


VOLUNTARY FAMILY PLANNING PROGRAMS THAT RESPECT, PROTECT, AND FULFILL HUMAN RIGHTS

A Systematic Review of Evidence

SEPTEMBER 2013 (Updated April 2014)

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VOLUNTARY FAMILY PLANNING PROGRAMS THAT RESPECT, PROTECT, AND FULFILL HUMAN RIGHTS

A Systematic Review of Evidence

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September 2013 (Updated April 2014)

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ACKNOWLEDGMENTS

This work grew out of a small contract with the Bill & Melinda Gates Foundation to explore the fundamentals of voluntary family planning and experiences with coercion in sexual and reproductive health programming. The scope expanded when our team began collaborating with Marie Stopes International and the World Health Organization—the two organizations are currently interested in providing guidance to country programs on rights-based family planning.

The search and review of evidence found in this document sought to inform and support the conceptual framework on voluntary, right-based family planning programs that is found in *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework* (Hardee et al., 2013).

This work has received positive feedback, and we are very grateful to all individuals and organizations for their constructive input and thoughtful consideration, especially other members of the team, Jan Kumar, Lynn Bakamjian, and Karen Newman for their careful insight and review. We would also like to thank the Resources Mobilization and Awareness Working Group of the Reproductive Health Supplies Coalition, who hosted two webinar consultations where the framework and evidence was presented. We thank the staff of the Bill & Melinda Gates Foundation for their valuable support and guidance, especially Win Brown and Monica Kerrigan.

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Finally, we thank Lori Merritt and Ginny Gordon of Futures Group for their expert editing and graphic design, respectively.

ABBREVIATIONS

AAAQ	availability, accessibility, acceptability, and quality
AFP	Advance Family Planning (project)
AIDS	acquired immune deficiency syndrome
BCC	behavior change communication
CBD	community-based distribution
CEDAW	Committee on the Elimination of Discrimination against Women
CHW	community health worker
DFID	UK Department for International Development
EC	emergency contraception
ECP	emergency contraception pill
FGM/C	female genital mutilation/cutting
FP	family planning
FPHSP	Family Planning Health Services Project
HIV	human immunodeficiency virus
HMIS	health management information system
HPP	Health Policy Project
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ICRW	International Center for Research on Women
IEC	information, education, and communication
IFPS	Innovations in Family Planning Services (project)
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
LAM	Lactational Amenorrhoea Method
LHW	lady health workers
MCH	maternal and child health
MDG	Millennium Development Goal
MSI	Marie Stopes International
NGO	nongovernmental organization
NPC	National Population Council
OBA	(Reproductive Health) Output-Based Aid (program)
OHCHR	Office of the High Commissioner for Human Rights
OSAR	Reproductive Health Observatories (in English)
OCP	oral contraceptive pill
PBI	performance-based incentives
QA	quality assurance
QI	quality improvement
Rs	rights
RCT	randomized controlled trial
RHSC	Reproductive Health Supplies Coalition
SAM	Service Availability Modules (DHS)
SP	simulated patient
SRH	sexual and reproductive health
STD	sexually transmitted disease
STI	sexually transmitted infection
UN	United Nations
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund

UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
VD	voucher distributor
WHO	World Health Organization
WHO/RHR	World Health Organization/Reproductive Health and Research

I. INTRODUCTION

Background

The principle of voluntarism has been a long-standing cornerstone of international support for family planning; and the need to respect, protect, and fulfill an expanded list of reproductive rights has been articulated, particularly since 1994. Yet, few attempts have been made to link voluntarism and human rights into a comprehensive operational framework to guide family planning policies and programs. To fully understand what a voluntary, rights-based family planning program should include and how to effectively implement it, a team of staff and consultants from Futures Group, EngenderHealth, and the Bill & Melinda Gates Foundation[1] drafted the **Framework for Voluntary, Family Planning Programs that Respect, Protect, and Fulfill Human Rights** as a way to clearly illustrate how voluntarism and human rights can be mutually reinforcing in family planning programs. Specifically, the framework was developed to

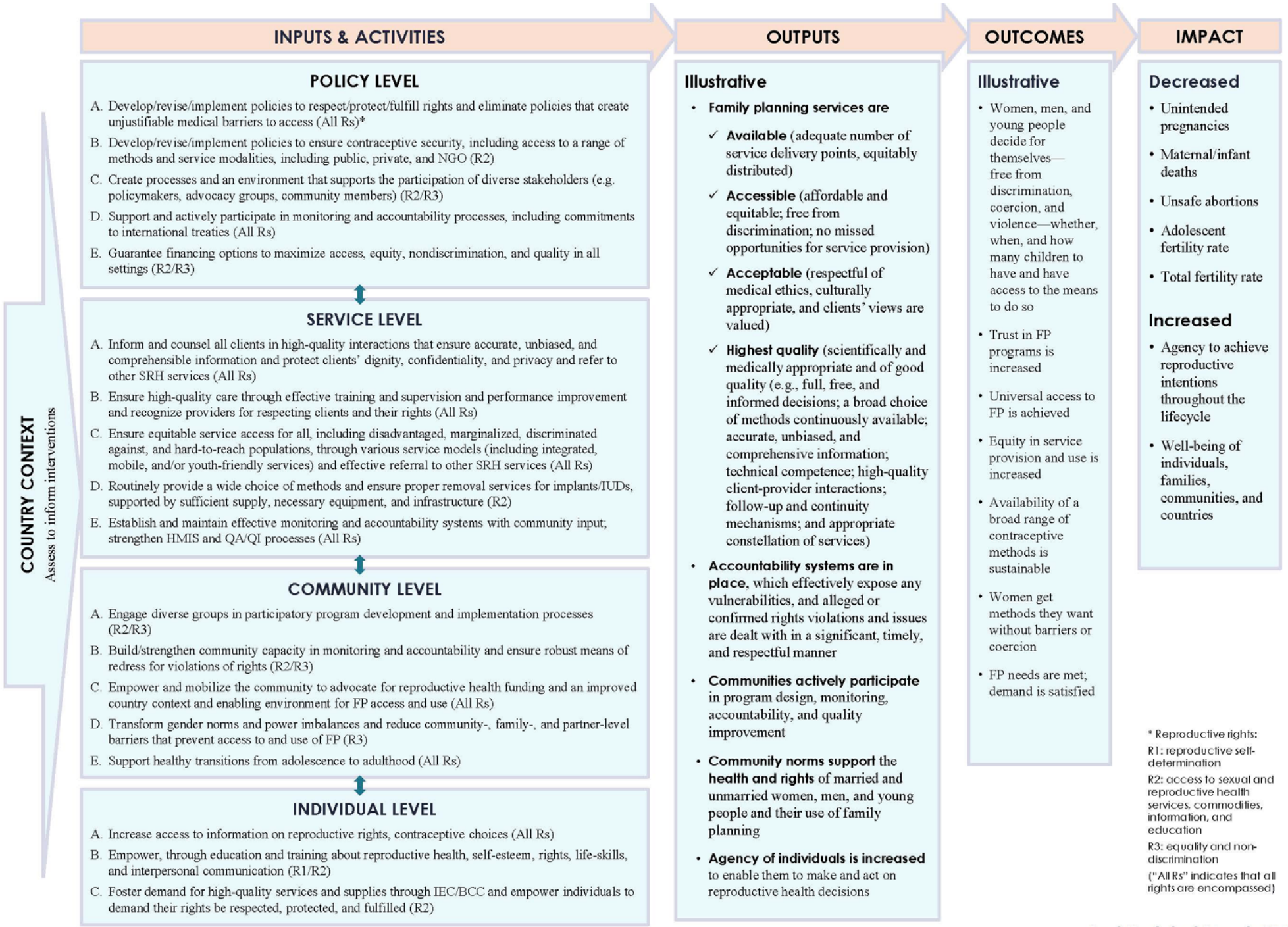
- Describe key family planning (FP) program elements in terms of rights, incorporating public health and human rights principles.
- Offer a practical approach to operationalizing reproductive rights in the development, implementation, and monitoring and evaluation of voluntary FP programs.
- Link program inputs and activities to public health and human rights outcomes and impact.
- Highlight how countries can invest in and make further progress toward the realization of rights as an inherent part of supporting comprehensive, high-quality FP programming.

The framework (see Figure 1) is designed as a logic model, linking inputs and activities with outputs and the outcomes and impacts. In the course of developing the framework, the team conducted (1) a literature review of current evidence for voluntary rights-based family planning to identify practices that promote a rights-based approach to achieving public health and rights outcomes and (2) a review of available tools that could help operationalize a voluntary rights-based approach. Until this work, no systematic review of rights-based family planning existed, and as such, there was a need to search for evidence and tools that could support and elaborate the components of the framework. The team synthesized the findings according to the framework's components and four levels, helping to identify the key actions or factors for family planning programs to implement or consider.

This paper focuses on the strategy, methodology, and findings of the literature review. Several of the documents reviewed are highlighted throughout the paper, while Annex 1 includes a complete list of the documents found. For details on the framework and the review of available tools, see the accompanying papers in this series, *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework* (Hardee et al., 2013) and *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Systematic Review of Tools* (Kumar et al., 2013).

[1] The team included expertise in global and country family planning programs, policy, monitoring and evaluation, reproductive rights, and gender. The expertise was augmented by reviews from a range of stakeholders at the global, regional, and national levels.

Figure 1. Framework for Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights



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Methodology

The literature review concentrated on relevant **interventions, evaluations, and case studies** to help achieve a better understanding of what elements are needed for a successful voluntary, rights-based family planning program. Because there is no existing definition of a rights-based approach to family planning, evidence related to rights-based programming is limited. Therefore, the review cannot be considered exhaustive but rather a good starting point for continued research. Our search strategy, described below, was guided by a series of questions related to what a successful voluntary, right-based family planning program should include.

Search Strategy

The questions guiding the search strategy included

1. How can we ensure public health programs oriented toward increasing access and use of family planning are voluntary and respect and protect rights in the way they are designed, implemented, and evaluated?
2. What works to promote voluntary, rights-based family planning? Or what rights-based interventions or tools increase family planning demand and/or access (service delivery)?
3. What evidence exists to support a rights-based approach to family planning?

The literature search (databases, individual websites, hand-search) was conducted to find

1. References that describe the "principles" of reproductive rights and empowerment (might include "approaches").
2. References to "tools" or "approaches" that can be used in family planning programs that support reproductive rights and empowerment.
3. References to "intervention studies" in family planning programs.

References for "principles" were largely defined in the work (hand-search) on the reproductive rights framework. References for "tools" were included if they addressed "elements" in the reproductive rights framework (broadly defined: availability, accessibility, acceptability, and quality). References for "intervention studies" were included if they described an impact or evaluation study that provided a family planning result—or a "rights-based outcome" where that can be identified. Any FP intervention study was reviewed and included if it supported reproductive rights and empowerment elements of the framework. References for "intervention studies" were reviewed a second time for final inclusion.

Searches for rights-based family planning interventions yielded no results. Pretty Darn Quick Evidence (a new database that provides quick access to high-quality health system and public health evidence, including systematic reviews and overviews of systematic reviews, primary studies included in those, and structured summaries) was searched and no rights-based studies or reviews were found.

Interventions (with evidence) in the "what works" family planning literature were found. They are mainly related to quality of care, although some demand-side interventions are also identifiable. The quality of care interventions, which relate to rights of clients and rights of providers, were deemed most applicable to our rights-based focus.

See Table 1 for details of the search strategy in PubMed/MEDLINE and POPLINE. In addition to searches of PubMed/MEDLINE and selected retrievals from POPLINE, snowballing review articles, such as the following four, also identified interventions:

1. Mwaikambo, L., I. S. Speizer, et al. 2011. “What works in family planning interventions: a systematic review.” *Studies in family planning* 42(2): 67–82.
2. Church, K., and S. H. Mayhew. 2009. “Integration of STI and HIV prevention, care, and treatment into family planning services: a review of the literature.” *Studies in family planning* 40(3): 171–86.
3. Bauman, K. E. 1997. “The effectiveness of family planning programs evaluated with true experimental designs.” *American journal of public health* 87(4): 666–9.
4. Samara, R., B. C. Buckner, et al. 1996. *Understanding How Family Planning Programs Work: Findings from Five Years of Evaluation Research*, EVALUATION Project.

The PubMed and MEDLINE searches were conducted within EndNote to facilitate duplicate removal. Screening of 2,695 references within EndNote used free-text/full-text terms (evidence, outcome, baseline, follow-up, intervention, and quality) and keyword terms (program evaluation and research). Screened sets exclude abortion, only include evidence in low-resource countries, and are limited to 1995–2012. Of around 500 intervention studies retrieved, approximately 292 are summarized in tables (see the narrative section below and Annex 1); the format for the evidence tables mirrors the format from Mwaikambo et al. (2011).

Table 1. PubMed/MEDLINE and POPLINE Search Strategy

MeSH Terms	# Records retrieved As of November 7, 2012	Additional records retrieved As of January 30, 2013
“Reproductive rights” [MeSH]	462 [YR: 1985–2012]	[2012=25] 8 new [2013=0]
"Human rights" [MeSH] AND "Women's Rights" [MeSH] AND "Family Planning Services" [MeSH] NOT "United States" [MeSH]	397 [YR: 1985–2012]	[2012=7] 1 new [2013=0]
"Family planning services" [MeSH] AND "voluntary" [AF]	411 [YR: 1985–2012]	[2012=12] 7 new [2013=0]
"Family planning services" [MeSH] AND “incentive” [AF] NOT "United States" [MeSH]	608 [YR: 1985–2012]	[2012=12] 3 new [2013=0]
"Family planning services" [MeSH] AND "informed consent" [MeSH] NOT "United States" [MeSH]	91 [YR: 1985–2012]	[2012=1] 0 new [2013=0]
"Family planning services" [MeSH] AND “rights” [AF] NOT "United States" [MeSH]	865 [YR: 1985–2012]	[2012=11] 0 new [2013=0]
"Health services" [MeSH] AND "contraception" [MeSH] and “rights” [AF] NOT "United States" [MeSH]	410 [YR: 1985–2012]	[2012=10] 3 new [2013=0]
"Family planning policy" [MeSH] AND “population control” [MeSH] NOT "United States" [MeSH]	124 [YR: 1985–2012]	[2012=2] 1 new [2013=0]
969 duplicates	Set of 2,399 [YR: 1985–2012]	X
Year limits	Set of 1,241 [YR: 1995–2012]	X

"Reproductive health services" [MeSH] AND "rights" [AF] NOT "United States" [MeSH]	251 unique new [YR: 1995–2012]	[2012=30] 4 new [2013=0]
"Reproductive health services" [MeSH] AND "policy" [AF] NOT "United States" [MeSH]	1,040 unique new [YR: 1995–2012]	[2012=59] 4 new [2013=3]
Combination set	Set of 2,532 [YR: 1995-2012]	X
"Family planning services" [MeSH] AND "quality of health care" [MeSH] NOT "United States" [MeSH] AND "baseline"[AF] (or "follow-up"[AF]) OR "outcome" [AF]	50 [YR: 1995–2012]	Baseline [2012=10] 8 new Follow-up [2012=8] 4 new Outcome[2012=14]10 new [2013=0]
"Contraception behavior" [MeSH] NOT "United States" [MeSH]	287 [YR: 2011–2012]	[2012=159] 21 new
	Set of 2,695 new unique [YR: 1995–2012]	74 new
Previous screened literature search (YR: 2008–2012) using the terms "program evaluation"; "contraceptive use or behavior"; "family planning"; "fertility." Free-text combinations for "evaluation" or "outcome" or "impact" with "intervention" PLUS studies identified in the 4 review articles cited in the text above for years before 2008.	497 [YR: 1995–2012]	X

Categorization

The review findings were categorized into the levels in the conceptual framework: policy, service, community, and individual. The majority of the evidence relates to the service delivery level, where studies predominantly evaluated approaches to quality of care, meeting the needs of providers (e.g., through training), and client-provider interaction. Evidence from the community level came from interventions related to community-based workers, changing of norms and behaviors (especially those related to gender, acceptance of FP), and interpersonal communication between spouses. The least amount of evidence pertained to interventions at the policy level. Policy change does not lend itself to studies and evaluation to the extent the other levels in the framework do, thus most of the interventions found in the literature did not provide sufficient level of evidence to complete the table. However, national policy documents and legislation were highlighted as well as a few interventions on the implementation of FP policies and their effect on contraceptive uptake or access to services. This level also includes national-level reproductive health or FP policies that aim to promote and protect rights regarding family planning. It is important to note that several studies had elements of their interventions that cut across the different levels of policy, service, community, and individual. However, we decided to categorize these studies into the level that corresponds with the majority of the intervention components. Descriptions of the range of interventions at the four levels and the evidence from cross-cutting interventions are presented below.

Based on the search criteria and categorization strategy, the evidence found by level is distributed as follows:

- Policy-level interventions: 29 policy documents/studies/evaluations
- Service-level interventions: 163 studies/evaluations
- Community-level interventions: 68 studies/evaluations
- Individual-level interventions: 32 studies/evaluations

II. REVIEW FINDINGS

Policy Level

Interventions to change policy are generally not the subject of evaluation, although a number of case studies documenting policy change exist. For example, a study comparing family planning in four pairs of countries—Bangladesh/Pakistan, Thailand/Philippines, Tunisia/Algeria, and Zimbabwe/Zambia—note the importance of policy elites sharing policy risk, along with institutional and financial stability, as the key factors that played a role in the success of family planning (Lee et al., 1998). Furthermore, the definition of policy implementation and how it relates to program implementation and evaluation is relatively new (Hardee et al., 2012; Hardee et al., 2013). Thus, most of the relevant literature at the policy level that we found to support voluntary, human rights-based family planning are national policy documents and legislation as well as a few interventions on the implementation of FP policies and their effect on contraceptive uptake or access to services. Although not evaluations in the same sense as those available for interventions at the service and community levels, the documents found at the policy level are nonetheless valuable.

For example, prior to the 2012 London FP Summit, the Resource Mobilization and Awareness Working Group of the Reproductive Health Supplies Coalition (RHSC) polled its members to identify policy changes "that stand to make a substantial contribution to meeting the unmet need for family planning" (RHSC, 2012: 2). The list of the top 10 policy issues shown in Box 1 represents the collective experience of more than 150 partners in 26 countries in the Global South.

Box 1. 10 Key Policy Changes Needed to Meet Unmet Need for FP—Perspectives from 26 Countries

1. Supportive legislative and policy development and implementation frameworks; prioritises the provision of family planning as an integral part of health services.
2. Ensure adequate and sustainable national resources for family planning at all levels (national, district , and local) to support procurement and provision of family planning services.
3. Develop a policy implementation structure that links central and decentralized institutions.
4. Focus on task shifting and improve the skills of the health workforce particularly at the community level.
5. Ensure registration, importation, procurement, and distribution of reproductive health essential medicines, contraceptives, and consumables using public and private sector infrastructures.
6. Establish policies that integrate family planning as part of the provision of sexual and reproductive health services.
7. Support gender equity and promote girls education.
8. Support policy development and implementation that prioritises provision of services for vulnerable and poor sectors of the population, including adolescents.
9. Include family planning in poverty reduction strategy development and implementation.
10. Provide a policy environment that is conducive for NGOs and faith-based organizations to provide a continuum of services.

Source: RHSC, 2012: 9.

In the review of policy-level interventions, we found 29 documents that adhere to the components necessary for a voluntary, rights-based approach to family planning. The interventions that have been reviewed relate to actions needed to ensure the governance, accountability, and support of family planning programs that respect, protect, and fulfill rights. Many interventions listed are those changed,

existing laws or policies about the provision of information, supplies, and services of family planning. The below section highlights some of the policy-level evidence found in Annex 1. The evidence is organized by the level (P=policy) and action (A, B, C, etc.) according to the framework (see Table 2).

Table 2. Distribution of Evidence, by the Components at the Policy Level of the Conceptual Framework

Bullets from the Policy Level Box of the Conceptual Framework	Key	Number of studies
A. Develop/revise/implement policies to respect/protect/fulfill rights and eliminate policies that create unjustifiable medical barriers to access	P-A	4
B. Develop/revise/implement policies to ensure contraceptive security, including access to a range of methods and service modalities, including public, private, and nongovernmental organization (NGO)	P-B	4
C. Create processes and an environment that supports the participation of diverse stakeholders (e.g., policymakers, advocacy groups, community members)	P-C	2
D. Support and actively participate in monitoring and accountability processes, including commitments to international treaties	P-D	4
E. Guarantee financing options to maximize access, equity, nondiscrimination, and quality in all settings	P-E	15

P-A. Develop/revise/implement policies to respect/protect/fulfill rights and eliminate policies that create unjustifiable medical barriers to access

Several countries have taken steps to ensuring the accessibility, availability, acceptability, and quality of family planning and reproductive health in national policies through constitutions and laws. These national-level documents guide development of national or sectoral policies (e.g., national population, family planning, or reproductive health policies) and operational policies (e.g. rules, regulations, codes, guidelines, plans, budgets, procedures, and administrative norms that governments use to translate national laws and policies into programs and services [Cross et al., 2001]). The example from Kenya illustrates the range of laws and policies—from the constitution to guidelines and standards that can affect family planning. The history of family planning in the Philippines shows how long policy change can take and the role of advocacy and use of international human rights treaty bodies. Finally, the story of Iran shows that policies can change from supporting family planning services to denying access to them.

Kenya—Constitutional Support for Reproductive Rights

For example, in 2010, the Kenyan government enacted a new constitution that states that reproductive health is the right of all citizens (Newman, 2012). Kenya's history with family planning has been largely positive, albeit with challenges. Though many changes are taking place and policies are in place to respect, protect, and fulfill rights, Kenya has experienced stalled fertility due to a lack of availability of FP services, especially for the poorest groups. Unwanted fertility rapidly declined in 1998 and after stalling, increased slightly in 2003 (Askew et al., 2009). During the time of the fertility stall, Crichton (2008) contends that the "policy space" for family planning shrank and that it has since expanded.

The right to family planning in Kenya can be traced to the inception of the family planning program in 1967, which subsequently saw an increase in the contraceptive prevalence rate from 7 percent in 1979 to 33 percent in 1993 (Kenya National Commission on Human Rights, 2012). Despite recent policy attention, unmet need for family planning is still high; and issues of commodity insecurity,

socio-economic issues, cost, and lack of accurate information serve as barriers for women to access family planning. However, with the 2010 Kenyan constitution and the implementation of the National Reproductive Health Policy of 2007, Kenya is working toward eliminating these barriers. In the progress toward respecting, protecting, and fulfilling the right to family planning, the Kenya National Commission on Human Rights has also made several recommendations to the government, including the need to promote gender equality as a national development priority and the need to integrate family planning with other development issues (Kenya National Commission on Human Rights, 2012).

The Philippines—Recent Policy Success after Years of Advocacy and Use of a Human Rights Instrument

The Philippines is another example of a country in which family planning policy has evolved over time. The Philippines has endured a long and tumultuous fight over family planning policy and programs, with strong opposition from the Catholic Church (Whaley, 2013). In 2012, after decades of advocacy and work to improve the family planning policy environment, the government approved a contraceptives bill that would allow for funding sexual education in schools throughout the country (Teves, 2012). This bill has come after a long, contentious debate regarding contraceptives, especially with consistent opposition from the Catholic Church. While the bill has yet to be signed by the president, it is a momentous opportunity for the country and a step in the right direction toward the provision of family planning services. Support for the bill was likely strengthened through use of a human rights instrument, namely the Committee on the Elimination of Discrimination against Women (CEDAW). In 2008, the denial of access to contraceptives for women sparked a request from nongovernmental organizations to the treaty monitoring body for CEDAW and an ongoing investigation on the ban of sale of modern contraceptives in public health centers (Cottingham et al., 2012). Although the results of the CEDAW investigation are pending, it has called attention to the FP policy environment in the country.

Iran—Pronatalist Policy Shift Inhibiting Reproductive Rights

Family planning policy is not static, as recent policy changes to inhibit access to family planning in Iran shows. In 2012, President Mahmoud Ahmadinejad announced a pronatalist policy and a plan to eliminate all funding to FP programs (Leahy Madsen, 2012). This announcement came as a shock, given that Iran's family planning program has been relatively strong and successful since its initiation in 1966 (Simbar, 2012). With a revitalization of the program in 1988, a Department of Population and Family Planning was established, resulting in increased access to services and free modern contraceptives, especially to rural couples. Iran had implemented FP policies and programs that were highly successful in improving family planning outcomes, lowering fertility rates, as well as upholding the right "that couples have a basic human right to decide freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect" (UN, 1968). The country's new policy does not uphold reproductive rights and is likely to result in a significant decrease in the availability of family planning services.

P-B. Develop/revise/implement policies to ensure contraceptive security, including access to a range of methods and service modalities, including public, private, and NGO

Contraceptive security, and having access to a range of contraceptives through various service modalities, ensures that various methods, services, and care are accessible to all. "Human rights standards require that a wide range of approved contraceptive supplies be continuously available" (Cottingham et al., 2012: 3). Thus, contraceptive stockouts inhibit women from realizing their right to services. In highlighting the policy environment for contraceptive security and supplies, a six-country case study was conducted to show the importance of a favorable policy environment for ensuring that reproductive health supplies are successfully distributed and available (Leahy, 2009). Studies in Bangladesh, Ghana, Mexico, Nicaragua,

Tanzania, and Uganda demonstrate each country's policy environment for contraceptive security. Despite distinct contextual and political differences in each of the case study countries, most of these countries have policy documents or legislation that clearly outline the need to achieve contraceptive security or include a list of contraceptives available in the country. However, despite the indication through policy documents that contraceptive security is important, the move from the policy document to implementation of the policy has yet to be made by some countries. Challenges in the implementation of reproductive supplies policies include lack of political will and participation, as evident in Nicaragua and Tanzania, or the overshadowing of the issue by other health issues such as HIV, as evident in Ghana.

While the development of any policy that speaks to reproductive health supplies or contraceptive security is of the utmost importance for ensuring a voluntary, rights-based family planning program, it is important to recognize the linkage that needs to be made between the policy level and service level regarding the issue of contraceptive security. While a policy regarding contraceptive security might be in place, those stakeholders working at the service level must take action to monitor and hold accountable those at the policy level who have yet to implement the policy. Relevant evidence is contained in the service level section.

P-C. Create processes and an environment that supports the participation of diverse stakeholders (e.g., policymakers, advocacy groups, community members)

Effective policy emerges when broad social participation is encouraged, no interest group dominates policy deliberations, decision making is evidence-based, and clear incentives exist for policymakers to be responsive and accountable to citizens (UNESCAP, n.d.). Participation was a cornerstone of the International Conference on Population and Development (ICPD) Programme of Action and

> "In the years since the ICPD, the relationship between civil-society organizations and governments has continued to mature. In many countries, including many developing countries, NGOs have moved closer to involvement in decision making. They are often included in discussion of national population policy and in official delegations to international and regional conferences. They are not only advocates for reproductive health and rights and gender equity but are also active in programmes to improve women's status and rights and reproductive health services (UNFPA, 1994: 46).

Significant advocacy takes place at the global and national levels by stakeholders in support of family planning and policy change—for example, through the Advance Family Planning Project that supports evidence-based advocacy to increase resources and political investment in high-quality family planning programs (AFP, n.d.).

There has been an increase in civil society involvement in the policy process in some countries (POLICY Project, 2000), although its involvement in implementation has lagged behind participation in implementation (Cooper et al., 2004). Our review of evidence, however, yielded few evaluations of interventions to establish participatory processes for policy for family planning. One study in Mali found that the participation and engagement of diverse stakeholders, such as religious leaders, can strengthen support for family planning; contribute to the adaptation of different tools and approaches by integrating religious material; and make family planning and reproductive health laws and policies comprehensible at the community level through translation (Fofana, 2010). A study from South Africa showed that top-down approaches to policy making and implementation can have adverse effects. For example, in South Africa, providers learned of a policy to provide free healthcare for pregnant women and children under age 6 years when the President announced the policy a few weeks before it was to be implemented. The workers expressed resentment at learning of the policy in such a manner and formed negative views on the value of the policy (McIntyre and Klugman, 2003).

P-D. Support and actively participate in monitoring and accountability processes, including commitments to international treaties

Monitoring and accountability processes at the policy level are integral to ensuring that reproductive health and family planning policies are fulfilled and implemented. Attention to accountability is gaining traction in family planning (Dennis, 2011). Bongaarts et al. (2012), in their review of family planning programs in the 21st century, note the importance of accountability mechanisms. Family planning policies that address accountability describe the governments and health systems as responsible for ensuring universal access to reproductive health information and services. Civil society benefits and contributes by learning about and assisting with the government's priorities. International donors demonstrate responsibility by pressing for increased efficiency (i.e., "value for money," especially important as funding declines and information on policy implementation becomes more readily available). United Nations (UN) treaty monitoring bodies are accountable for ensuring that governments provide their citizens access to family planning and monitor their investments in maternal and child health (Bongaarts et al., 2012). Accountability historically has been "upward" to policymakers, donors, and so on, but family planning programs are increasingly making efforts to be accountable to those for whom they are providing services**.**

As states sign and ratify international covenants and treaties, they are legally obligated to be accountable for their performance (Cottingham et al., 2012). UN bodies such as the Committee on Economic, Social, and Cultural Rights serve to monitor governments' adherence to the treaty through a reporting system (OHCHR, n.d.). Different mechanisms and processes can be implemented and used to achieve accountability (e.g., national courts, human rights treaty bodies, national human rights institutions, and elected health councils). Civil society organizations also participate in the monitoring of country commitments to human rights through shadow reports, which assess progress and shortcomings of country governments and their commitments (Equality and Human Rights Commission, n.d.).

Our literature search yielded no evaluations of interventions to monitor commitments to international treaties—although evidence of such actions and their outcomes exist. For example, the case noted above in the Philippines, in which NGOs issued an inquiry to CEDAW, is such an example. Another violation brought to the attention of CEDAW was that of a Roma woman in Hungary who was forcibly sterilized. CEDAW ruled that the country had failed to "to provide appropriate information and advice on family planning, and had not ensured that the woman had given her fully informed consent to be sterilized. It ordered the government to take specific measures to ensure the occurrence was not repeated" (Cottingham et al., 2012: 5). At the national level, three Namibian women who were HIV positive sought legal redress for what they claimed was forced sterilization. In 2012, the High Court of Namibia ruled that the women were sterilized without their consent, but the court did not link their sterilization to their HIV status, which the women had asserted ("Namibia: High Court Finds Gov't Coercively Sterilised HIV Positive Women," 2012; Smith, 2012).

Latin America leads the establishment of accountability mechanisms that link governments with communities, although such systems are growing in other regions as well. In Guatemala, for example, a memorandum of understanding signed in 2008 by the government and the Multisectoral Monitoring Group led to the establishment of the Reproductive Health Policy Implementation Board (OSAR Guatemala, n.d.). This group brings together more than 21 representatives from civil society and women's groups and researchers and others to serve as an accountability body that systematically monitors the challenges and advances made regarding reproductive health policy implementation. Decentralized lines of authority and accountability are also strong in Rwanda's family planning program (Chambers, 2012).

The International Planned Parenthood Federation's (IPPF) *Voices* project worked in the Western Hemisphere to create networks and coalitions and support advocacy for sexual and reproductive health

and rights. In Bolivia in particular, IPPF, along with the Center for Research, Education, and Services (CIES), IPPF's member association in Bolivia, worked to demand government accountability for the improvement of sexual and reproductive health of young people (IPPF, 2012: 6). As a result of much advocacy and participation in monitoring the accountability of the government, a Municipal Ordinance was passed in El Alto, one of Bolivia's most marginalized urban communities that required sexual and reproductive health (SRH) services to be provided through health centers offering specialized care. This process not only monitored government accountability in maintaining and supporting SRH services for youth, but it also ensured the participation of diverse stakeholders and reached a marginalized population.

P-E. Guarantee financing options to maximize access, equity, nondiscrimination, and quality in all settings

The International Covenant on Economic, Social, and Cultural Rights, in which the right to the highest attainable standard of physical and mental health is articulated, obliges States to undertake "steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."[2] Policies must be accompanied by adequate resources for implementation. Financing for family planning policies—through services and programs—comes from national, donor, and out-of-pocket sources. The literature is replete with examples of policies accompanied by insufficient funding. A study of implementation of sexual and reproductive health and rights in three countries in Africa found that "although countries had…policies, these did not translate into programs and service provision partly because of lack of funding for the implementation of policies," both from governments and donors (Oronje et al., 2011: 7). Analyses in Ghana, Ethiopia, and Nigeria found gaps in funding needs for family planning programs in each of the countries (Ghana NPC, HPP, and DFID, 2012; HPP, 2011; HPP, 2011). The 2011 Ouagadougou Declaration included a call to "ensure a steady increase in contributions of national budgets to support the cost of contraceptives" (in FP Ouagadougou Partnership n.d.).

Advocating for Budgets for Policies

One example of successful advocacy for financing comes from Mexico. Mexfam in Mexico approached local representatives and ministry members to advocate for the implementation of a national youth policy on sexual and reproductive rights and health (IPPF, 2012). The organization was told that no specific budget had been allocated to fulfill the activities under the policy. After collaboration with other partners and experts in public budgeting, the Mexican congress earmarked US$7.8 million for implementation of the youth policy for 2011 and increased the budget line to US$15.6 million in 2012 (IPPF, 2012).

Budget Line Items for Contraceptives, Instruments, Equipment, and Supplies

Efforts to advocate for budget line items for contraceptives have been successful in many countries, although how much of the line items are spent and whether they will be replenished is a question (Leahy, 2009). A case study from Turkey shows that the process of developing a budget line item has technical and political dimensions (Sine et al., 2004). In 1994, the Turkish government took over the full responsibility of providing family planning to its population. The MCH-FP Directorate in the Ministry of Health was able to obtain annual budget allocations for contraceptives and provide free services to the poor by mainly focusing on five program components: pushing for reform, improving the process of contraceptive distribution, strengthening institutions, taking into account contextual

[2] Article 12.1 of the International Covenant on Economic, Social, and Cultural Rights.

factors, and addressing the concerns of various stakeholders, program leaders, and service providers. Pilot studies that tested new operational policies and were successful in their outcomes helped win the confidence of the policymakers and other stakeholders. In this way, public policymakers became champions of the new reform and system.

Community-based Health Insurance

In Rwanda, the use of community-based, social health insurance, *mutuelles,* has played a role in the increased use of health services in the country (Sekabaraga et al., 2011). As part of the national system, Community-Based Health Insurance Scheme, *mutuelles de santé* are community-based health insurance programs in which the community enrolls members, provides information on the program, and collects membership dues. Individuals who enroll in the *mutuelles* are free to access all public and private non-profit health services in the country (Joint Learning Network, 2013). Between 2000 and 2007, Rwanda experienced an increase in the use of health services and specifically (Sekabaraga et al., 2011) an increase in family planning intake from 3.4 percent to 27.4 percent (May and Kamurase, 2009). Insured individuals used modern health services two times more than uninsured individuals in 2005, and while there is no evidence that *mutuelles* had a direct effect on this increase, a study by Sekabaraga et al. (2011) confirms that they did play a role.

