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Supplemental Table 1. Detailed Characteristics of Included Studies Addressing the Needs of Married Girls and Results

Author, year, country	Participant characteristics	Intervention details, setting, duration of intervention	Evaluation design	Quality	Program outcomes and results (Only statistically significant results presented)
CREHPA, 2004 Nepal	N=500 baseline, 401 endline (YCAG arm) N=500 baseline, 343 endline (MG arm) N=400 baseline, 268 endline (control) F, ages 10-24, married Additional engagement of husbands and community members	**Health -** SRH and maternal health; Physical health **Relationships and roles -** Social network **Life choices -** Agency **Norms** Youth Communication Action Groups (YCAGs) - monthly peer group meetings to discuss reproductive health and other social issues; YCAG mobilization of communities to participate in group activities including observation and celebration of reproductive health events, health fairs and talk programs in the village marketplace Mother's Groups (MGs) - monthly peer group meetings to discuss reproductive health and other social issues, including fundraising, trafficking, the prohibition of the manufacture, sale and consumption of alcohol, etc. Training for group-elected leaders – communication of reproductive health information and messages to group members and referrals of young couples to local community-based health care delivery systems IEC materials and media channels - dissemination of reproductive health knowledge and information to the community ***Duration: October 2000 - October/November 2002 (2 years)***	Quasi-experimental pre-post test, with two intervention arms (youth communication action groups (YCAG); mother's groups (MG)) and one control	Medium	**Health – SRH and maternal health** Knowledge about birth control pills YCAG areas (BL-EL): 1. When to start birth control pills - increased 25.2 percentage points (from 48.7% to 73.9%) ($p < .01$)** 2. What to do if missed pill for 1 day - increased 35.6 percentage points (from 36.8 % to 72.4%) ($p < .01$)** MG areas (BL-EL): 1. When to start pills - increased 18.9 percentage points (from 39.3% to 58.2%) ($p < .01$)** 2. What to do if missed for 1 day - increased 24.1 percentage points (from 28.5% to 52.6%) ($p < .01$)** No significant parallel increases in control. Knowledge about DMPA (a contraceptive injection also known by brand name Depo Provera) YCAG areas (BL-EL): 1. When to start DMPA - increased 35.6 percentage points (from 49.6% to 85.2%) 2. When to go for next injection - increased 37.8 percentage points (from 54.7% to 92.5%) 3. What to do if unable to receive injection on date specified - increased 25.3 percentage points (from 20.3% to 45.6%) 4. When a lactating mother can initiate DMPA - increased 7 percentage points (from 9.5% to 16.5%) (all $p < .01$)** MG areas (BL-EL): Parallel increases of… 1. 26 percentage points (from 48.8% to 74.8%) 2. 18.7 percentage points (from 57.9% to 76.6%) 3. 32.3 percentage points (from 15.2% to 47.5%) 4. 4.8 percentage points (from 6.5% to 11.3%) (all $p < .01$)**. No significant parallel increase in control. Knowledge of required antenatal care (ANC) visit frequency YCAG areas (BL-EL): 4 ANC visits required in pregnancy - increased 17.5 percentage points (from 14.9% to 32.4%) MG areas (BL-EL): increased 9.5 percentage points (from 9.7% to 19.2%) (both $p < .01$)** Knowledge of >2 post-delivery danger signs YCAG areas (BL-EL): increased 13.8 percentage points (from 4.4% to 18.2%)

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					MG areas (BL-EL): increased 8.9 percentage points (from 4.2% to 13.1%) (both p < .01)** Awareness of any sexually transmitted disease YCAG areas (BL-EL): increased 42 percentage points (from 54% to 96%) MG areas (BL-EL): increased 26.4 percentage points (from 27.2% to 53.6%) (both p < .01)** Knowledge of >1 HIV/AIDS risk behaviors YCAG areas (BL-EL): increased 68.6 percentage points (from 20% to 88.6%) MG areas (BL-EL): increased 23 percentage points (from 12.2% to 35.2%) (both p < .01)** Attendance of 4 or more ANC visits YCAG areas (BL-EL): increased 28.1 percentage points (from 24.8% to 52.9%) (p < .01)** MG areas: no significant increase Vitamin A consumption YCAG areas (BL-EL): increased 21.3 percentage points (from 41.8% to 63.1%) MG areas (BL-EL): 12.5 percentage points (from 15.9% to 28.4%) (both p < .01)**
Dyalchand et al., 2021 India	N=461 F, ages <20, married (baseline, intervention areas) Additional engagement of community members, village elders and other gatekeepers	Health - SRH and maternal health Norms Activities implemented by community health workers (CHWs): Behavior change communication - household visits (including counseling) to married adolescents; group meetings with married adolescents and other stakeholders; cross-village community gatherings Community surveillance and monitoring - monthly assessments of community reproductive health needs and service provision; oversight of service providers; engagement of village committees Referrals - assisting/accompanying married adolescents in referrals to reproductive and maternal health services; fostering demand for care Influencing social norms – awareness-raising among village elders and other gatekeepers about married adolescent girls' needs; discussions of gender equity ***Duration: January 2008 - June 2011 (3+ years)***	Quasi-experiment with pre-post test, difference-in-difference	Medium	**Health – SRH and maternal health** Use of full ANC care **-** increased 47.8 percentage points (from 8.2% to 56.1%) in the study sites and 17.2 percentage points in the control sites from baseline to endline (p < 0.01)** Consumption of at least three meals a day in the third trimester of pregnancy - increased 25.8 percentage points (from 56% to 81.7%) in the study sites and decreased 2.2 percentage points in the control sites from baseline to endline (p < 0.01)** Use of regular postnatal care **-** increased 14.1 percentage points (from 18% to 32.1%) in the study sites and decreased 6.3 percentage points in the control sites from baseline to endline (p < 0.01)** Use of treatment for postnatal complications **-** increased 34.8 percentage points (from 44% to 78.8%) in the study sites and 12 percentage points in the control sites from baseline to endline (p < 0.01)** Other findings: • Statistically significant dose–response effect of intervention participation for ANC, pregnancy nutrition and PNC. P-value not reported.

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					• Indirect exposure through living in the study area was significantly associated with higher full ANC use, 3+ meals a day in the third trimester, and regular PNC. P-value not reported. Minimal intervention effect on either of the delivery outcomes
Edmeades et al., 2016 Ethiopia	N=2,272 F, ages 14-19, ever-married Currently married N=1,930 Not currently married N=340 Additional engagement of influential community members	**Health** - SRH **Relationships and roles** - Marital relationship **Life choices** - Livelihoods **Norms** *Arm 1: SRH training* *Arm 2: Economic empowerment (EE) training (not analyzed here)* *Arm 3: SRH & EE combined training* *Arm 4: comparison group (delayed version of Arm 3)* Group-based peer education - twice monthly group meetings with training on: a tailored SRH curriculum (Arms 1 & 3); the Village Saving and Loans Association model (Arm 3); intra-household communication emphasizing conflict resolution techniques (Arms 1 & 3) Social Analysis and Action (SAA) groups - influential community members reinforced the program by recruiting and supporting participants and acting as agents of change ***Duration: 2011 - 2013 (2 years)***	Quasi-experimental pre-post test with three treatment arms plus control Nonrandom selection of eligible kebeles (districts) but random selection of implementation sites	High	**Health – SRH** Current use of modern contraceptives - increased 26.9 percentage points (from 51.3% to 78.2%) in the SRH arm ($p < .001$)*** and 14.3 percentage points (from 48.6% to 62.9%) in the combined arm from baseline to endline Use of SRH services for contraception - increased 29.1 percentage points (from 52.2% to 81.3%) in the SRH arm ($p < .001$)*** and 17.1 percentage points (from 52% to 69.1%) in the combined arm ($p < .05$)* from baseline to endline STI knowledge **-** increased 29.5 percentage points (from 68.9% to 98.4%) in the SRH arm ($p < .001$)*** and 25.9 percentage points (from 69.5% to 95.4%) in the combined arm ($p < .1$) from baseline to endline Tested for HIV **-** increased 20.5 percentage points (from 50.9% to 71.4%) in the SRH arm ($p < .05$)* and 13 percentage points (from 50.9% to 63.9%) in the combined arm ($p < .1$) from baseline to endline **Life choices - Livelihoods** Had personal savings - increased 71.6 percentage points (from 21.4% to 93%) in the SRH arm ($p < .001$)*** and 74.9 percentage points (from 23.8% to 98.7%) in the combined arm ($p < .001$)*** from baseline to endline Intention to invest savings - increased 26.9 percentage points (from 26.9% to 53.8%) in the combined arm ($p < .1$) but decreased 4 percentage points (from 32.9% to 28.9%) in the SRH arm from baseline to endline Ability to feed one's family - increased 11.6 percentage points (from 31.2% to 42.8%) in the SRH arm and 22.7 percentage points (from 25% to 47.7%) in the combined arm ($p < .1$) from baseline to endline

