASUREMENT INNOVATIONS

facilitator: Win Brown, University of Washington

Objective:
a) What data means for you and in your context
b) What are the challenges with respect to translating new indicators into actionable results

Connecting Research with the Reality of Data Use

Binod Joshi, Track20 Nepal: Works as a Monitoring and Evaluation officer with the Family Welfare Division in the Nepalese Ministry of Health and Population, seconded by the Track20 project. He works closely with the DHIS2 system and is involved in programmatic activities in the family planning and reproductive health sector.

Data story: His major role is to review data and indicators and measure progress by conducting annual estimations from different data sources to see how the indicators are doing and the changes over time.

Alyn Omondi, FP2030: Data analyst at Track20, seconded to FP2030 and stationed at the FP2030 Eastern and Southern Africa hub covering 23 countries. She supports the country focal point structure to actively use data to meet their FP2030 commitments and for advocacy.

Data story: The focal point structure consists of a government focal point, who identifies national family planning priorities and uses data for monitoring from sources such as PMA, DHIS2, DHS and model estimates generated by Track20; a donor focal point, who uses data to determine what initiatives to fund; a Civil Society Organization focal point, who uses self-reported process indicators to track government activity for accountability; and a youth focal point, who advocates for the needs of adolescents and young people. When the focal point structure was formed, it was realized that the youth were not using data for advocacy as most were data illiterate. FP2030 is working to build their capacity in this aspect.

Renu Golwalkar, Engender Health: Works at EngenderHealth in program design implementation and ongoing monitoring. If we cannot measure it, we cannot improve it. She supports country programs in integrating a robust gender, youth, and social inclusion lens into data collection and use. In the context of contraception and family planning programming, the program ensures that health systems understand the challenges that women and adolescents face in accessing contraception and getting the needs of socially marginalized groups included in program design implementation, monitoring and evaluation, within a do-no-harm framework. Gender power dynamics is included, taking into account the unintended harm that comes to users and service providers.

Data story: EngenderHealth is implementing a project in Tanzania to scale up family planning using three unique lenses: making sure that adolescents receive youth-friendly family planning and contraception services; ensuring that people living with disability are getting high quality, respectful, non-discriminatory contraception services and counseling; and integrating gender-based violence initiatives into family planning services. The project is gathering family planning-related data disaggregated by age and sex. Getting the data approved and integrated into the DHIS2 is the next step, but introducing new data and new indicators into existing tools is an uphill task. There is a need to ensure that data collection and use continue after the project ends, as well as intersectionality of the data. The ultimate goal is to improve the program approach to ensure that people are getting comprehensive equitable services.

Jacob Adetunji, Bill & Melinda Gates Foundation: He is a senior adviser, Data and Insights, in the Gender Equality Division of the Bill & Melinda Gates Foundation. He provides expert advice and technical guidance on family planning data and recommends optimal engagement strategies with external groups in family planning. His responsibilities include investing in innovative data platforms, improving metrics and indicators for family planning, promoting data use at the global, national, and subnational levels, and supporting global monitoring efforts for family planning.

The Bill & Melinda Gates Foundation is a funder and user of metrics and indicators. As a funder, it supports data collection, analysis, dissemination, modeling and any other process that is beneficial to its mission. It funds innovations in all these areas and users of data, using data for problem identification, description, and spreading to its platforms. The Bill & Melinda Gates Foundation also uses data for justification and development of its strategies, for monitoring and tracking its performance and use of funds, portfolio, and annual reviews. For any indicator to succeed within the Bill & Melinda Gates Foundation's environment, it needs to be easy to understand and explain, consistent, logical, culturally acceptable, and must demonstrate impact. Indeed, for the Bill & Melinda Gates Foundation to effectively influence the global health agenda, it requires rigorous and fact-based evidence.

Q: Of all the indicators that we use in our field, which is the one that is most misunderstood or misused?

Binod: The government of Nepal collects service statistics data every year, but it was not receiving all modern contraceptive prevalence rate (mCPR) data from the 753 local level structures. It therefore selected one mCPR indicator for budgetary support.
Alyn: Unmet need for contraception is the most misunderstood indicator. The reality is that half of the women classified as having unmet need either do not intend to use or do not want to use contraceptives.
Renu: Unmet need is an indicator that needs to be reviewed. When women say they made the decision to use family planning alone or jointly with their partners, it is often not known how much power dynamics in patriarchal societies and negative notions of masculinity play into that.
Jacob: Total fertility rate (TFR) is not a core indicator for family planning. It does not measure the impact of fertility today, but for the future. It is not about the number of children a woman has today, but how many she will have over time. For comparison it is good, but we are abusing it.

Questions and Comments

- *Multiple indicators and metrics:* The Bill & Melinda Gates Foundation does not have guidance on how many indicators should be used, but parsimony is important. Be as brief as possible and ensure consistency and logicality. The Bill & Melinda Gates Foundation works by generating demand and then meeting demand. For instance, intention to use seems to be the most logical, simple metric for capturing demand. The Bill & Melinda Gates Foundation's task is to remove obstacles, provide answers, ensure quality, and provide access.
- *Services for people living with disability:* EngenderHealth integrated disability screening within outreach programmes and has trained community health workers on how to help clients self-identify if they were living with a disability and if so, which kind of disability, and then provide short-term contraception or refer them for long-term methods to disability-friendly facilities. Providers were trained on how to treat the clients in a respectful, empathetic, non-judgmental, confidential way. At the exit interviews, many clients felt overwhelmed by the fact that someone cared to ask about their sexual needs; normally people assumed that because they had disability, they were asexual and did not need contraception.
- *Measuring success:* For FP2030, the best way to measure success is for the focal point structures to understand and use the new measures, and whether the indicators speak to the work they are doing in advocacy, program design, and budgeting.