Conditional Cash Transfers

A study in Mexico focused on conditional cash transfers to female household heads for use of health-promoting activities, such as contraceptive use and birth spacing, as well as for education (Feldman et al., 2009). This study pointed out the small but significant impact that these cash transfers could have on contraceptive use. Autonomy was also measured and showed influence on contraceptive use. While this study exemplifies a financing option to maximize access, especially for female heads of household, it also showed the influence such schemes can have on women's decision making and autonomy, which though not explicitly promoting rights, can lead to improvement for right-based family planning outcomes.

Performance-based Financing for Family Planning

A new trend in health programming to implement performance-based financing has implications for family planning. Given certain aspects of family planning program implementation history with the use of targets and incentives to increase contraceptive use (see introduction to this paper), there is understandable reluctance to consider performance-based financing as good for family planning—although some evidence suggests, that if implemented appropriately, this new focus can support voluntary, rights-based family planning. Based on a review of performance-based incentive (PBI) programs in more than 20 countries, Eichler et al. (2010) provide a list of "dos and don'ts" related to PBI at the individual, provider, health facility, and subnational/national levels. One of the country reviews, Burundi, highlights the scale-up of a "pay for performance" strategy, which describes incentivizing quality of care that began in three provinces in 2006 (Busogoro and Beith, 2010). Evaluations from the pilot studies showed that the strategy could contribute to the empowerment of health providers, as it allowed the providers to find innovative and creative ways to attract and sustain clients.

While PBI programs can be challenging, especially regarding issues of voluntarism and rights, it is an important tool and strategy that can transform some family planning programs. However, local histories and the context of where PBI programs are being implemented need to be considered, so as to respect and protect rights and avoid over-incentivizing, which can indeed lead to human rights concerns (Diamond, 2012).

Use of vouchers is one approach to performance-based financing. Two studies in Managua, Nicaragua, by Meuwissen and colleagues (2006a; 2006b) evaluate an intervention on voucher

distribution for free family planning services to poor, urban youth. One study used random sampling of vouchers and resulted in significant increases in knowledge and use of family planning services by voucher recipients. The other study used a quasi-experimental approach, which noted statistically significant changes in satisfaction among those who used vouchers.

A study in Bangladesh of the Maternal Health Voucher Scheme that encouraged market competition among healthcare providers found that while there were issues with implementation, the demand-side financing scheme sought to encourage expansion and use of services and to eliminate barriers to access (Ahmed and Khan, 2011). In Uttarakhand, India, a voucher scheme was piloted to expand access to services among the poor (USAID | Health Policy Initiative, Task Order 1, 2010). With the vouchers, beneficiaries can obtain FP and reproductive and child health services from a cadre of qualified private sector providers. Based on the successful pilot, the government decided to scale up the approach across the state, incorporating it in the 2010 update of the Health and Population Policy.

Implementation of a voucher program in Kenya, Reproductive Health Output-Based Aid (OBA), began in 2005 in three rural districts and two Nairobi slums (Arur et al., 2009). The voucher program included vouchers for both family planning and safe motherhood services, though uptake for safe motherhood vouchers was higher compared with family planning vouchers. The report of the program described a monitoring system that had been implemented to identify fraud by providers or distributors of vouchers, showing the importance of monitoring and tracking the new program. For example, voucher distributors (VD) were initially paid commission for each voucher they sold, creating an incentive for the distributors themselves—though this policy was later changed to giving VDs salaries. While scale-up is underway for the OBA program in Kenya, it is unclear how the family planning vouchers will fare, as the FP vouchers did not generate revenue potential for voucher service providers during the initial pilot.

Summary

Interventions at the policy level are intended to strengthen policy commitment and to inform policy development, implementation, and monitoring and evaluation that will improve access to and use of family planning programming. Some policy initiatives address directly reproductive rights, while others, such as contraceptive security and financing mechanisms, support reproductive rights implicitly. The interventions and studies highlighted in this review show the importance of different actors, networks, and processes of policy development that collaborate to form a comprehensive level that lays the groundwork for implementation of family planning programs at the service level and for participation, accountability, and interaction at the community level. While this review has attempted to summarize the main issues within the policy level components, there are evident gaps in the evidence. While many national-level policies and legislation provide support, funding, and attention to reproductive health, the integration of human rights is not evident and lacking in many countries' national-level guidance.

Additional to the gap in the evidence base for policy interventions or documents that address and integrate rights, Gruskin et al. (2007) add that three issues need further work: "the first is the development of adequate monitoring instruments that measure both health and human rights concerns; the second is building evidence of the effects of the application of the health and human rights frameworks to health practice; and the third is the creation of a research agenda to advance our understanding of the associations between health and human rights" (p. 453). With these gaps and recommendations in mind, family planning programs should strengthen efforts to develop, promote, and support rights-based family planning policies that are developed and implemented with wide stakeholder input and support.

Service Level

The service level yielded 163 interventions. These interventions span across issues related to quality of care, method mix, provider trainings, service delivery models, integration of services, and accessibility for youth. The interventions are organized by the level (S=service) and action (A, B, C, etc.) according to the framework (see Table 3).

Table 3. Distribution of Evidence, by the Components at the Service Delivery Level of the Conceptual Framework

Bullets from the Service Level Box of the Conceptual Framework	Key	Number of studies
A. Inform and counsel all clients in high-quality interactions that ensure accurate, unbiased, and comprehensible information and protect clients' dignity, confidentiality, and privacy and refer to other SRH services	S-A	31
B. Ensure high-quality care through effective training and supervision and performance improvement and recognize providers for respecting clients and their rights	S-B	37
C. Ensure equitable service access for all, including disadvantaged, marginalized, discriminated against, and hard-to-reach populations, through various service models (including integrated, mobile, and/or youth-friendly services) and effective referral to other SRH services	S-C	86
D. Routinely provide a wide choice of methods and ensure proper removal services for implants/IUDs , supported by sufficient supply, necessary equipment, and infrastructure	S-D	4
E. Establish and maintain effective monitoring and accountability systems with community input; strengthen HMIS and QA/QI processes	S-E	5

The majority of the studies related to the issues highlighted above include family planning outcomes. The results of several studies point out increases in contraceptive use, awareness of new methods, or improved provider attitudes and trainings, for example. While these outcomes are important to any family planning program, there is a need to emphasize the human rights outcomes that can also result from several of these interventions. Out of the 156 interventions, none include explicit rights-related outcomes. This does not, however, indicate a lack of rights-based components within the interventions themselves. As previously highlighted, service-level interventions mainly encompass elements related to quality of care. Improving quality of care has been a foundational aspect of family planning programing for more than two decades. While quality of care may not be an explicit right-based approach, it very much entails the critical aspects of quality service provision for family planning that respects, protects, and promotes rights in its own way. The quality of care framework was developed to reflect the experience of clients at the point of service. Thus, it focuses on clients who have made their way to health facilities or to a provider in another type of facility (e.g., pharmacy, community-based distribution point, etc.) The six elements of quality of care (choice of methods, information given to clients, technical competence, interpersonal relations, follow-up/continuity mechanisms, and appropriate constellation of services [Bruce, 1990])—are easily linked to human rights principles—such as those found in the General Comment 14 of the International Covenant on Economic, Social and Cultural Rights, outlining the necessary elements to the right to the highest attainable standard of health (availability, accessibility, acceptability, and quality) and also in the Principles of Human Rights Programming (participation, accountability, nondiscrimination, empowerment, and link to treaty bodies).

While emphasizing quality, it is important to understand the definition of quality that adheres to a rights-based approach. "Quality" refers to the availability, accessibility, and highest possible quality of services according to General Comment 14, Article 12 of the International Covenant on Civil and Political Rights. It is also important to note a more clinical approach to quality that stresses the importance of technical equipment and provider skill. This definition, however, failed to draw attention to the interpersonal dimensions of care, which are more similarly related to rights issues such as clients' privacy, dignity, and comfort (Huezo and Diaz, 1993). It is the fusion of these two definitions regarding high standards in a medical context and high standards of interpersonal care that make for an implicit right-based approach (Cottingham et al., 2012).

As there is evidence for 163 service-level interventions, only a few from each category are highlighted below. For the full list of interventions, see Annex 1.

S-A: Inform and counsel all clients in high-quality interactions that ensure accurate, unbiased, comprehensible information and protect clients' dignity, confidentiality, and privacy and refer to other SRH services

The search yielded interventions that related directly to outcomes regarding the client's rights, though not explicitly stating that "rights" were respected, protected, or fulfilled. Several interventions focused on providing or improving information given to clients on method use, side effects, and general counseling on family planning. One study done by Baveja et al. (2000) in India gave women who had not preselected a contraceptive method balanced information on available methods such as Norplant, low dose oral contraceptives, condoms, and intrauterine devices (IUDs). The study analyzed women's preferences for the available method mix and resulted in IUDs being the leading choice, with 58.6 percent of women choosing this option. Another intervention that focused on emergency contraception (EC) took place in Bangladesh in a study done by Khan and colleagues (2004, cited in Mwaikambo et al., 2011). About 3,900 married women were randomly placed into three intervention groups: the first received an educational brochure on EC and prophylactic, the second received just the informational brochure on EC, and the third, the control group, received no EC services. The results showed an increase in EC use in the two intervention groups.

Many of the education/information interventions were focused on postpartum women as their sample groups (Bolam et al., 1998; Lee et al., 2011; Todd et al., 2011; Akman et al., 2010; Barber, 2007; Lopez et al., 2010; Saeed et al., 2008). These studies resulted in improvements in women's contraceptive self-efficacy, increased use of contraceptives, and increased women's likelihood in using family planning methods.

A few of the interventions also included free method provision or family planning materials to the clients (Ngure et al., 2009; Zhu et al., 2009; IFPS, 2012). Two studies also provided pregnancy testing (Stanback et al., 2011) and testing for sexually transmitted diseases (Lazcano Ponce et al., 2000) to clients.

An assessment of a program to integrate gender also showed outcomes related to reproductive rights. As summarized by Rottach et al. (2009), "PROCOSI'S gender program produced a number of positive reproductive health outcomes, including a decrease in unmet need for contraception, improved client satisfaction and quality of care, increased staff awareness of SRH, and positive changes in behavior among male and female staff. The intervention produced moderate but important gender outcomes, including women's increased confidence in their capacity to discuss SRH and awareness of their rights to use contraceptive methods. Among partners, a decrease in tolerance of gender-based violence was found" (Palenque et al., 2007, cited in Rottach et al., 2009: 21).

Two studies that focused on rights-related outcomes in this category were that of Okullo and colleagues (2003) and Salazar and colleagues (2012). Okullo and colleagues evaluated a package of interventions that sought to increase readiness to clinics to offer family planning services, improve provider motivation, and empower clients to request high-quality services. This package of interventions, "Yellow Start Programme," was randomly assigned to two districts, and two other districts served as comparison groups. This pre-test and post-test study showed that the package of interventions did somewhat increase functioning of basic family planning services in the clinics, but the improvements were not significant when compared to baseline data. Also, while quality of care and provider motivation improved, client empowerment did not change. It is interesting to note that the study used two indicators to measure empowerment—observing if new clients asked questions during counseling and if clients reported not feeling shy to ask questions.

The other study that relates to rights is that done by Salazar and colleagues (2012). This study was not an intervention but rather an observational study done with 398 Nicaraguan women to understand the relationship between reversible contraceptive use and intimate partner violence. The women were interviewed 40–47 months after childbirth, and the study concluded that women exposed to a continual abuse pattern and those exposed to intimate partner violence had higher odds of contraceptive use than those not exposed. While this study was not an intervention, it highlights the issue of intimate partner violence and its relationship to contraceptive use. Salazar and colleagues call attention to women who are in vulnerable positions, such as the women in this study, and heed health facilities to identify these women and provide adequate support. The study highlights the need to make family planning services accessible and available to all individuals, especially those in vulnerable positions.

S-B: Ensure high-quality care through effective training and supervision and performance improvement and recognize providers for respecting clients and their rights

The studies in this category primarily related to provider training, client-provider interaction, and supportive supervision. Provider training can develop not only the technical skills and knowledge necessary to provide effective and successful family planning care but also counseling and treatment that respects the rights of the client. This is where the linkage should be made between the countries that make a commitment to respect, protect, and fulfill human rights through the signing of international treaties and the providers who must be trained and educated on human rights and how it can be incorporated into their work (Gruskin et al., 2007: 452).

Thirty-seven studies fall into category S-B. As previously mentioned, provider trainings were the bulk of the studies, including training on IUD insertion (see Box 2) or information on the Standard Days Method. The method-specific training interventions generally increased provider knowledge and skill on the method and resulted in scale-up of the method [although not defined as scale-up to achieve AAAQ (availability, accessibility, acceptability, and quality)].

Box 2. Example of Provider Training Intervention—Enhancing Technical Skills for IUD Insertion

The USAID-funded Family Planning Services Project (IFPS) in Uttar Pradesh, India, included interventions on provider trainings, quality assurance, integration of services, and promotion of methods. For example, one intervention included a three-tier training of auxiliary nurse midwives and lady health visitors that cover IUD insertion skills, screening of clients, and assessment of family planning knowledge and counseling. The intervention yielded positive results, including supportive, continuous supervision to trainees and individual attention to IUD clients.

IFPS Technical Assistance Project, 2012

Three studies highlighted here focused on provider training; however, each study is diverse in whom the actual providers are. For example, distinct from the training of medical officers, family planning nurses working in Egypt's Ministry of Health clinics were trained on family planning information, methods, and counseling (Halawa et al., 1995). Participant observation and client questionnaires were conducted to assess the impact of the nurses' training. Despite the use of control and intervention clinics, almost all clinics' nurses failed to provide counseling to clients in private; however, women in the intervention clinics displayed an increased knowledge about contraceptives, especially the pill and IUD.

A few interventions also focused on training providers on counseling skills, such as the use of the *Balanced Counseling Strategy* (León et al., 2005; León et al., 2003), which sought to improve care and increase clients' knowledge about their method choice through training, job aids, and reinforcement mechanisms. Results from a study in Guatemala showed that quality of care had improved, including longer sessions between clients and providers. A similar intervention was undertaken by Abdalla and colleagues (2002) in 30 clinics in Indonesia. The study compared three possible strategies for improving the impact of interpersonal communication between client and provider and counseling: self-assessments forms on interpersonal communication skills, peer review meetings to supplement the self-assessment forms, and only training on interpersonal communication and counseling. The results indicated that the peer-review meetings to supplement the self-assessment were more effective in improving provider communication skills than the other two strategies; however, the self-assessment strategy (without peer review) was more cost-effective in terms of improvements gained by amount of resources used.

Some of the studies in this category focused on client-provider interaction. A study by Kim et al. (2000) trained 201 providers in Indonesia on client-centered counseling. To reinforce the training, a self-assessment and a peer review were used as effective, low-cost strategies. The training helped providers with skills related to facilitative communication: establishing rapport, encouraging dialogue, and helping clients make decisions. Overall, the intervention had positive effects on communication between the client and provider as well as client satisfaction with their visit. Another study focusing on client-provider interaction took place in Punjab, Pakistan, with community workers (Sathar et al., 2005). Using two experimental areas and two control areas, a training program for community workers was designed using the SAHR (salutation, assessment, help, and reassurance) training. This training showed providers how to respectfully welcome clients, understand their clients' personal context, provide information and counseling, and set expectations for future interactions and services. As a result, there was a significant change in providers' behavior related to the elements of the training.

A handful of interventions related to provider training touched on the supervisory or monitoring mechanisms available within the health system in order to ensure that high-quality services were being delivered. For example, through a study by Agha and colleagues (2010) focused on training of midwives to deliver high-quality reproductive health services, supervisors were also trained to observe the quality improvement training in order to do follow-up visits to monitor the midwives' progress. This is an important aspect of training that involves supervision of providers, which ensures that providers are competent, committed, and caring.

S-C: Ensure equitable service access for all, including disadvantaged, marginalized, discriminated against, and hard-to-reach populations, through various service models (including integrated, mobile, and/or youth-friendly services) and effective referral to other SRH services

Service Models

The interventions presented here describe different models for service delivery, including health facility-based, community-based, mobile, referral, and social franchising models. This category also includes the type of workers delivering services, such as traditional medical practitioners, community health workers,

female village workers, and volunteer agents. Community-based distribution interventions were the most widely found interventions in this category (see Box 3).

Box 3. Example of Service Models—Community-based Distribution

This report reviews four country community-based distribution initiatives in Uganda, Madagascar, Nigeria and Kenya. Pilot studies and projects were undertaken in each country to develop and scale up community-based distribution of injectable contraceptives and were generally successful in each country, resulting in women satisfied with the quality of care received, uptake and use of injectables and knowledgeable community health workers. This study also points out the influence of successful program evidence on policy; for example, after sharing of field evidence and distribution of evidence-based promotional materials for injectable contraceptives, the Ugandan government amended the National Policy Guidelines and Service Standards for Sexual and Reproductive Health Rights to approve the provision of injectables by community health workers. This service model intervention speaks to issues of expanding method mix and improving access, while in some cases, such as in Uganda, presenting the availability and provision of injectables as a reproductive right.

Hoke et al., 2012

One intervention highlighted the role of private pharmacy workers in providing reproductive health services to emergency contraceptive users (Liambila et al., 2010). Pharmacists were updated on appropriate use of EC, side effects, regular FP methods and referrals for other FP methods, and STI (sexually transmitted infection) and HIV testing and counseling. While successful outcomes were expected with the intervention group of pharmacists who received all the updates, the study found no statistically significant differences in the provision of information on emergency contraception and family planning. The authors note, however, that this result could be due to a number of factors, citing the challenges that pharmacists face as their conflicting role as business people and public health service providers. This intervention also exemplifies the issues of availability and accessibility for family planning clients, as having the option to obtain emergency contraception and other family planning methods from a pharmacist might be more effective than using other service delivery models such as clinics, hospitals, or health centers.

Hossain and Phillips published a study in 1996 assessing government-instituted female village worker recruitment training in Bangladesh. The intervention was designed to improve the accessibility of contraception and provide support for family planning villages in Bangladesh. As a result of this training, the female village workers delivered home-based outreach, and, hence, sustained contraceptive use continued over time.

Social franchising is another type of service model. In one such program in Uganda, a private sector franchise employed 147 private sector clinics and recruited community health workers (Kaggwa et al., 2011). The workers provided basic education on family planning and acted as change agents in the community. As a result of the program, IUD and implant insertions increased by 90 percent in the franchise clinics, and the workers have played a positive provider role and effectively increased family planning client walk-ins to the clinics.

The final study to highlight is an evaluation by Mercer and colleagues (2005) on family planning use at static clinics in Bangladesh. This study evaluated a program that transferred family planning services to static community clinics after being previously provided through household visits and satellite clinics. Surveys were conducted and the results indicated that contraceptive prevalence remained constant in one of the clinics and increased in the other. It was evident that women had not become dependent on the home delivery of FP supplies.

Integrated services. The majority of the intervention studies related to integrated services had to do with HIV, mostly the promotion of dual method contraception and the provision of FP services alongside antiretroviral treatment and voluntary counseling and testing for HIV. Many interventions also focused on training providers on HIV or family planning, depending on the direction of the integration process. Quality of care of integrated HIV and FP services was not emphasized in any of the studies, though counseling on the integration of services was implemented and showed improvement in client knowledge.

Another area of study is the integration of family planning with maternal, neonatal, and child health services at different points of contact during the antenatal, labor and delivery, and postnatal periods and child health/immunization. One study focused on the integration of family planning with childhood immunization services in Togo (Huntingon and Aplogan, 1994). This study centered on provider messages related to family planning during immunization visits. The provider would say three short phrases, "Your child is still young and you should be concerned about another pregnancy too soon," "this clinic provides FP services that can help you delay your next pregnancy," and "you should visit the FP clinic after the immunization for more information." Eight intervention sites and eight control sites were designed for the study, which resulted in a significant increase in new FP acceptors at the intervention sites and better performance of immunization services in integration sites.

Another intervention was that by Abdel-Tawab and Saher (2011) in a pilot study on family planning integration with antenatal and postpartum care in Egypt. Two models were piloted and compared, including model 1 (which comprised of antenatal family planning counseling and five post-partum visits with family planning counseling) and model 2 (which contained an awareness-raising component for men in addition to the components of model 1). Model 2 was more successful in increasing use of FP services (47% compared with 36% of model 1). Also, end-line information revealed that more women knew of the three conditions of long-acting methods and at least two benefits of birth spacing compared to baseline knowledge. This study is a good example of a way to expand coverage of family planning services through other health visits or related health issues.

Mobile services. Mobile services play an important role in FP provision, as they address issues of access and equity and outreach to rural populations that otherwise would not be able to access services. In 2010, Eva and Ngo (2010) evaluated Marie Stopes International's (MSI) Mobile Outreach Services in Ethiopia, Myanmar, Pakistan, Sierra Leone, and Viet Nam. MSI's mobile outreach is an important example of a service model that provides FP services (in this instance, IUDs and implants to poor, rural women). The mobile services not only follow service guidelines and audits but also emphasize clinical quality, as services are conducted in rural settings. This evaluation reached 4,273 women—995 of whom chose implants as their family planning method and 3,278 who chose IUDs. To evaluate satisfaction with the services received at the mobile site, a retrospective study was conducted using multi-stage sampling. Results revealed overall satisfaction, noting that they (women users of IUDs and implants) would reuse the services again and recommend them to others.

Another, more recent study highlighting use of mobile services for FP methods was done by Azmat and colleagues (2013) regarding IUD use in a mobile outreach service program in Pakistan. This study followed up on mobile outreach services conducted by MSI, where 681 women received an IUD. The results indicated that 97 percent who received an IUD were given information by a service provider on where to follow up for their IUD should they have any complications. There were a small percentage of women who discontinued use, and 95 percent of them found it fairly easy to access removal services. While follow-up care and accessibility to services post-IUD or implant insertion might be a challenge for mobile service delivery, this study shows that, in Pakistan, an adequate back-up system is in place for those clients who need follow-up services.

Youth-friendly services. Youth face many access barriers to services, particularly related to stigma, confidentiality, and affordability. Many of the studies in this category sought to implement interventions that addressed these issues. Alongside the promotion of contraceptive methods, interventions also offered access and services related to STI and HIV testing at youth-friendly facilities. A few studies also promoted condom use and offered them free of charge to adolescent clients. It is important to note that this category strictly includes family planning for youth at the service level; the community level contains an action/input that focuses on youth and the healthy transition from adolescence to adulthood.

A study that used a series of interventions to impact youth took place in Uganda with approximately 5,000 females, men, and heads of households (Karim et al., 2009). Interventions and control groups were used to assess the impact of a multi-component intervention, such as capacity building, to strengthen technical and organizational ability for SRH programming, mass media campaigns, and peer provider trainings. This intervention had a positive impact on sexual behavior among young females but not young males. While this intervention sought to make an impact on youth and their access to sexual and reproductive health services, the disproportionate affect on females compared to males calls attention to the issue of gender roles and gender inequality in family planning and sexual reproductive health and the need to take into consideration the different impact these youth-aimed interventions can have on females and males.

An additional component of ensuring youth-friendly FP services is to train providers on how to interact with and provide services to adolescents and youth. A study by Meuwissen et al. (2006c) explores this issue in a study in Nicaragua with 37 doctors. The doctors in the study received training and guidelines on (1) how to deal with adolescents, (2) how to treat adolescents (treatment protocol), and (3) how to provide financial incentives to adolescents for seeking/using services. Pre and post-study assessments revealed a statistically significant change in the knowledge of youth regarding contraceptives and sexually transmitted infections. Barriers to contraceptive use were diminished, and some attitudinal changes were reported by doctors.

Access to equitable services is a significant component of a family planning program, especially when seeking to reach disadvantaged and marginalized groups. The various service models highlighted here are important to FP users and their ability to gain equitable access to information and services. While these service models continue to be designed and implemented, it is important to remember that while inequities can be diminished or perhaps even eliminated, it is not always guaranteed (Ortayli and Malarcher, 2010).

S-D: Routinely provide a wide choice of methods and ensure proper removal services for implants/IUDs, supported by sufficient supply, necessary equipment, and infrastructure

Contraceptive security is essential to ensuring the availability, choice, and use of high-quality family planning methods for individuals (USAID | DELIVER Project, 2010). A functioning contraceptive security system not only ensures that a wide variety of methods are available, but also that the resources for and quality and quantity of those methods are sufficient.

Models that show the importance of procurement and logistics management systems are evident in a six-country case study depicting the contexts and political, financial, and health environment for reproductive health supplies (Leahy, 2009). While the issue of contraceptive security and reproductive health supplies is dealt with primarily at the policy level, it is an issue that transcends to the service level. Many challenges are faced with contraceptive logistics, as is evident in a case study in Uganda. Weak human resource capacity at the district level in Uganda has made delivery of reproductive health supplies difficult (Leahy and Akitobi, 2009). Health systems strengthening also plays a central role in the ability

for contraceptive security processes to function properly, as poor management and the lack of transportation and human resources pose challenges in delivering supplies to service delivery facilities.

The role of service providers is also crucial to ensuring effectiveness in the contraceptive security process. Service providers support clients in choosing the right method, accessing products and services, and obtaining correct knowledge and information regarding contraceptive methods, risks, and use (USAID | DELIVER Project, 2010). Service delivery providers also have an important role to play in securing the "last mile" for contraceptive security—which is that the supplies are actually delivered and received at the health facility. To assist in this process and address the challenges often faced in achieving contraceptive security, service providers can supervise and monitor logistics functions (e.g., report on stockouts), provide data entry, and include logistics management in provider trainings to increase capacity in this area (USAID | DELIVER Project, 2010). In an assessment of the family planning logistics system of 25 health facilities in the Sembabule District of Uganda, a few challenges were faced that impeded a fully functioning contraceptive supplies logistics system, including financial resource constraints, lack of personnel, and lack of adherence to inventory policies at some facilities. These are just a few components that could impede a logistics system from functioning properly and successfully. Despite these issues, Sembabule District has an effective storage and warehousing of supplies; however, improvements still need to be made. The implementation of an effective contraceptive supplies system requires attention at all points of the process—from the policy guideline or budget line item establishing the need for contraceptive supplies down to the service provider administering a wide range of contraceptive methods.

Another important issue in managing contraceptive supplies is finance. The financing and cost of supplies are concerns found at the policy level, but they also affect the users of the facilities that distribute contraceptives. In Nigeria, for example, the supply chain for contraceptives moves from a contraceptive warehouse, which then distributes to the states, which then distributes to local government areas, which then finally ends up at service delivery points (Sommerlatte and Spisak, 2010). This system incurs some cost, which is then attempted to be recovered through user fees at the service delivery level, which, in turn, affects the accessibility, affordability, and acceptability of services for the individuals seeking them. While contraceptive supplies are crucial to any family planning program, the additional barriers and challenges that come with the distribution and supply chain management of the supplies can in fact deter individuals from obtaining or seeking family planning services.

S-E: Establish and maintain effective monitoring and accountability systems with community input; strengthen HMIS and QA/QI processes

This component of the service level, while important, did not yield much evidence on interventions to establish and maintain monitoring and accountability systems. While much work has been done to improve health management information systems (HMIS) and promote continuous quality improvement—for example, through quality improvement processes, such as COPE (EngenderHealth, 2003) and Improvement Collaboratives (USAID Health Care Improvement Project, n.d.), among many others—these interventions have not focused directly on monitoring and accountability for reproductive rights. The lack of evidence on interventions within the service level to ensure accountability and on mechanisms to investigate rights vulnerabilities and redress violations is a gap in the evidence base.

While the literature lacks evidence on family planning interventions related to monitoring and accountability systems, a few documents highlight the importance of management information systems for family planning, including a study done in Pakistan, as related to the work of lady health workers (LHWs). An assessment by Mahmood and Naz (2012) took a random sample of LHWs across four districts in Pakistan to review health management information systems related to the LHWs' work. The study found that the workers maintained the basic HMIS tools such as family registries, diaries, and monthly reports but lacked other important tools such as area maps and referral cards. The LHW

management information system is important as it keeps track of the health status of the community and provides evidence for health officials to evaluate performance of the LHWs. An effective HMIS is important for any family planning program.

Several other reports under this component, such as a study by Chalugai and colleagues (2005) in Malawi, revealed the importance of health leaders' commitment and dedication in designing and implementing an efficient health management information system. Having a functioning HMIS in place is necessary for a family planning program to be fully effective.

Summary

The studies highlighted for the service level provide just a few examples of the types of interventions needed to ensure that family planning programs are voluntary and that they respect, protect, and fulfill rights (see Annex 1 for a full list). At the service level, most evidence available supports interventions to improve quality of care and promote a variety of service models. Focusing on client information and rights, provider needs, and various service delivery models, the studies in S-A, S-B, and S-C embody significant aspects of family planning service delivery. While some studies did highlight equitable access, empowerment, and other rights-related aspects, most studies in this level did not explicitly call attention to rights approaches in family planning. While reproductive rights were not explicit in these studies, the elements of quality, accessibility, availability, and acceptability were evident throughout, especially in S-A and S-B. S-D, which described studies related to monitoring and accountability and HMIS, shows an evident gap in the literature on these issues and represents a call for more research. While not exhaustive, the review of the evidence pertaining to the service level identifies a need to make more explicit linkages with family planning interventions at the service level and human rights outcomes. Interventions related to quality of care already show these linkages, though future studies in this area must include rights-based outcomes and focus on rights-based approaches in order to bring about effective and successful voluntary, family planning interventions.

Community Level

The community level of the framework includes those actions and factors that empower the community to (1) participate in the development of policies and programs designed to serve them, (2) hold policymakers and service providers accountable, and (3) adapt norms and customs to facilitate the respect, protection, and fulfillment of community member's rights to high-quality, voluntary family planning information and services. The nature of community participation is process-oriented, and there are significant challenges in measuring the contribution of community participation to health outcomes (Zackus and Lysack, 1998).

When participatory processes are used, it is necessary to define the "community." Community is often defined as a geographical area or a group that shares common interests and values (Zackus and Lysack, 1998). For the purposes of the Framework for Voluntary, Human Rights-based Family Planning, "community" is defined as those who are directly affected by the relevant policies and programs; therefore, the community will change depending on whether the framework is applied at the national, subnational, or global level. Representatives of the community may include those who hold formal or informal positions that influence values and norms, civil society groups that represent the interests of the community, or community groups that form on an ad hoc basis to address a particular issue. An exhaustive review of the rich literature on community participatory approaches, community empowerment, and community capacity building in health was outside the scope of this literature review, which focused on community participation related to family planning.

Our systematic review returned about 68 articles related to community-level interventions overall. The interventions are organized by the level (C=community) and action (A, B, C, etc.) according to the framework (see Table 4). More than two-thirds of the interventions with evidence focused on supporting

adolescents and young people; the interventions were included in the community level because they often focus on education and community outreach activities that create an environment for young people to make healthy reproductive decisions. As noted in the service level section, there are also activities that can be taken at the service delivery site to create a space where young people will utilize services.

Table 4. Distribution of Evidence, by the Components at the Community Level of the Conceptual Framework

Bullets from the Service Level Box of the Conceptual Framework	Key	Number of studies
A. Engage diverse groups in participatory program development and implementation processes	C-A	6
B. Build/strengthen community capacity in monitoring and accountability and ensure robust means of redress for violations of rights	C-B	2
C. Empower and mobilize the community to advocate for reproductive health funding and an improved country context and enabling environment for family planning access and use	C-C	2
D. Transform gender norms and power imbalances and reduce community-, family-, and partner-level barriers that prevent access to and use of FP	C-D	10
E. Support healthy transitions from adolescence to adulthood	C-E	48

C-A. Engage diverse groups in participatory program development and implementation processes

Community participation in the program development process is expected to lead to a better assessment of the needs and priorities of the community, increased opportunities for diffusion of the family planning intervention, and improved balance of power between service providers and the community (Chambers, 1997). The extent to which a community will be empowered by this process depends heavily on the extent to which the community has the capacity to engage and the quality of their engagement. Five studies were identified that described a community participatory process in development or implementation.

Murthy and Klugman (2004) analyzed 18 World Bank health sector reform projects in South Asia that included sexual and reproductive health to determine to what extent community participation was integrated into the projects. They created three degrees of community participation (lower, middle, and higher) and six aspects to consider when describing community participation: definition of community, who represents the community, rationale for community participation in health, the depth of community participation, the scope of community participation, and the mode of community participation. Despite the emphasis on community participatory approaches, they found that only three of the programs had a higher degree of community participation. Evaluating the relative effectiveness of community participation went beyond the scope of their analysis.

Two interventions include community participation in FP implementation. Indonesia's family planning program has been considered highly successful at increasing contraceptive uptake and the programming of the BKKBN, Indonesia's national family planning program, is often described as promoting community participatory approaches. However, Shiffman (2002) argues that when communities only participate as volunteers and implementers and are not included in program development, the community works as an extension of the state, resulting in a state-community hybrid that features many top-down characteristics. The India Local Initiatives program included community health volunteers, but also included additional community participation pieces early in the program development process (Paxman et

al., 2005). This project increased contraceptive use within four of the northern states of India by 78 percent. Community volunteers were also empowered and enjoyed improved standing in their community.

One intervention described a process in which additional effort was included to address the community's broader health needs beyond family planning and to build trust within the community (Mansa, 1991). Within this community, family planning acceptance rates increased from 17 percent to a range between 24 and 40 percent in nine villages within three years. This process also contributed to the community's willingness to tackle other development problems such water pollution and adult literacy.

Community participation in social change movements, especially related to reducing the practice of female genital mutilation/cutting (FGM/C), has become a best practice promoted by the United Nations Children's Fund (UNICEF) (Diop et al., 2004; UNICEF, 2010). In its 2010 report, *The Dynamics of Social Change: Towards the abandonment of female genital mutilation/cutting in five Africa countries*, UNICEF provides case studies of programs in Senegal, Ethiopia, Sudan, Kenya, and Egypt that have made strides in reducing FGM/C. A variety of community participation and education approaches were used in the countries, but the projects all included community discussion, decision making, and advocacy for abandoning the practice. An important component within each campaign was community members publically committing to discontinuing FGM/C. Similar participatory processes may be necessary to change deeply entrenched norms and practices, including those specifically related to family planning and fertility.

Our systematic review found a significant gap in evidence for interventions that describe a conscientious approach to FP program participation for groups with limited access to power and resources. Additional research on this topic is warranted.

C-B. Build/strengthen community capacity in monitoring and accountability and ensure robust means of redress for violations of rights

Through a participatory process, a community's level of ownership over a program should increase. Once the program has been launched, the community will need to continue to be involved in monitoring the program and have accessible accountability mechanisms.

Two studies described community monitoring or accountability. Bjorkman and Svennson (2009) describe a project in which the communities' capacity to monitor and hold providers accountable was increased. The intervention increased the oversight of community health councils and communicated with health providers, while working with the community to learn about their experiences and increase expectations. The intervention was successful at increasing community participation in these activities, and they found large increases in health service use and improved health outcomes. Although the intervention was focused on child health outcomes, the intervention may be transferrable to family planning programs.

The forced and coerced sterilizations of HIV-positive women has received increased media attention over the past year. The International Center for Research on Women (ICRW) describes the process by which HIV-positive women learned about their human rights and learned that the sterilizations should not have happened without their consent (ICRW, 2009). After learning about their rights, they were able to partner with civil society groups to seek redress for the violation of their rights.

The search returned few studies on community monitoring and accountability. We recommend additional investment in interventions and evaluation of interventions aimed at increasing community capacity in monitoring and accountability in the family planning field.