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Engebretsen and Kaboré, 2011 Burkina Faso	N=NR for mères-éducatrices (mother educators) program in which married girl mentors supported married adolescents during their first pregnancy and birth Mères-éducatrices: F, ages 15-19, currently married with at least one child, well regarded in their communities A linked pilot program engaged these mères-éducatrices as mentors for girls at risk of early marriage and married girls: N=1400 F in-school and out-of-school, ages 10-21, married and unmarried; 1700 households	**Health** - SRH and maternal health **Life choices** - Agency **"Mères-éducatrices" program:** Household visits - mères-éducatrices (mother educators; married girls ages 15-19 with at least one child) provided information and support for married adolescents during their first pregnancy and birth; provided Vitamin A and iron supplements for those who were pregnant; engaged girls' gatekeepers (fathers, husbands, mothers-in-law) Health services utilization - mères-éducatrices provided escorts for married adolescents to health centers for prenatal visits and education sessions; sensitized health care workers to married girls' health needs and vulnerabilities **Pilot program*:** Training/support for mères-éducatrices - human rights, life skills, SRH, and livelihoods training for use as mentors and group educators; economic assistance to start income-generating activities (IGAs) Group-based peer education - mères-éducatrices provided education sessions to married and unmarried girls on FP, prenatal care, STIs, HIV, FGM, fistulas, etc. Household visits/referrals - mères-éducatrices visited married and unmarried girls with sexual and reproductive health needs and made appropriate referrals to health services Communication teams - community members in program sites made door-to-door visits, led awareness sessions and advocacy activities with adolescents' parents and traditional/religious leaders, and made case referrals to community services *Eliminating child marriage in Burkina Faso: A plan for protection, reinforcement, and community action ***Duration: NR***	Cross-sectional surveys of households and adolescent girls at baseline and endline	Low	Statistical significance not reported. Full results section: "Results showed increases in knowledge of the minimum legal age of marriage among heads of households and adolescents, in adolescents' knowledge of obstetric fistula and means to avoid pregnancy, and in adolescents' use of sexual and reproductive health services, particularly for delivery assistance."

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Erulkar and Muthengi, 2009 Ethiopia	N = 188T, 272C (baseline) N = 462T, 464C (endline) F, ages 10-19, married and unmarried Only one adolescent female eligible per household for data collection Additional engagement of community members through neighborhood meetings	**Health** - SRH and maternal health **Relationships and roles** - Social network **Life choices** - Schooling; Livelihoods; Agency **Norms** <u>Peer groups</u> - group formation by adult female mentors; safe social spaces for the most vulnerable and isolated girls to meet same-sex friends and interact with caring adults <u>Education support</u> - provision of school materials and support for in-school girls to remain in school and for out-of-school girls to return to school; nonformal education (literacy, numeracy, etc.) and livelihood training (agricultural techniques, poultry rearing, etc.) for other out-of-school girls <u>Referrals to health services</u> - young women who asked their mentors about FP and other reproductive health services were referred to a nearby health center; provision of clinic cards to participants <u>"Community conversations"</u> - participatory community dialogue to explore problems and jointly devise solutions; community members were engaged in discussions of key issues, such as early marriage, and in collective problem solving/collective action <u>Group mentor training</u> - female community leaders were trained in group facilitation techniques and in the provision of informal education and reproductive health, HIV, and AIDS education ***Duration: 2004 - 2006 (2 years)***	Quasi-experimental pre-post with control, controlling for age, socioeconomic status, marital status, and years of schooling	Medium	**Health - SRH and maternal health** <u>Ever-use of contraceptives among sexually experienced girls</u> BL 43.2%T, 36.1%C (not significant) EL 74.1%T, 44.8%C (p<.001) Odds ratio from weighted logistic regression analyses = 2.88** (vs. 1.00 in control site) (p<.01) <u>Likelihood of talking with a friend…about family planning</u> BL 29.5%T 37.7%C (p<0.001) EL 58.1%T, 44.8%C (not significant) <u>…about HIV/AIDS</u> BL 29.5%T 37.7%C (p<0.05) EL 58.1%T, 44.8%C (p<0.001) <u>…about STIs</u> BL 28.0%T 28.6%C (not significant) EL 50.1%T, 32.2%C (p<0.001) <u>…about condoms</u> BL 13.0%T 21.4%C (p<0.05) EL 24.3%T, 18.1%C (p<0.001) <u>Awareness of oral contraceptives</u> No significant treatment effect <u>Awareness of condoms</u> BL 26%T, 36%C (p<0.01) EL 32%T, 16%C (p<0.001) <u>Knowledge of STIs</u> Cannot always tell if one is infected with an STI (no significant differences) Cannot always tell if a man has an STI BL 35.6%T, 41.1%C (not significant) EL 60.9%T, 45.2%C (p<0.001) **Life choices AND Relationships and roles** <u>Preferred age of marriage</u> Reduced in both T and C, but no significant differences. <u>Ever been married (ages 10-14)</u> BL 10%T, 14%C, OR 0.66 (two thirds as likely compared to control, not significant) EL 2%T, 22%C, OR 0.09 (less than one-tenth as likely compared to control) p<0.001 <u>Ever been married (ages 15-19)</u> BL 46%T, 57%C, OR 0.87 EL 46%T, 30%C, OR 2.41 (2.41x MORE likely in treatment area, p<0.001) **Relationships and roles – Violence prevention and mitigation**

Author, year, country	Participant characteristics	Intervention details, setting, duration of intervention	Evaluation design	Quality	Program outcomes and results (Only statistically significant results presented)
					Likelihood of talking with a friend…about violence in the community BL 24.9%T, 38.2%C (p<0.01)
Erulkar and Tamrat, 2014 Ethiopia	N=1010, F, ages 10-24, ever-married Additional engagement of husbands	**Health** - SRH and maternal health; Physical health **Relationships and roles** - Marital relationship; Household roles; Violence prevention **Life choices** - Livelihoods; Agency **Meseret Hiwott:** Peer groups - girls' group meetings with female mentors covering topics such as sexually transmitted infections (STIs) and HIV/AIDs, voluntary counseling and testing (VCT), anti-retroviral therapy (ART), reproductive health, menstruation management, family planning, safe motherhood, communication and self-esteem, gender and power dynamics, and financial literacy; meeting spaces were community halls, participants' houses, or under trees Girls' group leader training - female mentors were recruited from rural communities and trained to mobilize and lead girls' groups; mentors recruited girls and negotiated participation with girls' gatekeepers **Addis Birhan:** Peer groups - partner program for husbands to support their wives and families including training on partner communication, non-violent and respectful relationships, caring for wives and children, alcohol and drugs, STIs, HIV/AIDS, VCT, ART, family planning, safe motherhood, and domestic violence and sexual violence; meetings utilized group discussions, role plays, storytelling, and illustrations; similar group leader training process ***Duration: end of 2008 - early 2012 (3+ years)***	Midline and endline population-based surveys* Groups disaggregated post-survey by 1) respondent not exposed to treatment, 2) wife (respondent) only exposed to treatment, and 3) both respondent and husband exposed to treatment *Not longitudinal data, so cannot attribute differences to program	Low	**Health - SRH and maternal health** Ever used family planning No participation (56.6%) Wives only participated (69.2%, 1.49 OR, p<0.1) Both wives and husbands participated (71.4%, 1.85 OR, p<0.001) Ever received couples voluntary counseling and treatment No participation (10.7%) Wives only participated (45.8%, 7.70 OR, p<0.001) Both wives and husbands participated (65.2%, 18.34 OR, p<0.001) **Relationships and roles - Partner communication and decision-making AND Health – SRH** Husband accompanied wife to clinic (past year) No participation (39.6%) Wives only participated (42.5%, not significantly different) Both wives and husbands participated (53.3%, 1.69 odds ratio relative to control, p<0.01) **Relationships and roles - Household roles and responsibilities** Husband helped with housework in last three months No participation (33.1%) Wives only participated (59.0%, 2.60 odds ratio relative to control) Both wives and husbands participated (80.8%, 8.36 OR) p<0.001 Husband helped with agricultural work in last three months (bivariate) No participation (86.1%) Wives only participated (84.8%) Both wives and husbands participated (93.3%) p<0.01 **Relationships and Roles – Violence prevention and mitigation** Been beaten in last three months No participation (8.9%) Wives only participated (9.4%, 1.66 OR (**more** likely), p<0.1) Both wives and husbands participated (4.3%, not significant)