- *Data and service quality:* FPDataPro has been embedded in Nepal's DHIS2 system to improve quality of data for budgeting and planning at the national level. The system has also eased the process of monitoring and prioritizing budgets and programs at the provincial level. At the same time, community monitoring has been introduced in two districts to provide feedback on quality of health services.
- *Investment case:* Dealing with an abstract construct like family planning can be challenging in trying to make an investment case and measuring success. Without simply counting people, the Bill & Melinda Gates Foundation wants metrics that can help to define, monitor, and provide understanding of the problem, and ultimately to measure success.
- *Power and agency:* Within the context of low total fertility rates, women already have the agency, autonomy, and voice to say that they do not want to have children. Conversely, in areas with low agency and autonomy, the TFR is high.

3.4 PREPARING FOR A POST-2030 MEASUREMENT AGENDA

Objective: Stepping back from specific indicators to reflect on what we want our post-2030 measurement agenda to focus on. Topics to explore include person-centered indicators, rights- and justice-based measurement, and the relationship between family planning measurement and reproductive agency indicators.

Beth Sully, Guttmacher Institute: When the SDGs were adopted, the sexual and reproductive health community developed a document with a set of mostly aspirational indicators, which was rather late in the game to get involved in the SDG process when the focus was on indicators rather than at the vision or goals stage. The only indicator of contraceptive use in the aspirational document was demand-satisfied for modern contraception. Nor was there time to collect new data. The idea is to begin the conversation earlier this time round, set our vision and goals, and decide where we want to be as a field in 2030.

Mengjia Liang, UNFPA: Agenda 2030 is a plan of action for people, planet, and prosperity. It is a country-driven plan, though UN agencies can provide technical input. A good trend now is that the voice of Civil Society Organizations has become louder, including citizen-generated data. The SDG target 5.6 is a huge milestone because it goes beyond access to services to women's autonomy and decision making, addressing barriers and rights. SDG 5.6.1 is about individual measurements of women's decision making on sexual and reproductive health and rights and it has three indicators: sexual autonomy, contraception autonomy, and health autonomy. So far, data is received mostly from DHS programs in 68 countries, and by integrating the questions into programs run by other partners. SDG 5.6.2 is also a composite indicator with 13 components, including family planning, comprehensive sexuality education, and HIV treatment and care.

Apoorva Jadhav, USAID: The USAID Office of Population and Reproductive Health works with partner countries to realize a world where ongoing improvement to sexual and reproductive health (SRH) contributes to longer, healthier, and more prosperous lives for all. It is important for the SRH community to identify indicators or questions that are no longer relevant. How do we measure outside some of the problematic indicators that we all agree need to go, including making space for contraceptive non-use? Moving forward, we need a shared language and definitions because if we cannot agree on it, how can we advocate to others, including funders? We need to disaggregate data to ensure no one is left behind, ensure SRH programming is person-centered, and coalesce around what is actionable for decision makers controlling the purse strings. Advocating for family planning and SRH will be easier when we can make a case for how reproductive empowerment is connected to socio-economic development.

Evelyne Opondo, ICRW: Refocusing the meeting on some of the elements of reproductive justice, how do we center marginalized people who need the greatest protection and bring them back into the conversation? How do we garner political will for the bigger goal? If the decision is to be made at a global level, we need a win-win solution for low and high TFR countries and to frame it in a way that strikes a chord with all. How do we build a groundswell, as well as an international movement, that will push this agenda to the finish line? The other piece that seems to have been forgotten is accountability, ensuring, for instance, that laws are in place for access to services and information so that the burden is not just on the woman, but also that the broader context in which she is operating can enable her to achieve her intentions. We also need to reflect on what is going on globally that we can strategically piggyback on.

Niranjan Saggurti, Population Council India: One of the central variables missing in the conversation is government. Are we blind on the political front to what is happening in countries, and what are we trying to achieve with the measurements? How are the indicators and language relatable to non-English-speaking countries where reproductive justice needs to happen? Post 2030, we are dealing with political autonomy, countries with a bigger voice in setting global agendas, changing technology, and changing generations. The vision for post-2030 is for a comprehensive framework where multiple sectors are made accountable, and indicators with global consensus that are acceptable to government authorities. Governments need clarity, simplicity, and data that indicates positive outcomes. DHS needs to shift from testing what is not correct to testing what is correct. How can we improve the new tool to serve advocates, governments, and policy makers?

Kerry MacQuarrie, DHS: DHS programs cannot propose or advocate for a certain direction. They produce data for use at the global level. Governments are another mainstay of the DHS, because the data is from their surveys. She posed a number of important questions to the group: Will recommendations that come out of this group be able to generate consensus at global and country levels so that DHS can be responsive to the needs of both, or will it create tensions? Are we ready to toss out unmet need? What can we give up to make space for the new measures being developed? What do we want to supplement or replace existing measures with that brings in a reproductive justice and human rights lens? How do we bring other people, governments, global monitoring bodies on board? What metrics would be succinct and compelling enough for advocacy and program needs, and resonate with funders as well?