C-C. Empower and mobilize the community to advocate for reproductive health funding and an improved country context and enabling environment for family planning access and use

Building the advocacy capacity of a community allows it to make requests and demand that funds be used appropriately, that services be provided in sufficient quantity and quality, that marginalized groups be able to receive services, and that other barriers to access be overcome. Two published interventions were identified through the literature review. Between 1993 and 1996, an intervention in Nepal considered diverse stakeholder input to prioritize community health needs. Through this process, service coverage in certain districts in Nepal increased from 4,283 to 12,127 recipients (Joicfp News, 1997). Another intervention in the Philippines combined education, policy, and advocacy interventions related to ecological resources and family planning. The communities that received the combined intervention showed significant positive changes in contraceptive prevalence, contraceptive use by youth, and parity, along with positive changes in income and environmental behaviors (D'Agnes and Castro, 2011).

C-D. Transform gender norms and power imbalances and reduce community-, family-, and partner-level barriers to prevent access to and use of FP

Decades of work in family planning and reproductive health have demonstrated that many sociocultural elements influence the use of family planning. These elements are often rooted in power dynamics within communities related to gender, age, ethnicity, marital status, and religion. Programs that raise awareness of family planning availability and its benefits without concurrently addressing these barriers may increase women's frustration and see limited progress (Sen and Batliwala, 1998). Programs that assess, acknowledge, and address these factors may promote the realization of rights more so than those which enable women to use family planning despite these factors. For example, a program that provides covert methods of contraception can increase a woman's ability to plan her family despite objections from family members. However, programs that actively work with family and communities to increase positive attitudes toward family planning and reproductive health can help a woman maintain contraceptive coverage and be more empowered in making her health decisions.

Nine studies describe interventions related to family planning that attempt to change norms, engage gate keepers, and involve men. Five of the interventions expressly included men in communication and outreach activities. Had the literature review extended to cover related health areas such as HIV/AIDS and maternal health, more studies would have been found related to changing gender norms (e.g., see Pulerwitz et al., 2006; Verma et al., 2009). Studies identified through the literature review reported increased spousal communication (Yassa and Farrah, 2003; Blake and Babalola, 2002) and increased contraceptive use (Kim et al., 1996; NIPORT, 1998; Phillips et al., 2012). Two media interventions used radio, print, community gatherings, and other publicity to change attitudes about the use of family planning, early marriage, girls' education, and other topics. The radio drama series resulted in significant changes in family planning use, maternal mortality, and desired family size (Barker and Okon, 2011). Bartel and his colleagues (2010) integrated a gender component into maternal health programming in Uttar Pradesh, India. The gender component did not result in a measurable increase in contraceptive use. Two other interventions were aimed at youth to change attitudes about gender equity. One was a school-based intervention where teachers were trained to discuss gender norms and promote gender equitable attitudes (Achyut et al., 2009). Another intervention was an informal education program for boys to teach them about reproductive health and gender equitable attitudes (Green et al., 2004). Both interventions reported improved attitudes toward gender equity.

C-E. Support healthy transitions from adolescence to adulthood

The 1994 ICPD called for additional attention to the reproductive health needs of adolescents. Adolescence and youth represent pivotal times for increasing knowledge and shaping attitudes toward

sexual and reproductive health. Numerous activities are aimed at increasing adolescents' and young peoples' knowledge about reproductive health and providing the supportive environment for them to adopt healthy reproductive health practices. This section includes activities that were geared toward adolescents, youth, and young people, both married and unmarried. The interventions targeted a range of ages between 12 and 29 years old. Overall, 62 studies were found that related to adolescents and youth. Many of the interventions are multifaceted, including community, education, media, and service delivery components. Youth interventions tended to focus on reproductive health more holistically by integrating HIV and STI, age at first sex and marriage, and pregnancy prevention objectives into programs.

Seven studies explicitly mentioned working with parents and leaders. The Berhane Hewan (Light for Eve) project in Ethiopia provided support for girls to remain in school and included community awareness activities to stress the importance of continued school attendance. The study was associated with considerable improvement in girls' school enrollment, reproductive health knowledge, and contraceptive use (Erulkar and Muthengi, 2009). Askew et al. (2004) reported on a multisectoral intervention that included mobilizing local civic and religious leaders and parents and training them on adolescent health and sexuality issues in Kenya. Community-based activities, including theater and public events, were used to raise awareness about youth issues. The activities were combined with facility-based interventions to create youth-friendly services. The intervention reported positive changes in knowledge, attitudes, and some reproductive health behaviors.

Cuidate, a sexual risk reduction program in Mexico, comprised a six-hour training for parents and adolescents. After four years, the adolescent program participants were more likely to be older at first sex and to use a condom or other contraceptive at first sex compared to the control group (Villarruel et al., 2010). Other studies that included parents and leaders along with educational components showed positive changes in knowledge, attitudes, and behaviors (Kim et al., 2001; Meekers et al., 1997, and Mathur et al., 2004); however, it was not possible to determine the relative contribution to outcomes of engaging parents and leaders in the intervention processes.

Six of the interventions actively promoted life skills trainings, including income-generating, vocational, and communication skills. Three of the interventions focused on girls reported increased age at marriage, increased likelihood of using contraception, and delayed childbearing (Nanda et al., 2011; Pande et al., 2006; Levitt-Dayal et al., 2001). One study reported improved self-determination and improved menstrual hygiene (Pande et al., 2006). The African Youth Alliance (2007) intervention took a comprehensive approach to SRH behavior change for both young women and men. The project had a positive impact on contraceptive use (including condom use) and several self-efficacy and knowledge antecedents to behavior.

The remaining interventions relate primarily to educating youth on reproductive health and are described in a review of family planning interventions by Mwaikambo et al. (2011). Three main educational approaches were used: peer education, school-based education, and media coverage. Mwaikamo et al. categorizes these as interpersonal communication and mass media interventions. Additional interventions usually accompanied the education, including activities to increase access to supplies or services. Education interventions reported on a variety of knowledge, attitude, and behavior outcomes. Mass media interventions generally supported peer outreach and expanded service delivery activities. As reported in Mwaikambo et al., mass media approaches are often difficult to evaluate but have been shown to positively influence knowledge, attitudes, and behaviors. Similarly, Mwaikambo et al. found that most studies that included peer outreach or school-based interventions were successful at changing knowledge and attitudes but were more limited in their impact on behaviors and outcomes such as reduced fertility. Our review included an additional seven studies that align with the findings from Mwaikambo et al.

Box 4. Example of a Community-level Intervention for Adolescents

The Better Life Options program seeks to empower young women to make better choices for the future. Girls are able to engage in income-generating activities, formal and non-formal education, vocational skills training, and health education and services. The program also works with parents, community leaders, and decisionmakers to raise awareness about the need for girls' empowerment. The training content included decision making, mobility, self-esteem/confidence/empowerment, childbearing and spacing, contraceptive use, and health-seeking behavior. Girls who participated in the program were more likely to complete secondary education, be older when they got married, use contraceptives, and utilize maternal and child health services when needed.

Levitt-Dayal, M., and R. Motihar, 2001.

Summary

Community-level interventions contribute significant value to family planning programs. Community attitudes and norms influence the behaviors of individuals within them. Policy change and community-level action are often both needed to see lasting change. Changing policy without working closely with communities often does not make a significant impact (Lee-Rife et al., 2012). Research on interventions to prevent child marriage or FGM/C has shown that policy- and community-level approaches need to be used. Thus, the community and policy levels are closely linked, supporting the idea that community participation is necessary for improving outcomes and lasting behavior change.

The variety of activities focused on youth is a good representation of community-based activities. However, this review highlights that the increased emphasis on youth may have reduced attention on adults who still need education about and access to family planning. The global community recognizes the opportunity of teaching young people to help them make healthy decisions as they mature into adulthood. But despite the widespread attention to youth and adolescence, in some areas, barriers still prevent young people from having access to services and supplies or support harmful practices for girls and young women. Investing in helping youth grow into healthy adults while supporting the rights of women currently in their childbearing years will be a key balance to strike in the coming years of family planning investment.

Community participation remains a challenging topic to define, implement, and measure. Despite decades of rhetoric on community participation, the evidence base supporting community participation and empowerment in family planning programs is limited. This represents one of the fundamental challenges of measuring rights-based approaches to health programs. The processes used to develop high-quality programs may not be explicitly described in the literature, even when good practices are used. A lack of evidence related to community participation is not necessarily due to an absence of the practice. In addition, because community participation is part of a process and not an intervention in and of itself, it is more difficult to determine whether the primary intervention benefitted substantially from participation. It is also difficult to determine the quality of participation and whether increased quality of participation increases community empowerment and health outcomes.

The search did not use terms such as “community participation,” “community empowerment,” or “community capacity building,” which likely limited community-level search results. Because community involvement is foundational to both rights-based and equitable health programs, additional literature reviews on these topics as they relate to family planning programs are warranted.

Individual Level

Focusing family planning programming on the policy, service, and community levels is important, but fundamentally, human rights center around individuals (Jacobson, 2000). Policies should support the human rights of individuals. Likewise, services, including community-based service delivery mechanisms, should focus on meeting the needs of individuals. Some interventions work with providers so they can provide individuals with higher quality services. Yet, other interventions are needed to increase the individual's personal knowledge and ability to exercise his or her rights.

In particular, the individual and community levels are tightly linked. Community participation and empowerment is dependent on the empowerment of the individuals within the community (Rifkin, 2003). Attitudes, values, and behaviors of individuals are strongly influenced by the surrounding community. After the policy, service, and community contexts are primed for a person to exercise their rights, the individuals themselves decide whether to use family planning. The ability to make these decisions is dependent on a person's level of knowledge of their rights, information about family planning options, and the empowerment they have in relation to their family, service providers, and the community at large (Upadhyay, 2001).

The interventions are organized by the level (I=individual) and action (A, B, C, etc.) according to the framework (see Table 5).

Table 5. Distribution of Evidence, by the Components at the Individual Level of the Conceptual Framework

Bullets from the Individual Level Box of the Conceptual Framework	Key	Number of studies
A. Increase access to information on reproductive rights, contraceptive choices	I-A	7
B. Empower, through education and training about reproductive health, self-esteem, rights, life-skills, and interpersonal communication	I-B	14
C. Foster demand for high-quality services and supplies through IEC/BCC and empower individuals to demand their rights be respected, protected, and fulfilled	I-C	11

I-A. Increase access to information on reproductive rights, contraceptive choices

Many interventions focused on increasing knowledge concentrate most explicitly on knowledge about family planning methods and less on rights, contraceptive options, and building a sense of entitlement to high-quality services. Seven studies focused on individual access to information. Boulay et al. (2002) describe the effectiveness of personal networks at disseminating information about family planning. In their study, an equal number of women heard a communications message through peers as had heard it from the media source. Both groups who reported hearing the message were more likely to use contraceptives than women who had not heard the message.

Social networking and technology make it possible to interact with individuals to provide information in novel ways. L'Engle et al. (2013) used text messaging to engage with 2,870 individuals about their contraceptive use. Some participants were willing to share information and preferences about their use of contraceptives and used the text messaging system to ask questions. Both men and women used the service to seek information about contraceptives, and the service may have promoted increased discussion and favorable attitudes toward contraceptives.

Individual or small group counseling courses are another vehicle to address individual knowledge and attitudes about family planning. Iranian women are required to attend a premarital sex education and couples communication course before they receive a marriage license. Mahamed and colleagues (2012) tested a new curriculum for this mandatory training, emphasizing contraceptive methods. Women who participated in the course were more knowledgeable and held more favorable attitudes toward family planning than women who went through the traditional course.

Myths and misperceptions about family planning negatively influence attitudes about family planning. Different regions may have different perceptions and biases against particular family planning methods (Garcia et al., 2006; FHI 360, 2010). Different groups also may have particular worries about using family planning. HIV-positive women have expressed concern that family planning might interfere with antiretroviral therapy, while adolescents have expressed a lack of trust in providers (Mbonye et al., 2012). Addressing these concerns through additional education is crucial.

We found little evidence of interventions that educated individuals about their reproductive rights or worked with women to educate them about their changing contraceptive needs throughout life. Additional interventions and evaluations of interventions that take a life cycle approach or that inform women about their reproductive rights are needed.

I-B. Empower, through education and training about reproductive health, self-esteem, rights, life-skills, and interpersonal communication

Increasing a person's knowledge of their reproductive rights without also working to enable them to exercise those rights can result in limited progress in family planning programs. Empowerment includes elements of individual agency and is related to one's perceptions of her/his relative skills, rights, and options (Malhotra et al., 2002; Gutíerrez et al., 2000; Crissman et al., 2012). Fourteen studies were found that related to personal empowerment. Studies that focused on providing education to men have been included under this bullet if they emphasized men's role as partners in reproductive decision making or spousal communication.

Crissman and colleagues (2012) investigated the relationship between sexual empowerment and contraceptive use among Ghanaian women. They found that women who were more sexually empowered (meaning the woman can discuss her sexual preferences and concerns with her husband) were significantly more likely to use contraceptives. Related studies on spousal communication have found that it strongly influences whether women use family planning (Bawah, 2002; Kamal and Islam, 2012). Despite the promising relationship between spousal communication and contraceptive use, few interventions focused on increasing spousal communication. One study in Pakistan prepared couples to initiate conversations about family planning (Saleem and Isa, 2004); of the 72 couples who participated, 34 initiated conversations about family planning or birth spacing and 24 couples were successful at selecting a family planning method. It is interesting note that where women initiated the discussion, the response from their spouse was not as favorable as when men initiated the conversation.

There have been a number of interventions that focus on educating men and encouraging their involvement in family planning decisions. Sternberg and Hubley (2004) reviewed articles published before 2003 to learn whether efforts to include men in family planning and reproductive health were effective at promoting reproductive health. They found that there was limited evidence related to male involvement and that key questions (e.g., about men's health and how male involvement affects women's empowerment) were not answered. Additional studies published since Sternberg and Hubley's review have shown that educating men about family planning improves attitudes toward family planning and promotes spousal communication (Sood et al., 2004; Ha et al., 2005; Nyako et al., 2011; Shattuck et al., 2011; Hussein et al., 2011; Odeyemi and Ibude, 2011; Hartmann et al., 2012).

Sternberg and Hubley's question about the impact of men's involvement in family planning on women's empowerment remains unanswered. Along with the findings from Saleem and Isa (2004), Nanda and colleagues (2011) found that when both men and women were exposed to family planning messages they were more likely to use contraceptives; however, when men alone were exposed to family planning messages, versus women alone, couples were more likely to use contraceptives, which may reflect men's greater decision-making power in the relationship. Additional interventions and evaluation of interventions related to addressing interpersonal power imbalances between women and family members are also needed.

We found significant gaps in the literature regarding empowerment interventions overall. There is some evidence to support further investment in interventions that promote health literacy for women and girls (LeVine et al., 2012). Women with more education are better able to navigate the health system, which benefits them and their children. Increasing a woman's communication skills can provide her with tools to advocate for herself while seeking reproductive health services.

I-C. Foster demand for high-quality services and supplies through IEC/BCC and empower individuals to demand their rights be respected, protected, and fulfilled

Unmet need for family planning is often assumed to be related to demand for family planning. When a woman wants to prevent a pregnancy for at least two years or to stop having children, she is considered to have an unmet need for family planning. Women who want to delay, space, or limit child bearing may face a number of community-level barriers that prevent their unmet need translating directly to demand for family planning. Helping women meet their fertility preferences often requires activities at the community level, as well as educational and empowerment activities at the individual level.

A rights-based approach to fostering demand for family planning includes some traditional demand-generation activities, including behavior change communication and media coverage, but it also includes an emphasis on changing expectations about the quality of services, human rights, and the availability of a choice of methods to meet reproductive needs. To meet equity elements of a rights-based approach, specific outreach to foster demand within vulnerable groups is also needed. There was limited evidence found in these areas; we recommend making additional investment in these type of interventions and the evaluation of such interventions.

Eleven studies described interventions that foster demand for contraception. Nine of the studies described demand mobilization and behavior change communication campaigns, which were used to spread messages about the benefits of family planning and the availability of services and supplies. These campaigns targeted various audiences. Eight of the nine studies found significant increases in use of contraceptives after interventions were implemented (Kane et al., 1998; Rogers et al., 1999; Kincaid, 2000; Luck et al., 2000; Valente and Saba, 2001; Snyder et al., 2003; Gupta et al., 2003; Van Rossem and Meekers, 2007). One study measured brand recognition after a social marketing campaign and found that the campaign did not result in logo recognition (Guilkey et al., 2011).

The remaining two studies described interventions for vulnerable populations. Both were workplace interventions in Asia: one designed for garment workers in Cambodia and the other for rural to urban migrants in China (FOCUS/CARE International, 2000; Decat et al., 2012). The interventions increased knowledge about contraception and reproductive health but had limited impact on the use of contraception.

III. SUMMARY AND RECOMMENDATIONS

In summary, the findings revealed some key actions/interventions needed at each level to ensure that

- **Policy level**—the conditions of governance (especially political commitment) and accountability (especially to the community) support family planning programs that respect, protect, and fulfill rights (especially in the areas of information, supplies, and services). All relevant policies and their implementation must support nondiscriminatory and equitable access to family planning by all individuals.
- **Service level**—the elements of quality of care (quality, accessibility, availability, and acceptability) guide programming to adhere to the highest standard of care and thus protect inherent human rights principles (especially in the areas of method mix, technical competence, and service integration). These elements are especially important in reaching youth with confidential and age-appropriate services.
- **Community level**—the political, financial, and social environments are supported by the effective participation of diverse community groups (especially youth) in all aspects of family planning policy and program development, implementation, and monitoring (especially in the areas of policy making, funding, and societal norms and equity).
- **Individual level**—the various contexts in which an individual lives allow the person to exercise his or her rights (especially in the areas of behavior, knowledge, access to information and services, and empowerment).

The search and review of evidence was not exhaustive, but rather an initial attempt to gather evidence that supports a voluntary, rights-based approach. The review of the literature encompasses interventions, program evaluations, and case studies that highlight important elements of any family planning program. While the findings in our review did not highlight any explicit rights-based outcomes, several studies touch on rights-related aspects such as quality, client rights, and nondiscrimination, which are crucial to a successful voluntary family planning program that supports rights. That being said, the review of evidence should be expanded and continuously updated to ensure the inclusion of all relevant material, so that programs have access to the most relevant and up-to-date information for programming.

A notable gap in our review of evidence highlights the need for more rights-based outcomes linked to public health outcomes in studies and interventions. Human rights need to be more explicit in studies referring to family planning interventions in order to ensure that rights become embedded in family planning programming. This review also highlights evidence that encompasses all or several levels of the conceptual framework, further showing the importance of linking rights and public health to ensure a comprehensive and successful family planning program.

ANNEX 1. EVIDENCE TABLES

Contents

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Policy/A: Develop/revise/implement policies to respect/protect/fulfill rights and eliminate policies that create unjustifiable medical barriers to access				
Askew, I., Ezeh, A., Bongaarts J., & Townsend, J. (2009). *Kenya's Fertility Transition: Trends, Determinants and Implications for Policy and Programmes*. Nairobi, Kenya: Population Council.	Kenya	Examination of fertility trends in Kenya and its implication for policies and programs.	Case study	Stalled fertility and poor quality of services continues in Kenya. Further policy dialogue and resources needed.
Crichton, J. (2008). Changing fortunes: analysis of fluctuating policy space for family planning in Kenya. *Health Policy and Planning, 23*(5), 339–350.	Kenya	Study on family planning policy space (policies related to contraceptive services). Sought to investigate why policy space contracted and expanded.	Case study; informant interviews; data triangulation 2006–2007	Policy space analysis can provide useful insights into the dynamics of routine policy and program evolution and the challenge of sustaining support for issues even after they have reached the policy agenda.
Kenya National Commission on Human Rights. (2012). *Realising Sexual and Reproductive Health Rights in Kenya: A myth or a reality? A Report of the Public Inquiry into Violations of Sexual and Reproductive Health Rights in Kenya.* Nairobi, Kenya: Kenya National Commission on Human Rights.	Kenya	Report investigation violations of sexual and reproductive rights in Kenya.	Public inquiry in response to complaint filed in 2009 by the Federation of Women Lawyers, Kenya and the Centre for Reproductive Rights, USA, alleging systematic violation of women's reproductive health rights in Kenyan health facilities.	Extent and nature of violations found; recommendations made for appropriate redress.
Simbar, M. (2012). Achievements of the Iranian family planning programmes 1956–2006. *Eastern Mediterranean Health Journal, 18*(3), 279–286.	Tehran, Iran (15 health centers) 65 FP providers and 75 FP clients	Assessment of family planning services through evaluation of facilities, equipment, provider-client interaction, care provision, client information, method use and satisfaction.	Descriptive study; observational checklists, informational forms and questionnaires	Clients were highly satisfied with services and had moderate knowledge on method use. Results also included adequate facilities and equipment and trained personnel.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Policy/ B: Develop/revise/implement policies to ensure contraceptive security, including access to a range of methods and service modalities, including public, private, and NGO				
Richardson, F., Chirwa, M., Fahnestock, M., Bishop, M., Emmart, P., & McHenry, B. (2009). *Community-based Distribution of Injectable Contraceptives in Malawi*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.	Malawi	Feasibility and acceptability study of paraprofessionals—whether health surveillance assistants or other community-based workers could provide injectable contraceptives at the community level. Ministry of Health and FP stakeholders came together through dialogue to enable a policy change and develop an operational program and training guidelines for community-based distribution (CBD) of injectables.	Data analysis; policy dialogue and advocacy 2008–2010	HSAs are now able to distribute injectable contraceptives though implementation of new policy remains an issue.
Leahy, E. (2009). *Reproductive Health Supplies in Six Countries: Themes and Entry Points in Policies, Systems, and Financing* (pp. 45). Washington, DC: Population Action International.	Bangladesh, Ghana, México, Nicaragua, Tanzania, and Uganda	Report assesses issue of reproductive health supplies in six countries. Assessment of policies, financing, health system, and overall country context for facilitating contraceptive security.	Case studies; interviews, field visits, and desk research	Importance of contraceptive commodities, securities, and logistics systems—as well as the policies that accompany and facilitate them.
Hotchkiss, D.R., Godha, D., & Do, M. (2011). Effect of an expansion in private sector provision of contraceptive supplies on horizontal inequity in modern contraceptive use: evidence from Africa and Asia. *International Journal for Equity in Health*, *10*(1), 33.	Nigeria, Uganda, Bangladesh, and Indonesia	Study investigates if the expanded role or private providers in the provision of modern contraceptives is associated with an increase in horizontal inequality in modern contraceptive use.	DHS data from 4 countries over multiple years; indices of inequality and inequality in contraceptive use; multivariate methods	Expansion of private commercial supply of contraceptive in all countries does not lead to increased modern contraceptive prevalence rate (MCPR) inequity; however, private sector can be an important source of supply to poor women without leading to increased MCPR inequity.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Becker, D., Olavarrieta, C., Garcia, S.G., & Harper, C. (2013). *Women's reports on postabortion family planning services provided by the public-sector legal abortion program in Mexico City, 121*(2), 149–153.	Mexico City, Mexico (3 Ministry of Health facilities) 402 women study participants	Evaluation of postabortion family planning services at public health facilities. Women were asked about information received on family planning methods; if methods had been offered, which methods; if they felt pressured to accept a particular type of contraceptive; and much more.	Surveys and interviews with women in public sector facilities September–December 2009	Majority of women were counseled about family planning and were offered a method. The majority of women in these facilities in Mexico City are receiving high-quality postabortion family planning care.
Policy/ C: Create processes and an environment that supports participation of diverse stakeholders (e.g., policymakers, advocacy groups, community members)				
Fofana, F. (2010). Pulling Together: Parliamentarians and Faith Communities. Paper presented at the USAID | Health Policy Initiative End-of-Project Symposium, Washington, DC.	Mali	Study on the effect of participation and engagement of religious leaders supporting family planning.	Case study	Many women in the communities now ask for "birth limiting" and religious leaders have become advocates for FP and spoken out against female genital cutting/mutilation.
McIntyre, D., & Klugman, B. (2003). The human face of decentralisation and integration of health services: experience from South Africa. *Reproductive Health Matters, 11*(21), 108–119.	South Africa (3 provinces) 25 health managers (at all levels)	Exploration of policy making, budgeting, and service implementation processes; focusing on decentralization, combined with efforts to promote integration, as a cornerstone of this health sector restructuring.	Interviews using structured, open-ended questionnaires Policy analysis since 1994	Health managers and other service providers need to be involved in the policy process to ensure effective policy implementation and wide stakeholder involvement.
Policy/D: Support and actively participate in monitoring and accountability processes, including commitments to international treaties				
Afghanistan Independent Human Rights Commission. (2009). *Shadow Report on Government of Afghanistan's II-IV Combined Report on ICESCR*. Kabul, Afghanistan: Afghanistan Independent Human Rights Commission.	Afghanistan	Shadow report to follow up on Afghanistan's commitment to the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of the right to health is evaluated.	Case study/investigation	Recommendations submitted to ICESCR regarding Afghanistan's violations and improvements needed for ICESCR, including article 12.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Health Policy Initiative, Task Order 1. (2010). *The Art of Moving from Policy to Action: Lessons Learned from the USAID | Health Policy Initiative (2005–2010).* Washington, DC: Futures Group, Health Policy Initiative, Task Order 1. AND Ministry of Public Health and Social Assistance (MSPAS), Guatemalan Association for Women Physicians (AGMM), and Health Policy Initiative, Task Order I. (2008). "Guatemala: La Política de Desarrollo Social y Población en Materia de Salud: Avances y Retos en su Implementación." Guatemala City: MSPAS, AGMM, Health Policy Initiative.	Guatemala	Creation of the national OSAR (National RH Observatory) as a mechanism for monitoring FP/RH policy implementation. The Health Policy Initiative helped form the National Alliance of Indigenous Women's Organizations for Reproductive Health and also helped launch the OSARs in several departments in Guatemala.	Accountability for FP/RH policy implementation, data analysis and use, and governance 2007–2009	OSARs have emerged as effective mechanisms to build and sustain policy advocacy and monitoring capacity in Guatemala and increase accountability for FP/RH policy implementation.
Chambers, V. (2012). Improving maternal health when resources are limited: safe motherhood in rural Rwanda. *Africa Power and Politics Policy Brief* 05. London: Africa Power and Politics Programme.	Nyamagabe and Musanze districts, Rwanda	Study on overcoming policy bottlenecks in order to make progress on maternal health.	Interviews and data/policy analysis 2009–2011	Importance of non-material resources in Rwanda, such as citizen participation and upward accountability. Policy drive from the top down is a crucial condition for progress at the grassroots level.
International Planned Parenthood Federation. (2012). *Holding Governments Accountable: Experiences from Five Latin American Countries* (pp. 12). New York: IPPF.	Perú, México, Bolivia, Panamá, and Dominican Republic	Report on *Voices* Project in each of the 5 countries listed covering topics related to government accountability for the sexual and reproductive health of young people.	Case studies	Each case study shows the importance of ensuring the sexual and reproductive rights of all women, men, and young people.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Policy/E: Guarantee financing options to maximize access, equity, nondiscrimination, and quality in all settings				
Meuwissen, L.E., Gorter, A C., & Knottnerus, J.A. (2006). Perceived quality of reproductive care for girls in a competitive voucher programme. A quasi-experimental intervention study, Managua, Nicaragua. *International Journal for Quality in Health Care, 18*(1), 35–42.	Managua, Nicaragua Of a random sample of 3,009 females, 700 respondents used services—221 with vouchers and 479 without vouchers	28,711 vouchers were distributed among female adolescents ages 12–20 years old to allow them free access to family planning services at 19 nearby clinics.	Community-based, quasi-experimental intervention study 2000–2002	Significant increases in knowledge and use of family planning by voucher recipients.
Meuwissen, L.E., Gorter, A.C., Segura, Z., Kester, A.D., & Knottnerus, J.A. (2006). Uncovering and responding to needs for sexual and reproductive health care among poor urban female adolescents in Nicaragua. *Tropical Medicine & International Health, 11*(12), 1,858–1,867.	Managua, Nicaragua 19 primary health clinics	16,850 female and 11,861 male adolescents ages 12–20 years old in disadvantaged areas of Managua received vouchers.	Medical files from 3,301 consultations with female adolescents were analyzed using descriptive statistical methods and multiple logistic regressions. 3 years	Significant increases in knowledge and use of family planning by voucher recipients.
Meuwissen, L, Gorter, A., Kester, A., & Knottenrus, J.A. (2006). Does a competitive voucher program for adolescents improve the quality of reproductive health care? A simulated patient study in Nicaragua. *BioMed Central Public Health* 6, 204.	Managua, Nicaragua 19 clinics 17 simulated patients (for survey) 28,711 vouchers distributed	3-month vouchers distributed free of charge to individuals ages 15–20 years old in order to access SRH care in any 4 public, 5 private, or 10 NGO clinics for one consult and follow-up visit. Providers were given training and guidelines, treatment protocols, and financial incentives for each adolescent they attended. A week prior to the intervention, a simulated patient (SP) would go into a clinic without a voucher; during the interventions SPs were sent with vouchers; and 1–2 months after intervention, SPs were sent without a voucher.	Pre-and post-intervention performance testing. Questionnaire given to all SPs after each visit. 15-month period; years not indicated	Some service quality improved during the voucher program; however, before the program started, 8 of the 16 SPs returned "empty handed," although all were eligible contraceptive users. During the program, 16 of the 17 SPs left with a contraceptive method and more SPs were involved in choosing a method. Shared decision making on contraceptive methods as well as condom promotion had significantly increased after the program ended. Female doctors had the best scores before, during, and after the intervention.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Meuwissen, L.E., Gorter, A.C., & Knottnerus, A.J. (2006). Impact of accessible sexual and reproductive health care on poor and underserved adolescents in Managua, Nicaragua: a quasi-experimental intervention study. *Journal of Adolescent Health*, *38*(1), 56.	Managua, Nicaragua (urban) n=3009, 12–20 year old female adolescents (n=904 voucher receivers; n=2105 non-receivers)	Vouchers gave free access to SRH care in 20 health centers, were distributed to adolescents in 4 markets, outside 19 public schools, in clinics, and on streets and house-to-house in 221 poor neighborhoods. Vouchers were not bound to the person who originally received them and could be passed to another adolescent (voucher traveling).	Evaluation PT-C; Crude odds ratios; adjusted Mantel-Haenszel odds ratios; logistic regressions 3–15 months after the vouchers were distributed	Utilization of services: + Knowledge of contraceptives: + Knowledge of STIs: + Prevention through condom use: + Condom use at last contact: + Use of modern contraceptives: 0 (overall) + (for school receivers)
Signorini, B.A., & Queiroz, B.L. (2009, draft). The Impact of Bolsa Familia Program in the Beneficiary Fertility.	Brazil In 2004, n = 24,338 (6.17% of the sample) households receiving Bolsa Familia benefits In 2006, n = 87,800 (21.42% of the sample) households receiving Bolsa-Familia benefits	The Bolsa Familia program began in 2003, uniting pre-existing social programs directed at poor families. In one component, families below the poverty line (which is R$50,00 per capita) would be provided a monthly minimum income of R$50.00 (US$21). Additional benefits given to each pregnant woman, infant, or school-aged child. The program's conditionalities include children's school attendance and the fulfillment of basic healthcare measures (immunization, going to the health clinic, prenatal care, and others). The most vulnerable families can receive up to R$172.00 monthly (about US$72).	Randomized control study: using the Household Sample National Survey (PNAD) for the years 2004 and 2006, estimated the first-differences for each year to find the average treatment effect on treated (ATT) To find comparable groups of treatment and control, used Propensity Score Matching methods; Regression model—first-differences approach 2-year comparison	Fertility: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Stecklov, G., Winters, P., Todd, J., & Regalia, F. (2007). Unintended effects of poverty programmes on childbearing in less developed countries: experimental evidence from Latin America. *Population Studies (Cambridge), 61*(2), 125–140.	Select poor communities in Mexico, Honduras, and Nicaragua All women ages 12–47 in the baseline sample (1997 for PROGRESA and 2000 for PRAF and RPS), who would have been ages 14–49 in the follow-up (1999 PROGRESA and 2002 PRAF and RPS). n=8,817 women for PROGRESA n=6,456 for PRAF n=2,409 for RPS	Households in the treatment group benefitted from the Conditional Cash Transfer programs and received transfers under the condition that their children enroll in and attend school and that family members obtain healthcare.	Randomized control trial with pre- and post-test: PROGRESA in Mexico, PRAF in Honduras, and RSP in Nicaragua In each case, communities randomly assigned to treatment and control groups For PROGRESA, 302 communities were randomly assigned to treatment and 186 to control For PRAF, 40 eligible communities were assigned to treatment and 30 to control For RSP, 21 treatment and 21 control communities Difference in difference models; probit models 2-year period under examination after each program was undertaken.	Fertility: Honduras: - Nicaragua and México: 0 Contraceptive use: Mexico: + Nicaragua: 0
Oronje, R., et al. (2011). Operationalising sexual and reproductive health and rights in sub-Saharan Africa: constraints, dilemmas and strategies. *BMC International Health and Human Rights, 11*(Suppl 3), S8.	Botswana, Burkina Faso, Cameroon, Ghana, Ethiopia, Nigeria, Rwanda, Senegal, and Uganda	9 country analysis on implementation of the Maputo Plan of Action (including the constitutional and policy environment).	Case studies; policy analysis; interviews	Prohibitive laws and governments' reluctance to institute and implement comprehensive rights approaches to SRH, lack of political leadership and commitment to funding SRHR policies and programs, and dominant negative cultural framing of women's issues present the major obstacles to operationalizing SRH rights.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Sine, J., Clyde, M.E., & Baser, Z. (2004). A Political Economy Perspective on Achieving Contraceptive Self-Reliance in Turkey. *POLICY Working Paper Series #13*. Washington, DC: Futures Group.	Turkey	Report examining how the MCH-FP Directorate overcame challenges to put in place a sustainable strategy for the public sector FP program and examining the processes that led to implementation two central components of Turkey's national self-reliance strategy: obtaining annual budget allocations for contraceptives and targeting free services to the poor.	Political Economy Framework	Effective policy dialogue led to MCH-FP Directorate leaders being successful in securing sufficient additional resources from the central treasury to fill the new funding gap for contraceptive supplies.
Sekabaraga, C., Diop, F., & Soucat, A. (2011). Can innovative health financing policies increase access to MDG-related services? Evidence from Rwanda. *Health Policy and Planning, 26*(Suppl 2), ii52–ii62.	Rwanda	Assessment of healthcare financing policies between 2000–2007. Attention given to healthcare policies related to poor groups' utilization of health services and reduced out-of-pocket payments for healthcare.	Case study	The paper concludes that the Rwanda experience provides a useful example of effective implementation of policies that reduce the financial barrier to health services, thereby contributing to the health MDGs.
Feldman, B.S., et al. (2009). Contraceptive use, birth spacing, and autonomy: an analysis of the Oportunidades program in rural Mexico. *Studies in Family Planning, 40(*1), 51–62.	Mexico (rural areas)	Assessment of "Oportunidades" cash transfer program and the effect of the program on contraceptive use and birth spacing among titulares (female household heads)	Experimental period 1998–2000 After incorporation of control group, 2000–2003	Titulares' autonomy increased more than that of the controls from baseline between 1998 and 1999. In 2000, titulares were more likely to use modern contraceptives than were women in the control group, although by 2003, all beneficiaries had the same probability of use.
Busogoro, Jean-François, & Alix Beith. (2010). Pay-for-performance for Improved Health in Burundi. Bethesda, MD: Health Systems 20/20 project, Abt Associates, Inc.	Burundi (3 provinces)	Scale-up of a supply-side-focused pay-for-performance (P4P) program that rewards hospitals and health facilities with regular payments determined by service utilization levels and performance on quality.	Case study 2006	Evaluations from the pilot studies showed that the strategy could contribute to empowerment of health providers, as it allowed the providers to find innovative and creative ways to attract and sustain clients.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Ahmed, S., & Khan, M.M. (2011). A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh? *Health Policy and Planning, 26*(1), 25–32.	Sarishabari, Bangladesh	Analysis of the maternal health voucher scheme, 2 years after implementation.	13 semi-structured interviews with stakeholders at the sub-district level	The resources made available through the scheme did not attract any new providers into the market, and public facilities remained the only eligible provider both before and after scheme implementation. Incentives provided through the voucher system did motivate public providers to offer a higher level of services. Voucher users were satisfied overall.
Arur, Aneesa, Gitonga, N., O'Hanlon, B., Kundu, F., Senkaali, M., & Ssemujju, R. (2009). *Insights from Innovations: Lessons from Designing and Implementing Family Planning/Reproductive Health Voucher Programs in Kenya and Uganda.* Bethesda, MD: Private Sector Partnerships-*One* project, Abt Associates, Inc.	Kenya and Uganda	Analysis of Uganda's Reproductive Health Voucher Project (RHVP) and Kenya's Reproductive-Health Output-Based Aid (RH-OBA) voucher pilot program. Purpose of the study and analysis was to identify guidelines to help design an effective FP/RH voucher program.	Policy analysis Kenya 2005 Uganda 2008	Uptake of vouchers in Kenya was high and almost two-thirds of voucher users opted for implants; Uganda's voucher uptake has been low but still too early to determine impact.
Brody, C.D., Freccero, J., Brindis, C.D., & Bellows, B. (2013). Redeeming qualities: exploring factors that affect women's use of reproductive health vouchers in Cambodia. *BMC International Health and Human Rights, 13*(13).	Cambodia (Kampong Thom, Prey Veng, and Kampot provinces) 15,631 vouchers for family planning distributed	Study sought to explore and understand women's perceptions and experiences with the voucher program, specifically accessing healthcare services prior to the program and redeeming their vouchers for services at facilities.	Qualitative exploratory study with focus groups; grounded theory 2011	Overall, positive experiences with voucher program; however, more comprehensive counseling during voucher distribution is needed, among other things
Bellows, N., Bellows, B., & Warren, C. (2011). The use of vouchers for reproductive health services in developing countries: systematic review. *Tropical Medicine and International Health, 16*(1), 84–96.	Bangladesh, Cambodia, China, Kenya, Korea, India, Indonesia, Nicaragua, Taiwan, and Uganda Voucher programs	Systematic review to identify reproductive health voucher programs and evaluations.	Systematic review; studies included cross-sectional before-and-after and quasi-experimental designs	Overall, reproductive health voucher programs increased utilization of RH services, improved quality of care and population health outcomes