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					<u>Been forced into sex in last three months</u> No participation (13.2%) Wives only participated (21.6%, **more** likely at p<0.01) Both wives and husbands participated (4.3%, not significant) **Note: not longitudinal data, just endline**
Falb et al., 2015 Côte d'Ivoire	N=682 F, ages >17, married with no previous microfinance experience Additional engagement of male partners or family members	**Relationships and roles** - Household roles; Violence prevention **Life choices** - Livelihoods; Agency **Norms** *Control: VSLA only (delayed GDG component)* *Intervention: VSLA and GDG combined* <u>Group savings program</u> - village savings and loans associations (VSLAs) in which women pool their funds, request loans for livelihood activities, and receive share-outs from interest after loans are repaid by members in their group <u>Gender dialogue groups (GDGs)</u> - women's discussion groups developed to promote gender equality within couples; included topics such the importance of nonviolence, women's contributions to the household, and household budgeting, saving, and planning; included participation by male partners ***Duration: October 2010 - July-August 2012 (23 months)***	RCT	High	Only endline comparisons - RCT **Relationships and roles - Violence prevention and mitigation** <u>Physical IPV</u> (intimate partner violence) Child brides**:** No significant difference between intervention and control groups in past-year physical IPV Nonchild brides: 0.45 odds of past-year physical IPV relative to control; p=0.05 <u>Sexual IPV</u> Child brides**:** No significant difference between intervention and control groups in past-year sexual IPV Nonchild brides: 0.46 odds of past-year sexual IPV relative to control; p=0.06 <u>Emotional IPV</u> Child brides: No significant difference between intervention and control groups in past-year emotional IPV Nonchild brides: 0.44 odds of past-year emotional IPV in intervention group relative to control; p=0.004 <u>Economic abuse</u> **-** also **Livelihoods** Child brides: 0.33 odds of past-year economic abuse in intervention group relative to control; p = 0.02 (intervention group one-third as likely to be economically abused as control group) Nonchild brides: 0.36 odds of past-year economic abuse relative to control; p=0.001
FRHS, 2006 India	Sample: Wives - N=1,866 baseline, 2,100 midline, 2,359 endline, F, ages 16-22, married Social mobilization arm only: Husbands - N=972 midline survey, mothers-in-law - N=75 in-depth interviews	**Health** - SRH and maternal health **Relationships and roles** - Marital relationship **Life choices** - Agency **Norms** *Arm 1: Social mobilization only* *Arm 2: Strengthening government services* *Arm 3: Social mobilization and strengthening government services combined* *Arm 4: Control* <u>Social mobilization strategy</u> - structured, interactive and recurrent health education sessions on reproductive health topics such as conception,	Quasi-experimental design pre-and-post with control, social mobilization arm, government services arm, and combined arm	Medium	Significance and percentages not reported throughout findings. **All intervention sites** showed similar increases in awareness of modern and spacing family planning methods **Arm 1: Social mobilization only** <u>Largest increases of all arms in:</u> Knowledge of maternal health, contraceptive side effects and abortion Postnatal check-ups Contraceptive acceptance (particularly of spacing methods) Treatment of gynecological disorders and partner treatment for symptoms of RTIs and STIs.

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	Social mobilization monitored	menstruation, MH, and HIV/AIDS; aimed to make married adolescents' RH needs more visible in their families and communities; empowered young married girls to voice their health needs; created demand for RH services among youth; implemented through indigenous, community-based women's and youth organizations (CBOs) and district health staff Strengthening government services strategy - training of local health officials to improve provision (supply) of government reproductive health services for married youth; complemented existing government efforts and worked with the state government to address gaps in training ***Duration: 2001 - 2006 (5 years)***			Both social mobilization arms (alone and combined with government services) performed well in: Information about morbidity and infertility Service use Qualitative data from social mobilization: "Mothers-in-law – who are often primary gatekeepers for young married women's health-seeking – are more likely to be supportive now than they were prior to the intervention." "The husbands' survey showed that most husbands are now aware of basic maternal care issues such as the need for antenatal care and are willing to seek treatment for problems during pregnancy and childbirth." "Still, only a minority of husbands actually accompany wives for care." **Arm 2: Government service activities only** "The GS-only site did not perform better than other sites on most outcomes." **Arm 3: Social mobilization and government service activities** Largest increase of all arms in: Basic awareness of reproductive morbidities and infertility
Handa et al., 2015 Kenya	N=1811 low-income households, asking about F, ages 12-24, married and unmarried (including cohabiting)	**Health** - SRH and maternal health **Life choices** - Livelihoods Unconditional cash transfers - ultra-poor households with at least one orphan or vulnerable child (OVC) under the age of 18* and with at least one deceased or chronically ill parent/caregiver qualified for the program; provision of monthly cash sums of 1500 Kenyan Shillings (Ksh, USD $21) with the expectation that the money would be used for the care and development of the OVC *OVCs over the age of 18 were no longer eligible 2011 third wave of data collection included a fertility module which asked females aged 12 to 24 a series of questions regarding pregnancy, health behavior around birth, and other fertility history** ***Duration: March-August 2007 - 2011 (4 years)***	Cluster RCT 28 treatment vs control areas Only endline data analyzed, relying on randomization at baseline	Medium	**Health - SRH and maternal health** **Cross-sectional estimates because fertility information was only collected in 2011 (wave 3 of the survey) Ever pregnant 4 - 5.5 percentage points (34%) less likely to be pregnant in endline data in 5 similar models with different covariates, all $p<0.05$ Protective factors - being the daughter or granddaughter of the household head, living in Nairobi, and school enrollment Risk factors - increasing age When the sample is broken down by school enrollment status, only girls who are not in school, controlling for demographic covariates, still showed a significant treatment effect (11.6 percentage points, $p<0.1$) "Program impacts on pregnancy appear to work through increasing the enrollment of young women in school, financial stability of the household and delayed age at first sex." Ever married or cohabiting Treatment not significant in all 5 models, and coefficients all close to zero. No significant effect on log of total fertility rate

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					No significant effect on marriage for men **Life choices - Livelihoods** "Impact evaluation results using the 2007 to 2011 data indicate that the program employed effective targeting (Handa et al. 2012), increased human capital investment (The Kenya CT-OVC Evaluation Team 2012b), [and] increased household consumption of food and non-food items (The Kenya CT-OVC Evaluation Team 2012a), thus meeting several important poverty-related targets."
Huda et al., 2019 Bangladesh	N=1601 from four slums, F, ages 14-19, married and cohabiting at least 6mo. In-depth interviews with girls N=42	**Health** - SRH and maternal health **Relationships and roles** - Marital relationship; Social network **Norms** <u>Peer groups</u> - meetings of married adolescent girls' (MAG) clubs in urban slums to discuss early marriage, unintended pregnancies (UP), contraceptive method use, available FP methods and service centres, and the roles of males and marriage registrars in FP; included games, story books, dance, music, and drama <u>MAG club leader training</u> - club leaders were recruited and trained on early marriage and its consequences, UP and their health and social consequences, importance of contraceptive method use in reducing UP and improving maternal and child health, information about available FP methods and the FP service centres, role of marriage registrars in FP information provision, and male contribution in FP <u>Demand for health services</u> - community health volunteers (Shyastha Shebikas) trained for promotion of LARCs and referrals/escorts for MNCH services <u>FP materials</u> - distribution of pictorial pocket-books with simplified messages on FP issues to married adolescent girls at club sessions; FP posters, flipcharts, and banners displayed in club rooms <u>Counseling</u> - Muslim, Hindu, and Christian marriage registrars trained to counsel couples together on the same topics covered in married	Quasi-experimental design using population-based surveys In-depth interviews and FGDs with wife participants and their husbands	Medium	**Health - SRH** <u>Knowledge of modern contraceptive methods</u> 15.3 times (Adj. OR: 15.3) higher than control (p<.0001) <u>Supports using family planning</u> 6.6 times (Adj. OR: 6.6) higher than control (p<.0001) <u>Husband supports family planning</u> 4.0 times (Adj. OR: 4.0) higher than control (p<.0001) <u>Discussed family planning with husband</u> 3.4 times (Adj. OR: 3.4) higher than control (p<.0001) <u>Knowledge of consequences of early pregnancy</u> 3.4 times (Adj. OR: 3.4) higher than control (p<.0001) <u>Family planning use</u> 1.8 (Ad. OR: 1.76) higher than control (p<0.002) **Health - SRH AND Relationships and roles - Marital relationship and decision-making AND Norms** <u>Belief that family planning is the joint responsibility of both husbands and wives</u> 3.4 times (Adj. OR: 3.42) higher than control (p<.0001)