Mengjia Liang, UNFPA: Agenda 2030 seeks to realize human rights for all, achieve gender equality, and empowerment of women and girls. Summit of the Future, being held this September, is a huge UN platform to discuss emerging trends and what could be relevant post-2030. The Summit has 12 themes but very little mention of gender and health. We are facing pushback, and we need to work together to make our voices heard. We need a solid management framework for reproductive agency, and we should be ready to offer a sound piece when it is time to negotiate the post-2030 agenda.

Reflections from group discussions

- It is going to take a movement. Is it realistic to think that what we are discussing here will make it into the measurements agenda for what comes out of the SDGs?
- We need to be intentional about our goals and the people we are targeting to get the most realistic measurements needed.
- Where does infertility fit into this conversation because it is part of fertility intention?
- In building infrastructure for any measure, we may want to include an opportunity to perfect our understanding of those indicators and tweak them as a way of building advocacy for their use.
- It was easier to propose demand-satisfied with the SDGs because we already had the FP2020 agenda and measurement. We need to think now what we want to push post-2030 and prepare. UNFPA needs to be central and at the table pushing this agenda.
- It is important to hold ground on what we have already and figure out how to get the political will to move forward.
- There is need to think not just about connection with gender, but also climate and the impact of climate change on fertility goals and outcomes.
- There is a case for keeping TFR.

Energizer during IUSSP Mombasa meeting

3.5 PARKING LOT DISCUSSION GROUPS

1. How do we build fertility intentions and desire for pregnancy prevention into person-centered family planning measures?
2. How do we incorporate couple-, community- and structural-level factors into person-centered measures?
3. Autonomy, agency, and empowerment: clarifying terminology and the relationship with measuring person-centered family planning.
4. What new measures will help to advance the collection of disaggregated data to bring more attention to inequities?

Group 1

- Adjusted (m)CPR – women who are using contraception and integrates the willingness to use a method.
- Contraceptive use for non-pregnancy prevention purposes.
- Measuring reproductive empowerment.
- Engendering all existing family planning indicators and disaggregating them by age, disability etc. to make them more inclusive.
- A comprehensive measure on multiple dimensions of reproductive agency – it could include multiple items applicable to different contexts and population sub-groups.
- Preference-aligned fertility management shall be tweaked to get non-use as well, and must include unmarried individuals.
- Revising unmet need to include person-centered family planning.

Group 2

- Revise the metrics on person-centered care (indicators that consider multiple contexts) and engage stakeholders, donors, and global advocates.
- Adolescent sexual and reproductive health agency; contraceptive misinformation; and contraceptive agency are prime candidates for investing further on research.
- Direct measurement of person-centered indicators (both program-specific and survey-specific) could be designed for informing programs and monitoring.
- Bring together all the stakeholders who contribute to reproductive empowerment, identify the indicators that are most appropriate, select 2 or 3 indicators, and do the pilot testing in select/ multiple countries.
- Invest in contraceptive motivation and find out what is making individuals choose a particular method (choice, agency, and other attributes) for commodity forecasting and new product development.
- Invest resources in how person-centered indicators (motivation, choice, decisions) are influenced by the household and community level.
- Multi-sectoral consensus for person-centered measure for reproductive justice.
- Leave no one behind as a principle of the SDG agenda.
- We do not need new data but rather to make existing data accessible. Disaggregated data is being collected by DHS.
- There is need for more consistency in data categories.
- What is a subjective measure of social status if we are to understand equities?
- What do we do with DHIS2 data and routine data collection (client data)? The government likes to use it but it is not representative and needs adjustment to be interpreted at a higher level.

Group 3

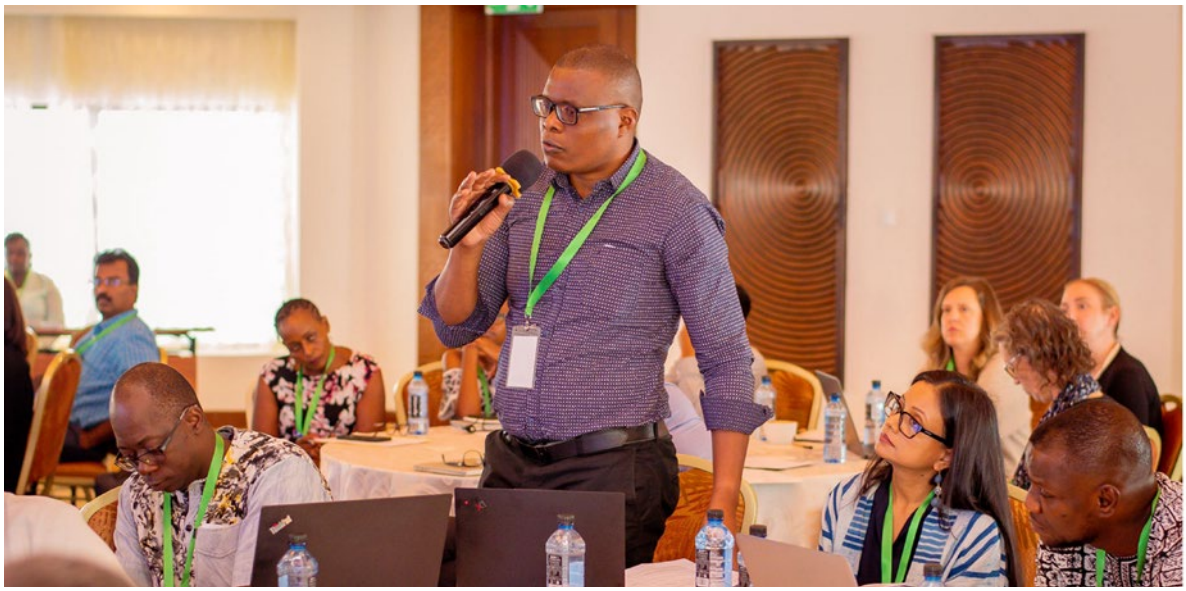
- All the measures should be human rights- and reproductive justice-informed. The people in the middle will have social norms and community norms measured, and men will have person-centered measures.
- Measures should be in two perspectives – self-reported ones, and what is measured at the community and health facility levels, which could then be collated for a final result.
- All-in-one questionnaire, including how to measure norms and policies, although not sure how to roll it into one instrument.
- Enabling environment policies would not be defined by the person giving person-centered care
- What if preference-aligned fertility management (PFM) looks good but pregnancies are unwanted?
- Contraceptive use as a tool for prevention of pregnancy - focusing on contraceptive use as the outcome in and of itself.
- Old DHS question on how acceptable the pregnancy would be for someone could be modified; consider framing in the negative as a current status indicator.
- Preference concordance metric combined with information/access information – test to see differences, or target the FP2030 measurement framework instead.
- Can indicators signal differences between countries that signal policy/financing investment, for example, high preference-aligned fertility management but deeply oppressive environment?
- Need indicators at different levels – think about what is most valuable at the country level.
- Could you build pregnancy prevention and infertility into one set of questions – how much they want to be pregnant/or not and how satisfied they are with their ability to meet that goal.
- Ask men and women the same question. There is a need for more questions on awareness of choice set and critical consciousness.
- Most community and structural level factors are at the national level and hard to connect to family planning programs.