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Service/A: Inform and counsel all clients in high-quality interactions that ensure accurate, unbiased, comprehensible information, and protect clients' dignity, confidentiality, and privacy and refer to other SRH services (All Rs)				
Aranas, C., Benabaye, R., Herrin, A., & Fort, C. (2011). Integrating Family Planning and Immunization: the Polomolok Experience in the Philippines. Paper presented at the 2011 International Family Planning Conference, Dakar, Senegal.	Polomolok, Philippines 1 rural health unit and 28 Barangay health stations Knowledge, attitudes, and practices (KAP) survey: baseline=269; end line=183	During an immunization visit, the provider said three short phrases to mother: (1) Your child is still young and you should be concerned about another pregnancy too soon; (2) This clinic provides FP services that can help you delay your next pregnancy; (3) You should visit the FP clinic after the immunization for more information. One center included a written version and posted it in the entry way.	Collection of data on new FP acceptors KAP survey of randomly selected mothers bringing children in for immunization 10 months	38% increase in FP use. 6 percentage point increase in CPR in Polomolok. Increased use of modern methods. No negative impact on immunization.
Johnson, B.R., Ndhlovu, S., Farr, S. L., & Chipato, T. (2002). Reducing unplanned pregnancy and abortion in Zimbabwe through post abortion contraception. *Studies in Family Planning, 33*(2), 195–202.	Harare (intervention site)—1,355 women recruited seeking postabortion care Mpilo (control site)—873 women recruited seeking postabortion care Intervention: 316 women Control: 320 women	Women were provided free, ward-based family planning, including counseling about short- and long-term fertility control. Women could receive pills, condoms, or Depo at the hospital or were referred for placement of implants, IUDs, or other methods. Control sites provided standard care, which did not emphasize family planning.	Repeat cross-sectional with comparison group; women were interviewed at 3, 6, 9, and 12 months and pregnancy tests were administered 12 months	Women who received the intervention were significantly more likely to use highly effective contraceptives. Women were less likely to have a pregnancy during the first year after the reference abortion

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Ngure, K., Heffron, R., Mugo, N., Irungu, E., Celum, C., & Baeten, J. M. (2009). Successful increase in contraceptive uptake among Kenyan HIV-1-serodiscordant couples enrolled in an HIV-1 prevention trial. *AIDS, 23*(Suppl 1), S89–95.	Thika, Kenya 213 HIV-1-serodiscordant couples	Multi-pronged intervention that included training of clinical and counseling staff on contraceptive methods; provision of free contraceptive methods to study participants; use of contraceptive appointment cards with clear dates for renewal of the time-dependent methods; ongoing contraceptive counseling; involvement of male partners during contraceptive counseling sessions to increase dual contraceptive uptake.	Baseline and end line; comparison with trial sites before v. after 2007; Anderson-Gill proportional hazards modeling used 2006–2007	No barrier contraceptive use increased after implementation of intervention; self-reported condom use remained high during follow-up. Pregnancy incidence was significantly lower compared to incidence before June 2007.
Stanback, J., Vance, G., Asare, G., Kasonde, P., Kafulubiti, B., & Chen, M. (2011). The Thin Blue Line: Does Free Pregnancy Testing Increase Family Planning Uptake? Paper presented at the 2011 International Family Planning Conference, Dakar, Senegal.	Ghana and Zambia 5 control clinics and 5 intervention clinics	Provide free pregnancy tests to non-menstruating women to eliminate unnecessary denial of methods.	Pre/post-intervention/control design	Percentage of women not receiving a method was reduced from 16% to 4% in intervention sites in Zambia. Percentage increased from 6% to 8% in Ghana.
Zhu, J. L., et al. (2009). Impact of post-abortion family planning services on contraceptive use and abortion rate among young women in China: a cluster randomized trial. *European Journal of Contraception and Reproductive Health Care, 14*(1), 46–54.	China (8 matched pairs of hospitals) 2,336 women younger than 25 years old were followed; 1,110 were followed for the basic package, and 1,226 for the comprehensive package	2 packages of care were provided: the first was a basic package with information and referral to FP services; the second comprehensive package included the basic services, plus counseling and free contraceptive materials, and involved the male partner.	Cluster randomized trial; odds ratios reported at 95% Cis	Both packages increased use of any contraceptive method, but the comprehensive approach also increased use of more effective methods. The rates of unwanted pregnancies and repeat abortions were somewhat reduced for both packages, with no significant statistical difference between them. Couples who receive the comprehensive postabortion FP service appear to use more effective contraceptive methods and show better compliance.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Lee, J.T., Tsai, J.L., Tsou, T.S., & Chen, M.C. (2011). Effectiveness of a theory-based postpartum sexual health education program on women's contraceptive use: a randomized controlled trial. *Contraception, 84*(1), 48–56.	Northern Taiwan 250 women split among 2 intervention groups and 1 control group	Group A: Were exposed to the transtheoretically based interactive postpartum sexual health education program Group B: Received a pamphlet (control) Group C: Routine teaching	Prospective, randomized controlled trial design with a pretest and three post-tests 3 days, 2 months, 3 months	Group A's sexual knowledge was not greater than the control group. No significant impact on attitudes towards sexual health. No significant impact on contraceptive efficacy compared with control group. Significant improvement in contraceptive self-efficacy.
Lopez, L.M., Hiller, J.E., & Grimes, D.A. (2010). Education for contraceptive use by women after childbirth. [Meta-Analysis Review]. Cochrane database of systematic reviews (1), CD001863.	10 randomized control trials (RCTs) met inclusion criteria	RCTs were considered if they evaluated the effectiveness of postpartum education about contraceptive use. The intervention must have started postpartum and have occurred within one month of delivery.	Assessment included all titles and abstracts identified during the literature searches with no language limitations. The data were abstracted and entered into RevMan. Studies were examined for methodological quality. For dichotomous outcomes, the Mantel-Haenszel odds ratio with 95% confidence interval was calculated. For continuous variables, we computed the mean difference (MD) with a 95% interval.	Two trials showed effectiveness with postpartum contraceptive counseling. Three trials showed evidence of effectiveness with a multifaceted approach, focusing on US and Australian youth with adolescent home visits or increased well baby care.
Baveja, R., et al. (2000). Evaluating contraceptive choice through the method-mix approach. An Indian Council of Medical Research (ICMR) task force study. *Contraception, 61*(2), 113–119.	India 10 human reproduction research centers n=8,077	Women who had not preselected a contraceptive were given balanced information on the available methods, including the new method Norplant (available methods were low dose oral contraceptives, condoms, CuT IUDs, sterilization, and Norplant. Providers were retrained to provide balanced information.	Service and demographic statistics reported	Women and providers differed on preferred methods; women's first choices were IUDs (58.6%) and Tubectomy (14.9%); provider's first choices were Norplant (35.6%), IUDs (32.8%), Tubectomy (19.2%).

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Barden-O'Fallon, J., & Speizer, I. (2011). What differentiates method stoppers from switchers? Contraceptive discontinuation and switching among Honduran women. *International Perspectives on Sexual and Reproductive Health, 37*(1), 16–23.	Honduras (4 urban areas: Tegucigalpa, San Pedro Sula, Santa Rosa de Copán, La Entrada and Gracias) 800 women consented to interviews from 13 health facilities within the 4 specified areas	Survey data on differences between switchers and users of contraceptives.	Data design: Questionnaires to obtain baseline and follow-up data Baseline questionnaire Oct–Nov 2006 Follow-up collected Oct–Dec 2007	41% of women (273) discontinued baseline method; of these, 117 switched and 156 stopped (for one month or more). Differences between switchers and stoppers stemmed from demographic characteristics, experience of side effects, discussion of discontinuation, and main reason for discontinuing.
Khan, M. E., et al. (2004). Introduction of emergency contraception in Bangladesh: Using operations research for policy decisions. Washington, DC: Population Council.	Bangladesh (districts of Tangail and Mymensingh) 12 health clinics chosen: 8 were intervention sites and remaining 4 were controls n=3,900 married women (1,300 for each of the 3 groups were chosen at random	2 interventions undertaken: training of providers; provision of emergency contraceptive pill (ECP) information and services under the 2 different models. On-demand model provided all FP clients (except IUD, implant, and sterilization acceptors) with counseling and a brochure on EC. Prophylactic group provided the same information services but in addition provided women with 2 packets of EC to use in case of an emergency. The control group received no EC services.	2 different service delivery models: of 8 interventions sites, some provided an on-demand delivery model of EC where counseling and brochures on ECP was given and clients encouraged to come back if needed EC; other sites acted in prophylactic delivery model--same counseling and brochure in addition to 2 packets of ECP 9 month intervention: March 2001–November 2001	Before the study, women did not have knowledge of EC and it is an unmet need. Providers results: many knew unprotected sex was common—many unwanted pregnancies are aborted—and welcome the introduction of ECP into the FP program as they had little to no knowledge of it before intervention. Training of providers on this method increased their knowledge on the availability of it. 50 master trainers and 900 trainers have trained 15,000 providers, and EPC is being provided in 17 districts. EC use: +

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Steele, F., Curtis, S.L., & Choe, M. (1999). The Impact of Family Planning Service Provision on Contraceptive-use Dynamics in Morocco. *Studies in Family Planning, 30*(1), 28–42.	1992, 1995 Morocco DHS and 1992 Morocco DHS-Service Availability Modules (SAM) 4,753 women interviewed (3,324 interviewed in 1992; 1,429 new)	Panel study using DHS and SAM data from 1992 and 1995 to examine the relationship between the service environment and contraceptive adoption and continuation, linking individual data on contraceptive-use dynamics (DHS) with community data on the service environment (SAM).	Panel study using DHS and SAM data to analyze contraceptive adoption, pill users in Morocco (no other method), switching behavior, and service variables Event history analysis is used to evaluate impact of FP program indicators, net of individual characteristics, on contraceptive adoption after a birth, on discontinuation, and on switching Discrete time event history models are also used as durations of contraceptive use are recorded to the nearest month, assuming measurement in discrete time rather than in continuous time 1992, DHS &SAM, 1995 DHS; Fieldwork conducted April–May 1995	Number of methods available significantly increases postpartum contraceptive adoption, but has a weak effect on switching from the pill to other method. Women who use nongovernment sources are more likely to discontinue pill use for method-related reasons than those who use government sources. The availability of public health centers within 5KM increased method adoption following a birth, but it does not have a significant effect on discontinuation.
Padilla, M.B., & Fort, A. (2001). Results of the Second Follow-up Study of the Dominican Republic Performance Improvement Project Evaluation. Chapel Hill, NC: Intrah, PRIME II Project. Technical Report #28. Addendum to Technical Report #19.	San Cristobal, La Vega, and La Romana, Dominican Republic 163 clients at baseline 166 at first follow-up 290 at second follow-up	Pilot study to evaluate efficacy of RH interventions. Interventions included reproductive health training for providers, "expectation setting" (communication of expectations to both providers and clients regarding norms of service quality within the Dominican Social Security Institute), and dissemination of educational materials.	Client satisfaction surveys, direct observation of client-provider interaction, and interviews with providers March–April 1999 baseline: August 1999–August 2000 follow-up	San Cristobal Province showed consistent and statistically significant improvements in client-provider interaction of all three sites.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Okullo J., et al. (2003). *Improving Quality of Care for Family Planning Services in Uganda*. Washington, DC: DISH II Project, FRONTIERS and Population Council.	Kamuli, Luweero, Masaka, and Masindi, Uganda 624 clients pre-intervention and 627 post-intervention	Package of interventions that sought to increase readiness of clinics to offer basic FP services, to improve provider motivation, and to empower clients to request high-quality services. Seven "readiness" interventions in the Yellow Star Programme (YSP) targeted provider motivation and client empowerment.	Out of 4 districts, 2 were randomly assigned to an experimental group and two were comparison groups. Interviews with providers and clients, observation of client-provider interactions, and a time motion study were conducted Pre-intervention November 2000, and post-intervention February 2002	Package of interventions did somewhat increase functioning of basic FP services in all clinics, but improvements were not significantly different when compared with the baseline. Quality of care had immediate effect, increasing the number of clinics attaining most of the basic quality standards set by Yellow Star Programme.
Todd, C.S., et al. (2011). Intensive counseling in the immediate postpartum period to improve maternal and neonatal outcomes: a randomized controlled trial in Kabul, Afghanistan. Paper presented at the 2011 International Family Planning Conference, Dakar, Senegal.	Kabul, Afghanistan (4 public hospitals) Women in labor were randomly selected upon admission to the hospital	Randomized control trial; intervention of counseling vs. standard of care. Women in the intervention arm received intensive counseling on three behaviors: breastfeeding, contraceptive use, and vaccination from a staff person dedicated to providing counseling.	Crude and adjusted risk ratios with log-binomial generalized linear model Birth, 6, and 12 months	(Contraceptive use only) 82.6% of participants completed the study. Increased use of contraceptives was slightly associated with the intervention ARR1.11 (95%CI: 1.02-1.21). No effect on pregnancies, possibly due to reliance on less effective modern and traditional methods.
Lazcano Ponce, et al. (2000). The power of information and contraceptive choice in a family planning setting in Mexico. *Sexually Transmitted Infections, 76*(4), 277–281.	Mexico City (polyclinic) 2,107 total participants: 1,033 in the control and 1,074 in intervention	Provide information on sexually transmitted diseases (STDs) and contraceptive methods; provide free STD testing.	Randomized control trial; bivariate analysis using chi^2 and student t tests Two weeks per patient	Intervention group was 4 times less likely to choose an IUD when contraindicated because of STIs
Akman, M. et al. (2010). The Influence of Prenatal Counseling on Postpartum Contraceptive Choice. *Journal of International Medical Research, 38*(4), 1243–1249.	Turkey (Marmara University Hospital) n=180; 60 in intervention group; 120 in control group	Intervention group received prenatal counseling; control group received an educational leaflet about postpartum family planning during routine prenatal care.	Randomized control trial 6–9 months postpartum	No significant difference in contraceptive use between the two groups.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Barber, S.L. (2007). Family planning advice and postpartum contraceptive use among low-income women in Mexico. *International Family Planning Perspectives, 33*(1), 6–12.	17 Mexican states n=2,238 urban low-income women	Analysis of the relationship between prenatal family planning advice and subsequent contraceptive use.	Retrospective cohort study; logistic regression models Within 12 months of giving birth	Women who received FP advice prenatally were 2.2 times more likely to use FP.
Sherwood-Fabre, L., Goldberg, H., & Bodrova, V. (2002). The impact of an integrated family planning program in Russia. *Evaluation Review, 26*(2), 190–212.	Russia (3 cities) 6,000 women ages 15–44	Physician training. Information, education, and communication activities. Contraceptive supplies ensured for 6 months at facilities. Intervention goal was to reduce abortion-related maternal mortality by changing physicians' and women's knowledge and practices concerning FP.	Quasi-experimental, three stage cluster sample design 36 months Randomized control trial: 2 project cities (Yekaterinburg and Ivanovo) and 1 control city (Perm) Logistic regression 3 years	Inconclusive results about impact. Discussing various methods with a provider: 0 Women's attitudes about FP became more favorable: 0 Contraceptive use: 0 Abortions: +
Brown, L., et al. (1995). Quality of care in family planning services in Morocco. *Studies in Family Planning, 26*(3), 154–168.	Morocco (5 provinces) 50 service delivery points of the national family planning program	Test instruments of measuring quality. Improve service delivery by identifying components of service delivery in need of attention and heighten awareness of quality as an important programmatic priority using situation analysis instruments.	Mixed methods—quantitative survey data reported 2 years	Increased awareness of quality of services. Efforts enacted to improve quality of care.
RamaRao, S., Lacuesta, M., Costello, M., Pangolibay, B., & Jones, H. (2003). The link between quality of care and contraceptive use. *International Family Planning Perspectives, 29*(2), 76–83.	1,728 new FP users were interviewed to assess quality of care from FP providers; 1,460 were surveyed 16 months later to learn about their contraceptive status	Comparison in FP use and relative quality of care experienced by client.	Cross-section survey design; chi-squared and t-tests; logistic regression models 16 months	Women receiving high quality of care were more likely to be using contraceptives at follow-up.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Canto de Centina, T., Canto, P., & Ordoñez Luna, M. (2001). Effect of counseling to improve compliance in Mexican women receiving depot-medroxyprogesterone acetate. *Contraception, 63*, 143–146.	Merida, Yucatan, Mexico 350 women	Intervention to determine the effect of pretreatment counseling upon discontinuation of Depo-Provera.	Patients in counseling group (intervention group) received information on alternative contraceptive methods and control group received routine counseling	Counseling on expected side effects and other information before initiation of method greatly increases Depo's continuation rates in women of this area.
Saeed, G. A., Fakhar, S., Rahim, F., & Tabassum, S. (2008). Change in trend of contraceptive uptake—effect of educational leaflets and counseling. *Contraception, 77*(5), 377–381.	Pakistan 648 women	Counseling and an informational leaflet was provided to postpartum women; follow-up was conducted when women returned for postpartum checkups.	Quasi-experimental design 8–12 weeks	600 women completed the intervention and follow-up; significantly more women in the intervention group were using contraceptives at follow-up. These women also used more modern methods.
Salazar, M., Valladares, E., & Hogberg, U. (2012). Questions about intimate partner violence should be part of contraceptive counselling: findings from a community-based longitudinal study in Nicaragua. *Journal of Family Planning and Reproductive Health Care, 38*(4), 221–228.	Nicaragua 398 women	No intervention; observational study about relationship between contraceptive use and intimate partner violence.	Logistic regression and statistical tests to test relationships. 40–47 months	Women exposed to a continued abuse pattern and those exposed to intimate partner violence had higher odds of reversible contraceptive use that those not exposed to intimate partner violence.
Sinha, N. (2005). Fertility, Child Work, and Schooling Consequences of Family Planning Programs: Evidence from an Experiment in Rural Bangladesh. *Economic Development and Cultural Change, 54*(1), 97–128.	Bangladesh (rural) n=4,892 ever-married women n=2,520 boys and girls (10–16) in the children sample	The treatment villages were provided with an intensive family planning program maintained by the International Centre for Diarrhoeal Disease Research, Bangladesh.	Pre/post-test with control: longitudinal data from Matlab covering 139 villages, with 70 villages in the treatment area and 69 in the control area Regression analysis 18 year period from start of program until the Matlab Health and Socioeconomic Survey was fielded in 1996	Fertility: + Labor force participation: Boys: + Girls: 0 Schooling: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Phillips, J.F., Hossain, M.B., & Arends-Kuenning, M. (1996). The long-term demographic role of community-based family planning in rural Bangladesh. *Studies in Family Planning, 27*(4), 204–219.	Bangladesh (rural) A brief questionnaire was added to 2 rounds of the Sample Registration System in 1993 to elicit responses about exposure to the overall regimen of services	In the MCH-FP Extension Project study areas, service-outreach encounters are routinely monitored by research workers who visit households in 90-day rounds and record respondents' recall of the dates of household visits from government and other outreach workers.	Pre/post-test: results assess the effect of outreach on contraceptive prevalence for successive 18-month periods at the beginning of the project period (1982–1984), at the middle (1986–1988), and in the most recent period (1990–1992). Generalized logit regression; logit regression. 8 year period	Change in reproductive preferences: + Contraceptive use: +
DeGraff, D.S. (1991). Increasing contraceptive use in Bangladesh: the role of demand and supply factors. *Demography, 28*(1), 65–81.	Bangladesh (all villages in Matlab region) Merged (from 1982 and 1984 surveys) of 5,417 women of reproductive age—refined to 3,840 observations to include those women currently married or not pregnant	Data analysis on previously conducted surveys to determine the differences in contraceptive use between a Family Planning Health Services Project (FPHSP) area and non-FPHSP area. The FPHSP is the treatment area.	Used previous data collected from 1982 and 1984. A subset of the villages that are analyzed are covered by the FPHSP while the remaining areas are not (comparison area). Analysis is an examination of differences between treatment and comparison areas. Analytical framework (decision-making framework) is guided by individuals' decision regarding contraceptive used based on joint effects of demand for children, supply of contraceptives, and costs of contraception (including resources and social and psychic costs). Multivariate model also used to analyze data/statistics. 1982 and 1984 survey/data analysis conducted in 1991 (assumption based on date of article)	CPR is higher in the FPHSP area. More knowledge of methods affected behavior of non-FPHSP group; FPHSP area was affected by side effects—discouragement from using contraception. Recent visits from field workers had no impact on current contraceptive use. Child demand factors given greater consideration in FPHSP area. Contraceptive cost variable—greatest contribution to difference in predicted probabilities across areas.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Varkey, L.C., et al. (2004). Involving Men in Maternity Care in India. In FRONTIERS (Ed.). Washington, DC: Population Council.	New Delhi, India Baseline n=581 pregnant women (10–26 weeks pregnant) and 488 husbands at intervention and 486 women at control sites 6–9 month follow-up n=327 women and their husbands from the intervention group and 302 women and their husbands from the control group	Interventions included training providers to conduct brief counseling sessions and behavior change communication, introduction of new IEC materials, and training on new clinical practices. Main components included an individual or group counseling session in the antenatal clinic, separately for men and women; couple counseling sessions during antenatal and postnatal clinics; screening of all pregnant women for syphilis; and syndromic management of men reporting urethral discharge and men and women reporting genital ulcers as part of the individual counseling.	Pre-intervention survey Post-intervention survey 2 years Randomized control study: Non-equivalent control group study design in which 6 Employees' State Insurance Corporation dispensaries with the highest antenatal clinic attendance were purposively selected—3 were assigned to the intervention and 3 acted as controls. Analysis of variance; z-statistics	Knowledge of condoms for dual protection increased in intervention groups. Knowledge of lactational amenorrhoea method (LAM) increases in intervention groups. Increased use of FP at 6 and 9 months in intervention groups. Greater intention to use among non-using women in the intervention group.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Kunene, B., et al. (2004). Involving men in maternity care, South Africa. In FRONTIERS (Ed.), (pp. 57). Washington, DC: Population Council.	KwaZulu-Natal Province, South Africa 8 urban and 4 rural clinics; 2,082 (1,081 control and 995 intervention) women and 584 (intervention) men recruited into the study At follow-up, 694 women and 558 men in the control group interviewed; 729 women and 608 men in the intervention group interviewed	2 components: improving existing antenatal care services including information, education, communication and dissemination of an information leaflet and a booklet for couples to read and discuss ("Ukuba umzali"); and introducing strengthened individual and group counseling for pregnant women and their partners. Men were invited to participate in 3 counseling sessions through the maternity period. Two were to take place during pregnancy and the other 6 weeks post-delivery. Each clinic developed its own plan to conduct couple counseling.	Cluster randomized controlled trial at 6 intervention clinics and 6 control clinics 6 months post-recruitment; recruitment occurred for 17 months	92% of women and 74% of men read the booklet. 23% of women and 27% of men participated in countless counseling sessions with a partner. 22% of women and 2% of men participated in couples counseling without a partner. Intervention did not have a significant impact on use of contraceptives. Men in the intervention group were more likely to assist their partner if a pregnancy-related emergency arose.
García, S.G., Lara, D., et al. (2006). Emergency contraception in Honduras: knowledge, attitudes, and practice among urban family planning clients. *Studies in Family Planning, 37*(3), 187–96.	ASHONPLAFA clinics in Tegucigalpa and San Pedro Sula Honduras 1,406 clients at baseline and 1,287 at follow-up	The local affiliate of IPPF, ASHONPLAFA, developed EC introduction activities (an EC kit; EC information/education campaign). The baseline study documents EC knowledge, attitudes, and practices of FP clients before the outreach activities, and the evaluation study documents these same things 2 years after.	Multivariate log regression models to determine independent effects of demographic and sexual history variables on outcomes: (1) heard of EC; (2) would use EC, (3) had concerns about EC Baseline survey conducted in September 2001; follow-up survey in 2003	Awareness of EC increased from 5% at baseline to 20% at follow-up; conversely, follow-up clients were less likely than baseline clients to report they would use EC.
Brambila, C., Ottolenghi, E., Marin, C., & Bertrand, J.T. (2007). Getting results used: evidence from reproductive health programmatic research in Guatemala. *Health Policy and Planning, 22*, 234–245.	Guatemala 44 operations research projects	Review of 44 operations research projects to highlight results that contributed to changes and improvement in program operations in reproductive health.	Review 1988–2001	No study, single-handedly, leads to widespread change. The research provided practitioners with a body of evidence to support needed change and created an environment for evidence-based decision making.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Foss, A.M., Hossain, M., Vickerman, P.T., & Watts, C.H. (2007). A systematic review of published evidence on intervention impact on condom use in sub-Saharan Africa and Asia. *Sexually Transmitted Infections, 83*, 510–516.	62 studies Sub-Saharan Africa and Asia	Systematic review of published evidence on the impact of interventions on levels of condom use in different partnerships in sub-Saharan Africa and Asia.	Database search that resulted in 62 studies out of 1,374 that met inclusion criteria Studies published between 1998 and 2006	Interventions targeted youth, sex workers, and women using postabortion or safe motherhood services. Interventions primarily used peer or health education combined with STI testing and treatment. 42 studies of 62 reported significant increases in condom use.
Service/B: Ensure high-quality care through effective training and supervision and performance improvement and recognize providers for respecting clients and their rights				
León, F., et al. (2005). Providers' compliance with the Balanced Counseling Strategy in Guatemala. *Studies in Family Planning, 36*(2): 117–126.	Quiché, Jutiapa, Quetzaltenango, and Jalapa, Guatemala 40 clinics	Balanced Counseling Strategy to improve FP care and clients' knowledge of method choice in Guatemala. Randomly assigned intervention sites and control sites. Interventions included use of job aids, method cards, and provider training sessions, which lasted 6 hours and included health center medical directors, nurses, and providers. "Mystery clients" were also used to enact one of two client profiles and fill out a checklist after receiving care from a provider in order to evaluate quality of care.	Non-equivalent control group quasi-experiment with pre- and post-test components October 2001–2002	Providers trained in strategy enhanced quality of care significantly regardless of performance at baseline. Counseling sessions increased by 9 minutes but real-client load did not change.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Naik, S., Suchi, T., & Lundgren, R. (2010). Options for maintaining quality family planning counseling: strategies for refresher training. *International Journal for Quality in Health Care, 22*(2), 145–150.	Guatemala 80 providers	1 day training on Standard Days Method followed by refresher training within 2-month time frame. Training covered informed choice in FP, screening for method eligibility, use of CycleBeads, involvement of men to support SDM, conducting of follow-up visits, awareness raising of method, recording of user information, and use of job aids.	3 intervention groups with 1 control group 3-month follow-up evaluation through use of pseudo-simulated client methodology 2004	Providers who received refresher training scored over 70% on knowledge compared with 42% for control group (no refresher). Groups who received the individual KIT for the refresher training had providers retain more knowledge over time but this was more costly. Group KIT and traditional refresher training produce slightly lower results at significantly less cost.
Combary, P., Newman, C., & Royer, A. C. (2001). Follow-up and evaluation of a distance learning program for family planning service providers in Morocco. Chapel Hill, North Carolina, University of North Carolina at Chapel Hill, School of Medicine, Program for International Training in Health [INTRAH], PRIME Project, 2001 Jun. ix, 85 p. (PRIME Technical Report No. 24 A).	Fez and Marrakech, Morocco 40 nurses, health assistants, or birth attendants 50% of trained providers were evaluated; 10 providers served as a control group	Distance learning course was provided to health providers to improve their FP service delivery. The course included the following learning dimensions: knowledge related to the provision of FP methods and service management; counseling skills on side effects and infection prevention; and behaviors linked to management of information.	2 types of evaluation design: Implementation evaluation to document project activities and results evaluation to measure the outcomes or achievements of the program. Implementation evaluation used questionnaires and interviews; Results evaluation used pre- and post-test of knowledge Intervention October 1998–December 1999 Evaluation 1999	Learners' skills and practice scores increased from 16.8 to 28 points, a statistically significant difference. Counseling scores of learners/participants were significantly higher than the scores of non-learners.
Agha, S. (2010). The impact of a quality-improvement package on reproductive health services delivered by private providers in Uganda. *Studies in Family Planning, 41*(3), 205–215.	Uganda 248 midwives	Train midwives on quality improvement self-assessment tool. Train supervisors to observe quality improvement and do follow-up visits for midwives in one intervention arm.	Pre- and post-test quasi-experimental panel study; difference-in-differences ordinary least squares (OLS) regression model 8 months	Family planning service provision was improved among midwives who used the tool and had supervisor follow-up visits.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Jain, A.K., RamaRao, S., Kim, J., & Costello, M. (2012). Evaluation of an intervention to improve quality of care in family planning programme in the Philippines. *Journal of Biosocial Sciences, 44*, 27–41.	20 municipalities in Davao del Norte Province in Philippines 40 health facilities and 1,728 women interviewed	Evaluation of intervention that aimed to improve quality of care within the constraints of service delivery and focused on client-provider interaction. This was done through training of family planning service providers working in the public sectors facilities and training of their supervisors.	Quasi-experimental design, matching 20 municipalities of Davao del Norte into 10 pairs; each pair split into an experimental group and a control group 40 facilities overall (rural health units and barangay health stations). 3 interviews were also conducted by women who received services from the 40 facilities Training for providers was conducted in March 1997, interviews of women conducted in 1997, 1999, and 2000	Intervention improved providers' knowledge and quality of care received by clients; good quality of care at time of initiating contraception increased likelihood of continuation and decreased likelihood of unintended pregnancy and unwanted birth. Women in both the experimental and control groups did not appear to be affected by the provider training—perhaps because the quality of care at the control clinics was fairly good and the effect of the training intervention was not significant enough to make an impact.
Vernon, R., et al. (1994). A test of alternative supervision strategies for family planning services in Guatemala. *Studies in Family Planning, 25*(4), 232–238.	Baja Verapaz, El Progreso, Jutiapa, Escuintla, San Marcos, and Quiche areas in Guatemala 12 districts in experimental group; 6 districts in control group	2 alternative supervisory strategies tested by the Family Planning Unit in Guatemala. "Indirect supervision" consists of a brief (4–6 hour) group meeting attended by the supervisor and all FP service-delivery personnel in the district; the "self assessment" consists of a 2-day workshop in the district on quality of care and use of self-assessment checklists.	Quasi-experimental, nonequi-valent control-group design 1992–1993	Women served by experimental groups seemed to be better satisfied than women in the control group. New supervisory strategies were more cost-effective than traditional supervision strategies, and new status allowed supervisors more direct and substantive contact with service delivery staff.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Wesson, J., et al. (2007). Reaching providers is not enough to increase IUD use: a factorial experiment of 'academic detailing' in Kenya. *Journal of Biosocial Sciences 40*: 69–82.	45 public health clinics in 5 districts in Western Province, Kenya 131 providers; 480 CBD agents at baseline; 120 providers and 402 CDB agents at follow-up	Purpose of the intervention was to increase the uptake of the IUD in Kenya. Facility sites were randomly assigned to receive the intervention for providers only, CBD agents only, both providers and CBD agents, or none at all. Interventions included education/motivation visits to clinic providers and CBD agents as well as provision of information, education, communication and promotion materials.	Baseline data interviews and follow-up interviews Factorial experiment that tests the effect of more than one treatment factor using a design that permits an assessment of interaction between treatments Baseline January to March 2004; follow-up October to December 2004	281 IUDs provided during baseline and 234 in three months follow-up. Targeting both providers and CBDs increased IUD provision by 6.5 IUDs per quarter per facility. Intervention was not cost effective and only increased provision of IUDs when both providers and CBDs were targeted.
Warren, C., et al. (2009). Safeguarding maternal and newborn health: improving the quality of postnatal care in Kenya. *International Journal for Quality in Health Care 22*(1): 24–30.	Embu District, Eastern Province, Kenya (4 health facilities) 24 providers trained initially; 52 further trained at the request of Ministry of Health	Postnatal care package intervention introduced through a 3-day training for staff of maternal and child health clinics. 3 targeted assessments at 48 hours of birth, at 1–2 weeks of birth, and at 6 weeks of birth. Client-provider interactions were observed at these targeted intervals.	Pre- and post-test cross-sectional design with direct observation of client-provider interactions to measure quality of postnatal care Pre-intervention September 2006; post-intervention July 2007	Significant improvements noted in counseling for family planning and return to fertility at 6 weeks with more women accepting a method at 6 weeks (35–63%).
Stanback, J., et al. (2007). Improving adherence to family planning guidelines in Kenya: an experiment. *International Journal for Quality in Health Care, 19*(2), 68–73.	Kenya (72 clinics from 41 districts) 177 providers and 482 clients at baseline 176 providers and 451 clients at follow-up	Training workshops on guidelines and updates for guideline content and best practices. Managers were trained first and instructed to update their untrained co-workers after. Providers in randomly selected areas received a "cascade training package" (instructional materials and tips). Other randomly selected providers also received supportive supervision visits as a second reinforcement.	2-stage cluster randomized experiment in 72 clinics; control and experimental sites Intervention from October 1999–April 2000; follow-up July 2000	After the intervention, quality of care improved. The cascade training package showed less impact than supportive supervision, but the cascade training was more cost-effective.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Carron, J.M., Melian, M.M., & León, F.R. (1994). *Developing Tools of Low-cost Use to Improve the Quality of Care of Rural CBD in Paraguay. FINAL REPORT*. Washington, DC: Population Council.	12 rural districts in Paraguay (Concepcion, Pedro Juan Caballero, Caaguazú, Cuidad del Este, San Estanislao, Carapegua, Villa Rica, San Pedro, Coronel Bogado, Coronel Oviedo, Encarnacion, San Igancio) 180 rural community-based distributor providers (CBD)	To evaluate effectiveness and cost-effectiveness of annual FP provider training; an interactive counseling guide (ABC) and a supervisory guide (BFI) were developed. The total 12 districts were divided into 4 groups: 3 groups given the annual FP course; 3 groups given the ABC; 3 groups given the BFI; and 3 groups given both ABC and BFI. A total of 15 CBDs were trained (used either the annual FP course, ABC, or BFI) in each of the 4 district groups.	Simulated client surveys and pre-tests/post-tests were given to evaluate the quality of care of each different intervention at each group site May 1992–July 1993	All interventions were effective at improving quality of care, with slightly more improvement among the ABC sites. The annual FP course was discontinued; the ABC was instituted as part of the programming; and a new annual FP course with ABC elements was created for training new CBDs.
Adeokun, L., et al. (2002). Promoting Dual Protection in Family Planning Clinics In Ibadan, Nigeria. *International Family Planning Perspectives, 28*(2), 87–95.	Ibadan, Nigeria 3 NGO-sponsored clinics; 3 government clinics	Train FP provider to counsel on sexual behavior, condom negotiation, and dual protection. Provide female condoms, development of management information systems, and supervision of clinic quality and personnel.	Baseline and follow-up service data Randomized control trial 27 months	Increased acceptance of condoms for dual protection. Improved counseling on dual protection.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Abdel-Tawab, N., Nawar, L., Youssef, H., & Huntington, D. (2000). Integrating Issues of Sexuality into Egyptian Family Planning Counseling (pp. 47). Washington, DC: Population Council.	4 MOHP clinics and 2 clinical services improvement project clinics 25 providers; 503 female clients	Contraceptive update training for providers. Sexuality training for providers.	Case-control at study sites 6 weeks	Found that clients have a need for sexuality information and counseling. Providers acknowledged the need for the sexuality training, as the information presented was new to most of them. There was an increase in positive attitudes about barrier methods. There is no improvement in the intervention group on counseling about barrier methods. Increased sexuality counseling in intervention sites. Clients in the intervention group were more likely to receive a condom.
Combary, P. et al. (1999). Study of the effects of technical supervision training on CBD supervisors' performance in seven regions of Ghana. *Technical Report No. 7*. Chapel Hill, NC: University of North Carolina at Chapel Hill, School of Medicine, Program for International Training in Health [INTRAH], PRIME Project.	Ghana (7 regions: Ahsanti, Brong Ahafo, Northern regions, Greater Accra, and Eastern and Western regions) 32 CBD agents in total	2-week technical supervisory training for CBD supervisors. Training included information on improving the quality of reproductive health information and services through technical support. Training also included information on contraceptive methods and issues related to gender and development, among other things.	Quasi-experimental design with an experimental group receiving the technical supervisory training and a control group with no training (Delayed Program Strategy). Pre-intervention assessment and post-intervention assessment Assessment in 1996 Intervention and follow-up from April–November 1997	43% increase in technical skills (from baseline to follow-up) for CBDs in experimental group. On-the-job performance of both trained CBD supervisors and agents improved.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Azmat, S.K., et al. (2011). Paying for performance: Findings of an 18-month assessment of the effectiveness of demand side output-based intervention to long-term family planning franchise services in Pakistan. International Conference on Family Planning. Dakar, Senegal. Marie Stopes Society-Pakistan.	Pakistan (Sindh and Punjab provinces) Baseline of 5,000 married women of reproductive age; end line of 4,000 married women of reproductive age	Used the SURAJ intervention model, which trains, accredits, and supports local private healthcare providers to enhance their capacities and businesses in remote, semi-urban and urban areas. Additionally, the intervention used a voucher scheme to let poor women receive free, long-term FP methods. 8 providers intervention districts and 8 provider control districts were used to test intervention.	Quasi-experimental (pre- and post-test) mixed-method design with sequential implementation. Baseline and end line surveys 18-month intervention/pilot: February 2009–August 2010	Increase in the percentage of FP ever users with 34% at pretest and 62% at post-test CPR increase in intervention group from 27.2% at pretest to 48.0% at post-test. IUD most used method.
Azmat, S.K., et al. (2012). Rates of IUCD discontinuation and its associated factors among the clients of a social franchising network in Pakistan. *BMC Womens Health, 12*, 8.	Pakistan 2,789 women of reproductive age	Assessment of the frequency and reasons for discontinuation of intrauterine contraceptive devices (IUCDs). Study also measured client level of satisfaction and accessibility to the services.	Retrospective cohort study 6, 12, and 24 months	22% of women experienced health problems. 18% of women discontinued use. Many would return to the service provider they received services from.
Brambila, C., Lopez, F., Garcia-Colindres, J., & Donis, M.V. (2005). Improving access to services and interactions with clients in Guatemala: The value of distance learning. *Journal of Family Planning and Reproductive Health Care, 31*(2), 128–131.	Guatemala (rural, 20 health districts) 230 doctors, nurses, and nurse auxiliaries trained	Distance-learning program that included 30 in-class hours and 120 in-service practice hours over a 4-month period that included training in core reproductive health concepts and messages, re-organization of patient flow and contact requirements, integrated service delivery, and client's unmet needs. Cascade approach to training, with 1 health district director and 1 chief nurse from each district trained to replicate the program at a local level.	Pre- and post-intervention assessments 1 intervention group and 1 control group, each with 20 randomly selected health districts May–August 2001	Intervention reduced the number of pre-consultation contacts, reduced client waiting times, screened more frequently client's FP needs, and provided more complete information concerning range of methods; delivered more methods upon request. CPI time was not improved.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Charandabi, S.M-A., Vahidi, R., Marions, L., & Wahlström, R. (2010). Effect of a peer-educational intervention on provider knowledge and reported performance in family planning services: a cluster randomized trial. *BMC Medical Education, 10*, 11.	Tabriz, Iran 74 family health units	Evaluation of a peer education program that had both intervention and control groups. There were three phases to the intervention period. Phase 1 included an assessment of educational needs of providers. Phase 2 was the actual intervention, with the intervention group receiving an educational program including eight pages of educational material and a two-hour discussion session. Those in the program (in-charge providers) were to distribute the materials and have the same discussions at their own health facilities within a month. Phase 3 included the follow-up tests (1 and 27 months) after intervention.	Questionnaire for needs assessment Multiple linear regressions	Total scores/provider knowledge in the intervention group were significantly higher than in that of control group at both follow-ups.
Hubacher, D., et al. (2006). The impact of clinician education on IUD uptake, knowledge and attitudes: results of a randomized trial. *Contraception, 73*, 628–633.	Nicaragua (3 MOH districts) 40 MOH clinics	40 health facilities randomly assigned to 4 intervention groups. 1st group (Medical Education only) trained MOH physicians to meet with FP providers and discuss IUD benefits and risks and demonstrate proper insertion techniques. 2nd group (IUD Checklist only) had laminated guide sent to facilities to help providers identify women eligible for IUDs. 3rd group (both medical education and IUD checklist) received both interventions. And the last/4th group served as the control group with no interventions.	Evaluation design included impact of intervention and usefulness of medical education/materials. Post-intervention survey given to providers to measure IUD knowledge and attitude November 2004–May 2005	Intervention showed that there was no impact on uptake of IUD or provider knowledge/attitude.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Huntington, D., et al. (1995). Improving medical care and counseling of postabortion patients in Egypt. *Studies in Family Planning*, *26*(6), 350–362.	Egypt (El-Galaa Teaching Hospital and El-Minia Medical University) 550 clients (exit interviews), 154 physicians, and 66 nurses/social workers	Training program for providers (OB/GYN specialists) included demonstration and supervised practice of vacuum aspiration. Master trainers (those who were trained) were then to instruct their junior colleagues individually and provide supervision as well as follow-up training. Vacuum aspiration and holistic care was emphasized. Protocol for clinical procedures was also used in training.	Uncontrolled, quasi-experimental (pre-post intervention) study. Situation Analysis Methodology (observations, interviews and review of medical records) used to examine quality of care provided in OB/GYN wards where postabortion patients were treated May–December 1994	Majority of physicians treating postabortion patients reported no previous training in FP prior to study. After intervention, knowledge of method improved slightly with statistical significance.
León, F., et al. (2003). *One-Year Client Impacts of Quality of Care Improvements Achieved in Peru*. Washington, DC: Frontiers in Reproductive Health. Population Council.	Peru (MOH directorates) 214 clinics, 74 supervisors, and 215 clients	2-day provider training and 1-day re-training on job aids, which included user-friendly method cards for providers, method pamphlets for clients, and monitoring guidelines for supervisors. Out of the 24 health directorates, half were randomly assigned to control and experimental groups.	Client questionnaires applied to in-home interviews Quality of care monitored and measured through service tests and direct observations of third party) 2000–2001	4-minute increase in the client-provider session length; improved client knowledge of methods (IUD and hormonal).
León, F., et al. (2003). *Effects of IGSS' Job Aids-Assisted Balanced Counseling Algorithms on Quality of Care and Client Outcomes*. Washington, DC: Population Council.	Guatemala 20 providers	Balanced Counseling Strategy for social workers and physicians. 8-hour group training over 2 days and reinforcing visits.	Client exit interviews, home follow-up, and analysis of service stats 2001–2002	The intervention changed the counseling behavior of physicians and social workers and enhanced the quality of family planning care. Continuation in the use of family planning diminished from month 1 to month 6, particularly in the case of the pill, but the behavior of pre- and post-intervention client cohorts were undistinguishable.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Abdalla, H. (2002). *Cost-effectiveness of self-assessment and peer review in improving family planning provider-client communication in Indonesia*. *Analyzing Cost and Quality Case Study*. Bethesda, MD: Quality Assurance Project, Center for Human Services.	Indonesia (East Java and Lampung provinces) 30 clinics	Comparison of three possible strategies for improving the impact of interpersonal communication and counseling. Interventions tested included a self-assessment, a series of 8 forms that address specific interpersonal communication skills. Providers had to complete 1 of the 8 forms every week over 16 weeks. The second intervention strategy was a peer review, including 30–60 minute meetings intended to supplement the self-assessment exercise. 1 district from each of the 2 provinces were grouped as "Training" (only the interpersonal communication and counseling training), the "Training plus the self-assessment," and the "Training plus the self-assessment and peer review."	Measurements in effectiveness of interaction, client-provider interaction, and facilitative communication 1998	Peer review combined with self-assessment was found to be more effective in improving providers' facilitative communication skills than the self-assessment or the training alone. Self-assessment is a better "buy" in terms of improvements attained for the amount of resources used.
Halawa, M., et al. (1995). Assessing the impact of a family planning nurse training program in Egypt. *Population Research and Policy Review, 14*, 395–409.	Assiout and Beheira, Egypt 16 MOH clinics	Evaluation of impact of a training program for FP nurses working in MOH clinics. 1 nurse from 4 experimental clinics attended a 2-week training program. Nurses at the control clinics (4 clinics) did not receive new training until after study. To assess impact, participant observations and client questionnaires were conducted.	Quasi-experimental, with pre- and post-test design June 1991–December 1991	Participant observation indicated that job performance in the experimental clinics improved subsequent to attending training. In almost all clinics, nursed failed to provide counseling to clients in private. Women in experimental groups (compared to control group) displayed increased knowledge about contraceptives, especially the pill and IUD.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
IFPS Technical Assistance Project (ITAP). (2012). "Chapter 9—Enhancing Technical Skills for IUCD Insertion." In *20 Years of the Innovations in Family Planning Services Project in Uttar Pradesh, India: Experiences, lessons learned, and achievements*. Gurgaon, Haryana: Futures Group, ITAP.	Uttar Pradesh, India 10,854 auxiliary nurse midwives and lady health visitors	Three-tier training structure beginning with a 12-day training-of-trainers program for master trainers, followed by a 12-day training of district trainers (by master trainers) and 6-day training of auxiliary nurse midwives and lady health visitors. Trainings covered screening of clients, IUCD insertion skills, preparation of instrument tray and chlorine solution, and sterilization of instruments and non-surgical items.	Baseline and end line of insertion skills, FP knowledge, and counseling February 1997–January 1998	85% of auxiliary nurse midwives and lady health visitors had adequate scores in FP counseling and IUCD training, compared with 30% at baseline.
IFPS Technical Assistance Project (ITAP). (2012). "Chapter 9—Postpartum Family Planning." *20 Years of the Innovations in Family Planning Services Project in Uttar Pradesh, India: Experiences, lessons learned, and achievements*. Gurgaon, Haryana: Futures Group, ITAP.	Uttar Pradesh, India	Series of workshops with participants from medical college faculties and medical professionals. Training on national, international, and standard guidelines for laparoscopic tubal ligation, minilaparotomy, abdominal tubectomy, and infection prevention.	Clinical training	150 medical officers trained in laparoscopy, 165 doctors trained in abdominal tubectomy, 10,989 health staff trained on infection prevention.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Jain, S.C., Barkat, A., Lundeen, K., Faisel, A.J., Ahmed, T., & Islam, M.S., (1999). Improving family planning program performance through management training: The 3Cs paradigm. *Journal of Health & Population in Developing Countries. 2*(1), 1–25. Evaluation Study # 1 &2.	Dhaka, Bangladesh (Evaluation #1); Bangla, Bangladesh (Evaluation #2) 19 thanas	Baseline study of training for thana family planning officers. Training concentrated on identification and correction of unsound/mistaken knowledge and beliefs about population dynamics and FP behavior, improvement in methodological competence, and improvement in role perception and role commitments (Evaluation #1). End line to estimate over and under reporting, assess improvement in CPR and continuation rate, and assess shift in rate of clinical and non-clinical methods.	Three-step sampling method: interviews (Evaluation #1); questionnaires and field work (Evaluation # 2) November 1997–January 1998 (Evaluation #1) March–May 1998 (Evaluation #2)	Average increase in CPR for all 19 thanas was 5.47 percentage points. Over reporting of CPR was limited to 8 thanas, and error rate in reports on method switch was high and pervasive. Almost all thanas had over reported their contraceptive continuance rate by an average of 6.6. percent (Evaluation #1). The trainees inflated their CPR baseline and underestimated their achievements (Evaluation # 2).
UNICEF, CDC. (2002). "UNICEF and CDC Report on Afghanistan Women's Health Public Health Report 117, no.6." In Rottach, E., Schuler, S.R., & Hardee, K. (2009). *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence*. Washington, DC: IGWG, USAID, and Population Action International.	Afghanistan 47 FP service providers	Training midwives and doctors through the Women's Empowerment Model, which uses five strategies: role modeling, development of critical thinking skills, individual consultations, fostering of teamwork and personal responsibility; and overcoming of fatalism.	Pre- and post-tests of trainee's knowledge and clinical skills 2005–2007	Increase from 53% to 89% in trainee knowledge of FP methods, counseling strategies, STIs, and HIV/AIDS. Clinical skills test average score of 86% in areas of infection prevention procedures, correct use of medical instruments, counseling strategies, IUD insertion, and removal and detection and treatment of STIs.
Carneiro Gomes Ferreira, A.L., et al. (2011). The effectiveness of contraceptive counseling for women in the post abortion period: an intervention study. *Contraception, 84*(4), 377–383.	Northeast Brazil 246 women: half in control group and half in intervention group	Personalized counseling on contraceptive acceptability; standard of care for controls.	Randomized control trial 6 months	98.4% of intervention group was using contraceptives; 70.6 in control group, $p<.001$; Probability of adherence of use to any contraceptive method 6 months after the abortion was 41% greater in the intervention group.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Ogu, R., et al. (2012). Outcome of an intervention to improve the quality of private sector provision of post abortion care in northern Nigeria. *International Journal of Gynecology & Obstetrics, 118*(Suppl 2), S121–126.	Nigeria Private medical providers in Northeastern Nigeria	Providers trained to provide high-quality postabortion care, postabortion family planning, and integrated STI/HIV care.	Evaluation of service data/observational 10 years overall 15-month in-depth study	Providers seemed to provide better quality services. No deaths were reported over the 10 year period. 1.3% experienced mild to moderate complications, down from 35% prior to intervention. 84.5% of women accepted family planning.
Diop, N., Moreau, A., Benga, H., et al. (1998). *Etude de l'efficacité de la formation du personnel socio sanitaire dans l'éducation des clientes sur l'excision et dans les traitements de ses complications au Mali*. Bamako, Mali: Population Council.	Bamako, Mali 108 health personnel (obstetricians, gynecologists, family planning providers)	Training clinic staff about FGM/C; supervising trained clinic staff.	6 health sites/clinics with no intervention 2 months in 1997	Considerable increase in knowledge and beliefs/attitudes of clinic staff.
Babalola, S., et al. (2001). The impact of a regional family planning service promotion initiative in sub-Saharan Africa: evidence from Cameroon. *International Family Planning Perspectives, 27*(4), 186–193.	Cameroon (8 provinces—targeting urban residents) Baseline n=1,367 women Follow-up n=1,150—of which 571 (42%) from baseline	Gold Circle (GO) campaign rewarded and promoted FP quality improvements through a certification process and a quality-of-care diagnostic tool. On the supply side, the campaign attempted to increase the availability of FP methods and improve clinic management, client-provider interactions, and infection prevention practices. The campaign also used mass media (TV and radio jingles as well as print materials) and community activities to create demand.	Pre/post-test study—used a household survey, supplemented by service statistics from government clinics and nongovernment clinics Interrupted time-series analytic method for service stats; conditional change model; logistic regression analysis; poisson regression analysis 1998–1999	Ideation: + Contraceptive use: +