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		girls' groups; distribution of FP pocketbooks to husbands ***Duration: July 2014 - August 2016 (26 months)***			
IRH et al., 2016 Uganda	N=2,465 *Very young adolescents* – 225 F/225 M ages 10-14 and attending school *Older adolescents* – 556 F/551 M ages 15-19, unmarried, without children *Newly married/parenting* - 307 F/200 M married/cohabiting with or without children *Adults* – 194 F/207 M ages 19+ (community members)	**Health** - SRH **Relationships and roles** - Marital relationship; Household roles; Violence prevention **Norms** Community Action Cycle - collective dialogue and action implemented by community leaders and mobilizers through Community Action Groups (CAGs) to promote and sustain change related to social norms and attitudes toward gender, RH, and violence Radio drama - Oteka radio dramas aired twice a week on at least one local radio station; narrated fictional families facing challenges related to relationships, sexuality, violence, alcohol, sharing resources and responsibilities, and parenting Village Health Teams (VHTs) - members participated in gender reflections and adolescent-friendly SRH service orientations in order to reduce stigma and link adolescents to FP/RH services; health facility staff also trained to deliver respectful, gender-sensitive care Toolkit - community or school-based groups in each village used a gender equity and SRH toolkit to engage with the intervention components ***Duration: July 2012 - September 2014 (27 months)***	Quasi-experimental pre and post with control, propensity score analysis with difference-in-difference estimates	Medium	All results significant at the p<0.05 level for newly married, newly parenting (NM/NP) girls **Health - SRH** Percentage points **greater** than control at endline: Communication with partner about family planning use in last 3 months 12% Family planning seeking behavior 16% Current family planning use 10% Intention to use family planning in the future 10% Insignificant variables not reported. **Relationships and roles - Marital relationship and decision-making; Household roles and responsibilities AND Norms** Percentage points **greater** than control at endline: Equitable partner-decision-making score 9% Household role sharing score 7% Couple communication score 12% Men's involvement in sharing of hhold roles 17% Men involvement in at least two childcare tasks 10% Insignificant variables not reported. **Relationships and roles - Violence prevention and mitigation** Percentage points **lower** than control at endline: Violent response to partner conflict 16% "Though some indicators in this category improved, the majority of changes were not statistically significant." Insignificant variables not reported.
Jacobs et al., 2017 Burkina Faso; Senegal	Burkina Faso: N=17,067 DHS survey, F, ages 15-49; N=961, age 15-19 for analysis Senegal: N=15,688 DHS survey, F, 15-49; N=996, ages 15-19 for analysis	**Health** - SRH Mass media - mass media campaign (generic, not a specific campaign) disseminating family planning messaging via radio, TV, newspaper, and print; cross-sectional evaluation assessed exposure to FP messaging and related FP behaviors *Duration: NR; used DHS data (Burkina Faso: 2010; Senegal: 2010-2011)*	Cross-sectional, secondary analysis of DHS data using propensity score matching	Low	**Health - SRH** Knowledge of a modern contraceptive method Burkina Faso: Adjusted odds ratio (aOR) = 13.66, p<0.0001 Senegal: aOR = 6.72, p<0.0001 Future intention to use contraception aOR = 1.74 for both countries; Burkina Faso p=0.002; Senegal not significant (p=0.086) Modern contraceptive use Senegal: aOR 2.3, not significant (p=0.073) Burkina Faso: Not significant

Author, year, country	Participant characteristics	Intervention details, setting, duration of intervention	Evaluation design	Quality	Program outcomes and results (Only statistically significant results presented)
KEM Hospital Research Centre, n.d. India	N=114 couples baseline, 76 couples endline, M and F, ages 14-25, married	**Health** - SRH Peer education - SRH information sessions and group discussions led by trained community-level educators (CLEs) Referrals - clinical referrals via CLEs or counselors to good, quality clinical services to address SRH concerns raised by participants Counseling - professional SRH couples counseling for young married men, women or couples ***Duration: 2000 - 2003 (3 years)***	Quasi-experimental pre- and post without control. Plus quantitative and qualitative monitoring	Low	**Health - SRH** SRH knowledge Men's and women's awareness of various health issues (menstruation, delivery, contraception, abortion) increased but not for other issues covered in the sessions. Even if an individual did not attend a session, their awareness increased if their partner attended. Qualitative data suggest that couples were discussing the SRH issues outside of the sessions. Percentages, significance, and other issues not reported.
Khan et al., 2008 India	N=1200, 24 experimental villages and 24 control villages (600 F recruited for each group), pregnant 3-6mo, ages <24 Additional engagement of husbands, mothers-in-law, health care providers, community health workers, and community leaders	**Health** - SRH and maternal health **Relationships and roles** - Marital relationship IEC materials - leaflets (distributed in villages), posters, wall paintings (at important community buildings), and a pocket booklet (distributed to health care providers, women, and their families) displaying messages about HTSP and FP methods; pre-tested and evaluated by the intended audience Training for community workers (CWs) - Lady Health Visitors (LHVs), Auxiliary Nurses and Midwives (ANMs), Male Health Workers (MHWs), Anganwadi Worker (AWs), and Accredited Social Health Activists (ASHAs) oriented in pre- and postnatal care, LAM, postpartum contraception, and counseling skills Inter-sectoral coordination - AWs and ASHAs visited households of pregnant women and lactating mothers to explain the need and advantages of HTSP; ANMs from each area led group meetings on the above topics; MHWs were assigned responsibility to conduct group meetings with the husbands of the pregnant women and counsel them individually Educational campaign - HTSP educational campaign and counseling by community workers (CWs) targeting pregnant women, their husbands, mothers-in-law, and community opinion leaders; group counseling of husbands on HTSP by male health workers (MHWs) Monitoring and supervision - monitoring and supervision of project activity quality and attendance *Duration: July-August 2006 - March 2008 (21 months)*	Quasi-experimental pre-post with control, clustered by village, baseline and two endlines	Medium	Husband-wife discussed family planning methods (endline) T: 61% (n = 560) C: 39% (n=570); p<0.001 Not significant: Husband-wife discussed when to have next child Mother-in-law and daughter-in-law discussed timing of next pregnancy Mother-in-law and daughter-in-law discussed family planning methods Knowledge of spacing methods and emergency contraception Correct ECP use Baseline combined (n=1197) 2% Endline T: (n=570) 19% C: (n=560) 4% Correct condom use Baseline: 86% Endline T: 93% C: 85% Correct OCP use Baseline: 56% Endline: T: 92% C: 83% IUD is for 10 years Baseline 0.5% Endline: T: 46% C: 5% IUD placed in uterus Baseline: 39% Endline: T: 85% C: 45% Postpartum contraceptive use Can describe 3 conditions for practicing LAM (Endline 4mo postpartum): T: 0-78% C: 0-<1% Practicing LAM at 4mo postpartum: T: 0-23% C: 0-0% Using family planning at 9mo postpartum: T: 63% C: 32% p<0.001; no sig change in type Pregnant 9mo postpartum: T: 10% C: 16%; p<0.01 Pregnancy due to contraceptive failure (primarily the condom) 9mo postpartum

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					T: 53% C: 20% Variables increasing likelihood of contraception use: Treatment 1.6x more likely to use contraception at 9mo; p<0.001 Husband-wife communication (odds ratios regardless of treatment or control) Discussed when to have next child 0.550; p<0.01 (less likely) Discussed family planning method use 7.806; p<0.01 Discussed both of the above 4.235; p<0.001 Knowledge of one or more spacing methods: 1.2X more likely to use contraceptives at 9mo p<0.001, *when the treatment variable is removed*
Luseno et al., 2017 Zimbabwe	N=35, F, orphaned, ages 17-26, who had married by wave 5 of larger RCT study (N=328)	**Health** - SRH **Relationships and roles** - Marital relationship **Life choices** - Schooling; Livelihoods Parent study was an RCT which provided school support to orphaned girls: School support - payment of school fees, uniforms, exercise books, and other school supplies (e.g., pens, soap, underpants, and sanitary napkins); female teacher “helper” who monitored participants’ school attendance and assisted with solving attendance problems Post-intervention evaluation focused on the experience of married girls related to SRH and maternal health, marital relationship, schooling, and livelihoods *Duration: 2007-2011 (4 years); data for marriage study collected October 2012 – November 2013*	Quasi-experimental pre-and-post with control, sample too small for significant findings* In-depth interviews with sampled girls	High	Qualitative findings: A majority of participants in both groups talked about how they wished they had done things differently, that marriage prematurely ended their opportunities for education and skill development, and that there would have been advantages to postponing marriage. Receiving school support did not appear to improve health-related factors. School support may not result in safer sexual networks or greater ability to negotiate for safe sex for young women. No difference was found in level of education or type of occupation between men marrying intervention vs control group participants. Average age of husbands was also similar. Pregnancy was among the most common reasons for marriage across both groups. Advancing age was also strong predictor of marriage independent of condition and certain religious sects are also associated with early marriage in Zimbabwe and may have over-ridden the beneficial effects of the intervention. The greatest benefit of school support appears to be in delaying marriage and pregnancy while increasing educational attainment. Quantitative: These results are not significant due to low sample size **Health – SRH and maternal health** ↓ positive attitudes toward SRH services ↓ use of SRH services ↓ likely to use family planning ↓ HIV testing, ↑ HIV positivity ↓ likely to immunize children **Relationships & roles - Marital relationship**