Group 4

- As a field, we are sloppy in use of terminology and need clear conceptual frameworks, narrowed down to give a broad understanding of what we need to measure. The basis for narrowing it down exists because even if we are using slightly different terms, we are beginning in the same geographical space.
- Agency and empowerment are more reflective of what we are aiming for, rather than autonomy. Empowerment is a larger process that is difficult to capture, but we could focus on agency, its components and key indicators, which are easier to articulate, and form specific measures around it and have clear reproductive health outcomes. We need to call it reproductive agency reflective empowerment, which helps us hone in on what we are measuring.
- For reproductive agency, we need to focus on what we are measuring, or a couple of expressions of agency that are most relevant. Existing questions do not capture consistent elements. By focusing on reproductive agency, would we also be capturing economic agency, initiating sex, and contraception?
- Agency is a person-centered measure; you can begin from there as it is a very easy framework to use. Person-centeredness is a quality of care or the way in which a woman engages with the health system, and agency would be critical to that. But is agency inherently person-centered, as there is a value judgment?

Further Reflections

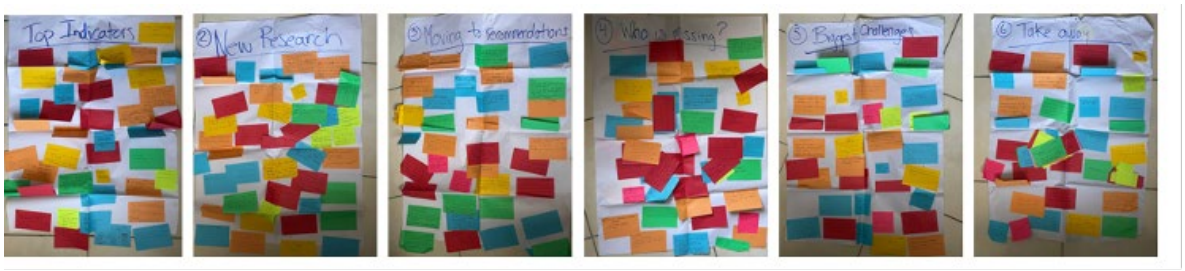
- We need a suite of indicators; what exists in 5.6.1 and 5.6.2, around agency, intention to use etc. that could be considered at the community level, as opposed to an individual level? The indicators can include perceived quality of care, interpersonal relationship, and engagement with the health systems.
- Do we need new categories of disaggregated data, or to make existing data available, accessible, and usable for disaggregation?
- DHIS2 is not necessarily the best quality data in terms of catchments or for health-seeking behavior. So, what if the data we want to disaggregate is problematic? What can it be replaced with?
- Should we be asking what women want in the future? What if we asked what problems they are facing now?



Inputs from a participant at IUSSP Mombasa meeting

3.6 REFLECTING BACK AND MOVING FORWARD

In this section, the Panel requested participants in the meeting to consider six high-level questions to help inform their work going forward. This was done by putting sticky notes on six sheets of paper with specific questions or prompts. After each question or prompt below, we have listed the thoughts from participants on the sticky notes with no specific order or organization.



What are the top 2 or 3 indicators that you would use to measure family planning (current, new, or aspirational)?