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Nawar, L., et al. (2004). *Impact of improved client-provider interaction on women's achievement of fertility goals in Egypt*. Washington, DC: FRONTIER, Population Council.	Egypt (4 governorates were selected from Lower Egypt) n=300 women in each study group (intervention and control) at 7 month follow-up and 295 in each for the 13 month follow-up	Intervention clinics received a comprehensive intervention package for 6 months. This included system-related, provider-related, and client-related factors intended to increase providers' technical knowledge and attitudes about FP counseling as well as provider motivation.	Pre/post-test with control. A cohort of new FP acceptors were enrolled, and follow-up after the initial visit continued for a 13-month period. Chi-square test; t-test; multiple regression analysis; life table analysis; multiple logistic regressions Client outcomes were measured at 7 and 13 months through home interviews	Contraceptive use: 0 Knowledge about FP: + (at 7 months)
Bolam, A., et al. (1998). The effects of postnatal health education for mothers on infant care and family planning practices in Nepal: a randomised controlled trial. *BMJ, 316*(7134), 805–811.	Urban and periurban Kathmandu, Nepal n=540 mothers, 135 to each of the four groups, and follow-up 403 (75%) at 3 months and 393 (73%) at 6 months	20 minute, one-on-one health education at birth and 3 months later. Key messages given by health educators included advantages of breastfeeding, dangers of diarrhea, symptoms and response to acute respiratory infection, and importance of restarting FP no later than 8 weeks after birth.	Individual-level randomization: 4 groups of new mothers were randomly allocated to receive health education just after birth and 3 months later (group A), at birth only (group B), at 3 months only (group C), or never (group D) Women were followed up on at 3 and 6 months postpartum at their homes	Contraceptive use/uptake of FP: + (at 6 months for groups A & B) Exclusive breastfeeding: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Díaz, M., et al. (1999). Expanding contraceptive choice: findings from Brazil. *Studies in Family Planning, 30*(1), 1–16.	Municipality of Santa Barbara d'Oeste in Sao Paulo, Brazil	Santa Barbara Project undertook several interventions: institution of collaboration among municipal health authorities, CEMICAMP staff (project leaders), and community representatives; training of medical, auxiliary, and attending staff of 11 health facilities in quality of care and participatory approaches; innovation in appointment scheduling; and institution of family planning referral center.	Baseline research conducted through focus groups (68 women) and interviews (95 exit interviews with women who received gyno care and 75 interviews with users of clinics); and through 31 interviews with providers of 11 municipal health facilities. Evaluation conducted using the same approach as baseline design, Baseline data between November 1994 and March 1995 Evaluation between July and September 1996	Baseline study showed that availability and accessibility of women's health services was impeded by issues related to provider time constraints, the great demand for services; appointment scheduling; and general lack of knowledge of FP or contraception by providers—general issues of quality of care. Evaluation showed that interventions taken to remedy issues found in baseline study were well-received—provider trainings and referral centers overall broadened reproductive choice and accessibility to services. Greatest increase was in number of new users of oral contraceptives.
Taylor, J. (2008). "Revitalizing Underutilized Family Planning Methods. Using Communications and Community Engagement to Stimulate Demand for the IUD in Uganda." In *Acquiring Knowledge*. ACQUIRE Project (Ed.), (pp. 8). New York, New York: EngenderHealth.	Hoima and Mayuge, Uganda FP facilities in 4 districts	AQUIRE project focus on increasing availability of services for long-acting and permanent methods and use of facility-based FP services; multiple interventions included training for MOH supervisors and coordinators to improve management skills, provision of IUD supplies, technical assistance, supervision and quality improvement training, radio campaigns, and other communication activities such as drama shows, speeches, and media briefs.	Performance Needs Assessment; in-depth interviews and focus groups 2006–2008	Notable uptake of IUDs; positive attitude toward FP.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Sathar, Z., et al. (2005). Introducing client-centered reproductive health services in a Pakistan setting. *Studies in Family Planning, 36*(3), 221–234.	Bhalwal Tehsil of the Sargodha District of Punjab, Pakistan 78 staff and 72 community workers in first round; 77 staff and 86 community workers in second round	Training program—SAHR (salutation, assessment, help, and reassurance)—that uses a client-centered approach; areas covered included family planning, infant health, and maternal health to ensure that services respond to client needs and address gender-related and familial constraints to healthcare service use.	Quasi-experimental design. Two experimental areas and two control areas. No personnel in control area were trained. Situation-analysis methodology to measure readiness of facility to provide services and quality of services December 1999–June 2001	SAHR training able to change some important elements of providers' behaviors. Providers can be trained to carry out their duties in a manner different from what they are accustomed to.
Agha, S., Balal, A., & Ogojo-Okello, F. (2004). The impact of a microfinance program on client perceptions of the Quality of Care perceptions of the quality of care provided by private sector midwives in Uganda. *Health Services Research, 39*, 6.	Kampala, Mukono, and Mpigi districts, Uganda (experimental) Mbarara and Kampala districts, Uganda (control) 15 midwives	Evaluation to assess impact of microfinance program that provided business skills training and revolving loans to midwives. 15 experimental clinics and 7 control clinics. Midwives who ran clinics took out loans and received 5 days of business skills training including elements of business planning, record keeping, financial reporting, credit management, and marketing. Trainees were also encouraged to increase client satisfaction by improving the quality of services offered.	Quasi-experimental with pretest and post-test to evaluate impact of intervention. Client exit surveys provided feedback on client perceptions of quality of care December 2000–March 2002	For clients, intervention had positive impact on perceived availability of drugs, fair charges, cleanliness, and privacy. Midwives receptive to business loan training.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Service/C: Ensure equitable service access for all, including disadvantaged, marginalized, discriminated against, and hard-to-reach populations, through various service models (including integrated, mobile, and/or youth–friendly services) and effective referral to other SRH services				
Palenque, E., Riveros Hamel, P., & Vernon, R. (2007). *Consolidating a Gender Perspective in the PROCOSI Network. Frontiers Final Report.* Washington, DC: Population Council AND Palenque, E., et al. (2004). *Effects and Costs of Implementing a Gender Sensitive Reproductive Health Program. Frontiers Final Report.* Washington, DC: Population Council.	Bolivia 17 organizations PROCOSI Gender-Sensitive Reproductive Health Program	Training and workshops to determine which area (institutional policies and practices, practices of providers, client satisfaction, client comfort, use of gendered language, information, communication and training, and monitoring and evaluation) each organization should improve on. Action plan developed and package of print materials and videos related to gender, FP, and RH given.	Mixed methods; pretest and post-test Interviews, surveys, and cost analysis 2001–2003	Significant decreases in unmet need for family planning for all sites aggregated. Significant changes in outcomes related to quality of care, including more comfortable interactions with health providers and some positive changes in provider practices. Significant increase in screening of FP needs.
Kalanda, B. (2010). Repositioning family planning through community based distribution agents in Malawi. *Malawi Medical Journal, 22*(3).	Pilot areas: Chitipa, Ntchisi, Chiradzulu, Malawi Control areas: Karonga, Dowa, and Mulanje, Malawi Baseline total of 1,637 in pilot, 1,704 control district Evaluation total of 1,615 in pilot, 1,592 in control district	3 pilots and 3 control districts were chosen to determine feasibility of implementing a comprehensive, district-wide CBD approach to delivery of FP. Community-based distributors counseled clients in residences on FP and supplied them with chosen method or referred them to nearest clinic. The distributors were also providing counseling through using and distributing leaflets, flyers, and posters.	Baseline and evaluation study through household questionnaires and women's questionnaires. Fisher exact chi-square was used to test statistical significance in proportions of interest between pilot and control districts at the baseline and end line Intervention in 1999 Evaluation in 2003	Baseline: approval of FP was the same in pilot and control districts. Evaluation: at the end of the project, there was a higher approval rating in the pilot districts, which was statistically significant when compared with the control districts.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Bashour, H.N., et al. (2008). Effect of postnatal home visits on maternal/infant outcomes in Syria: a randomized controlled trial. *Public Health Nursing, 25*(2), 115–125.	Damascus, Syria n=876 women	Three groups of new mothers were randomly allocated to receive either 4 postnatal home visits, 1 postnatal home visit, or no visit; during these visits, midwives provided information, education, and support. Registered midwives with special training made a home visit or series of home visits providing information, education, and support to women. Visits included postnatal care, physical exams, and counseling on breastfeeding and family planning.	Randomized control trial: 3 groups of new mothers were randomly allocated to either group A (4 postnatal home visits), group B (one visit), or group C (no visits) Chi-square tests; ANOVA	Only significant difference in outcomes among groups was in the area of exclusive breastfeeding. Current contraceptive use: 0 Postpartum care uptake: 0 Breastfeeding: + Impressions about home visits: +
Kambo, I, et al. (1994). Use of traditional medical practitioners to deliver family planning services in Uttar Pradesh. *Studies in Family Planning, 25*(1), 32–40.	Baghra and Morna in Muzaffarnagar District in Uttar Pradesh, India 22 male practitioners enrolled in the study Baseline total of 1,850 women Follow-up total of 1,650 women	Use of traditional practitioners who were trained to motivate and recruit family planning acceptors in order to increase contraceptive knowledge and use in rural communities. Practitioners were trained for 11 days in issues related to the national family welfare program; human reproduction; family planning methods, including use, possible side effects and management, the referral system, and other relevant user and provider information. Monthly meetings were held among practitioners, district health officials, project investigators, etc. to discuss problems and provide continuous education and support/encouragement.	37 villages—20 in intervention block and 17 in nonintervention block—each village had 1 resident institutionally trained traditional medical practitioner Cross-sectional community surveys: 1 at baseline and 1 follow-up after the 2-year intervention period March 1984–September 1987	Women in the intervention villages had become more informed (knowledge of contraceptives methods and how to use them increased by 86% compared with 70% in nonintervention village). Contraceptives of choice shifted to reversible methods, initiated by young women and more frequently among conservative rural groups than had been the case prior to intervention. Higher rates of use for the pill in particular.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Sarwari, M.M. (2011). Community Based Postpartum Family Planning in Afghanistan. Paper presented at the 2011 International Family Planning Conference, Dakar Senegal.	Afghanistan (initially implemented in 13 provinces from 2007–2009) Expanded to 11 more provinces in 2009–2010 Expanded to remaining 10 provinces in 2010–2011	Educate stakeholders at the national, provincial, district, and community levels through postpartum FP meetings and orientation workshops. Build capacity of community health worker (CHW) trainers, community-based healthcare officers, CHWs, and community health supervisors. Conduct joint postpartum FP supportive supervision at the community and facility levels.	Quarterly HMIS data collected from 13 original USAID-supported provinces for FP services in health posts Household survey at 2007 baseline and 2009 follow-up 3 years	CPR increased from 35.7% to 42.5% between 2007 and 2009 in the 13 pilot provinces.
Netzer, S., & Mallas, L. (2008). *Increasing Access to Family Planning Among Indigenous Groups in Guatemala*. Washington, DC: Health Policy Initiative, Task Order 1.	Quiché, Guatemala (5 districts)	Interviews conducted with service providers, indigenous women, community educators, and traditional midwives to gather information on barriers faced in accessing services. List of service delivery practices to address identified barriers to use of FP/RH services.	Interviews; advocacy April 2006–2008	National Family Planning Strategic Plan included several recommendations developed as a result of this work; the Director of the National Reproductive Health program made a public declaration about removing barriers at the service provision level and increasing equitable access to FP/RH services among indigenous people.
Hong, R., Mishra, V., & Fronczak, N. (2011). Impact of a quality improvement programme on family planning services in Egypt. *Eastern Mediterranean Health Journal, 17*(1), 4–10.	Egypt 637 family planning facilities	Comparison of Gold star facilities to non-Gold star facilities 4 years after conclusion of Gold Star Program. Gold Star Program sought to promote supply of high-quality FP services through better training and supervision of providers and to stimulate demand for FP through higher quality services to the public.	Data taken from Egypt Service Provision Assessment survey from 2004; 1,930 observations and interviews of providers/clients 2004	Gold Star facilities had significantly better availability of FP methods, counseling, and examination services than non-Gold Star facilities; they were also more likely to adhere to higher quality practices in counseling and examination than in non-Gold Star facilities.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Malarcher, S. (2009). A review of the evidence developed for a technical consultation on expanding access to injectable contraception (pp. 48). Research Triangle Park, North Carolina: Family Health International.	18 articles met review criteria	Expanding access to injectable contraceptives through community health workers.	Systematic review	CHWs were found to provide services of high or higher quality than clinic-based providers or other providers; they provided safe injections, were acceptable to community members, and were able to reach users who had not previously used contraceptives, including indigenous women.
Mensch, B., M. Arends-Kuenning, & Jain, A. (1996). The impact of the quality of family planning services on contraceptive use in Peru. *Studies in Family Planning, 27*(2), 59–75.	892 clusters (both rural and urban) in Peru	Study assessing the Peru Situation Analysis; service facilities included in the situation analysis were determined by clusters included in DHS.	Situation analysis methodology; linking service-delivery data for Peru from 1992 situation analysis to behavioral and demographic data from 1991-2 DHS; purpose was to produce a representative of service points accessible to inhabitants of each DHS cluster administered by 5 separate questionnaires Survey conducted between October and December 1992	Results broken into 2: descriptive findings and results of log regression models assessing quality of care and demand variables on likelihood of women using contraceptives. Quality of care in rural areas low relative to towns/cities; contraceptive use is greater among women living in clusters with better quality of care.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Sanogo, D., et al. (2003). Improving quality of care and use of contraceptives in Senegal. *African Journal of Reproductive Health, 7*(2), 57–73.	Senegal (5 regions: Thies, Kaolack, Saint Louis, Tambacounda, and Fatick) Baseline respondents: 1, 320 Follow-up respondents: 1,110	The government of Senegal created reference centers for family planning based on notions of improving quality of care. The strategy included substantial inputs to improve infrastructure, equipment, supplies, and personnel skills.	Baseline interview was conducted in facilities soon after interviewee had received services. Interviewees were first-time users of contraception, users of a specific method, or those switching or re-starting after a hiatus. Follow-up interviews were conducted either at the facility or in a home. Indicators of quality of care used were choice, needs assessed, informed provided, treated well by provider, and whether linked to future services. Baseline interview between October 1997 and January 1998 Follow-up 16 months after first interview, between March and June 1999	Those who attended reference centers reported better care than those attending health centers (reference centers received 4.3 out of 5 units of care; health centers received 3.8 out of 5). Quality of care received at the time of adopting contraceptives has an influence on the subsequent contraceptive use. Good care received indicated they were 1.3 times more likely to be using a method than others.
Katz, K., et al. (1998). Increasing Access to Family Planning Services in Rural Mali Through Community-based Distribution. *International Family Planning Perspectives, 24*(3), 104–110.	Kolondieba District, Mali (5 sub-districts) Pretest survey: 2,994 men and women Post-test survey 2,551 men and women	Community-based contraceptive distribution program incorporated into 2 sub-districts; information and education only provided in 2 other sub-districts; and 1 sub-district was control group.	Pre- and post-test intervention survey questionnaires; use of variables selected as representative measures of FP knowledge, attitudes, and practices. Chi-squared/t-tests used to establish statistical significance. Pre-test December 1991–February 1992 Post-test December 1993 and January 1994	The program had more of an effect on contraceptive knowledge and use than did education alone, while both were associated with more substantial changes than found in the control group. Knowledge of contraceptive use after (99%) v. 10% in the CBD group, 71% v. 10% in education-only, and 53% v. 10% in the control group.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Bazle Hossain, M., & Phillips, J.F. (1996). The impact of outreach on the continuity of contraceptive use in rural Bangladesh. *Studies in Family Planning, 27*(2), 98–106.	Sirajganj and Abhoynagar, Bangladesh	Assessment of intervention/program with government-instituted, female village worker recruitment training and posting designed to improve the accessibility of contraception and to provide support for FP in villages in Bangladesh (family welfare assistants).	Longitudinal surveillance (8 years) Interviews conducted by female interviewers Multivariate analysis 1992	Household outreach pronounced net effect on continuity of contraceptive use throughout the study period and magnitude of this effect increased with time; sustained contraceptive use continues to benefit from home-based outreach even after a decade of service encounters.
Mwebesa, W., et al. (2011). The role of community based organizations in expanding access to injectable contraception. International Family Planning Conference, Senegal, Save the Children.	Nakasongola District, Uganda 758 Depo acceptors	Community-based program that established network of 130 volunteer CBD agents; depo acceptors are followed to time of 2nd injection.	Pilot study—methodology not indicated 2004–2005	CDB results equal or slightly better than clinic results in safety, quality of care, continuation, and satisfaction.
Nanyombi Kaggwa, M. (2011). Increasing uptake of LARC methods in the private sector through community health worker led communication strategies in Uganda. International Conference on Family Planning, Senegal, Population Services International.	Uganda (12 districts and 5 regions) 3,800 respondents	Women Health Project, a private sector franchise, employed use of 147 private sector clinics; recruited 3–5 influential CHWs to work as volunteers; and used provider-led mobilization strategies to involve service providers in community mobilization efforts. CHWs act as change agents and provide basic education on FP services and how to recognize common side effects, address myths and misconceptions, advocate for individual and community needs, and encourage communities to seek for the services needed.	Lot Quality Assurance Sampling method to collect structured interviews Population-based approach used to assess the community's knowledge and attitudes toward Women Health Project program components Client exit interviews conducted with target populations 2008 program initiation 2010 evaluation	Since start of the program, IUD and implant insertions increased by 90% in franchise clinics; 43% of clients accessing long-term methods have been referred to the health facilities by CHWs; positive provider perception of CHW's role and effectiveness in increasing FP client walk-ins.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Nguyen, H., et al. (2012). Encouraging maternal health service utilization: An evaluation of the Bangladesh voucher program. *Social Science & Medicine, 74*, 989–996.	Sub-districts in Bangladesh 2,208 women in household survey	"Demand-Side Financing program" aims to encourage use of maternal health services, in particular, qualified birth attendance, and mitigate the financial costs of delivery. Vouchers give women access to antenatal care checkups, safe delivery in a health facility or home with provider, emergency obstetric care, and 1 postnatal care checkup after delivery. Women were only eligible for their first or second births and only if they practice family planning in between the two.	Household surveys from 32 sub-districts—16 intervention sites and 16 control sites. Cross-sectional multivariate regression of births in the prior 6 months; panel analyses constructed using birth histories Mid-2007 intervention piloted 2009 evaluation survey conducted	Women in the intervention sites had 46.4% higher probability of using a qualified provider and 13.6% point higher probability of institutional delivery. Program significantly increased use of antenatal care, postnatal care, and delivery with qualified providers.
Routh, S., et al. (2001). Coping with changing conditions: alternative strategies for the delivery of maternal and child health and family planning services in Dhaka, Bangladesh. *Bulletin of the World Health Organization, 79*(2), 142–149.	Siddiquebazar and Wari, Dhaka, Bangladesh 400 for each survey in intervention and comparison area	Intervention was to test alternatives to a door-to-door service delivery strategy. Two alternatives included distribution of services from community service points and delivery of services from a static primary health clinic. The first strategy (community service points) included female fieldworkers providing contraceptive commodities and MCH-FP counseling services in the community (schools and clubs rather than at home).This strategy was tested in Gandaria. The second alternative was entirely clinic-based, where a range of MCH-FP services were given at a primary healthcare clinic in Hazaribag (area of Dhaka).	Intervention sites with alternative strategies and quasi-experimental nonequivalent control groups with pre- and post-test measurements January 1996–May 1997	Clinic-based service delivery strategy was found to be a feasible alternative to the resource-intensive door-step system. In both alternative strategies, an increase was seen in the proportion of clients obtaining family planning methods from commercial sources and static clinics.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Kifle, Y., et al. (2011). Increasing post abortion contraceptive uptake among clients in Ethiopia. Paper presented at the 2011 International Conference on Family Planning, Dakar, Senegal.	Ethiopia 27,521 clients of post-abortion counseling	Strengthen availability and quality of FP and comprehensive abortion care services in Ethiopia. Strengthen provider skills/competencies in FP and comprehensive abortion care. Support improved management and supervision systems. Improve facility readiness (infrastructure, logistics, etc.). Strengthen referral systems and mechanisms.	Evaluation of service data 3 years	Increases in uptake over time. 60% of clients used FP. 30% of users chose a long-acting method.
Chee, G. (2003). Using financing to motivate a for-profit health care provider to delivery family planning services: Is it a cost-effective intervention? A study of the AAR health services in Kenya. *International Journal of Health Planning and Management, 18,* 205–220.	Nairobi, Kenya Ksh 23 million loan amount to AAR health services	Loan granted to AAR to establish a clinic system. Summa Foundation (provider of loan) wanted to promote sustainable private sector family planning ventures. Clinic system included a medical center and 3 outreach clinics. One of the outreach clinics, Kairobangi Outreach Clinic, was designed primarily to service women and children, families of workers in the area. All FP methods (except surgical) were available.	Cost-effectiveness and FP outputs measured September 1995–December 1996	AAR given incentive to offer but not promote FP services, though number of FP clients increased. Intervention produced with no or low cost.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Awoonoor-Williams, J.K. et al. (2004). Bridging the gap between evidence-based innovation and national-health sector reform in Ghana. *Studies in Family Planning, 35*(3), 161–177.	Nkwanta District, Ghana 891 heads of households, 1,064 women and 180 community leaders, health officials, and school personnel	District survey to examine the plausibility that the effects of the Navrongo experiment are robust in a similarly isolated, albeit no research setting (Nkwanta District). Community-based Health Planning and Services (CHPS) initiative in order to identify practical means of overcoming operational constraints to effective community-based care.	30-cluster survey (rapid survey method) to evaluate impact of FP program at a low cost 2002	Exposure to CHPS program increased odds of FP knowledge twofold; CHPS program successfully introduced information about FP to population. Navrongo effects are transferable to impoverished rural settings elsewhere, confirming the need for strategies to bridge the gap between Navrongo evidence-based innovation and national health sector reform.
Mercer, A., et al. (2005). Use of family planning services in transition to a static clinic system in Bangladesh: 1998–2002. *International Family Planning Perspectives, 31*(3), 115–123.	Abhoynagar and Mirsarai, Bangladesh 11,000 households	Evaluation of a program that transferred family planning services to static community clinics (previously FP provided through household visits and satellite clinics). Study assessed changes in utilization and coverage of FP.	Three types of surveys: longitudinal quarterly survey, cross-sectional survey, and survey of local managers, supervisors, and community clinic service providers 1998–2002	Contraceptive prevalence remained constant in Abhoynagar and increased in Mirsarai. One-third of contraceptive users in Abhoynagar used community clinics and one-fifth used them in Mirsarai. Women had not become dependent on home delivery of FP supplies.
Liambila, W., Obare, F., & Keesbury, J. (2010). Can private pharmacy providers offer comprehensive reproductive health services to users of emergency contraceptives? Evidence from Nairobi, Kenya. *Patient Education and Counseling, 81*, 368–373.	Nairobi, Kenya 16 pharmacies	Evaluation of the provision of RH information and services to users of EC by private pharmacists. Intervention components included updating private pharmacy providers on appropriate use of EC and how to best dispense to clients (updates included information on EC use, how it works, side-effects, regular FP methods or referral for methods, and referral services for STI and HIV testing/counseling). Laminated filers were also given to pharmacists to place behind counters and IEC materials on EC were also given.	Baseline and end line assessments with logic regression models Pilot study conducted in 2008	Control and intervention pharmacies showed differences in the provision of information on EC and FP but the differences were not statistically significant. This can be attributed to several intervention issues, but also to the challenges pharmacists face in their dual and conflicting roles as business people and public health service providers.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Hasna, F.S. (2006). Utilization of family planning services in the governorate of Zarqa, Jordan. *Journal of Transcultural Nursing*, *17*(4), 365–374.	Zarqa Governorate, Jordan 4 clinics	Comparison of FP use patterns and evaluation of different service delivery models. MCH training center of the Ministry of Health, Soldiers' Families Welfare clinics, Zarqa MCH clinic in Zarqa Palestinian refugee camp, and mobile clinic of Jordanian Association for Family Planning and Protection.	Service statistics, clinic observations, and focus group discussions Service observation used through MAQ checklist June 1997–June 1998	Providers reflected cultural pattern of hierarchy and patriarchy—women were perceived as "ignorant." Resource constraints.
Skibiak, J.P., Chambeshi-Moyo, M., & Ahmed, Y. (2001). "Testing Alternative Channels for Providing Emergency Contraception to Young Women." Nairobi: The Population Council. In Denno, D., Chandra-Mouli, V., & Osman, M. (2012). Reaching Youth with Out-of - Facility HIV and Reproductive Health services: A systematic review.	Lusaka, Zambia 5 residential compounds	Assessment of efficacy of 4 groups of providers in providing prescriptions and supplying EC. 4 groups include 10 pharmacies out of stock of EC, 5 outpatient clinics, 25 peer counselors conducting outreach, and 18 community sales agents trained to give prescriptions. Prescription cards handed out to clients.	Quasi-experimental; distribution of info cards 2000	Pharmacies were popular sites for getting EC prescriptions as well as the EC itself. Peer counselors were relatively popular among those who actually obtained EC but community sales agents were not.
Kosgei, R.J., et al. (2011). Impact of Integrated Family Planning and HIV Care Services on Contraceptive Use and Pregnancy Outcomes: A Retrospective Cohort Study. *Journal of Acquired Immune Deficiency Syndromes*, *58*(5).	Western Kenya 4,031 women participating in the Academic Model Providing Access to Healthcare	Integration of family planning into one of the care teams.	Retrospective cohort study 16 months	16.7% increase in new condom use. 12.9% increase in new FP use, including condoms. 3.8% reduction in the incidence of new FP use, excluding condoms.
Chabikuli, N.O., et al. (2009). The use of routine monitoring and evaluation systems to assess a referral model of family planning and HIV service integration in Nigeria. *AIDS*, *23*(Suppl 1), S97–S103.	Nigeria 40 health facilities	Co-located HIV/FP services, which operated separately, began referring patients to the other services.	Pre/post retrospective survey; cross-sectional review of service utilization registers of HIV and FP clinics Wald test for significance 12 months–15 months	Average attendance at FP clinic increased from 67.6 visits to 87.0 visits ($p<.0001$). Monthly mean CYP increased from 32.3 to 38.2 ($p=.0090$).