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					↓ happiness in marriage **Life choices - Schooling; Livelihoods** ↑ +1 year education ↑ food security Equal perceptions of having resources compared to others
Malak et al., 2021 Jordan	N=205, F, 13-18, married, in refugee camps, excluded girls who self-reported any physical or psychological disorders before marriage	**Health** - Mental health Counseling - mental health counseling services provided to teenage married girls as needed during health center visits in refugee camps *Cross-sectional design; no post-counseling evaluation mentioned (change in survey results not reported) *Duration: May 2018 - September 2018 (5 months)*	Cross-sectional survey with convenience sample (no follow-up)	Low	**Health - Mental health** *Associations from cross-sectional data (using Depression, Anxiety, and Stress Scale (DASS)) Depression 39.5% had moderate to extremely severe depression symptoms Model containing girl's age, father's and mother's educational levels, and previous trauma was statistically significant; ($F_{(4,200)} = 46.351$; $p < 0.001$; $R = 0.694$; $R^2 = 0.481$; adjusted $R^2 = 0.471$) Significant predictors were previous trauma ($B = -0.603$; $p < 0.01$) and father's educational level ($B = -0.179$; $p < 0.01$) Anxiety 35.6% had moderate to extremely severe anxiety In correlational terms, girl's age at marriage was significantly correlated ($p = 0.01$) with anxiety levels ($r = -0.223$) Model containing girl's age, age at marriage, father's and mother's educational levels, and previous trauma was statistically significant; ($F_{(5,199)} = 31.834$; $p < 0.001$; $R = 0.667$; $R^2 = 0.444$; adjusted $R^2 = 0.430$) Significant predictors were previous trauma ($B = -0.578$; $p < 0.01$) and father's educational level ($B = -0.144$; $p < 0.05$) Stress 9.8% had moderate to extremely severe stress Model containing girl's age, age at marriage, husband's educational level, father's and mother's educational levels, family income after marriage, and previous trauma was statistically significant; ($F_{(7,197)} = 22.397$; $p < 0.001$; $R = 0.666$; $R^2 = 0.443$; adjusted $R^2 = 0.423$) Significant predictors were previous trauma ($B = -0.532$; $p < 0.001$), husband's educational level ($B = -0.146$; $p < 0.05$), father's educational level ($B = -0.210$; $p < 0.05$), and family income after marriage ($B = -0.246$; $p < 0.001$) In correlational terms, girl's age at marriage ($r = -0.220$, $p=0.01$) and family income *after* marriage ($r = 0.137$, $p=0.05$) were significantly correlated with stress levels

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Mathur et al., 2005 Nepal	Quantitative: N=373 M and F, 84 married F (baseline) N=359 M and F, 81 married F (endline) Ages 14-21 Qualitative: FGDs, IDIs, KIIs, and other methods; 9 activities with 4-5 groups (baseline), 5 activities with 20 groups (endline) *Nepal study only (India study is presented in FRHS, 2006)	**Health** - SRH and maternal health **Norms** **Community mobilization with participatory methods:** Planning - collaborative planning process between project staff and youth and adult community members to identify, discuss, prioritize, and develop interventions that would best address community needs assessment Intervention components - resulting interventions linked direct youth RH programs with other programs that were deemed to influence the environment youth lived in, such as adult education programs, activities to address social norms, and economic livelihoods interventions Community advisors - development of adolescent coordination team and parents advisory committee to assist with coordination between project staff and community, encourage community participation and ownership, and provide project feedback **Traditional methods:** Control components - adolescent-friendly services, peer education and counseling, and teacher training that focused on STDS and unwanted pregnancies without linking to broader social constraints *Nepal study only (India study is presented in FRHS, 2006) *Duration: 1998 - 2003 (5 years)*	Quasi-experimental pre-and-post with control; cross-sectional (not panel) data In-depth interviews, focus group discussions, and "other participatory methods such as community mapping, lifelines, body mapping, reproductive health problem trees, and reproductive health service matrices"	Medium	*Intervention: community mobilization with participatory methods* *Control: traditional methods* Intervention and control were each implemented in an urban (Kathmandu) and a rural site (Nawalparasi); only rural site results were presented in this paper Sample size too small for significance (81 across T and C at endline) **Health - SRH and maternal health** Knowledge of maternal health Antenatal care: Community mobilization not more effective than traditional approach (control) Delivery: The traditional approach was more effective in increasing knowledge of serious problems during childbirth from baseline to endline (study sites: 49% to 67%; control sites: 40% to 88%) Use of maternal care services Use of antenatal services: Community mobilization 48% to 67%, traditional 41% to 37% Use of facilities for delivery: Community mobilization 26% to 50%, traditional 18 to 23% Use of postnatal care services: 27% to 20% community mobilization, 6.1% to 0% traditional
Mehra et al., 2018 India	N=1,770, 944 F, 826 M, ages 10-24, 371 ever-married Additional engagement of parents, in-laws, community leaders, and elected/administration officials	**Health** - SRH **Relationships and roles** - Social network **Life choices** - Schooling; Agency Youth information centres (YICs) - safe spaces in which young male and female groups received age and culturally appropriate life skill-based educational sessions from peer educators, focusing on SRHR from gender and sexuality perspectives; included promotion of education retention, entertainment, facilitation of peer communication, and access to referrals for counseling and treatment Peer educator training - peer educators trained in life skills-based comprehensive education on SRHR; the importance of completing school education, learning vocational skills, delaying	Cross-sectional post-test	Low	Cross-sectional endline data **Health - SRH** Timing of pregnancy The average age at first conception increased 0.85 years from 17.54 years to 18.39 years. Exposure to YICs Young people who did not have exposure to Youth Information Centres had a higher risk for early pregnancy for boys (reporting for their wives) (ORcrude=2.89; $p<0.05$) and girls themselves (ORcrude=2.42, $p<0.05$). *ORs adjusted for socioeconomic and confounding factors:* Participants not using the YICs had a higher likelihood of early pregnancy (aOR=3.00; $p<0.05$).

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		marriage and pregnancy; and behaviour change communication tools Community mobilization and media - posters in the community addressing pertinent questions related to early adolescent girls; meetings of parents, local governance, religious leaders, teachers, health service providers, and community stakeholders; advocacy, awareness, and information campaigns with local civil society groups, NGOs, and media; facilitation of collective action by district administration, law enforcement, and relevant departments *Duration: 2009 - 2013 (4 years)*			Access to media, caste/class Having no access to media was associated with early pregnancy for both boys reporting for their wives (ORcrude=1.52, p<0.05) and girls themselves (ORcrude=1.85, p<0.05) Girls who came from lower castes/classes (OBC/SC/ST) were more likely to conceive early (ORcrude=1.78, p<0.05) than those from better-off classes. Men who said that their wives came from a lower caste/class (OBC/SC/ST) had almost twice the likelihood to conceive early (ORcrude=1.92, p<0.05) as compared to those from better-off classes. Associations with access to mass media and caste were not significant at p<0.05 in the fully adjusted model.
Muthengi et al., 2016 Kenya	N=452, F, ages 15–19, married in urban slums in four cities and towns in Kenya (Nairobi, Thika, Nakuru and Kisumu) Qualitative subsample: N=48, 32 F, 15 M	**Relationships and roles** - Violence prevention **Life choices** - Livelihoods *The data is from a baseline survey and larger qualitative study of girls aged 15–19 residing in urban slums in four cities and towns in Kenya (Nairobi, Thika, Nakuru and Kisumu) for an intervention program aimed at building social, health and economic assets for vulnerable adolescent girls. "Findings are consistent with the program intervention targeting girls in the study sites based on the asset-building theory to economically empower girls through financial education and savings while also building their health and social assets." *Duration: August - December 2013 (5 months; baseline study)**	Cross-sectional secondary analysis of survey data coupled with content analysis of in-depth interviews	Low	*Baseline survey data only (cross-sectional) **Relationships and roles - Violence prevention AND Life choices - Livelihoods** Associations of physical violence (0 times in the last six months vs 1 or more) with… Work status: Work was associated with 87% greater odds of violence compared to not-working (OR = 1.87, p<0.01)** Saved money in previous six months: No significant difference in odds of violence between girls who did not work and those who worked but had regular savings Saved money * work status: Work with no regular saving was associated with 95% greater odds of violence compared to not-working (OR = 1.959, p<0.01)** Earning a higher income (greater than or equal to the median income) with no regular saving was significantly associated with increased odds of experiencing physical violence (OR = 2.640, p<0.05)* Qualitative findings indicate savings decrease girls' dependency on men and allow them to leave abusive partners Partner trust ("Your partner trusts you with money"): Partner trust regarding money was associated with 63% lower odds of violence compared to not having partner trust (OR = 0.365, p<0.05)* Qualitative:

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					Both men and women discussed relationship dynamics that contribute to physical violence, including lack of trust and norms about power dynamics and a woman's role in a relationship. The main reason reported for lack of trust between partners was suspected or actual infidelity. In communities with patriarchal gender norms and high levels of poverty, female employment and financial conflicts can be triggers of violence in marriages. Girls' management of and access to independent financial resources through savings can potentially help to reduce this risk.
Pande et al., 2006 India	Survey: N=616, Lab tests: N=437 F, married, ages 16-22 FGDs: Husbands, N not reported *CMC study only (FRHS and KEM studies are presented in FRHS, 2006, and KEM Hospital Research Centre, n.d., respectively)	**Health** - SRH and maternal health Program: Reducing Reproductive Tract Infections among Married Youth in Rural Tamil Nadu, Christian Medical College, Vellore (CMC)* The study compared two different community-based approaches for providing youth-friendly, accessible, affordable and effective diagnosis and treatment for RTIs and STIs among adolescents and young women and men: <u>Community-based health aide</u> - trained to diagnose and treat in the home; lives in the community and is more accessible but has less training in diagnosis and treatment than a medical doctor <u>Female doctor</u> - periodically provided treatment at a clinic held at a subcenter; patients were referred by a second set of health aides who were trained to identify symptoms and refer to doctor for formal diagnosis and treatment *CMC study only (FRHS and KEM studies are presented in FRHS, 2006, and KEM Hospital Research Centre, n.d., respectively) *Duration: 2001 - 2006 (5 years)*	Quasi-experimental design with two study arms, one with a community-based health aide; another with a female doctor, and one control arm Focus group discussions with young men	Medium	**Health - SRH** Comparison of health aide (Arm A) vs doctor (Arm B) in helping women with RTIs Overall, health aides in both arms interviewed more than three-quarters of all eligible women to assess symptoms of reproductive morbidity. <u>% RTIs diagnosed symptomatic</u> The monitoring data indicated that a larger percentage of interviewed women across the four cycles were deemed symptomatic in the doctor arm (33%) than the health aide arm (21%). <u>% symptomatic RTIs treated and cured</u> Health aides in Arm A treated on average 52.8% of symptomatic women…and 35% were cured of symptoms, compared to 27.5% treated and 19.8% deemed symptom-free in Arm B (female doctor). <u>% symptomatic RTIs followed up</u> Consistently weaker in Arm A (health aides) than in Arm B (female doctor) (figures not reported). <u>% women knowing more than 2 RTI symptoms</u> Arm A showed a nearly 6% higher increase (from 36.8 to 69.7%) than Arm B (from 45.1 to 76%). <u>RTI prevalence</u> RTI prevalence dropped by about 50% in Arm A, from 45.2% to 22.9%, and by 58% in Arm B, from 31.5% to 13.2%. Significance not reported throughout.

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Pathfinder International, 2015 Burkina Faso	N=650, F, ages 15-19, married girls or first-time mothers	**Health** - SRH and maternal health Individual - trained community health workers to reach young married women (YMW) and first-time parents (FTP) at their homes with individualized SRH information, counseling on HTSP and contraception, and couples' communication, as well as to make referrals (and sometimes escorts) to health facilities Community - small group discussions with YMW and FTP—led by trained YMW (trained on community sensitization, AYSRH topics, HTSP, and group facilitation)— to complement home visits; community theatre and group discussions with male partners and group discussions with key community leaders to sensitize them to HTSP and contraceptive messaging; engagement of gatekeepers (partners, mothers-in-law, co-wives, and traditional and religious leaders) Structural - disseminated national adolescent and youth sexual and reproductive health (AYSRH) standards and integrated youth-friendly services across facilities to ensure an enabling environment for changes at the individual and community levels *Duration: 2012 - 2015 (3 years)*	Qualitative monitoring data - focus group discussions with implementing partners, community health workers, and small group leaders	Low	**Health - SRH and maternal health** Female report of contraceptive use 41%-82% (n=650). Significance not reported. Implementation research findings: "To reach [young married women] and [first-time parents], implementers must first cultivate the engagement and support of key gatekeepers," who may block contraceptive use due to inaccurate information. **Mothers-in-law**: should introduce the project to mothers-in-law before addressing [young married women] and [first-time parents]." **Co-Wives: "**Co-wives in urban settings posed barriers to project participation because they feared that [young married women] supported by the project and using contraception would become more available to satisfy the sexual needs of the husband." "Including co-wives in small group discussions, and speaking with them separately at home visits to listen to their concerns and needs, reduced barriers." **Partners**: "Large age gaps between spouses contributed to an unequal power dynamic that made it difficult for the young woman to express herself openly." **Urban vs. Rural**: Urban mothers-in-law responded more significantly to messages that included discussion of the workload burden distributed throughout the household as a result of daughter-in-law's early or closely spaced births, while rural mothers-in-law appeared to respond to messages oriented toward basic information about the concepts of [healthy timing and spacing of pregnancy]." **Young married women vs. first-time parents** "[M]essages that focused on the risks of early pregnancy were most effective for [young married women] with no children; messages on HTSP were most effective for [first-time parents]; and messages that emphasized the costs of providing for large families were most effective for [young married women] with several children who were more receptianteve to learning about family planning."
Santhya and Haberland, 2007 India	F, newly married, pregnant, or postpartum for the first time Full sample N not reported. 1000+ girls participated in groups, 1800+ girls received home visits,	**Health** - SRH and maternal health **Relationships and roles** - Marital relationship; Social network **Life choices** - Rights and access to legal support; Agency **Norms** Health education and information - education provided to first-time parents (young women and	Quasi-experimental study, two treatment communities (Vadodara and Diamond Harbor), surveys at baseline and endline, no pre-	Medium	The intervention had significant, positive effects on girls' autonomy, reproductive health knowledge and practice, and couple relations. No sample sizes or significance levels provided throughout paper. *Arm 1: Vadodara* *Arm 2: Diamond Harbor* *Arm 3: Control* **Both villages:**

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	1400+ husbands received home visits Additional engagement of senior family members and health care providers	their husbands) on prevention of reproductive tract infections, contraception, sex as a voluntary, safe, and pleasurable experience, planning for delivery of first birth, care during pregnancy and the postpartum period, and breastfeeding, as well as ways for husbands to support wives during pregnancy, childbirth, and postpartum and the importance of communication, respect, and joint decision-making between husband and wife; implemented through home visits by female and male outreach workers, educational materials, counseling in clinics, group discussions, and community activities <u>Modifying existing services</u> - education of health service providers on the needs of young, newly-married couples and first-time parents; provision of safe delivery kits and training for traditional birth attendants; transportation to health services for young parents; home visits to new mothers within six weeks postpartum <u>Married girl groups</u> - formation of married girls peer groups to reduce isolation and increase their agency with educational topics such as legal literacy, vocational skills, pregnancy and postpartum care, savings and credit management, gender dynamics, relationship issues, and nutrition; visits to local institutions; development projects; celebrations *Duration: n.d. (2 years)*	assignment to treatment/control In-depth interviews at baseline.		<u>Autonomy</u> Significantly greater: 1. say in household decision-making 2. freedom of movement 3. report of having a friend in whom to confide <u>Health</u> Significantly greater reproductive health knowledge <u>Partner relations</u> Significantly more likely to have discussed contraceptive use with their husbands **Diamond Harbor only:** <u>Autonomy</u> Significantly more likely to adhere to egalitarian gender role attitudes <u>Health</u> Significantly more likely to: 1. have comprehensive antenatal check-ups 2. have made delivery preparations 3. have had a postpartum check-up 4. have breastfed their babies immediately after birth 5. have fed their babies colostrum <u>Partner relations</u> Significantly more likely than women in the control villages to express their opinion when they disagreed with their husbands **Vadodara only:** <u>Health</u> Significantly more likely to have routine postpartum check-ups and use of contraceptives for delaying the first birth <u>Partner communication</u> Significantly more likely to have discussed timing of first pregnancy with their husbands
Shattuck et al., 2011 Malawi	N=397 M, ages 18 and over, married to or living with a female sexual partner younger than 25 who was not currently pregnant or breastfeeding a child younger than 6 months	**Health** - SRH **Relationships and roles** - Marital relationship <u>FP information and resources</u> - male motivators—married men chosen for their use of and enthusiasm for modern contraception— visited participants with information on modern family-planning options and local facilities offering these methods, and they were instructed on correct condom use <u>FP motivation</u> - male motivators sought to positively influence participants' attitudes toward family planning and their motivation to adopt family planning through sharing their own	RCT In-depth interviews	Medium	**Health - SRH AND Relationships and roles - Marital relationship** <u>General communication, communication frequency measures</u> 1. Differential change across arms (P < .05) 2. Significant predictors of uptake of contraceptive use (P < .01), odds ratio 0.61 3. Single survey question - ease of discussing family planning with one's wife (b = 0.45; odds ratio [OR] = 1.57; P = .08) 4. Single survey question - frequency of discussing family planning with one's wife (b = 0.48; OR = 1.62; P = .02) 5. Qualitative**:** "Many interview participants said that overall communication with their wives or girlfriends was enhanced