Indicators identified include: satisfaction with ability to control; preferences fulfilled; what people want; decision making strengthened; developing a dimension and a set of indicators for it; satisfaction with services received; contraceptive method mix; fertility goal measures; know contraceptive use; CPR; intention to use; new users; family planning agency; family planning approval; fear of side effects; preferred method; MCPR; composite indicator (mCPR and Rights aspect); agency; family planning use; people who want family planning; PFM; pregnancy acceptability; contraceptive decision-making; total users of contraceptive method; reproductive empowerment scale; fertility intentions met; satisfaction with current method; measure of access to quality contraceptive services; composite measure of affordability, availability and range of methods from provider site; reproductive agency; reproductive empowerment; integrate youth lens; integrate intersectionality lens; stock outs; arriving at a fertility decision; negotiation dynamics; support from partner/family; contraceptive services; person-centered care provision; index of supportive social norms for agency in pregnancy decision-making; family planning self-efficacy; contraceptive decision-making agency; pregnancy intention; and agency over reproductive intentions. Indicators in the form of questions included: Do you want to do something to help you get pregnant? Do you want to do something to prevent pregnancy? Are you currently practicing any form of pregnancy avoidance behavior?

If you had the ability to invest in the development of a new measure of person-centered family planning measurement, in what areas of research would you put your money?

Areas to invest in include: consolidation of agency; fulfilled preferences; developing control over people's lives; gather 300 organizations working on the same thing; better measures of fertility preferences and contraceptive preferences; satisfaction with decision-making engagement; indicators of women's resistance to fertility pressures; women's collective action regarding policy restrictions, abortion, and contraceptive access; special studies-mixed methods to test concepts and indicators and refine them in relation to person-centered care in the context of the community, family, normative, and legal environment; sexual and reproductive wellbeing; assessing level and quality of person-centered care at the structural/facility level; women's empowerment; index of social norms supporting agency in pregnancy decision-making; preference-aligned fertility management; cause and impact of family planning/contraceptive services and declining fertility rate; validating the measure across different contexts and populations; measuring women's reproductive empowerment; measures of resistance to covert family planning and covert abortion; question wording and global generalizability of a measure on fertility intentions met; extensive formative

research at the country level; expansion of family planning beyond contraception for pregnancy prevention; development of new measure to understand reproductive life goals; knowledge of family planning methods and side-effects; family planning agency; improving a cohesive measurement framework for the upstream enabling environment; formative/qualitative community-level surveys to test incorporation into larger surveys; self-care for SRH, postpartum family planning; understanding the intersections between individuals and the environment in which they live; preferences and desire to use contraceptives; influence of key stakeholder pressure; adolescent-focused family planning and sexual autonomy; how to operationalize PFM; adolescent SRH agency; contraceptive misinformation and awareness of rights; reproductive aspirations and goal-setting; contraceptive motivation; learnings from countries where TFR is 2:1 or below; aspirational sexual and reproductive wellbeing; better measures of fertility preferences and contraceptive preferences; satisfaction with decision-making engagement; indicators of women's resistance to fertility pressures; women's collective action regarding policy restrictions on abortion and other contraceptive access.

Who is missing from the conversation on improved measurement?

Those missing from the conversation include: women groups; policy makers; civil society organization representatives; global south governments; family planning implementing partners; ministries of health and SRH programs; measurement people from the global south; governments; men and boys; end users of contraception; single people; program implementers and evaluators; donors; LGBTQIA population; faith-based representatives; someone who can speak with authority to the trade-offs between health areas or investment areas; Europeans; specialist on health inequalities; communities; economists; data collectors who have insights into how questions should be worded.

What do you see as the biggest challenge(s) to improving demand-side family planning measurement?

The biggest challenges will be: generating evidence on iteration between social norms, reproductive agency and empowerment; definition of the term demand-side and its operationalization; convincing donors that demand-side is vital and that improved measurement will help drive progress; no clear way to bring stakeholders together to form a consensus; moving away from unmet need into new adopted measures; lack of country willingness to value and measure women's preferences being met; agreement on how to move forward and time to ditch unmet need; buy-in from governments and the public; unlearning the unmet need measure at country and global level; lack of clear conceptual framework and definitions; focusing too much on the individual level and forgetting the oppressive environment; trying to please all constituencies; agreement on indicators that would redefine demand-satisfied; country/global advocacy for change; tension between family planning rights and return on investment for health impact; streamlining work done to build consensus, definition, and language; opposition from those happily and hopelessly wed to unmet need; measuring norms and their part in agency; having harmonized data available across countries; little understanding of gender power dynamics that impact women's reproductive decision-making; acceptability of radical change outside this group; donor and government resistance to moving away from easy-to-count measure; bringing together a group like this before data and indicators are devolved; failure to clearly articulate, operationalize, and measure demand; bringing LMIC-focused measurement scientists to the table.

What is the main thing you are taking home from this meeting to bring into your future work?

Takeaways from the meeting: need to convert or replace unmet need measure; find new person-centered questions for family planning need, agency and norms; how to measure preference; need for more inclusive disaggregated data; there is feasibility for a better person-centered metric that requires only small changes to current data collection and methodology; energy, inspiration and eagerness to engage; it may be about finding an indicator, or a set of indicators, or developing a composite index; there is need to look at indicators to refine their usefulness; we need to meet more to avoid duplication and maximize resources; continue to push for person-centeredness in family planning research and programming; contacts with power holders from UNFPA and USAID; agency indicators.