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Gwarzo, U., et al. (2011). Changes in contraceptive use among female ART clients following efforts to integrate family planning into ART services in Cross River State, Nigeria. 2011 International Conference on Family Planning, Dakar, Senegal.	5 health facilities in 5 local government areas, Nigeria 335 women interviewed at baseline; 80% re-interviewed at follow-up	Comparison of two integration packages. First package included integration activities related to advocacy with stakeholders, training of providers of antiretroviral treatment on basic FP/RH messages, introduction of monitoring and evaluation tools, and a system of referring clients to FP services for modern methods other than condoms. The second package included integration activities related to training of FP providers on the HIV/RH integrated training module, sensitization workshops, supportive supervision, monitoring and evaluation training on tools and referral services community mobilization.	2-group, pre- and post-test cohort design Interviews at baseline and 1 year later 12 months	32–37% of women had an unmet need for FP. Both groups increased contraceptive use significantly (p=.001; p=.021). No significant difference between basic and enhanced groups.
Mullick, S., Khoza, D., Askew, I., Maluka, T., & Menziwa, M. (2006). Integrating Counseling and Testing for HIV into Family Planning Services: What happens to the quality of FP? Paper presented at the Linking Reproductive Health, Family Planning and HIV/AIDS in Africa, Addis Ababa.	South Africa 24 high-volume family planning clinics	Intervention group trained FP providers on voluntary counseling for HIV; in some control sites, train providers on conducting the test as well.	Pre/post intervention and control; statistical tests of differences	FP services may have improved slightly with the integration of voluntary counseling only; but the control clinics (without HIV integration) showed similar effects, so it may not have been related to the intervention.
Searing, H., Randiki, M., Farrell, B., Masita-Mwangi, M., & Gutin, S. (2008). Evaluation of a family planning and antiretroviral therapy integration pilot in Mbale, Uganda. AQUIRE Project (Ed.), (pp. 38). New York, New York: EngenderHealth.	TASO clinic, Mbale, Uganda Serves 2,000–3,000 clients and conducts 500 home visits	Train providers to provide FP services along with antiretroviral treatment. Conduct assessment, implement training, and provide information to the community.	Case study 8 months	3-fold increase in patients accessing FP services; two-thirds of patients say they use condoms every time they have sex; patients access condoms, pills, and injectable contraception.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Dudley, L., & Garner, P. (2011). Strategies for integrating primary health services in low- and middle-income countries at the point of delivery. Cochrane Database Syst Rev(7), CD003318.	5 randomized trials and 4 controlled before and after studies	Adding services to existing services provided. Integrating vertical services into single, special services.	Systematic review	Adding services can increase service use but may not improve health status. Integrating services may decrease use, client knowledge, and satisfaction and may not result in any difference in health outcomes.
Mukakarara, V. (2011). "Family Planning Task-Shifting in Rwanda: Increasing Availability of Services by Training Nurses to Insert IUDs." IntraHealth/USAID. PowerPoint Presentation.	Gasabo, Gicumbi, Nyagatare, and Rulindo districts, Rwanda	HIV/AIDS Clinical Services Program (HCSP): Training on IUD insertion for health providers; competency training for nurses in 26 health centers.	Launched 2007	IUD training improved the proximity of IUD services to health center clients; nurses administering long-acting FP methods have improved their technical skills.
Stephenson, R., et al. (2011). A randomized controlled trial to promote long-term contraceptive use among HIV-serodiscordant and concordant positive couples in Zambia. *Journal of Women's Health*, *20*(4), 567–574.	1,502 discordant and concordant couples participated a randomized trial; 957 were included in the multivariate analysis	Control group received compassionate care. Intervention 1: watch a video on long-acting contraceptive methods. Intervention 2: watch a video on motivational future behaviors, such as writing a will, financial planning, and family planning information. Intervention 3: both motivational and FP information presented.	Randomized control trial	Of current users (324), 30% decided to switch from OCPs to longer acting methods. Of non-users (1,178), 92% adopted a contraceptive method. 40.5% chose OCPs. 40.7% chose injectables. 12.2% chose and implant. 3.7% chose an IUD. 3.0% chose tubal ligation.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Huntington, D., & Aplogan, A. (1994). The integration of family planning and childhood immunization services in Togo. *Studies in Family Planning, 25*(3), 176–183.	Togo 8 intervention sites and 8 control sites of the Expanded Program of Immunizations	During an immunization visit, the provider said three short phrases to the mother: (1) Your child is still young and you should be concerned about another pregnancy too soon; (2) This clinic provides FP services that can help you delay your next pregnancy; (3) You should visit the FP clinic after the immunization for more information.	Quasi-experimental 2-group design; pre/post intervention surveys of women leaving the clinic; post-intervention provider perception survey 6 months	There was a significant increase in new FP acceptors at the intervention sites compared to FP acceptors at the control sites. Increase resulted in 56 new users to 140 new users at the intervention site. Immunization services were performed just as well or better during the integration. The majority of providers (96%) found the experiment favorable.
Bradley, H., Gillespie, D., Kidanu, A., Bonnenfant, Y-T., & Karklins, S. (2009). Providing family planning in Ethiopian voluntary HIV counseling and testing facilities: client, counselor and facility-considerations. *AIDS, 23*(Suppl 1), S105–S114.	Oromina region, Ethiopia 8 public sector voluntary counseling and testing (VCT) facilities 4,019 men and women at baseline and 4,027 at end line	Family planning counseling messages for young, single, and premarital clients. FP counseling, condoms, and pills and referrals to on-site FP nurses for clinical methods.	Quasi-experimental, pre- and post-intervention surveys and interviews 2006–2008	6% of clients received contraceptive methods, though immediate need was lower than expected. FP counseling in VCT increased from 2% to 41% for women and 3% to 29% for men.
Integrating Family Planning and HIV Services Improves Service Quality. (2008) (pp. 2). New York: Population Council.	North West Province, South Africa 18 FP clinics and 129 providers	Integration of HIV prevention services, including counseling and testing, into FP programs.	18 FP clinics with 6 clinics in a counseling and testing group, 6 in a referral group, and 6 in a control group 129 providers trained with Balanced Counseling Strategy Plus toolkit from 12 experimental clinics (baseline and end line) 3 year study	Integration was feasible and acceptable and quality of counseling improved in both intervention models (counseling and testing group and referral group) in all indicator categories. Significant increases in use of condoms and other contraceptive methods.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Mark, K.E., et al. (2007). Contraception among HIV concordant and discordant couples in Zambia: a randomized controlled trial. *J Women's Health (Larchmt), 16*(8), 1200–1210.	Lusaka, Zambia 251 couples	Dual method contraceptive promotion among HIV-positive concordant and discordant couples already using condoms.	Randomized controlled trial with 2 intervention groups and 1 control group Intervention group 1 received education and an offer of contraceptives and intervention group 2 received the same, as well as a presentation designed to reduce outside pressures to conceive 1996–1998	Higher contraceptive initiation rate in both intervention groups. Intervention had no impact on incidence of pregnancy, and HIV-positive women who initially selected injectable contraception were less likely to abandon method and less likely to conceive than other participants.
Mullick, S., et al. (2008). *Feasibility, Acceptability, Effectiveness and Cost of Models of Integrating HIV Prevention and Counseling and Testing for HIV within Family Planning Services in North West Province, South Africa* (pp. 26). Washington, DC: Population Council.	South Africa 129 service providers	Training of service providers and service managers on how to integrate HIV counseling and testing into FP services using the BCS-Plus tool—in order to test the acceptability, feasibility, and cost of two different models of integration and to evaluate effectiveness.	3-arm cluster randomized controlled trial with 2 intervention groups and 1 control group (baseline and end line)	Providers implementing the referral model were significantly more likely to discuss STI/HIV risk factors with clients after the intervention, while providers implementing the testing model improved their discussion of the increased risk of HIV with an STI. No significant differences in quality of FP counseling scores for either intervention group or quality of client-provider rapport.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Stephenson, R., et al. (2011). A randomized controlled trial to promote long-term contraceptive use among HIV-serodiscordant and concordant positive couples in Zambia. *Journal of Women's Health, 20*(4), 567–574.	Zambia 1,502 couples	Reviews of evidence in support of policies and programs to decrease HIV prevalence.	Randomized controlled trial (baseline and end line) Not specified	Baseline contraceptive use low; after intervention, uptake of contraceptive method almost universal and the most popular method choices were injectables and oral contraceptive pills. Couples who viewed the video on methods were more likely to choose the IUD than those who did not view the video.
Warren, C., Shongwe, R., Waligo, A., Mahdi, M., Mazia, G., & Narayanan, I. (2008). *Repositioning postnatal care in a high HIV environment: Swaziland, Horizons Final Report*. Washington, DC: Population Council.	Manzini and Hhohho regions, Swaziland 356 postpartum women and 54 healthcare providers	Determine if RH guidelines on postnatal care would result in the timely and high-quality provision of maternal and newborn care in the postnatal period, increase use of postnatal care services among all postpartum women, and improve the care and follow-up of HIV-positive postpartum women and their infants. Facility preparedness also assessed as well as observation of client-provider interaction in consultations.	Pre- and post-test July 2006–May 2007	Postpartum women were three times more likely to attend postnatal care within 1 week of delivery post-intervention. Quality of care assessment demonstrated a 4-fold increase in the proportion of services that included all aspects of care: maternal and newborn healthcare, HIV counseling, family planning provision and information, and improved provider-client relationships.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Brickley, D.B., et al. (2011). Sexual and reproductive health services for people living with HIV: a systematic review. *AIDS Care, 23*(3), 303–314.	Africa, United States, and United Kingdom 9 studies	Systematic review	Studies published between 1990 and 2007	The review identified mostly positive effects on the outcomes measured such as condom and contraceptive use and quality of services. Research gaps remain, including the need to establish the best approaches for addressing the needs and choices of people living with HIV.
King et al. (1995). A family planning intervention to reduce vertical transmission of HIV in Rwanda. *AIDS, 9*, S45–S51.	Rwanda 502 women	Non-pregnant or infertile women previously tested for and counseled on HIV viewed an informational video about hormonal contraception and then participated in a facilitated discussion. They were given access to oral or injectable hormonal contraception and Norplant at the research clinic; those who used these methods were seen every 3 months.	Longitudinal cohort study; pre- and post-test	120 women in the study became new hormonal method users, continued their previous use of a hormonal method, or switched to another hormonal method following the intervention. There was a shift to use of longer lasting hormonal methods. Rates of oral and injectable contraceptive use were similar among HIV-positive and HIV-negative women.
Jones, et al. (2006). Influencing sexual practices among HIV-positive Zambian Women. *AIDS Care, 18*, 629–634.	Lusaka, Zambia 240 HIV-positive women	Efficacy of culturally tailored behavioral interventions to increase use and acceptability of sexual barrier products among HIV-positive women in Zambia. The 3 intervention sessions included video presentations on barrier methods, an introduction to using vaginal lubricants/suppositories, and a discussion of women's experiences.	Randomized controlled trial	Group intervention participants used sexual barriers and male condoms more often than the individual one-on-one participants; all participants increased use of female condoms, lubricants with condoms, and lubricants alone.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Jones et al. (2004). A sexual barrier intervention for HIV +/- Zambian women: Acceptability and use of vaginal chemical barriers. *Journal of the International AIDS society, 13*(6).	Zambia 150 women	Group and individual intervention participants attended a 3-session intervention plus pre- and post-test HIV counseling; control participants received pre- and post-test counseling only.	Randomized controlled trial	All participants increased use and acceptability of female condoms and vaginal products and maintained male condom use at 6 and 12 months.
Stringer et al. (2007). A randomized trial of the intrauterine contraceptive device vs. hormonal contraception in women who are infected with the human immunodeficiency virus. *American Journal of Obstetrics and Gynecology, 197*(144): e1–e8.	Zambia 599 postpartum women with HIV	Women received either a copper IUD or hormonal contraception and researchers followed up for at least 2 years.	Randomized controlled trial	Women who randomly received hormonal contraception were more likely to become pregnant than those who randomly received an IUD. Clinical disease progression per 100 women-years, hormonal contraceptive users: 13.2 and 8.6 in IUD users.
Fasubaa, O.B., & Ojo, O.D. (2004). Impact of post-abortion counselling in a semi-urban town of Western Nigeria. *Journal of Obstetrics and Gynaecologyl, 24*(3), 298–303.	Western Nigeria 238 patients	Evaluation of impact of postabortion counseling on sexual behavior among patients who had treatment for an induced abortion and/or a resulting complication.	Structured questionnaire 1999–2001	Percentage of women using contraception increased from 30 to 53 at time of interview. Number of subjects with multiple sex partners fell.
Baumgartner, J.N., et al. (2012). Service delivery characteristics associated with contraceptive use among youth clients in integrated voluntary counseling and HIV testing clinics in Kenya. *AIDS Care, 24*(10), 1290–1301.	Kenya 20 VCT clinics 349 young people (ages 15–24)	Through surveys and observations, learn which integrated approaches best promote modern contraceptive use among youth seeking VCT services.	Descriptive study; pre/post interviews 3 months	Little evidence of specific service characteristics associated with contraceptive behavior.
Creanga, A.A., et al. (2007). Does the delivery of integrated family planning and HIV/AIDS services influence community-based workers' client loads in Ethiopia? *Health Policy and Planning, 22*(6), 404–414.	Ethiopia 340 community-based health workers	Situation analysis of characteristics of community-based health workers.	Situation analysis/interviews 3 months	Religious characteristics, affinity for meeting new people, and other characteristics influenced whether community-based health workers provided integrated services.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Gillespie, D., Bradley, H., Woldegiorgis, M., Kidanu, A., & Karklins, S. (2009). Integrating family planning into Ethiopian voluntary testing and counselling programmes. *Bulletin of the World Health Organization, 87*(11), 866–870.	Ethiopia 4,019 VCT clients	Providers were trained on counseling and service provision.	Pre/post client interviews 18 months	4 times as many women were provided information on contraceptive options. Increased contraceptive uptake, but overall uptake was low because of low levels of unmet need at baseline.
Kalyanwala, S., Acharya, R., & Francis Zavier, A. J. (2012). Adoption and continuation of contraception following medical or surgical abortion in Bihar and Jharkhand, India. *International Journal of Gynecology and Obstetrics, 118, (*Suppl 1), S47–51.	Jharkhand and Bihar, India 679 women who underwent medical or surgical abortion	Observational study: interviews of women who had abortions to learn about their contraceptive choices.	Exploratory prospective study 6 months	Women who had surgical abortion adopted contractive methods earlier than those who had a medical abortion. Discontinuation rates were similar. Those who had surgical abortion were more likely to be sterilized after the procedure, possibly because the procedure was free.
Nguyen, P.H., & Budiharsana, M.P. (2012). Receiving voluntary family planning services has no relationship with the paradoxical situation of high use of contraceptives and abortion in Vietnam: a cross-sectional study. *BMC Women's Health, 12*, 14.	Vietnam 1,281 women	No intervention; observational study on relationship between FP use and induced abortion in Vietnam.	Cross-sectional survey	There was no relationship between voluntary family planning and fewer induced abortions. Gender of previous child was marginally significant; when a woman's child was a boy, she was more likely to have had an induced abortion.
Rasch, V., Yambesi, F., & Massawe, S. (2006). Post-abortion care and voluntary HIV counselling and testing- an example of integrating HIV prevention into reproductive health services. *Tropical Medicine and International Health, 11*(5), 697–704.	Tanzania 706 women who had unsafe abortions	Women were offered postabortion contraceptive services and VCT.	Interviews/questionnaires; nested case-control design January 2001–July 2002	58% of women who had unsafe abortions accepted HIV testing, and these women were more likely to accept using a condom.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Division of Reproductive Health under Ministry of Public Health and Sanitation, FHI, JHPIEGO, USAID/APHIA II Eastern and Tharaka District Health Management Team-Kenya. Introducing Community Based Distribution of Injectable Contraceptives: Experiences and outcomes from a pilot project in Tharaka District, Easter Province of Kenya. Final Report 2010.	Tharaka District, Eastern Province Kenya 31 community-based distributors	3-week training for community-based distributors on providing injectables and emergency contraception; adaptation of training materials and other job aids; monitoring quality of services.	Training for community-based distributors Use of indicators as basis for data collection August 2009–September 2010	CBD provision of services may have boosted demand for Depo in health facilities. More than 1,245 clients reached, with 67% accepting Depo.
Agha, S., Karim, A.M., Balal, A., & Sosler, S. (2007). The impact of a reproductive health franchise on client satisfaction in rural Nepal. *Health Policy and Planning*, *22*, 320–328.	Nepal (rural): Rupandehi District (intervention); Nawalparsi District (comparison) Providers=70 (at baseline) and 64 (at follow-up) Clients of 70% of interviewed providers' were interviewed during a 2-day period Married women ages 15–45: 480 from intervention and 480 from comparison Service delivery statistics	A pilot fractional franchise network of 64 nurses and paramedics was launched to improve quality of RH services under brand name Sewa. To join franchise, franchisees paid a one-time registration fee and annual membership fee. They were given 7 days of training in FP service delivery by EngenderHealth & JHPIEGO. Network was supported by marketing activities.	1 intervention and 1 control district Random effects logit model Baseline surveys: April–May 2001 Follow-up surveys: December 2002–January 2003	Overall client satisfaction: + Returning clients: + Current use of FP: + (marginally significant net effect at p=.067) Use of ANC during last pregnancy: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Hennink, M., & Clements, S. (2005). The impact of franchised family planning clinics in poor urban areas of Pakistan. *Studies in Family Planning, 36*(1), 33–44.	Pakistan (urban) Ever-married women ages 15–45, residing within 2–3 kilometer radius of each clinic (in study areas) or within a poor urban area of similar size in control sites Baseline n=5,338; end line n=5,502	4 new FP clinics were opened as part of a national franchise of RH clinics. Each clinic was similar in size and located in its own building. All clinics adhere to the same service delivery protocols and provide identical services, including contraceptives (pill, condoms, injectables, IUDs, female sterilization), pregnancy testing, pregnancy termination, and advice about sexual health. Each operates both clinic-based and outreach services. A fee is charged, but less than private health facilities; subsidized treatment fund is available to poor clients.	4 study sites (urban secondary cities of Gujranwala, Hyderabad, Sargodha, and Shikarpur) and 2 control sites (urban secondary cities of Gujrat and Larkana) Factor analysis; logistic regression 18 months	Knowledge: + Sterilization: + Condom: - Overall CPR: 0 Unmet need: +
Rahman, M., DaVanzo, J., & Razzaque, A. (2001). Do better family planning services reduce abortion in Bangladesh? *Lancet, 358*(9287), 1051–1056.	Bangladesh (rural) n=147,753 pregnancy outcomes between 1979 and 1998, including 4,100 abortions	Married women in the comparison group received standard visits every 2 months from female welfare assistants, including provision of pills and condoms. In treatment areas, community health workers visited married women of reproductive age every 2 weeks to provide FP counseling and deliver injectables, pills, and condoms at the doorstep; and ICDDR, B sub centers provide integrated MCH and FP services.	Pre/post-test with control: longitudinal data from Matlab, which includes data on pregnancy outcomes from 2 similar areas—treatment and comparison areas—since 1966 Relative risks; X^2 1979–1998	Abortion rate: + Unintended pregnancies: +

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Debpuur, C., et al. (2002). The impact of the Navrongo Project on contraceptive knowledge and use, reproductive preferences, and fertility. *Studies in Family Planning, 33*(2), 141–164.	Ghana (rural) n=8,998 currently married women gathered in an average of 2.4 panel years for each respondent over a maximum of 6 panel years	Nurse outreach: relocating nurses to villages trained, equipped with motorbikes, and provided with a management information system for monitoring doorstep service delivery. Services included doorstep and community-based curative care and supplies of oral contraceptive and condoms. Zurugelu community-based outreach: community health volunteers, also called health aides, trained to provide basic healthcare services, RH education, outreach to men, and contraceptive supplies. Treatment areas included nurse outreach, Zurugelu community-based outreach targeting men, and a combination of both.	Pre/post-test with control: longitudinal register of all 139,000 individuals—augmented with an open-cohort of 1,900 compounds in which all married women of reproductive age have been interviewed annually since 1993 (analysis of 6 panel data sets) Regression models; logit models; odds ratios 1993–1999	Knowledge of contraceptive methods: + (separate txs & combined) Knowledge of supply points: + Fertility preference for limiting or spacing: + Contraceptive use: 0 (for separate txs) + (for combined) Fertility: +
Douthwaite, M., & Ward, P. (2005). Increasing contraceptive use in rural Pakistan: An evaluation of the Lady Health Worker Programme. *Health Policy and Planning, 20*(2), 117–123.	Pakistan (rural) n=4,277 currently married rural women ages 15–49 (931 from non-intervention control areas and 3,346 from LHW areas)	Lady health worker delivers a range of services related to maternal and child health, including immunizations, growth monitoring, FP, and health promotion and education. FP responsibilities include motivating women to practice FP and providing pills and condoms and referrals for injections, IUDs, and sterilization. Each LHW is attached to a government health facility.	1 intervention and 1 control group Logistic regression 6 years after the program began	Contraceptive use/Ever-use of modern reversible methods: +

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Kincaid, D.L. (2000a). Social networks, ideation, and contraceptive behavior in Bangladesh: a longitudinal analysis. *Social Science & Medicine, 50*(2), 215–231.	Bangladesh n=860 married women ages 14–49 (65.5% of the original baseline survey)	Government field workers were trained to organize group discussions with women in the homes of opinion leaders (satisfied current adopters) who are geographically dispersed to cover the entire village network. The jiggasha meetings or network approach in which this discussion occurs provide an opportunity for social comparison, support, and influence. This approach was compared to home visits by female welfare assistants and no visits.	Pre/post-test with control: logistic regression Follow-up of the same respondents from baseline was conducted 2.5 years after baseline	Elements of ideation: + Contraceptive use/Prevalence of modern method use: + Continuation rate of FP use: +
Khan, M. E., et al. (2008). *Promoting healthy timing and spacing of births in India through a community-based approach.* Washington, DC: FRONTIER, Population Council.	India (rural Meerut District) Baseline, n=605 experimental and 592 control At 4 months, n=554 experimental and 541 control At 9 months, n=570 experimental and 560 control	Educational campaign by 267 community workers addressing pregnant women, their husbands, mothers-in-law, and community leaders; using IEC materials (leaflets, posters, wall paintings, and pocket booklet on healthy timing and spacing of pregnancy. Community workers (auxiliary nurse midwives, accredited social health activists, and Anganwadi workers) were trained on all educational topics. Coordination and support among the district authorities of the 2 departments and village level community workers was enhanced. A printed work register was given to the workers to ensure systematic coverage of all relevant topics.	Pre/post-test with control: the experimental (24 villages) and control (24 villages) groups recruited 600 women at 3 to 6 months pregnancy with parity of 0 or 1 Logistic regression Interviewed at recruitment (3–6 months pregnant), 4 months postpartum, and 9 months postpartum	Discussions on LAM, STIs and HIV/AIDS: + Discussions on FP with husbands: + Correct knowledge for all methods: + Contraceptive use: + (at 9 months) Pregnant: + (at 9 months)

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Xiaoming et al. (2000). Integrating HIV Prevention Education into Existing Family Planning Services: Results of a Controlled Trial of a Community-Level Intervention for Young Adults in Rural China. *AIDS and Behavior*, *4*(1), 103–110.	China n=748 young adults at baseline, ages 18–30 n=710 at follow-up	Integrate AIDS prevention into the existing family planning services. The experimental township received a multifaceted 12-month intervention that included written materials, videos, radio programs, small group discussions, home visits, individual counseling, and a free supply of condoms. The intervention providers included family planning workers, village doctors, and women's leaders.	Randomized control trial: 2 townships randomly assigned to experimental or control conditions—2 villages in each randomly selected Chi-square; t-test (no differences between groups) 12-month follow-up	Using condoms as main contraceptive method: +
Ross, D. A., Dick, B., & Ferguson, J. (2006). Preventing HIV/AIDS in young people: A systematic review of evidence from developing countries. UNAIDS Interagency Task Team on Young People (Ed.), (pp. 357). Geneva: WHO.	Worldwide	Systematic reviews of the evidence for policies and programs to decrease HIV prevalence among young people, as a contribution toward achieving universal access to prevention, treatment, and care and attaining the Millennium Development Goal related to AIDS.	Systematic review; expert review May 2004–2006	Annex of interventions