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		experiences, engaging participants in discussions exploring how rigid gender roles and norms can lead to negative outcomes, and challenging the notion that a large family is a sign of virility <u>FP behavior</u> - male motivators encouraged participants to become involved in decisions related to family planning and family size and helping them practice discussing fertility and contraceptive desires with their wives or girlfriends, with an emphasis on joint decision-making power; participants were connected to FP methods through home or hospital visits *Duration: 2008 (< 1 year)*			by their increased comfort with discussing family planning, which some attributed directly to their interactions with the male motivator." Gender attitudes, family planning self-efficacy, and gender norms scales not significant across treatment v control. <u>Other qualitative findings</u> 1. "Ease of use was the main reason for selecting a given [contraceptive] method." 2. "Men found financial arguments for family planning more persuasive than other arguments: 13 out of the 14 men" "Men were also inspired to use family planning to benefit the health of their wives, girlfriends, or children's health."
Silverman et al., 2019 Niger	N=2,152, 1072 F ages 13-19, 1080 husbands Additional engagement of community members as mentors, influential community members/ gatekeepers, parents, and in-laws	**Health** - SRH and maternal health **Relationships and roles** - Violence prevention *Arm 1: Household visits only* *Arm 2: Small group sessions only* *Arm 3: Household visits and small group sessions* *Arm 4: Control* <u>Household visits</u> - monthly visits by gender-matched CHWs to individuals (married adolescent girls and their husbands) to discuss information and counseling on healthy timing and spacing of pregnancies (HTSP) and access and use of modern contraceptive methods <u>Peer groups</u> - twice monthly single-sex small discussion groups led by female community members trained as mentors to discuss general health and life skills, reproduction anatomy and health, use of modern contraceptive methods to accomplish HTSP, gender norms that impede contraceptive use and female autonomy, couples' communication regarding fertility decisions, and gender-based violence; monthly small groups for husbands led by trained male community members on the same topics <u>Community</u> - monthly village-level dialogues led by two trained facilitators engaged community gatekeepers and key influencers (e.g., traditional and community leaders, parents and in-laws) in creating an environment supportive of HTSP and contraceptive use among married adolescent girls and their husbands	Four-arm cluster RCT, difference in difference	High	**All intervention participants (Arms 1-3):** <u>Contraceptive use among non-pregnant women</u> Intervention: 10% to 41% Control: 17% to 29% Significantly larger increase (p only provided for individual arms) <u>Intimate partner violence</u> No significant difference between **all** treatment participants and control. **Arm 1: Household visits only** <u>Female report of contraceptive use</u> 1. Logistic regression: Significantly higher odds than control (aOR=5.38, p<0.001) 2. Linear regression: Increased by 19.4% (p<0.001) relative to control 3. Greater effects than the arm including only small groups (ps<0.05) <u>Male engagement as predictor of contraceptive use</u> 1. Logistic regression a. Women whose husband attended at least one home visit (aOR=6.9, 95%, p=0.02) b. Wives whose husbands attended **four or more** home visits (aoR=9.0, p=0.03) 2. High male visit participation was associated with significantly higher odds of modern contraceptive use **after controlling for female visit participation level** (aOR=11.6, p=0.02) <u>Female engagement as predictor of contraceptive use</u> 1. Controlling for male engagement, high wife visit engagement associated with significantly higher odds of use (aOR=6.6, p=0.03).

Author, year, country	Participant characteristics	Intervention details, setting, duration of intervention	Evaluation design	Quality	Program outcomes and results (Only statistically significant results presented)
		Duration: May 2016 - June 2018 (26 months)			2. Linear regression: women attending seven or more home visits 18% higher use relative to fewer visits (p=0.03) Intimate partner violence No significant difference **Arm 2: Small group sessions only** Women's contraceptive use Male or female engagement as predictor of contraceptive use No significant difference relative to control Intimate partner violence 1. Logistic regression: lower relative to control (aOR=0.35, 95% CI 0.14-0.89, p=0.03). 2. Linear regression models, lower relative to control by 8.3% (95% CI -15.6—0.9). 3. Both arms that included small group sessions produced greater effects than the arm including only home visits (ps<0.01). **Arm 3: Household visits and small group sessions** Contraceptive use 1. Logistic regression: (aOR=4.41, 95% CI 2.02-9.64, p<0.001). 2. Linear regression: use increased by an additional 20.3% (10.0-30.7%, p<0.001) relative to control. 3. Both arms that included household visits produced greater effects than the arm including only small groups (ps<0.05). Male or female engagement as predictor of contraceptive use
Stark et al., 2018 Ethiopia	N=919 F, ages 13-19, Sudanese and South Sudanese in refugee camps 457 in intervention; 462 in control, 31 total clusters Additional engagement of caregivers	**Relationships and roles** - Violence prevention; Social network **Norms** Girls' group sessions - weekly adolescent girl life skills sessions in safe spaces* improving communication, friendship building, and awareness of GBV and sexual and reproductive health, with 45–60 min of facilitated content and 30 min of unstructured time (30 in-person group sessions); delivered by trained female refugee mentors aged 18–30 years who spoke the same languages as participants Caregiver sessions - 8 monthly discussion groups for enrolled girls' caregivers, which covered topics such as communication skills, supporting adolescent girls, and understanding violence and abuse; delivered by IRC staff with assistance from translators	Two-arm, single-blinded, cluster RCT	High	**Relationships and roles** - Violence prevention Sexual violence No significant effect on report of sexual violence, physical violence, emotional violence, transactional sex, or feelings of safety in their homes, schools, friends' homes and neighbors homes. **Relationships and roles** - Social network Social networks Having friends one's own age - 1.71 greater odds (p=0.005, adjusted for covariates) Having a trusted non-family female adult in their life - 1.997 greater odds (p<0.001, adjusted for covariates) **Norms** Attitudes around rites of passage Believing a girl should get married - 1.88x more likely in treatment (aOR=1.88, p=0.027) Believing a girl should have her first child after age 18 2x more likely (aOR=2.04, p=0.005).

Author, year, country	Participant characteristics	Intervention details, setting, duration of intervention	Evaluation design	Quality	Program outcomes and results (Only statistically significant results presented)
		*Safe spaces were accessible to all women and girls living in the camps for unstructured activities in between COMPASS sessions *Duration: 29 July 2015 - 4 September 2016 (approx. 13 months)*			
Subramanian et al., 2018 India	*Phase 1*: N=118,883 (F ages 12-14, M/F ages 15-19, and young couples with a parity of 0 or 1) *Phase 2*: N=95,245 (F ages 12-14 & M/F ages 15-19 and their parents, young couples with a parity of 0 or 1) *Phase 3*: N=376,956 (M/F ages 15-19 and their parents, young couples with a a parity of 0 or 1 or with 2 or more children) Ages 12-24 Additional engagement of family members and other gatekeepers (husbands, parents, and mothers-in-law), community members (religious leaders, community elders), and the health service delivery system (including community health workers)	**Health** - SRH Outreach to women - for married young women with up to 2 children, female lay health workers (called "change agents") conducted home visits and group meetings to counsel and refer women for services at planned intervals timed with life events such as marriage, pregnancy, and newly parenting a child; for newlywed couples, PRACHAR hosted "newlywed ceremonies" that combined education and entertainment Outreach to men - male change agents reached husbands of young women through regular small-group meetings, which included dialogue and discussion on sexual and reproductive health and gender; newlywed ceremonies (see above) Supply and demand of health services - government and private-sector contraceptive services were mapped and received small enhancements (e.g., training) from PRACHAR, with referrals to these services made by the change agents Family and community **-** mothers-in-law were reached with home visits and small groups, and the wider community was engaged through community meetings, street theater performances, wall paintings, puppet shows, and information, education and communication (IEC) materials	Multiple quantitative population-based quasi-experimental evaluations from three project phases; performance monitoring; qualitative interviews with beneficiaries Phase 1 tested a comprehensive model, Phase 2 compared the effectiveness of different single-intervention arms to the comprehensive model, and Phase 3 tested a streamlined government-NGO model with greater potential for scale-up	Medium	Adjusted Odds Ratios for Current Contraceptive Use Among Young Married Women Aged 15–24 (Phase I and II) and Aged 15–34 (Phase III) in PRACHAR Intervention Models **Phase I** 3-Year Comprehensive NGO Model (n=4,075) Adjusted Odds Ratio 3.84 p<0.001 T: 4.3-20.7% p<0.001 C: 2.8-4.7% Phase I home visits - aOR=2.30; P<0.001 **Phase II** 2-year home visit model (n=3,913) Adjusted odds ratio 2.00 p<0.01 T: 18.3%-18.2% C: 11.2%-6.3% Phase II 2-year comprehensive NGO model and Phase II volunteers only model not significant Changes in type of contraceptive not significant **Factors influencing likelihood of contraceptive use:** Exposure to intervention, adjusted odds ratios relative to control Wife only 1.99 p<0.01 Husband only not significant Both partners 3.69 p<0.001 Exposed to group meetings - (aOR=3.16; P<.001, adjusted for education, caste, and standard of living index).)" Reached with home visits at multiple life cycle stages (newlywed, before pregnancy, during pregnancy, and after first birth) - highest ever use of contraception 7 to 12 home visits - "A relationship was observed between the **number of home visits** and ever use of contraception among young married women, with 7 to 12 visits as the 'tipping point' where more than half of contraceptive users had initiated use." Earlier contraceptive use - aOR=13.70; P<.001 regardless of treatment or control Wives participated in decision making about contraceptive use **-** (aOR=1.5 for couples without children and aOR=1.2 for couples with 1 child) regardless of treatment or control