3.6.1 Reflecting and Moving Forward: Recommendations for the Steering Committee

- Get influential scientists from all over the world to sign on for the next panel meeting to show that what happens in this group is a scientific priority. Make a declaration to show that we have large support for change.
- Make a call to action as the starting point of a process of standardization of recommendations from the group.
- Next workshop to assemble indicators with definition, numerator, denominator, and potential data sources, finesse that so that we can know where the gaps are and prioritize action. Create a way for all these measurements to feed into each other. Vet the indicators widely across countries and stakeholders.
- Get representation in key meetings coming up this year. Being in the room helps to open doors and allows us to know what we need to do to prepare. IUSSP 2025 provides an opportunity to have an evening of discussion on this agenda.
- We are at the beginning of something big to create a focus on person-centered, demand-side family planning. In terms of conceptual clarity, we should be methodical and inclusive so that it is not struck down by criticism and opposition. First define all these concepts, then operationalize the concepts through a working group so that there is mobilization and coherence around the central issues. Publish in a scientific journal, get support from UNFPA and big donors.
- It would be important as we talk about next steps to state what problem we are solving, how much it is costing women and others, and the extent to which established indicators are contributing to this and constraining the movement that we want. Ensure we include those most left behind.
- The data landscape is fundamentally changing. We are in an ecosystem and there are other platforms that we need to complement this process. Let us anticipate that new world, be ready for it and embrace it.
- Match the ideal with what can be operationalized, not just working with data that exists but with Vision 2030 in mind. Invest in and commit to narrative change and package evidence to respond to multiple audiences. Once we reach a consensus on indicators, develop a technical brief with inputs from members of the panel and put forward the recommendations of this group in a special issue.
- Use Delphi or other processes to get to a concrete consensus. Move forward as a united front; make recommendations and get as many people and organizations as possible to sign on. Voting could begin with this group and move to other stakeholders.
- Set up a community of practice and have regular meetings to dive deep into setting the agenda. Form a concept definition and operationalization working group and task forces for each area identified in this meeting, with a combination of research and program people.

- Distil complexities into one metric at a time. There can never be a single metric, but each needs to be easily measured. Narrow down questions to be addressed. Which ones need to change and what evidence do they require?
- Recommendations should consider the practicality of gathering information to adequately capture any new measures developed.
- Summarize key discussions from this meeting and talk to governments about what is useful for buy-in; prioritize country context for next steps.

"The papers presented this week have challenged us to confirm what our values are in this field, and to reflect those values in the measurements we build and promote."

Win Brown

APPENDIX 1: MEETING AGENDA

IUSSP expert group meeting

Assessing approaches to demand-side family planning measurement with a reproductive justice and rights lens

March 5-7, 2024, Mombasa, Kenya

Meeting objectives

- Convene researchers, program implementers, policymakers, advocates, and other civil society members to come together and examine measures and measurement approaches with a reproductive rights and justice lens.
- Identify measures that can be used to assess family planning progress, opportunities, and gaps in a way that is reflective of individuals' self-identified needs and goals (i.e., person-centered)
- Discuss ways forward to advance global family planning measurement

DAY 1 – TUESDAY, MARCH 5

TIME	SESSION		FACILITATOR
08:30-09:00	**Arrival**		
09:00-10:00 (60 min)	**1.1 Welcome and Introductions** Objective(s): Welcome all participants, outline meeting objectives, and get to know one another a little		Beth Sully & Ilene Speizer
		presenter	
	Opening Remarks from BMGF, USAID and IUSSP	Jacob Adetunji Madeleine Short Fabic Mary Ellen Zuppan	
	Meeting objectives • IUSSP Panel • Participant self-reflection	Beth Sully Ilene Speizer	
	Getting to know who's in the room • Introductions • Ice breaker	Facilitated by: Madeleine Short Fabic Georgina Binstock	
10:00-10:15 (15 min)	**Coffee Break**		

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10:15-12:15 (120 min)	**1.2 Grounding frameworks and terminology for family planning measurement with a reproductive rights and justice perspective** *60 minute – Panel presentations* *60 minute – Group discussion* Objective(s): Review and discuss key measurement frameworks and terminology to ground the EGM discussion.	Georgina Binstock

	presenter
Human Rights-based Family Planning Framework: How can it Guide Measures of Demand?	Karen Hardee
Reproductive Justice in the global context	Evelyne Opondo
Conceptualizing and measuring women's reproductive choice and agency using the Can-Act-Resist Framework	Anita Raj
Centering people's needs, values and preferences in reproductive health measurement	Chistine Dehlendorf
Shared language and meaning: Measuring family planning-related needs and demands	Madeleine Short-Fabic
Overview of preliminary findings from systematic review on person-centered demand-side family planning measurement	Ilene Speizer

12:15-13:30 (75 min)	**Lunch**	
13:30-15:00 (90 min)	**1.3 Intention to use as an indicator of demand for family planning** *60-minute presentation* *30-minute group discussion* Objective(s): Review and discuss new research on intention to use as an indicator of demand for family planning	Ilene Speizer

Paper presentations	**Presenter**
Scoping review on Intention to use	Victoria Boydell
Among women who intend to use contraception, who fulfills and who doesn't?	Simon Peter Kibira
Association between intention, contraceptive use, and contraceptive self-efficacy in premarital relationships among adolescents in Rajasthan	Francis Zavier
Discussant	Jacob Adetunji

15:00-15:15 (15 min)	**Coffee Break**	

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15:15-17:15 (120 min)	**1.4 Implications of intention to use for measurement and programming: Pragmatic and incremental improvement or unhelpful repurposing of an existing measure?** *20-minute Reflections* *50-minute break out groups* *50-minute report-back and large group discussion* Objective(s): Group discussion and reflections on implications of and opportunities for using intention to use as a new measure of family planning demand **Participant reflections on Intention to Use** Jamaica Corker Chelsey Porter Erlank Renu Golwalkar George Odwe	Jamaica Corker
17:15-17:45 (30 min)	**1.5 Day 1 Wrap Up** Objective: Reflections on Day 1 discussions	Yohannes Wado