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Santhya, K.G., & Haberland, N. (2007). *Empowering Young Mothers in India: Results of the First-time Parents Project. New York, Population Council*. AND K.G. Santhya, et al (2008). *Empowering Married Young Women and Improving Their Sexual and Reproductive Health: Effects of the First-time Parents Project*. New Delhi, Population Council. AND Population Council (2006). "Meeting the Health and Social Needs of Married Girls in India: The First-time Parents' Project's Implementation and Reach" (New Delhi: Population Council) in Rottach, E., Schuler, S.R., & Hardee, K. (2009). *Gender Perspectives Improve Reproductive Health Outcomes: New Evidence*. IGWG, USAID, and Population Action International. First-Time Parents (64).	India	Information provision, healthcare service adjustments, and group formation intervention components targeted at young women who were newly married, pregnant, or first-time postpartum. Female and male outreach workers provided information; healthcare providers educated on the special needs of young, newly married couples and first-time parents.	Quasi-experimental with pre- and post-intervention surveys Intervention and control sites January 2003–December 2004	Young women in the intervention more likely to have discussed contraceptive use and timing of first pregnancy with their husbands. In some sites, young married women who were exposed to the intervention had more mobility and were more likely to illustrate equitable gender norm attitudes.
Abdel-Tawab, N., & Saher, S. (2011). Scaling up integration of family planning into antenatal and postpartum care: A case study from Egypt. Paper presented at the 2011 International Family Planning Conference, Dakar, Senegal.	20 health facilities and surrounding villages Assuit and Sohag Scaled up to 500 facilities serving 200,000 pregnant women per year	2 test models were piloted and compared to standard of care. Model 1: antenatal FP counseling and 5 postpartum visits with FP counseling. Model 2: same as model 1 with awareness-raising component for men.	Case control at pilot sites; scale-up Period not provided	Model 1: 36% increased use of FP services Model 2: 47% increased use of FP Services Control site: 3% increase More women in the scale-up districts knew the 3 side-effects of LAM, at least 2 benefits of birth spacing, and when fertility returns after a live birth. There was an increase in use of FP services compared with before the intervention.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Ahmed, S., et al. (2011). Impact of Integrating Family Planning within a Community-Based Maternal and Neonatal Health Program in Rural Bangladesh. Paper presented at the 2011 International Family Planning Conference, Dakar, Senegal. AND Ahmed, S., Mungia, J., Ahmed, S., Winch, P., Al Kabir, A., McKaig, C., & Baqui, A. (2011). Impact of promotion of Lactational Amenorrhea Method within a community-based maternal, neonatal and child health program in rural Bangladesh. Paper presented at the 2011 International Family Planning Conference, Dakar, Senegal.	Bangladesh (Rural) 4 intervention unions of 2,247 women 4 control unions of 2,257 women	Women were enrolled prior to their 8th month of pregnancy. The intervention group received maternal and neonatal healthcare, plus community health workers could provide contraceptives. The control group received counseling on LAM and FP only. Community mobilization component: meetings with husbands, mothers-in-law, and community leaders to raise awareness of postpartum family planning.	Cluster randomized design 18 months	FP use increased from 18% ever used to 47% use at 18 months among the intervention groups. Among the control groups, it increased from 21% ever used to 34% at 18 months; the difference was significant. LAM had a positive effect on the duration of exclusive breastfeeding; duration of exclusive breastfeeding was 25% higher at 6 months.
Mullany, L. et al. (2010). Impact of Community-Based Maternal Health Workers on Coverage of Essential Maternal Health interventions Among Internally Displaced Communities in Eastern Burma: The MOM Project. *PLoS Medicine*, *7*(8), e10000317.	Eastern Burma 2,442 individuals	Three-tiered, community-based network of providers (traditional birth attendants in first tier, health workers in second tier, and maternal health workers in third tier, overseeing birth attendants and health workers). Training of workers in clinical and nonclinical skills including strategies for community mobilization, engagement, counseling and training, and supervision.	Two-stage cluster sampling as pre- and post-tests 2005–2008	Use of modern methods to avoid pregnancy increased from 23.9% to 45.0%, and unmet need for contraception reduced from 61.7% to 40.5%.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Spaulding, A., et. al. (2009). Linking Family Planning with HIV/AIDS Interventions: a systematic review of the evidence. *AIDS, 23*(Suppl 1), S79–S88.	Africa (11 studies) Caribbean (2 studies) Europe (2 studies) Asia (1 study)	Systematic review of studies of interventions linking SRH and HIV services. Study rigor and study design and quality were assessed and ranked.	Systematic review of peer-reviewed journals and unpublished program reports Articles included reported post-intervention evaluation results from an intervention linking FP and HIV services between 1990 and 2007 Studies included had to be published between January 1, 1990 and December 31, 2007	16 interventions were categorized into 6 types: FP services provided to voluntary counseling and testing clients; FP and voluntary counseling and testing services provided to maternal and child health clients; FP provided to people living with HIV; FP and HIV services provided by community health workers; voluntary counseling and testing provided to FP clinics; and voluntary counseling and testing and FP provided to women receiving postabortion care.
Kennedy, C.E, et al. (2010). Linking sexual and reproductive health and HIV interventions: a systematic review. *Journal of the International AIDS Society, 13*, 26.	Africa, United States, United Kingdom, India, Thailand, China, and Haiti 185 studies	Review of efficacy of the linkages between SRH and HIV programs.	Systematic review of evidence Studies from 1990–2007	Positive effects shown for key outcomes related to HIV incidence, STI incidence, condom use, contraceptive use, uptake of HIV testing, and quality of services. Factors promoting effective linkages included stakeholder involvement, capacity building, positive staff attitudes, non-stigmatizing services, and engagement of key populations.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Mansa, E. (1991). Growing confidence. Villagers in Ghana's IP pilot areas learn the power of self-help. *Integration, 29*, 35–37.	Ghana 9 villages	Provide parasite testing, treatment, and prevention. Emphasize the health benefits of birth spacing. Teach nutrition and production of nutritious food for young children. Provide family planning counseling and services. Establish trust with the community through these health interventions.	Measure baseline FP usage and FP usage in the pilot villages 3 years	Baseline FP acceptance rate: 17.4% At 2 years: 29% At 3 years: ranged between 24.67–40.6% in the 9 villages Increased community empowerment measured by communities willingness to tackle development problems such as deforestation, water pollution, and adult literacy.
Cisek, C., & Cankatan, H. (1997). Stimulating Private Healthcare Facilities to Increase and Improve Reproductive Health Services: The KAPS Network in Turkey. SOMARC Occasional Paper. Futures Group International, Retrieved from http://pubs.futuresgroup.com/OCCPPR21.pdf.	Private sector in Istanbul, Turkey	Organize a network of facilities and providers. Establish network delivery standards. Establish maximum pricing levels and post in clinic. Use public relations to publicize network. Information hotline. Community promoters. Mass media (radio spots).	Observational case study 1994–1996 (approx. 2 years)	Increased interest in participating in the network. Increase from 8% to 32% in knowledge that FP services are available. Infection prevention improved and other quality improvements were made. 10% increase in postabortion counseling (from 7 to 17%). Increase of postpartum FP counseling from 0 to 31%.
Gwatkin, D.R., Wagstaff, A., & Yazbeck, A. (2005). Reaching the poor with health, nutrition, and population services: what works, what doesn't, and why. Washington, DC: World Bank. Chapter 5: Kenya: Reaching the Poor through the Private Sector—A Network Model for Expanding Access to Reproductive Health Services.	Kenya (urban and rural) 500 households 102 Kisumu Medical and Educational Trust member providers 50 nonmember providers	A private provider network subsidized by the public sector to provide reproductive health and other services for the poor. The research goal was to determine whether there was significant benefit to poor populations through the provision of services by private providers.	Cross-sectional surveys of households and providers Evaluate household and patient socioeconomic status among network members and nonmembers T-tests, logistic regression	The poor benefit from the network in a nondiscriminatory manner; they are able to access services through the network. However, the network does not have a strong pro-poor bias, so the poor are not benefitting more than others in the catchment areas.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Ngo, A., Alden, D., Pham, V., & Phan, H. (2010). The impact of social franchising on the use of reproductive health and family planning services at public commune health stations in Vietnam. *BioMed Central Health Services Research, 10,* 54.	Da Nang and Khanh Hoa, Vietnam 36 commune health stations	Evaluation of Government Social Franchise (GSF) model that was developed to improve family planning and reproductive health service quality and capacity in commune health stations. Clinics were required to meet quality standards regarding facilities and appearance, service delivery, measurement, and evaluation and carry out communication activities to promote new brand of clinics.	Quasi-experimental design Assessment of franchise models through clinic record analysis and household surveys Pre- and post-test design with control group 2007–2008	45% increase in family planning clients in franchise-member clinics.
Sultan, M., Cleland, J.G., & Ali, M.M. (2002). Assessment of a new approach to family planning services in rural Pakistan. *American Journal of Public Health, 92*, 1168–1172.	Pakistan 175 geographical clusters and 31 randomly selected households in each cluster 4,676 women interviewed in 163 rural clusters	This study assess the impact of the new approach to FP services—the training of lady health workers. Study determines whether use of modern reversible methods of contraception is higher in rural localities served by these community-based workers than in other localities.	Data on contraceptive use and access to services collected from the rural portion of the Pakistan Fertility and Family Planning Survey and interviews were also conducted. Survey conducted in late 1996 and early 1997	Married women living within 5km of 2 community-based workers were significantly more likely to be using a modern, reversible method of contraception than those with no access. In an area where both community and lady workers are present, probability of using a reversible, modern contraceptive method increases by 74%. The community-based programs started by the Ministry of Health and Population Welfare are having an impact on access and use of contraceptive and services.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Lopez, L.M., Tolley, E.E., Grimes, D.A., & Chen-Mok, M. Theory-based interventions for contraception. Cochrane Database of Systematic Reviews 2011, Issue 3. Art. No.: CD007249. DOI: 10.1002/14651858.CD007249.pub3.	14 RCTs met inclusion criteria	Trials tested a theory-based intervention for improving contraceptive use. We excluded trials focused on high-risk groups and preventing sexually transmitted infections or HIV. Interventions addressed the use of one or more contraceptive methods for contraception. The reports provided evidence that the intervention was based on a specific theory or model. The primary outcomes were pregnancy, contraceptive choice, initiating or changing contraceptive use, contraceptive regimen adherence, and contraception continuation.	The primary author evaluated abstracts for eligibility 2 authors extracted data from included studies Calculated the odds ratio for dichotomous outcomes No meta-analysis conducted due to intervention differences Period not included	The main outcomes were pregnancy, choice of birth control method, change in birth control use, and continuing to use birth control. We found 14 trials. Two of 10 trials with pregnancy or birth data had better results for a theory-based group. Four of 10 trials with birth control use (other than condoms) also showed better outcomes in a treatment group. For condom use, a theory-based group had better results in 3 of 8 trials. Social Cognitive Theory was the main basis for 5 trials, of which 3 showed positive results. Two based on other social cognition models had good results, as did 2 of 4 that used motivational interviewing. Thirteen of the 14 trials had several sessions or contacts. Of seven programs with good results, 5 focused on teenagers of which 4 had group sessions. Three trials with good results worked with 1 person at a time. Seven trials were rated as good quality; 3 of those worked well.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
IFPS Technical Assistance Project (ITAP). (2012). "Chapter 12—Integrated Reproductive and Child Health Approach." In *20 Years of the Innovations in Family Planning Services Project in Uttar Pradesh, India: Experiences, lessons learned, and achievements*. Gurgaon, Haryana: Futures Group, ITAP.	India 33 districts	Integrated RCH camps providing antenatal check-ups, gynecological examinations, FP counseling, sterilization, and IUCD insertion services, iron folic acid tablets, pregnancy tests, and treatment of reproductive tract infections or STDs. Medical professionals' team in attendance to provide services.	Workshop with policymakers to come up with integrated approach 1998	Largest public health intervention taken on by project. By 2006, 60,148 reproductive and child health camps and FP counseling servicing above 1.8 million clients and modern spacing methods distributed to 1.2 million clients.
Melo, J., et al. (2008). Low Prevalence of HIV and Other Sexually Transmitted Infections in Young Women Attending a Youth Counseling Service in Maputo, Mozambique. *Tropical Medicine and International Health 13*(1): 17–20.	Maputo, Mozambique 445 young women with access to a youth-friendly clinic	Providing clinic services that are youth-friendly, conveniently located, affordable, confidential, and non-judgmental can increase use of clinic reproductive health services, including HIV testing and counseling. Survey and lab exam to determine prevalence of STIs in a group of young women attending the Adolescent and Youth Friendly Service to evaluate knowledge, practices, and attitudes about STIs.	Survey using a self-administered KAP questionnaire 435 of the 445 women underwent laboratory examination for vaginosis, candidiasis, trichomoniasis, gonorrhea, chlamydiosis, syphilis, and HIV November 2002–April 2003	Participants had a high of awareness and knowledge of STIs and HIV. Candidiasis was the most prevalent reproductive tract infection (36%), followed by vaginosis (13%) and trichomoniasis (7.6%). HIV seroprevalence was 4%. 42% were negative in all tests.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Neukom, J., & Ashford, L. (2003). *Changing Youth Behavior through Social Marketing: Programs Experiences and Research Findings from Cameroon, Madagascar, and Rwanda*. Washington, DC: Population Reference Bureau.	Madagascar Network of youth-friendly, private sector clinics	Providing clinic services that are youth-friendly, conveniently located, affordable, confidential, and nonjudgmental can increase use of clinic reproductive health services, including HIV testing and counseling. Survey to evaluate the development and promotion of a network of youth-friendly, private sector clinics offering HIV testing, STI treatment, and other reproductive health services.	Survey 2000–2002	Following the development and promotion of a network of youth-friendly, private sector clinics offering HIV testing, STI treatment, and other RH services, the number of youth seeking services increased from 527 to 2,202 (predominately female) over 2 years. Clinics offered confidential, convenient, and affordable services by nonjudgmental providers to attract youth. Mass media and face-to-face communication campaigns using peer educators, television and radio spots, television talk shows, films, and mobile condom use demonstration teams were also effective in increasing use of clinics.
Cleland, J., Ali, M., & Shah, I. (2006a). Trends in Protective Behavior among Single vs. Married Young Women in sub-Saharan Africa: The Big Picture. *Reproductive Health Matters, 14*(28), 17–22.	18 African countries	Promoting condoms for pregnancy prevention may increase condom use for safe sex among young people. Condoms for pregnancy prevention.	Analysis of survey data 1993–2001	Use of condoms for pregnancy prevention rose significantly in 13 of 18 countries between 1993 and 2001, and the median proportion increased from 5.3% to 18.8%. Condom use at more recent coitus rose from a median of 19.3% to 28.4%. Of these, 58.5% of condom users were motivated by a wish to avoid pregnancy.
Juarez, F., & Martín, T. (2006). Safe Sex Versus Safe Love? Relationship Context and Condom Use among Male Adolescents in the Favelas of Recife, Brazil. *Archives of Sexual Behavior, 35*(1), 25–35.	Brazil 678 male adolescents	Promoting condoms for pregnancy prevention may increase condom use for safe sex among young people. Condom use for pregnancy prevention.	Analysis of survey data; logistic regression and multinomial logit analysis May 2000	Condoms were the preferred method of contraception for 95% of sexually active adolescents. Avoiding pregnancy is a primary motivation for young men in steady relationships.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Meuwissen, L.E., Gorter, A.C., Kester, A.D., & Knottnerus, J.A. (2006). Can a comprehensive voucher programme prompt changes in doctors' knowledge, attitudes and practices related to sexual and reproductive health care for adolescents? A case study from Latin America. *Tropical Medicine and International Health, 11*(6), 889–898.	Nicaragua 37 doctors	Doctors received (1) training and guidelines on how to deal with adolescents, (2) a treatment protocol, and (3) financial incentives for each adolescent attended.	Pre-/post-interviews with doctors; answers grouped into sub-themes and scores compared using nonparametric methods Time period not provided	Statistical significant changes were observed in knowledge of contraceptives and sexually transmitted infections. Barriers to contraceptive use were reduced and some attitudinal changes were observed.
Mbonye, A.K. (2003). Disease and health seeking patterns among adolescents in Uganda. *International Journal of Adolescent Medical Health, 15*(2), 105–112.	Jinja District, Uganda 4 clinics with adolescent friendly services 4 clinics with regular services	Compare effects of high-quality, accessible, and affordable adolescent friendly services with regular services.	KAP surveys among adolescents and service providers at the intervention and control clinics Time period not provided	Adolescents at the intervention sites were more likely to access the following services: antenatal care, maternity care, family planning, STD management, and lab services. Adolescents at pilot sites were also more knowledgeable on FP methods, STDs, and HIV.
Zuurmond, Maria A., Geary, Rebecca S., & Ross, David A. (2012). The Effectiveness of Youth Centers in Increasing Use of Sexual and Reproductive Health Services: A Systematic Review. *Studies in Family Planning, 43*(4), 239–254.	17 programs total in Rwanda, Togo, Zimbabwe, Ethiopia, Ghana, Kenya, South Africa, Botswana, Burkina Faso, Gambia, Ghana, Guatemala, Lesotho, Nigeria, Tanzania, Trinidad and Tobago	Youth centers as a method of reaching youth with SRH services.	Systematic review 1990–2010	Youth centers were found to be expensive, used by very small numbers, and used most frequently by males and older individuals.
Denno, D., Chandra-Mouli, V., & Osman, M. (2012). Reaching Youth with Out-of -Facility HIV and Reproductive Health services: A systematic review. *Journal of Adolescent Health, 51*, 106—121.	United Kingdom, United States, Malawi, Denmark, France, Zambia, Canada, Mexico, The Netherlands 20 studies	Review of the effectiveness of approaches that provide young people with health services related to HIV and reproductive health use.	Systematic literature review Articles published prior to March 2010	Studies generally demonstrated positive impact, although results varied across settings and approaches. Promotion of over-the counter-access to EC in various countries among most successful approaches. Out-of-facility approaches can be important avenues to reach youth.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Speizer, I. S., Kouwonou, K., Mullen, S., & Vignikin, E. (2004). Evaluation of the ATBEF Youth Centre in Lome, Togo. *African Journal of Reproductive Health, 8*(3), 38–54.	ATBEF Youth Center, Lome, Togo 2,083 males and females ages 10–24 (817 of baseline found at follow-up 1; 893 of baseline found at follow-up 2)	Clinical services offered through a youth center and advertised on television. Establishment of a youth center in March 1998 to offer adolescent RH clinical services, recreational services, counseling, IEC, and vocational and literacy classes.	Multiple matched cross-sectional surveys; multivariate regression analysis 4 years PS-NC (reflexive controls) Logistic regression Follow-up 1: 16 months after baseline Follow-up 2: 1 year after first follow-up	Peer outreach had a significant influence on use of the health center. Television advertising had a significant influence on use of the health center. Youth center use was significantly associated with contraceptive adaption and consistent use; main contraceptive was condoms. Youth center served groups who were less likely to be served elsewhere (younger, unmarried, no prior pregnancy).
Mmari, K.N., & Magnani, R.J. (2003). Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia. *Journal of Adolescent Health, 33*(4), 259–270.	Lusaka, Zambia 10 clinics: 2 control clinics and 8 intervention clinics with 4 combinations of interventions	Train health providers and peer educators to provide youth-friendly services. Mixed methods—qualitative and service use data reported.	4.75 years	Mixed results; significant changes were not found due to weak statistical power; community-level factors such as parental support may be more important than the training of service providers.
Karim, A.M., et al. (2009). The Impact of the African Youth Alliance Program on the Sexual Behavior of Young People in Uganda. *Studies in Family Planning, 40*(4), 289–306.	Uganda 1,548 males, 1,628 females, and 2,732 households	Multi-component intervention for Ugandan youth that included mass media campaigns, institutional capacity building to strengthen technical and organization ability for SRH programming, peer provider services, appropriate SRH curriculum, and behavior change component (life planning skills).	Self-reported exposure design and static group comparison Intervention and control groups with survey and questionnaires Evaluation from April–June 2006	The intervention had a positive impact on sexual behavior among young females but not young males. Girls exposed to the program were 13 percentage points more likely to report they had consistently used condoms and 10 percentage points more likely to have used contraceptives compared with girls who were not exposed to program.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Service/D: Routinely provide a wide choice of methods and ensure proper removal services for implants/IUDs, supported by sufficient supply, necessary equipment, and infrastructure				
Subramanian, L., Farrell, B., Kakande, H., Kumar, J., Johri, N., & Gutin, S. (2008). *Revitalizing long-acting and permanent methods of family planning in Uganda: ACQUIRE's District Approach*. AQUIRE Project (Ed.), (pp. 48). New York, New York: EngenderHealth.	4 districts, Uganda	Increase the capacity of the health clinics to provide FP, especially LAPMs	Case study 2 years	Increased use of FP, including LAPM, compared with baseline.
USAID | DELIVER PROJECT, Task Order 1. (2010). *Measuring Contraceptive Security Indicators in 36 Countries.* Arlington, VA: USAID | DELIVER PROJECT, Task Order 1.	36 countries	Assessment of contraceptive security indicators and overall contraceptive security environment in each country.	Data collection and analysis Time period not provided	Set standard for CS indicators.
Leahy, E., & Akitobi, E. (2009). *A case study of reproductive health supplies in Uganda* (pp. 34). Washington, DC, Population Action International.	Uganda	Overview of how RH supplies are programmed, managed, and funded in Uganda. Study reports on policies, systems, and budgets, providing an evidence base for advocacy efforts.	Case study; document review and analysis and stakeholder interviews Time period not provided	Information from report can provide means for collaboration and coordination, and advocacy level and information may be useful to other countries in similar situations.
Sommerlatte, A., & Spisak, C. (2010). *Nigeria: Costing of the Contraceptive Logistics Management System*. Arlington, VA: USAID | DELIVER PROJECT, Task Order 1.	6 states, Nigeria 44 facilities	Information collection on total supply chain costs of the contraceptive logistics management system and estimation of costs being addressed by the country's cost recovery scheme.	Data collection and function-based supply chain costing tool used for analysis 2010	Sample size data: System is operating well below capacity; labor is the main cost driver for all tiers.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Service/E: Establish and maintain effective monitoring and accountability systems with community input; strengthen HMIS and QA/QI processes				
Mahmood, A., & Naz, S.S. (2012). *Assessment of Management Information System [MIS] of National Program for Family Planning and Primary Health Care [LHW Program]*. Washington, DC: Population Council.	Jhelum and D.G. Khan (Punjab), Mardana (KPK), and Sukkur (Sindh) districts, Pakistan 154 lady health workers	Assessment of the LHW-MIS in order to understand the success and challenges of the system and its implications for the family planning program.	Random sampling April–June 2011	LHW-MIS maintains basic tools such as family registries, diaries, and monthly reports, but lacks tools such as area maps and referral cards.
Gage, A.J., & Zomahoun, D. Influence of the Service Delivery Environment on Family Planning Outcomes in Nigeria. November 2011. MEASURE Evaluation PRH, *Working Paper Series*. WP-11–122.	Nigeria	Assessment of the association between contraceptive use and method choice, health worker training, equipment availability, and perceived needs in local FP facilities. Specifically, assessment of quality of care and quality assurance mechanisms.	Household survey; multi-stage stratified sampling design 2009	Positive association between availability of an increased range of contraceptive methods and the use of quality assurance systems in the local government area.
Chaulagai, C.N., et al. (2005). Design and implementation of a health management information system in Malawi: issues, innovations and results. *Health Policy and Planning, 20*(6), 375–384.	Malawi	Design of the Malawi health management information system, including minimum indicators established, training of personnel, and cascade approach for training. This also included the introduction of client health booklets, which sought to improve quality of personal health care, specifically important to women and family planning needs.	HMIS system design and implementation Time period not provided	Despite HMIS established, use of information in decisions has not been improved. Several areas of the HMIS need to be improved, but most importantly, dedication and commitment of leadership to have an efficient health system and HMIS must be a priority.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Bertrand, J., & Sullivan, T. (2000). Quick Investigation of Quality (QIQ): Monitoring quality of care in clinic-based family planning programs. MEASURE Evaluation Bulletin. Monitoring the Quality of Care in Family Planning. Number 1, 2000.	Ecuador, Turkey, Uganda, and Zimbabwe	Development of QIQ tool and indicators; field-tested in countries listed.	Three methods of data collection to assess the quality of care: facility audit, observation, and client exit interview Time period not provided	Considerable variation between countries; possible low-cost tool.
McCarrier, M., Moyo, I., & Williams, T. (2000).Quick Investigation of Quality (QIQ) in SEATS-supported family planning clinics in Zimbabwe. Monitoring quality of care in clinic-based family planning programs. MEASURE Evaluation Bulletin. Monitoring the Quality of Care in Family Planning. Number 1, 2000.	Zimbabwe 39 facilities	Monitoring of facility readiness, provider procedures, and counseling and client satisfaction through use of the QIQ tool.	Field-test	Overall, good quality of care found in the Zimbabwe facilities. Facilities were prepared, and clients believed they were receiving good care and services. A high proportion of clients were knowledgeable about their selected method.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Community/A: Engage diverse groups in participatory program development and implementation processes				
Diop, N.J., Faye, M.M., Moreau, A., Cabral, J., Benga, H., Cissé, F., Mané, B., Baumgarten, I., & Melching, M. (2004). The Tostan Program: Evaluation of a Community Based Education Program in Senegal. New York: Population Council.	Senegal 30 participants	Village committee set up to manage education program. Training course taught 3 times a week, covering hygiene, women's health, human rights, and problem solving. Trainees and participants share information and hold public discussions and facilitate process of community consensus building in renouncing female genital cutting.	Quasi-experimental, case-control design 20 intervention villages and 20 control villages Baseline and end line Time period not provided	FGC prevalence among daughters of women in intervention group had significantly declined at end line. Awareness of at least two consequences of female genital cutting increased among men from 11% to 83% immediately after participating in program but declines slightly by end line. Positive RH outcomes included increase in knowledge of contraceptive methods by men and women in intervention group.
Murthy, R., & Klugman, B. (2004). Service accountability and community participation in the context of health sector reforms in Asia: implications for sexual and reproductive health services. *Health Policy and Planning, 19(*Suppl. 1), i78–i86.	Asia 18 World Bank projects	Programs incorporate community participation in the design or implementation of the project.	Project processes were analyzed for the extent and quality of community participation Time period not provided	Only 3 of 18 projects incorporated deep participation; many participatory approaches included the community in implementation but not in the design of the policy or program.
Paxman, J., Sayeed, A., Buxbaum, A., Huber, S., & Stover, C. (2005). The India Local Initiatives Program: a model for expanding reproductive and child health services. *Studies in family planning, 36*(3), 203–220.	4 northern states in India 3 NGO implementing agencies 784,000 people	The program promoted community and local government participation, recruited and trained community health volunteers, added 232 sites for government services, and established community health committees in 620 villages.	Pre-/post-coverage measures 4 years	78% increase in contraceptive use (on average). 67% increase in child immunizations. Empowerment of female volunteers and improved standing in their community.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Shiffman, J. (2002). The construction of community participation: village family planning groups and the Indonesian state. *Social Science & Medicine, 54*(8), 1199–121.	Indonesia Family planning networks	Analysis of the quality of community participation in the Indonesian FP community networks program.	Case study of Indonesian community-based family planning networks Time period not provided	Author argues that the community participation aspect of the BKKBN was limited by the top-down implementation by the state. Participation was in implementation and not in program development. This created a hybrid of state community-based programming, a previously unknown phenomenon.
UNICEF (2010). The Dynamics of Social Change: Towards the Abandonment of Female Genital Mutilation/Cutting in Five Africa Countries. Florence, Italy: UNICEF.	Senegal, Egypt, Ethiopia, Kenya, and Sudan 5 case studies of programs aimed to change norms related to female genital mutilation	Examine elements of community participation to promote social change and increase the well-being of girls.	Case study/program evaluation Time period not provided	Progress was made in all countries in abandoning female genital mutilation (countries selected because of success, but provide concrete example of community mobilization to create social change).
Mansa, E. (1991). Growing confidence. Villagers in Ghana's IP pilot areas learn the power of self-help. *Integration, 29*, 35–37.	Ghana 9 villages	Provide parasite testing, treatment, and prevention. Emphasize the health benefits of birth spacing. Teach nutrition and production of nutritious food for young children. Provide family planning counseling and services. Establish trust with the community through these health interventions.	Measure baseline FP usage and FP usage in the pilot villages 3 years	Baseline FP acceptance rate: 17.4%. At 2 years: 29%. At 3 years: FP acceptance ranged between 24.67–40.6% in the 9 villages. Increased community empowerment measured by communities willingness to tackle development problems such as deforestation, water pollution, and adult literacy.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Community/B: Build and strengthen community capacity in monitoring and accountability and ensure robust means of redress for violations of rights				
Bjorkman, M., & Svennson, J. (2009). Power to the People: Evidence from a Randomized Field Experiment on Community-based Monitoring in Uganda. *Quarterly Journal of Economics*, 735–770.	9 districts, Uganda 50 communities	NGOs facilitated village and staff meetings in which members of the communities discussed baseline information on the status of health service delivery relative to other providers and the government standard. Community members were also encouraged to develop a plan identifying key problems and steps the providers should take to improve health service provision. The primary objective of the intervention was to initiate a process of community-based monitoring that was then up to the community to sustain and lead.	Randomized field experiment 12 months	Treatment communities are more involved in monitoring the provider, and the health workers appear to exert higher effort to serve the community. Large increases in use and improved health outcomes—reduced child mortality and increased child weight—that compare favorably to some of the more successful community-based intervention trials reported in the medical literature.
International Community of Women Living with HIV/AIDS (ICW). (2009). *The Forced and Coerced Sterilization of HIV Positive Women in Namibia*. London: International Community of Women Living with HIV/AIDS.	Namibia 230 HIV-positive women	Young Women's Dialogues were being held in Namibia when it was revealed that 3 of 30 women had been sterilized without their consent; education about rights and advocacy and accountability mechanisms were started.	Qualitative interview data unclear Time period not provided	Cases of rights violations were identified; some went through the legal process. The high court of Namibia found that women's rights were violated through forced/coerced sterilization.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Community/C: Empower and mobilize the community to advocate for reproductive health funding and an improved country context and enabling environment for family planning access and use				
JOICFP. (1997). Community women move forward. Nepal. *JOICFP News 272*, 4. Tokyo Japanese Organization For International Cooperation Family Planning: Tokyo, Japan.	Nepal No sample size given	The workshop focused on a review of health projects in Panchkhal and Sunsari and offered strategies for implementation in 1997 that would improve quality of care. Workshop participants included women's volunteers, field workers, community health workers, and health committee workers. At first, groups discussed maternal health, child health, and women's health issues; then participants formed groups and chose topics of their own.	Pre-post; informal result reporting 3 years	It was revealed in the workshop that service coverage in Panchkhal increased from 4,283 to 12,127 recipients during 1993–96. Family planning clients increased from 657 to 1,490. Also in Panchkhal, advances were made in forming 135 mothers' groups, training, distribution of first aid kits, and construction of sanitary toilets. In Sunsari, the number of clinics rose from 10 to 220, and the number of clients increased from 631 to 7,280. Family planning services were provided to 1,713 persons in 1996—up from 32 persons in 1993. 73% of deliveries in 1996 were attended by medical personnel or traditional birth attendants. Community-based primary health care units were registered in all areas as nongovernmental organizations.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
D'Agnes, L.A., & Castro, J.R. (2011). Translating family planning research to action and scaling up in Philippines. Paper presented at the 2011 International Family Planning Conference, Dakar, Senegal.	Philippines	Behavior change communication messages through peer educators and community-based distributors regarding RH and coastal resource management for improved food security. Policy and advocacy to develop plans that include policies and budgets for both RH and coastal resource management (CRM) use combined RH+CRM messaging in one area, RH in another, and CRM in another to test effects.	Quasi-experimental design Pre-/post-project measurement via household surveys and parallel resource and ecological assessments Multivariate regression analysis 6 years	Combined approach had significant impact on parity, CPR, contraceptive use by youth, sexual activity among males, income, poverty, and environmental behaviors.
Community/D: Transform gender norms and power imbalances and reduce community-, family-, and partner-level barriers that prevent access to and use of FP				
Blake, M., & Babalola, S. (2002). Impact of a male motivation campaign on family planning ideation and practice in Guinea. PRISM project (pp. 20). *BMJ*, *316*(7134), 805–811.	15 prefectures of 3 administrative regions, Guinea Religious panel study: n: 98 Evaluation survey: n: 1,045	Phase 1: Religious leaders' advocacy —print, conferences, video. Phase 2: Multimedia interventions—launches, music contests, community mobilization, print materials, audio materials, publicity materials, materials for service providers.	Panel study among religious leaders Population-based study among men and women of reproductive age Religious panel: 4 months Evaluation survey: 14 months	Significant changes in religious leaders' attitudes toward family planning and acceptance of specific methods of family planning. No significant increase in use; but significant increase in intent to use. Increased spousal communication and spousal approval of FP. Overall modern CPR increased insignificantly to 4.9% for women and didn't change for men. However, among women not using at baseline, 13% began using a modern method after high exposure to media messages.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Phillips, J.F., Jackson, E.F., Bawah A.A., MacLeod, B., Adongo, P., Baynes C., & Williams, J. (2012). The long-term fertility impact of the Navrongo project in northern Ghana. *Studies in Family Planning*, *43*(3), 175–190.	Northern Ghana	Provide family planning to women through trained community health officers. Involve men and leaders in discussions about family planning and fertility.	Quasi-experimental design 15 years	Inclusion of a community mobilization component increased the impact of the family planning intervention.
Bartel, D., Simon, C., & Barnes, B. (2010). Meeting Challenges, Seeding Change: Integrating Gender and Sexuality into Maternal and Newborn Health Programming through the Inner Spaces, Outer Faces Initiative (ISOFI) (pp. 16). New Delhi: CARE International and ICRW.	Uttar Pradesh, India Intervention: n: 329 Control: n: 339	Both groups received the same community-based maternal and newborn health package of services; except the intervention group had gender and sexuality components layered into the project. Incorporated men into discussions about maternal and newborn health. Reduce women's isolation and lack of mobility. Discuss norms and beliefs about gender roles. Community media events. Facilitated dialogue among community members about normal expectations for men and women in the community.	Quasi-experimental operations research design, comparing 4 sub-districts of Raebareilly with 4 sub-districts of Barabanki Qualitative methods Quantitative multistage sampling 2 years	No significant difference in contraceptive use between the two groups.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Barker, K., & Okon, E., (2011). Results of a Nigerian Family Planning Radio Drama. International Conference on Family Planning. Dakar, Senegal. Population Media Center.	Kano, Kaduna, Sokoto, Katsina states in Nigeria Hausa-speaking individuals over the age of 15	Radio drama, Ruwan Dare that launched 208 episodes with story lines about reproductive health, early marriage, obstetric care, girls' education, birth spacing, and small family size (2 year Program).	Qualitative and quantitative formative research for development of radio drama. Baseline and end line conducted for evaluation. Multivariate analysis conducted. Intervention began July 2007	Evaluation noted use of family planning was 5.6 times greater at end line. Listeners were 2.4 times more likely than non-listeners to report current use of family planning; 50% reduction in maternal mortality rate achieved in 2 of the broadcast states. Desired family size fell from 7.43 to 5.93. Listeners were 1.7 times more likely to know where to get FP services and listeners were more likely (80%) than non- listeners (60%) to say pregnancies should be spaced.
Yassa, A., & Farah, S. (2003). Men in Jordan Get Involved in "Together for a Happy Family" (pp. 2). Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs.	Jordan	National mass media campaign promoting men's involvement in family planning.	Pre-/post-survey data analysis 5 years	Proportion of men who discussed FP with their wives, used FP, and regarded FP as safe and effective increased significantly. Ideal family size decreased to 3.8 from 4.3. There was a reported increase in shared decision making and discussion with the spouse.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Kim, Y.M., Marangwanda, C., & Kols, A. (1996). Involving men in family planning: the Zimbabwe Male Motivation and Family Planning Method Expansion Project, 1993–1994 (pp. 57). Baltimore, MD: Johns Hopkins School of Public Health, Center for Communication Programs. *Sexually Transmitted Infections, 76*(4), 277–281.	Zimbabwe 5 sites	2nd motivation campaign that sought to encourage male involvement in family planning and encourage use of long-term methods to limit family size through communication campaigns (radio drama, radio and TV spots, posters/newspapers/magazines). Training and workshop also given to providers to help improve counseling and management skills, as well as help promote the communication campaign.	Baseline and end line; household surveys; regression analysis 1993–1994	Exposure to campaign associated with rise in use of modern contraceptives. Those exposed to 3 or more campaign components were 1.6 times more likely to use a modern method; women reporting discussion of FP with spouse increased from 37% to 57%.
Piotrow, P., Kincaid, D.L. et al. (1992). Changing men's attitudes and behavior: the Zimbabwe Male Motivation Project. *Studies in Family Planning, 23*(6), 365–375.	Zimbabwe Baseline 711 married men; 892 men for follow-up Same intervention as Kim & Marangwanda	Male Motivation Project objectives were to increase knowledge of FP methods among men of reproductive age, promote more favorable attitudes about FP, increase use of modern methods, and promote male involvement and joint decision making. The campaign in Zimbabwe sought these objectives through a radio drama series, educational talks for men, and pamphlets on family planning.	Baseline and follow-up surveys One-group pre-/post-test design Control group not applicable due to radio broadcast that reaches entire Zimbabwe population Baseline conducted April–June 1988, follow-up conducted October–December 1989	Men exposed to the project were more likely to mention and use modern family planning methods; men exposed to the campaign were significantly more likely than other men to make the decision to use FP and to say that both spouses should decide how many children to have.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
National Institute of Population Research and Training [NIPORT]. (1998). Getting men involved in family planning. Experiences from an innovative program. Final report. (pp. 49). Dhaka, Bangladesh: Population Council.	Kalihati Thana, Bangladesh Population: 395,311	Multi-pronged approach including information, education, and communication materials; orientation of officers; participation workshops for field workers; national workshops on male involvement; strengthening of supervision of health providers; training on no-scalpel vasectomies; male hours at clinics, etc.	Pre-/post-data analysis 1 year	Increases in condom use from 2,163 to 3,075. Increase in new condom acceptors from 932 to 1,724. Increase in vasectomy acceptors from 2 to 71. Overall increase in contraceptive acceptors from 25,343 to 28,303.
Green, C.P., Selim, M., Gamal, A., & Mandil, O. (2004). Promoting gender sensitivity among boys in Egypt. Paper presented at the APHA.	11 governorates, Egypt 2,314 at baseline and 2,224 end line	New Visions Program—non-formal educational program for boys and young men in order to increase reproductive health knowledge and gender sensitivity and encourage development of key life skills.	Evaluation survey; records analysis; baseline and end line 2002–2004	Statistically significant improvement in gender equitable attitudes and knowledge of family planning methods.
Achyut, P., Bhatla, N., & Verma, R.K. (2009). Gender equitable teachers support Family Planning: Findings from a school based intervention in India. Paper presented at the International Conference on Family Planning—Research & Best Practices.	Maharashtra, Rajasthan, and Goa, India 412 teachers trained	Teachers were trained to discuss and lead gender norm change discussions in public schools.	Pre-/post-survey data analysis Time period not provided	Improved gender equitable attitudes, but no statistical tests performed.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Community/E: Support healthy transitions from adolescence to adulthood				
Askew, I., Chege, J., Njue, C., & Radeny, S. (2004). *A Multi-sectoral Approach to Providing Reproductive Health Information and Services to Young People in Western Kenya: Kenya Adolescent Reproductive Health Project*. Washington, DC: FRONTIER, Population Council.	Kenya (rural) Total baseline n=3,653 adolescents (87%) and n=1,192 parents (93%) Total end line n=3,774 adolescents (89%) and n=1,143 parents (93%) (also included cost analysis)	Multisectoral approach: community-based approach included mobilization for engaging local civic and religious leaders and parents and reaching out-of-school youth with peer educators, training them in adolescent health and sexuality issues, and holding sessions during religious and community meetings—drama, theater, video shows, and targeted public events. Facility-based approach included training staff, creating designated spaces within the clinic for adolescents, and inviting out-of-school peer educators to hold group and individual meetings. School-based approach included training teachers, establishing extracurricular classes, and recruiting, training, and supervising school-based peer educators.	Cluster randomization of sites; 2 intervention sites Site A = community- + facility-based interventions Site B = community-, facility- + school-based interventions Site C = 1 control site Two-sample, two-tailed test of differences 42 months	Received RH information: + Knowledge of contraception: + Knowledge of STIs: + Awareness of preventive behaviors: + (site A: abstinence & condoms; site B males: abstinence) Knowledge of reproductive physiology: 0 Disapproval of male premarital sex: + (site A) Disapproval of premarital childbearing: + (site A) Approval of condom use: + Sex: 0 Delay of onset: + (site A boys & site B) Secondary abstinence: + Discuss RH issues with their parents: + (those who met with a peer educator) Use of protection at last sex: + (sites A & C girls) - (site B boys) Pregnancy: + (site A & C)