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					Sustainability of effects 4-8 years later, Phases I, II Adjusted Odds Ratios for Current Contraceptive Use Among Married Women Aged 15-34 in Areas Where PRACHAR Phase I, Phase II, or Phases I & II Were Implemented 4-8 Years Earlier Ever used contraception 2.06 $p<0.01$ Currently using contraception 1.57 $p<0.01$ Initiated contraception within 3 months of consummating marriage (parity 0 or 1, n=636) 4.95 $p<0.05$ Initiated contraception within 3 months of first birth (parity 1, n=478) aOR=3.13, $p<0.05$ Initiated contraception within 3 months of first birth (parity 2, n=748) aOR=1.61, $p<0.05$
The ACQUIRE Project, 2008 Nepal	N=960, 480 F age <21, 480 M husbands, married FGDs: 4 with husbands, 4 with mothers-in-law Additional engagement of service providers at government health facilities, influential community members (such as mothers- and sisters-in-law) and youth under 25 years of age	**Health** - SRH **Relationships and roles** - Marital relationship **Norms** <u>Peer education network</u> - door-to-door visits, individual interactions, and group activities to increase reproductive health knowledge among married adolescents; encouragement of spousal communication and decision making on reproductive health, as well as partner involvement in maternal health care; referrals to health services, distribution of condoms and contraceptive pills, and condoms stocked at designated community locations <u>Peer educator training</u> - basic training on reproductive health and dissemination skills; facilitation and communication skills training; leadership development training; street drama performance arts training; "Teen Saathi Abhiyan (TSA)" campaign engaged peer educators to share their knowledge and skill with close friends in order to support peer educators at events <u>Quality of health services</u> - training of providers on the reproductive health needs of married adolescents and youth-friendly services and provision of additional essential medical equipment and technical support <u>Family and community</u> - advocacy among influential community members on the reproductive health needs and rights of married adolescents; sensitization of mothers-in-law and sisters-in-law to support married adolescents' involvement in	Cross-sectional quasi-experiment with household surveys, 30-clusters (VDCs), no control Qualitative FGDs	Low	Percentages baseline to endline, significance levels not reported **Health - SRH and maternal health** <u>ANC & delivery</u> Four or more antenatal care visits during their last pregnancy - 29% to 50% Delivered with the help of a skilled birth attendant - 24% to 31% Deliveries taking place at home - 75% to 67% <u>Awareness of contraception</u> Awareness of two or more modern methods of contraception - almost universal at endline Awareness that condom use can prevent pregnancy - 65% to 93% <u>Contraceptive use qualitative</u> Discussions with mothers-in-law further revealed the widespread belief that contraceptive use before first pregnancy causes infertility. <u>Delayed sexual initiation</u> Median age at *gauna* (the local custom when a married girl moves into her husband's home following menarche, for consummation of the marriage) - 15 years to 16 <u>HIV/AIDS</u> Heard of HIV/AIDS - married girls 20% - 32.8%, married boys Aware of 3 modes of transmission - married girls 2.7% - 5.1%, married boys 12% - 28% Aware of 3 preventative measures - married girls 2.7% - 5.8%, married boys 12% - 35% <u>Median age at first birth</u> Remained at 17 years, not significant

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		reproductive health decision making and access to services IEC materials - flex chart with RH and FP messages, flipcharts for use in group discussions, RH training manual, "Waves of Change" video documentary *Duration: 2005 - 2007 (2 years)*			**Relationships and roles - Marital relationship AND Norms** Partner communication Discussed where to deliver with their spouse - 24% to 40% Belief that husband and wife together responsible for family planning - married girls - 37 to 65%; husbands - 57 to 79%
Undie et al., 2014 Kenya	N=707, 472 F, married, ages 14-19, 235 M husbands (baseline) Additional engagement of community members using radio/Facebook with listener participation and discussions, community health workers, and health service providers	**Relationships and roles** - Marital relationship Media campaign - interactive media campaign (twice weekly radio soap opera series and weekly discussion segment about the life of a married adolescent girl, with an accompanying Facebook page for discussion; text messaging and call-ins to encourage listener participation) intended to communicate RH/Family planning and HIV messages to married adolescent girls CHW training - trained on: key RH/FP and HIV information and services relevant to the needs of married adolescent girls and their partners; use of modified Community-Based Health Information System (CBHIS) monitoring tools; and intensive follow-up (via regular home visits and referrals to health facilities); CHWs received monthly honoraria (approx USD $25) if they met certain criteria, logoed t-shirts, and participation certificates Distribution of information and IEC materials - CHWs provided regular household visits to married adolescent girls and their husbands with RH/FP and HIV information, services, and referrals; information leaflets related to the media campaign were mailed for free to listeners and posters were distributed to health facilities *Duration: 2009 - 2011 (2 years)*	Pre- and post-intervention design without control, some measurement of exposure on select indicators	Low	Percentages of married adolescent girls (n=350), baseline - endline **Health - SRH and maternal health** Use of family planning Baseline 38%-45% ($p=0.005$) Girls reporting exposure to the intervention more likely to use family planning ($p=0.006$) Method of family planning Injectables 68%-56% ($p<0.05$) (Male) Condoms 13%-25% ($p<0.01$) Pills 9%-1% ($p<0.05$) Implants 2%-9% ($p<0.01$) ANC: Month of pregnancy at which 1st ANC visit made 7-8 months 13%-8% ($p=0.046$) Total number of ANC visits made 4 visits: 22%-30% ($p=0.017$) Girls exposed to the intervention more likely to have attended ANC four times during their last pregnancy ($p=0.009$) Delivery site (n=351,365) Home 44%-36% ($p<0.05$) Govt. health facility 48%-55% (not significant) Other months of first ANC visits, other total number of ANC visits, other place of delivery, and type of birth attendant not significantly changed. Postpartum family planning (n=124, 153) Implants 2%-7% ($p=0.028$) Condom 6%-19% ($p=0.001$) No significant differences in other postpartum family planning methods, HIV testing and counseling, utilization of prevention of mother-to-child transmission (PMTCT) of HIV services, or timing of postnatal care visits. **Relationships and roles – Marital relationship and decision-making** Wives whose husbands… Provided transportation/transportation money to go for ANC services 53%-65% ($p=0.001$)

Author, year, country	Participant characteristics	Intervention details, setting, duration of intervention	Evaluation design	Quality	Program outcomes and results (Only statistically significant results presented)
					Provided money to plan for the delivery 69%-79% (p=0.003) Provided money to pay for delivery services 62%-60% (p=0.021)
Walgwe et al., 2016 Kenya	N=NR, F, pregnant or parenting, ages 13-19 Household surveys N=NR School surveys N=1413 F, ages 13-19, 167 school principals Additional engagement of local Department of Education, community stakeholders, and policymakers	**Life choices** - Schooling Media - interactive media campaign (including radio messaging) that targeted schools and communities to increase demand for secondary school education among teenage mothers through enhanced awareness of existing, supportive school retention and re-entry policies for pregnant and parenting students within Homa Bay County* Advocacy - evidence-based advocacy to promote policy implementation Policy dialogues - two policy dialogues (held in August 2014 and April 2016) with about 200 Homa Bay County school principals and other education decision makers *Kenya's national school health policy permits pregnant students to remain in school for as long as possible, and Kenya's school re-entry policy encourages re-entry after childbirth *Duration: 2014 - 2016 (2 years)*	Cross-sectional baseline and endline data	Low	**Life choices - Schooling** Out-of-school girls who re-entered school BL: 10% EL: 16% ("Significant," p-value not reported) Qualitative: "The policy dialogue mechanism was a valuable way to accurately convey the evidence to multiple levels of decision makers – county governments and principals – through work-related structures. Participants were able to understand the content of, and rationale for, the policies, deliberate in an open forum, and contribute to collective solution creation."

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Supplemental Table B. Intervention duration by region

Region	NR	Up to 18 months	18-35 months	3+ years
Middle East and North Africa (MENA)		Malak 2021		
South Asia			CREHPA 2004 Huda et al, 2019 (26 months) Khan et al, 2008 Santhya and Haberland, 2007 The ACQUIRE Project, 2008	Dyalchand et al, 2021 FRHS, 2006 KEM Hospital, n.d. Mathur et al, 2005 Mehra et al, 2018 Pande et al, 2006 Subramanian et al, 2018
West Africa	Engebretsen and Kaboré, 2011 Jacobs et al, 2017		Falb et al, 2015 Silverman et al, 2019 (26 months)	Pathfinder, 2015
East Africa		Muthengi et al, 2016 (baseline) Stark et al, 2018 Walgwe et al, 2016	Edmeades et al, 2016 Erulkar and Muthengi, 2009 IRH et al, 2016 (27 months) Undie et al, 2014	Erulkar and Tamrat, 2014 Handa et al, 2015
Southern Africa		Shattuck et al, 2011		Luseno et al, 2017
LAC, North America, East Asia, Europe and Central Asia				