DAY 2 – WEDNESDAY, MARCH 6

TIME	SESSION	FACILITATOR
08:00-08:30	**Arrival**	
08:30-09:00 (30 min)	**2.1 Welcome and Day 1 Recap** Objective(s): Outline meeting objectives for day 2 and recap connections to Day 1 conversation.	Irene Casique
09:00-11:00 (120 min)	**2.2 Measurement of contraceptive method preferences** *75-minute presentation* *45-minute group discussion* Objective(s): Review and discuss new research on the measurement of contraceptive preferences	Niranjan Saggurti

Paper presentations	Presenter
How do we measure contraceptive method preferences? Evidence from a scoping review	Carolina Cardona
Meeting preferences for specific contraceptive methods: An overdue indicator of need for and quality of care	Kristen Burke
Discussant	Lonkila Moussa Zan
Are contraceptive method preferences stable? Measuring change in the preferred method among Kenyan women	Peter Gichangi
Contraceptive method preference-use discordance in Kigoma, Tanzania: Results from a population-based survey of reproductive aged women	Sarah Huber-Krum
Discussant	Moazzam Ali

11:00-11:15 (15 min)	**Coffee Break**	

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11:15-12:45 (90 min)	**2.3 Integrating method preference into new measures of family planning demand** *60-minute presentation* *30-minute group discussion* Objective(s): Review and discuss new research on integrating method preference into new measures of family planning demand	Georgina Binstock

Paper presentations	**Presenter**
Measuring Unmet Need for Contraception Using a Person-Centered Algorithm: An Application with a Community-Based Sample of Rohingya Women in Bangladesh	Octavia Mulhern
Preference-aligned fertility management: Assessing the feasibility of a new measure of contraceptive autonomy	Claire Rothschild
Validation of the Preference-Aligned Fertility Management Index in Uganda and Nigeria	Kelsey Holt
Discussant	Mahesh Karra

12:45-13:30 (45 min)	**Lunch**	
13:30-15:15 (105 min)	**2.4 New measures of demand, choice, and use** *75-minute presentation* *30-minute group discussion* Objective(s): Review and discuss new research on other measures of family planning demand, choice and use.	Abdoul-Moumouni Nouhou

Paper presentations	**Presenter**
Capturing the dynamic nature of choice: Development of a measure of contraceptive hesitancy in Cameroon and Kenya	Lotus McDougal
Revising the definition of "demand satisfied for family planning:" A cross-sectional study to explore incorporating person-centered constructs of demand, choice, and satisfaction	Jewel Gausman
Predicting unintended pregnancy rates through contraceptive information deprivation in Nigeria: evidence from the Nigeria demographic and health survey and Google Trends	Tosin Oni
How it was, and of course, how it should be: Moving toward a better measurement of contraceptive prevalence among unmarried women	Apoorva Jadhav
Discussant	Moazzam Ali

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15:15-16:30 (75 min)	**Coffee Breakout Group Session** **2.5 Discussion on data sources, new data insights & measures, and other innovations** *15-minute Introduce breakout groups* *15-minute Get coffee and find tables* *45-minute Discussion (2 rotations)* Objective(s): Discuss the role of different data sources in supporting family planning measurement innovations, new data insights and measures, and other innovations in the field of data	Clémentine Rossier & Fred Makumbi

Breakout group topics	Facilitator
Experience from PMA on piloting new measures using panel data	Fred Makumbi
Innovations in Demographic Health Survey (DHS)	Kerry MacQuarrie
New analyses and measures using DHS data	Jeffrey Edmeades
Modeling approaches to improve person-centeredness in measures	Marita Zimmerman
Real-time digital data insights - experience from Nivi	Ben Bellows

16:40-17:00 (30 min)	**2.6 Reporting back from coffee table discussions and full group discussion** *20-minute facilitator report-back* *10-minute Wrap up* Objective: Share back coffee breakout groups and have a large group discussion around data sources to support the development and implementation of new measures of demand for family planning	Clémentine Rossier
17:00-17:30 (30 min)	**2.7 Day 2 Recap** Objective: Recap Day 2 discussion	Francis Onyango
18:30	**Group Dinner at 18:30** Transport to dinner will begin at 18:00. Dinner will be on the Tamarind Dhow, a dinner boat cruise that will take us around the harbor of Mombasa	

DAY 3 – THURSDAY, MARCH 7

TIME	SESSION	FACILITATOR
07:30-08:00	**Arrival**	
08:00-08:30 (30 min)	**3.1 Review Day 3 Agenda** Objective: Outline meeting objectives for day 3 and recap connections to Day 2 conversation	Abdoul-Moumouni Nouhou
08:30-10:15 (105 min)	**3.2 New research on contraceptive and reproductive autonomy and agency** *75-minute presentation* *30-minute discussion* Objective(s): Review and discuss new research on reproductive autonomy and agency. **Paper presentations** — **Presenter** Measuring women's contraceptive decision-making and enabling legal frameworks - outcomes of a multi-stakeholder policy consultation — Jennie Greaney Agency in Family Planning: A scoping review of the conceptualization and measurement of agency in low- and middle-income countries — Francine Wood Family Planning Self-Efficacy as a measure of Reproductive Agency: Findings from Bihar, India — Nandita Bhan Development and Validation of a Measure of Contraceptive Decision-making Agency in Nigeria and Uganda — Sneha Challa **Discussant** — Jay Silverman	Irene Casique
10:15-10:30 (15 min)	**Coffee Break**	
10:30-11:30 (60 min)	**3.3 Engaging data users in measurement innovation** *20-minute opening reflections; 5 minutes allotted to each panelist* *40-minute facilitated discussion with panelists and full group* Objective(s): a) what "data use" means for you and in your context; and (b) what the challenges are for our field with respect to translating new indicators into actionable results. **Presenter** Binod Joshi Alyn Omondi Jacob Adentunji Renu Golwalkar **Facilitator:** Win Brown	Win Brown

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11:30-13:00 (90 min)	**3.4 Preparing for a post-2030 measurement agenda** *45-minute fire side chat with panelists* *45-minute group discussion* Objective(s): Stepping back from specific indicators, reflect on what we want our post-2030 measurement agenda to focus on. Topics to explore include person-centered indicators, rights- and justice-based measurement, and the relationship between family planning measurement and reproductive agency indicators. **Panelists** Mengjia Liang Kerry MacQuarrie Apoorva Jadhav Niranjan Saggurti Evelyne Opondo **Moderator:** Beth Sully	Mengjia Liang & Beth Sully
13:00-14:00 (60 min)	**Lunch**	
14:00-15:15 (75 min)	**3.5 Working group sessions to dive deeper into topics that have come up during the meeting** *75-minute participant-led small discussion groups* Objective(s): Create space for participant-initiated small groups discussions of topics that we didn't have sufficient time to discuss during the meeting **Initial proposed topics:** • The measurement of fertility intentions and its implications for family planning measurement • The role of qualitative data in advancing family planning measurement • What are the implications of our measurement discussion for family planning policy and programming? • What new measures will also help to advance the collection of disaggregated data to bring more attention on inequities? • How do we better incorporate couple- and community-level measures into person-centered measurement of family planning?	Georgina Binstock
15:15-15:30 (15 min)	**Coffee Break**	
15:30 –17:00 (90 min)	**3.6 Reflecting back and moving forward** *20-minutes - Individual reflection* *40-minutes - Small group discussion* *30-minutes - Large group discussion* Objective(s): Taking stock of where we are in the development of new measures and what are priority measures to try to expand the use of	Beth Sully
17:00-17:30 (30 min)	**3.7 Closing out the meeting**	Ilene Speizer and Mary-Ellen Zuppan
17:30	**Goodbye happy hour on the beach**	

APPENDIX 2: LIST OF PARTICIPANTS

First name:	Last name:	Institution/Employer:
Jacob	Adetunji	Bill & Melinda Gates Foundation
Moazzam	Ali	WHO
Ben	Bellows	Nivi Inc.
Nandita	Bhan	Jindal School of Public Health & Human Development, O.P. Jindal Global University
Georgina	Binstock	Centro de Estudios de Población y CONICET
Victoria	Boydell	Institute of Women's Health at the University College London
Win	Brown	University of Washington
Kristen	Burke	University of Texas at Austin
Carolina	Cardona	Johns Hopkins University
Irene	Casique	Universidad Nacional Autónoma de México
Nirali	Chakraborty	Metrics for Management
Sneha	Challa	University of California San Francisco
Jamaica	Corker	Independent Researcher
Christine	Dehlendorf	University of California, San Francisco
Yohannes	Dibaba Wado	African Population Health and Research Center (APHRC)
Jeffrey	Edmeades	Avenir Health and the DHS Program
Jewel	Gausman	Guttmacher Institute
Peter	Gichangi	Technical University of Mombasa, PMA
Renu	Golwalkar	EngenderHealth
Jennie	GREANEY	UNFPA
Karen	Hardee	Hardee Associates
Kelsey	Holt	University of California, San Francisco
Sarah	Huber-Krum	Centers for Disease Control and Prevention
Apoorva	Jadhav	United States Agency for International Development
Binod	Joshi	Track20/Nepal
Mahesh	Karra	Boston University
Mengjia	Liang	UNFPA
Simon	Kibira	Makerere University School of Public Health
Kerry	MacQuarrie	DHS Program
Fredrick	Makumbi	Makerere University
Lotus	McDougal	Center on Gender Equity and Health, University of California San Diego
Octavia	Mulhern	Guttmacher Institute
Abdoul-Moumouni	NOUHOU	Groupe de Recherche et d'Action pour le Développement (GRADE Africa)
George	Odwe	Population Council
Alyn	Omondi	Avenir Health
Tosin	Oni	Obafemi Awolowo University, Ile-Ife, Nigeria
Francis	Onyango	Population Council
Evelyn	Opondo	International Center for Research on Women, Africa Region

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Chelsey	Porter Erlank	Clinton Health Access Initiative (CHAI)
Anita	Raj	Newcomb Institute, Tulane University
Clémentine	Rossier	University of Geneva
Claire	Rothschild	Population Services International
Niranjan	Saggurti	Population Council
Madeleine	Short Fabic	US Agency for International Development (USAID)
Jay	Silverman	UCSD
Ilene	Speizer	Maternal and Child Health, University of North Carolina at Chapel Hill
Elizabeth	Sully	Guttmacher Institute
Francine	Wood	Center on Gender Equity and Health at the University of California San Diego
Lonkila Moussa	Zan	ISSP/Université de Ouagadougou
Francis	Zavier	Population Research Centre, Gandhigram, Tamil Nadu, India
Marita	Zimmerman	Bill & Melinda Gates Foundation, Institute for Disease Modeling
Mary Ellen	Zuppan	IUSSP