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Erulkar, A., & Muthengi, E. (2009). Evaluation of Berhane Hewan: A program to delay child marriage in rural Ethiopia. *International Perspectives on Sexual and Reproductive Health, 35*(1): 6–14.	Mosebo, Amhara, Ethiopia	Berhane Hewan (Light for Eve) program components group formation, support for girls to remain in school, and community awareness through non-formal education sessions, neighborhood meetings, and referrals to health clinics for FP/RH issues.	Quasi-experimental design with baseline and end line surveys Intervention and control villages 2004–2006	Intervention was associated with considerable improvement in girls' school enrollment, age at marriage, reproductive health knowledge, and contraceptive use. Girls in intervention group were more likely to be in school than those in control group. Sexually experienced girls in intervention group had elevated odds of having ever used contraceptives.
Villarruel, A.M., Zhou, Y., Gallegos, E.C., & Ronis, D.L. (2010). Examining long-term effects of *Cuidate*—a sexual risk reduction program in Mexican youth. *Revista Panamericana de Salud Publica, 27*(5): 345–351.	Monterrey, Nuevo Leon, Mexico 708 adolescents	Sexual risk reduction intervention presenting abstinence and condom use as culturally appropriate behaviors for both males and females—delivered by trained facilitators in a small group format. Experimental group included 6-hour curriculum given to parents and adolescents and the control group included the general health promotion group. This evaluation is a 48-month follow-up to examine the long-term effect of sexual behavior and use of condoms or other contraceptives.	Questionnaire given to participating adolescents. $10 given upon completion 48-month follow-up, though year of intervention was not given	Participants in program more likely to be older at first sex or to use condom or other contraceptive method at first sex compared with those in the control group. Effects of intervention on consistent condom use, condom use at last sex, and number of sexual partners not significant.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Adamchak, S.E., Kiragu, K., Watson, C., Muhwezi, M., Nelson, T., Akia-Fiedler, A., Kibombo, R., & Juma, M. (2007). The Straight Talk Campaign in Uganda: Impact of Mass Media Initiatives, Summary Report. *Horizons Final Report.* Washington, DC: Population Council.	Uganda 2,040 adolescents and 678 parents in 6 districts: Apac, Arua, Ntungamo, Kamuli, Kisoro, and Soroti	Mass media and social marketing campaigns are modestly effective in persuading female and male adolescents to change high-risk behaviors. Straight Talk mass media communication program using radio shows and newspapers, as well as school-based activities, to increase knowledge of sexual and reproductive health among adolescents, as well as gain a more balanced attitude toward condoms and better communication with parents about sexual and reproductive health issues.	Community-based survey August–September 2005	Ugandan adolescents benefited from Straight Talk activities. Exposure to the activities is associated with greater knowledge about sexual and reproductive health, more balanced attitudes toward condoms, and more communication with parents about sexual and reproductive health issues. For girls, exposure further associated with a greater self-assuredness, greater sense of gender equity, and the likelihood of having a boyfriend but not a sexual relationship.
Purdy, C.H. (2006). Fruity, Fun and Safe: Creating a Youth Condom Brand in Indonesia. *Reproductive Health Matters, 14*(28), 127–134.	Jakarta, Surabaya, Medan, and Bandung, Indonesia 474 respondents ages 15–24 (half men/half women)	Interviews conducted to understand sexual behavior of unmarried youth. In response to issues that arose from interviews, a campaign on Fiesta condom was launched in 2003. The campaign used Fiesta condom as a vehicle to provide information on a range of issues. The campaign consisted of a media campaign (TV, radio, and print), collaboration with MTV Indonesia, and text messaging.	Baseline survey to collect information on youth sexual behaviors; mass media campaign launched promoting Fiesta condoms and follow-up focus groups conducted Interviews conducted November 2004 Condom campaign launched 2003–2004 Focus groups conducted 2006	Campaign resulted in strong brand image for Fiesta condoms; young people identify Fiesta as "their" brand.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Neukom, J., & Ashford, L. (2003). *Changing Youth Behavior through Social Marketing: Programs Experiences and Research Findings from Cameroon Madagascar, and Rwanda*. Washington, DC: Population Reference Bureau (PRB).	Rwanda 150,000 youth	Mass media and social marketing campaigns are modestly effective in persuading female and male adolescents to change high-risk behaviors. Social marketing campaign—using peer educators, radio shows, print materials, and mobile video-unit shows—targeted youth with messages promoting the use of a multipurpose, youth-friendly center that provides VCT, STI diagnosis, and RH services.	Case control survey 2000–2002	Youth exposed to the program were more likely to use VCT services and more likely to have had an HIV test in the past year, increasing from 2% among both sexes to 7% in males and 9% in females. Females in particular showed an increase in perception of personal reproductive health risks (61% compared with 32%).
Magnani, R., Robinson, A., & Seiber, E. (2000a). Evaluation of 'Arte y Parte': An adolescent reproductive health communications project implemented in Asuncion, San Lorenzo and Fernando de la Mora, Paraguay. Washington, DC, Pathfinder International/Focus on Young Adults.	Asuncion, San Lorenzo and Fernando de la Mora, Paraguay Males and females from in-school and out-of-school sites, ages 15–19: n=947 pretest, n=1,575 follow-up	Program included adolescent-specific mass media product development and product placement, as well as peer education. Program was designed to (a) increase the media's understanding and coverage of adolescent RH issues, (b) increase knowledge of SRH issues to promote responsible sexual behavior among adolescents, and (c) improve communication and negotiation skills related to SRH issues among young adults. Peer educators received 80 hours of training.	Randomized control study (reflexive controls): Chi-square tests; F-tests; Students' t-tests; logistic regression 30 months between pretest and follow-up	Knowledge that condoms prevent STI: + Believe both partners are responsible for protection: + Believe that girls who use protection are responsible:+ Ever had sex: 0 Condom use at first sex: +

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Meekers, D. (2000). The effectiveness of targeted social marketing to promote adolescent reproductive health: The case of Soweto, South Africa. *Journal of HIV/AIDS Prevention & Education for Adolescents & Children, 3*(4), 73–92.	Soweto, South Africa (treatment community); Umlazi, South Africa (control community) (both locations are urban) Females ages 17–20 Pretest: n=226 Post-test: n=204	Participatory media development—live weekly talk shows; mass media campaign; peer education; and targeted condom distribution. 70 adolescents trained in participatory media development process, peer education, and condom distribution. 300 condom distribution outlets opened to support intervention. Communications: television, print media, radio (limited reach).	1 intervention and 1 comparison site Logistic regression 1 year after pretest	Awareness about risks of becoming pregnant: + Perceived susceptibility to sexual risk: 0 Believe condom use is best way to protect against HIV/AIDS: + Believe condom use is best way to protect against pregnancy: + Believe other contraceptives are the best way to protect against pregnancy: + Perception of barriers to pregnancy prevention: 0 Discussed contraceptives/self-efficacy for pregnancy prevention: + Discussed STD/HIV prevention: 0 Sexual experience: 0 Current use of condoms to prevent pregnancy: 0 Condom use at last sex: + (but at p=.10) Awareness about risks of becoming pregnant: +
Karim, A.M., Williams, T., Patykewich, L., Ali, D., Colvin, C.E., Posner, J., & Rutaremwa, G. (2009). Impact of the African Youth Alliance Program on the Sexual Behavior of Young People in Uganda. *Studies in Family Planning*, 40(4), 289–306.	Uganda 1,548 males, 1,628 females, and 2,732 households	Multi-component intervention for Ugandan youth that included mass media campaigns, institutional capacity building to strengthen technical and organization ability for SRH programming, peer provider services, appropriate SRH curriculum, and behavior change component (life planning skills).	Self-reported exposure design and static group comparison. Intervention and control groups with survey and questionnaires. Evaluation from April–June 2006	The intervention had a positive impact on sexual behavior among young females but not young males. Girls exposed to the program were 13 percentage points more likely to report they had consistently used condoms and 10 percentage points more likely to have used contraceptives compared with girls who were not exposed to program.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Agha, S. (2002). A quasi-experimental study to assess the impact of four adolescent sexual health interventions in Sub-Saharan Africa. *International Family Planning Perspectives, 28*(2), 67–70 & 113–118.	Cameroon (Edea and Bafia) Botswana (Lobatse and Francistown) South Africa (Soweto and Umlazi) Guinea (Kankan and Conary) Cameroon: 1,606 at baseline and 1,633 at end line Botswana: 1,002 for baseline and 2,396 for end line South Africa: 221 in baseline and 204 in end line Guinea: 2,016 in baseline and 2,005 for baseline	Evaluation of national social marketing programs where programs sold subsidized, branded condoms to traditional and nontraditional outlets to promote the brand. Each country study had intervention and comparison groups. The interventions consisted of peer educators promoting behavior change and motivation for contraceptive products (Cameroon); campaigns promoting safer sex broadcast on community radio stations and adolescent volunteers to distribute condoms (South Africa); retailers' workshop on adolescent sexual health and counseling to appeal as "youth-friendly" (Botswana); and peer educators trained on issues related to HIV/AIDS, FP, and communication techniques (Guinea).	Quasi-experimental design Evaluation of intervention Baseline and post intervention surveys for each study 1997–1998	Interventions improved health perceptions (benefits and barriers) for women and had positive impact on contraceptive use. In Cameroon and Botswana, men were less likely (after intervention) to have multiple or casual partners. South Africa and Guinea programs were less intensive and had a limited reach.
Kim, Y.M., Kols, A., Nyakauru, R., Marangwanda, C., & Chibatamoto, P. (2001). Promoting sexual responsibility among young people in Zimbabwe. *International Family Planning Perspectives, 27*(1), 11–19.	Zimbabwe: Mutare (urban), Maphisa, Tongogara, Nzvimbo, and Nemanwa (all towns at the center of rural districts) Males and females ages 10–24, with half the sample between ages 15–19: n=1,426 pretest; n=1,400 follow-up	Youth multi-media campaign for education about RH issues. Trained providers in "youth-friendly services," encouraged parental involvement, and included peer educators. Communications: posters, leaflets, peer education radio, drama, campaign launch events, hot line, training programs for drama, seminars to solicit media, and local leadership involvement.	5 intervention and 2 control sites Chi-square tests; logistic regression Follow-up 1 year after pretest, 3 months after completion of intervention	Knowledge of FP: + Knowledge of RH: 0 Sexual decision making: 0 Discussion with anyone about RH topics: + Refused sex: + Use of contraception: + Have only one partner: + Start using condoms: + Use of RH services: +

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Meekers, D., Stallworthy, G., & Harris, J. (1997). Changing adolescents' beliefs about protective sexual behavior: the Botswana Tsa Banana program. *Working Paper* No. 3. Washington, DC: Population Services International [PSI], Research Division.	Lobatse, Botswana (treatment); Francistown, Botswana (comparison) Males and females ages 13–18: n=1,002 baseline; n=2,396 follow-up	Youth-friendly outlets for RH information and products that referred adolescents to Tsa Banana clinics; multi-media campaign; social marketing of condoms; peer sales outreach to community; and education sessions in school. Communications: radio, print media, and information targeted to parents, teachers, and community leaders.	1 intervention and 1 comparison site Logistic regression 16 months after baseline, 8 months after implementation of project	Believe that condoms reduce AIDS and pregnancy risk: Males: 0 Females: + Believe AIDS is not curable: Males: 0 Females: + Believe sex leads to marriage: Males: 0 Females: + Believe sex increases one's status: Males: - Females: 0 Believe sex is an AIDS risk: 0 Believe abstinence is protective: Males: 0 Females: + Attitude toward females initiating condom use: 0
Agha, S., & Van Rossem, R. (2004). Impact of a school-based peer sexual health intervention on normative beliefs, risk perceptions, and sexual behavior of Zambian adolescents. *Journal of Adolescent Health, 34*(5), 441–452.	Zambia (urban secondary, boarding schools) n=416 respondents ages 14–23 (at baseline) were interviewed in all three survey rounds (86% follow-up rate)	Single session school-based peer sexual health intervention included discussions, condom demonstration, drama skits, and leaflet.	Pre/post-test with control: 3 schools were randomly assigned to the intervention and 2 to the control condition (session on water purification) Mixed effects logistic regression growth curve; adjusted odds ratios First follow-up: 1 week Second follow-up: 6 months after intervention	Normative beliefs about abstinence: + (sustained until 6 months) Approval of condom use and intention to use: + (not sustained at 6 months) Normative beliefs about condom use: + (only at 6 months follow-up) Condom use: 0 Multiple regular partners: + (only at 6 months follow-up)
Brieger, W.R., Delano, G.E., Lane, C.G., Oladepo, O., & Oyediran, KA. (2001). West African youth initiative: outcome of a reproductive health education program. *Journal of Adolescent Health, 29*(6), 436–446.	8 Nigerian communities 2 Ghanaian communities In- and out-of-school males and females ages 12–24 n=1,714 pretest; n=1,801 post-test	Worked with youth serving organizations to develop activities for youth. All sites developed peer education programs. Some sites worked in schools (secondary or post-secondary). Others worked with out-of-school youth.	10 intervention and 10 control sites Logistic regression 18 months	Knowledge of AIDS/STI, pregnancy prevention, SRH: + (in school) Contraceptive opinion: 0 Contraceptive self-efficacy: + (in school-males) Willingness to buy condoms: + (in school-males) Willingness to buy foaming tablets: + (in school) Used modern contraceptives: + (in school)

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Cartagena, R.G., Veugelers, P.J., Kipp, W., Magigav, K., & Laing, LM. (2006). Effectiveness of an HIV prevention program for secondary school students in Mongolia. *Journal of Adolescent Health, 39*, 925.e9-925.e16.	Mongolia Males and females ages 15–19; n=647	A sexual health peer education program for secondary school students was launched in 2001. Peer educators (boys and girls) were chosen by local GTZ coordinators and teachers based on: openness, student interest, grades, expressiveness, communication skills, and friendliness. They were trained for 3 days in reproductive health, HIV and STI transmission, symptoms and prevention, safe sex, and discussions and interactive communication skills.	16 schools—8 intervention and 8 control Multilevel regression 3 years	Knowledge, attitudes, and self-efficacy: + Consistent condom use during last 3 months: 0
Magnani, R., Gaffikin, L., & Espinoza, V. (2000b). *Evaluation of Juventud EsSalud: An adolescent reproductive and sexual health peer education program implemented in six departments in Peru*. Washington, DC: Pathfinder International, FOCUS on Young Adults Program.	Peru: 6 departments: Lima, Lambayeque, Ica, San Martin, Arequipa, and Tacna n=6,962 secondary school males and females	3rd-year secondary school students selected as peer leaders and trained by health professionals over a 2-month period. Each leader was responsible for making at least 25 youth contacts in a 6-month period. Content of peer leader workshops: sexual development, body consciousness, self-esteem, assertiveness, anatomy and physiology, values, STIs/HIV, parenthood, relationships, and adolescent pregnancy.	Pilot project Chi-square tests; logistic regression 18-month follow-up period	Knowledge of correct day of ovulation: + Know that woman can get pregnant at first sex: + Believe could convince partner to use a condom: 0 Ever had sex: + (only measured among boys) Contraceptive use at last sex: + (among boys only)
Özcebe, H., & Akin, L. (2003). Effects of peer education on reproductive health knowledge for adolescents living in rural areas of Turkey. *Journal of Adolescent Health, 33*(4), 217–218.	Turkey (rural) Treatment: n=113 females and n=109 males ages 15–24; Control: n=108 females and n=201 males ages 15–24	Volunteers, who were married or unmarried women and men ages 15–24 years old, were designated as peer educators and trained on reproductive health issues.	Peer education intervention was conducted in 2 villages, while another 2 villages served as a control group One-way variance analysis Time period not provided	Knowledge level for females: + Knowledge level for males: +

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Speizer, I.S.,Tambashe, B.O., & Tegang, S. (2001). An evaluation of the 'Entre Nous Jeunes' peer-educator program for adolescents in Cameroon. *Studies in Family Planning, 32*(4), 339–351.	Cameroon: Nkongsamba and Mbalmayo Males and females ages 10–25: n=802 pretest; n=818 post-test	Peer education program to increase contraceptive prevalence and reduce prevalence of STIs and unwanted pregnancies. Activities: trained peer educators to provide information to peers in communities and refer them through discussion groups and one-on-one meetings and developed health associations. Developed and distributed promotional materials (calendars, comic strips, posters).	1 intervention and 1 control site Logistic regression 17 months after pretest, 3 months after intervention completion	Knowledge of contraceptives: + Knowledge of female STI symptoms: + Knowledge of male STI symptoms: Males: + Females:0 Use of modern method: + Condom use at last sex: +
Van Rossem, R., & Meekers, D. (2000). An Evaluation of the Effectiveness of Targeted Social Marketing to Promote Adolescent and Young Adult Reproductive Health in Cameroon. *AIDS Education and Prevention, 12*(5), 383–404.	Edea, Cameroon (treatment community); Bafia, Cameroon (control community) Males and females ages 12–22: n=1,606 pretest; n=1,633 post-test	Peer education (28 adolescents trained as peer educators), youth clubs in schools, mass media campaign, behavior change communication, social marketing of condoms. Communications: brochures, posters, community radio, and live talk shows targeting youth with messages about RH and condom use.	1 intervention and 1 comparison site Logistic regression 15 months after pretest, 13 months of intervention	Knowledge of preventive behavior: + Knowledge of FP methods: + Perceived risk for STI/AIDS: Males: + Females: 0 Perceived risk for unwanted pregnancy: 0 Awareness of responsibility for use of protection: + Discuss sexuality and contraceptive use: + Ever visited health center for contraceptive information: 0 Onset of sexual activity <15: Males: 0 Females: + Use of modern method to prevent pregnancy: Males: + Females: 0 Ever tried condoms: Males: 0 Females: + Condom use at last sex: 0 2+ sexual partners in last 30 days: Males: + Females: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Van Rossem, R., & Meekers, D. (1999b). An Evaluation of the Effectiveness of Targeted Social Marketing to Promote Adolescent Reproductive Health in Guinea. *Working Paper* No. 23. Washington, DC: Population Services International, Research Division.	Conakry and Kankan, Guinea Males and females: n=21,016 pretest	Peer education; media materials; intense, targeted marketing effort in context of broader social marketing activity; distribution of free contraceptives to adolescents; development of logo "My Future First" to identify youth-friendly retail outlets. Small youth-friendly service component (certain clinics held special hours for youth) and recreational activities. Communications: brochures and posters. Also added theater, dance, and discussion groups to existing social marketing program.	Selected neighborhoods in each city were chosen for the intervention while others were chosen as comparison sites Logistic regression 13 months after pretest, about 8 months of intervention period	Awareness of risk for HIV: 0 Awareness of risk for HIV: 0 Awareness of risk for pregnancy: + Knowledge of condoms as contraception: + (males only) Knowledge of other forms of contraception: + (females only) Visited a health center in past year: + (females only) Discussed sex often: + (males only) Sexually experienced: 0 Onset of sexual activity by age 15 or earlier: + (males only) 2+ sexual partners during past 4 weeks: + (marginally significant for both at .08) Usually uses condoms: + (males only) Used condom during last sexual encounter: +
Kanesathasan, A., Cardinal, L.J., Pearson, E., Gupta, S., Mukherjee, S., & Malhotra, A. (2008). Catalyzing Change: improving youth sexual and reproductive health through DISHA, an integrated program in India. Washington, DC: International Centre for Research on Women.	Bihar and Jharkhand, India 176 villages	DISHA (Development Initiative Supporting Healthy Adolescents) stressed youth participation through peer education and youth group and livelihoods training; youth-friendly SRH services and health services, service delivery, and building of technical and implementation capacity of NGOs.	Quasi-experimental; baseline and end line; surveys and focus groups 2005–2007	Age at marriage increased by nearly two years. Youth were 14 percent more likely to know the legal age at marriage for girls and were 17 percent more likely to know where to access pills. Adults were 7 percent more likely to feel girls should wait until they are 18 to marry.

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FRONTIERS. (2002). Peer Education as a strategy to increase contraceptive prevalence and reduce the rate of STIs/HIV among adolescents in Cameroon. Yaoundé, Cameroon: Population Council.	Mokolo neighborhood of Yaoundé, Cameroon 2,504 respondents for baseline survey and 2,464 respondents for end line survey 49 peer educators trained	Training of 49 peer educators in effective RH communication and teaching techniques. Production of a magazine on adolescent reproductive health. Baseline and end line surveys assessed the knowledge, attitudes, and behavior of youth ages 12–24 in 1 intervention site and 1 control site.	Quasi-experimental research design with 1 intervention site and 1 control site Baselines were conducted at both sites to measure knowledge and extent of condom use as prevention against STIs/HIV and unwanted pregnancies 19 months; July 2000–February 2001	5,000 youth were reached through the peer education campaign and 2,000 were reached through the magazine campaign. 22% of respondents in control site and 44% in intervention site had read the magazine at least once. Adolescents in the intervention site adopted behavioral changes to prevent STI/HIV transmission and unwanted pregnancies more often than the control site.
Mathur, S., Mehta, M., & Malhotra, A. (2004). *Youth reproductive health in Nepal: Is participation the answer?* Washington, DC: International Center for Research on Women [ICRW].	Nepal Baseline: n=724 adolescents ages 14–21 End line: n=979 adolescents ages 14–25	At the control sites, traditional RH research and interventions—adolescent-friendly services, peer education and counseling, and teacher training—were employed. At intervention sites, youth and adult community members identified a broader set of 8 integrated interventions: adolescent-friendly services, peer education and counseling, IEC campaign, adult peer education, youth clubs, street theater, livelihood opportunities, and teacher education.	2 intervention sites (1 rural and 1 urban) and 2 control sites (1 rural and 1 urban) Quantitative, qualitative, and participatory methods Multivariate regressions; odds ratios 12–24 months	Correctly identified at least 2 modes of HIV transmission: + (urban and rural females) Ever discussed sex with anyone: + (rural females) Had premarital sex: + (urban unmarried males) Contraceptive use: 0 Ever visited an organization for FP advice: + (marginally significant at .06 for rural married females) Knowledge of at least 1 serious problem during childbirth: + (rural males) Experience of pregnancy: 0 Currently in school: + (rural females) Membership in group activities: + (rural females)

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Daniel, E.E., Masilamani, R., & Mizanur, R. (2008). The Effect of Community-Based Reproductive Health Communication Interventions on Contraceptive use among Young Married Couples in Bihar, India. *International Family Planning Perspectives, 34*(4), 189–197.	Bihar, India 20 intervention villages, 7 comparison villages 650,000 men and women	Workshops and behavior change communication provided essential reproductive health information and addressed key issues of concern among young people. Female change agents and training officers offered information to men and women.	Baseline and end line data; surveys with logistic regressions 2004 evaluation	Contraceptive use low at baseline in both comparison and intervention areas. Demand increased from 25% at baseline to 40% at follow-up in intervention areas but remained unchanged in comparison areas.
Tu, X., Lou, C., Gao, E., & Shah, I.H. (2008). Long-term effects of a community-based program on contraceptive use among sexually active unmarried youth in Shanghai, China. *Journal of Adolescent Health, 42*(3), 249–258.	Shanghai, China (suburban) 2,227 unmarried youth ages 15–24 interviewed at baseline; 2,042 were interviewed immediately after the intervention (91.7% of baseline) 2,249 were interviewed at long-term follow-up (28 mos. later) (32–34% of baseline and post-test samples)	Intervention was designed to increase knowledge and enhance access to services related to sexuality and reproduction among unmarried youth. Involved 3 activities: IEC—building awareness through dissemination of educational materials, instructional videos, lectures, and small group educational activities; and provision of counseling—a youth health counseling center was set up. Activities enhanced access to services specifically contraceptives through local FP units, a youth counseling center, and educational activities.	With a panel: a nonrandomized community trial with 1 intervention group and 1 control group x^2; logistic regression First follow-up: 20 months Second follow-up: 28 months (cross-sectional sample at second follow-up)	Use of withdrawal method: + Consistent contraceptive use: 0 Contraceptive use ever, use of contraceptive at each intercourse combined with frequent use, condom use ever, and withdrawal use ever: 0

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Doyle, A.M., Ross, D.A., Maganja K, Baisley K, Masesa C, et al. (2010). Long-term biological and behavioral impact of an adolescent sexual health intervention in Tanzania: Follow-up survey of the Community-based MEMA kwa Vijana trial. *PLoS Medicine, 7*(6), e1000287.	Mwanza Region, Tanzania 20 rural communities	20 communities randomized into intervention group (58 primary schools and 18 health facilities) and control group (63 primary schools and 21 health facilities). Intervention included teacher-led, peer-assisted, in-school education; youth-friendly health services; community activities; and youth condom promotion and distribution. This study is an evaluation to determine the long-term impact of intervention on prevalence of HIV, other STIs, pregnancy, and sexual health knowledge, attitudes, and reported sexual behavior.	Cross-sectional survey June 2007–July 2008	Intervention did not significantly reduce HIV risk or HSV-2. Intervention did lead to a sustained improvement in young people's SRH knowledge and some reported sexual behaviors.

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Bhuiya, I., Rob, U., Chowdhury, A.H., Rahman, L., Haque, N., et al. (2004). *Improving Adolescent Reproductive Health in Bangladesh*. Washington, DC: FRONTIER, Population Council.	Bangladesh (urban) n=about 6,000 adolescents (ages 13–19) and about 3,000 parents were interviewed in total (from baseline and end line)	Strategy I (Site A) provided RH education to out-of-school adolescents linked with adolescent-friendly services at health facilities as well as community support activities. Strategy II (Site B) provided RH education to both in-school and out-of-school adolescents linked with adolescent-friendly services at health facilities and community support activities.	Pabna (Site A), Dinajpur (Site B), and Rangpur (Site C) Sites A & B were intervention sites while Site C served as a control Bivariate and multivariate analyses Baseline Feb–April 2000 End line April–June 2002	Knowledge of HIV/AIDS: + (among Site B boys only) Knowledge of three routes of transmission: + (Site A & B boys & Site B girls) Knowledge of contraceptives: + (Site B boys and Site A girls) Knowledge of fertile period: + (Site A & B boys and Site B girls) Knowledge of potential health risks of early pregnancy: + (Site B & C boys and Site C girls) Attitudes toward RH education and services: 0 (no differences among boys); - (Site A older girls) Attitudes toward contraceptive use: + (Site B boys, older boys of Site A, & Site A girls) Condom use: 0 RH service utilization: + (Site A & B)
Lou, C., Wang, B., Shen, Y., & Gao, E. (2004). Effects of a community-based sex education and reproductive health service program on contraceptive use of unmarried youths in Shanghai. *Journal of Adolescent Health, 34*(5), 433–440.	Shanghai, China (suburban) n=2,227 unmarried young people (ages 15–24) were recruited at baseline (about 92% were successfully followed-up)	Main activities: (1) building awareness, disseminating educational materials, playing instructional videos, giving lectures, and conducting small group activities; (2) setting up a youth health counseling center and distributing contraceptives free of charge; and (3) community activities.	Pre/post-test with control; a nonrandomized community trial with 1 intervention group and 1 control group Chi-square tests; logistic regression models; generalized Estimating Equations (GEEs) 20 months after the intervention	Used contraceptive at onset of sexual intercourse: + Ever contraceptive use, regular contraceptive use, and condom use: + Jointly decided on contraception: + (males only)

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Magnani, R., Gaffikin, L., Aquino, E., Seiber, E., Almeida, M., & Lipovsek, V. (2001) Impact of an Integrated Adolescent Reproductive Health Program in Brazil. *Studies in Family Planning, 32*(3), 230–243.	Salvador, Bahia, Brazil n=4,777 male and female youth	Sexual reproductive health education program with the provision of adolescent-appropriate RH services at linked public health facilities.	6 intervention and 6 control sites Logistic regression 30 months after pretest	Received SRH-related information from school sources or health professional: + SRH knowledge: 0 Ever had sex: 0 Condom use: 0 Utilization of clinics: 0
Ross, D.A., Changalucha, J., Obasi AI., Todd, J., et al. (2007). Biological and behavioural impact of an adolescent sexual health intervention in Tanzania: a community-randomized trial. *AIDS, 21*(14), 1943–1955.	Mwanza, Tanzania (rural) Baseline: n=9,645 adolescents—all those ages 14 years and older in late 1998, who were in years 4–6 of primary school in 20 communities End line: n=7,040 (73%)	MEMA kwa Vijana (Good things for young people) intervention. Four components: community activities; teacher-led, peer-assisted sexual health education in years 5–7 of primary school; training and supervision of the health workers to provide "youth-friendly" sexual health services; and peer condom social marketing.	Randomized control trial; community randomized trial of 20 communities; panel sample biomarkers; two-way ANOVA; t-statistics; logistic or poisson regressions; random effects model 3 years	Knowledge of pregnancy prevention: + Attitudes to sex: + (males only) More than one sexual partner: Males: + Females: 0 Condom use: + Condom use at last sex: Males: + (marginally at .06) Females: 0 STI symptoms: 0 HIV incidence: 0 HSV2 seropositive: 0 Protective effect of the intervention on syphilis, C. trachomatis, gonorrhea, vaginalis, and pregnancy: 0
Cabezón, C., Vigil, P., Rojas, I., Leiva, M.E., et al. (2005). Adolescent pregnancy prevention: an abstinence-centered randomized controlled intervention in a Chilean public high school. *Journal of Adolescent Health, 36*(1), 64–69.	Santiago, Chile (peripheral community, San Bernardo) n=1,259 girls from an all-girls high school	TeenSTAR abstinence-centered sex education program consists of 14 units; each was developed in one or more 45-minute class—allows a full-year course with a one class per week schedule. Each unit is interactive, comprised of group discussions, brainstorming, fertility awareness instruction, homework, videotapes, and skills building. Focuses on biological and physiological aspects of fertility—mentions contraceptive methods but stresses abstinence.	Randomized control trial; 3 cohorts: the 1996 cohort (425 students, no intervention); the 1997 cohort (210 students received intervention, 213 did not); and 1998 cohort (328 received intervention, 83 did not) Risk ratio; chi-square tests 4 years of observations	Pregnancy rates: +

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Chong, A., González-Navarro, M., Karlan, D., & Valdivia, M. (2013). Effectiveness and Spillovers of Online Sex Education: Evidence from a Randomized Evaluation in Colombian Public Schools. *National Bureau for Economic Research Working Paper* #18776, February 2013/Poverty Action International.	Colombia 138 ninth grade classrooms from 69 public schools in 21 cities	Students in intervention classrooms participated in an online sex education course.	Randomized control trial Econometric specification OLS regression model; tested for spillover effects at non-experimental classroom in experimental classroom schools IV analysis 11 weeks of intervention; 6 months after intervention, condom vouchers offered to students	Intervention students had more knowledge of STIs, sexual violence, pregnancy prevention, and condom use. Intervention students were more likely to redeem condom vouchers. Intervention students were 40% more likely to redeem condom vouchers; treated girls were more likely to procure condoms and other contraceptives.
Eggleston, E., Jackson, J., Rountree, W., & Pan, Z. (2000). Evaluation of a sexuality education program for young adolescents in Jamaica. *Revista Panama de Salud Publica, 7*(2), 102–112.	Jamaica n=945 female and male 7th grade students, ages 11–14 from "new secondary" and "all age" schools	Specially developed family-life education curriculum. Content: reproductive anatomy and physiology; benefits of sexual abstinence; negative consequences of sexual activity and pregnancy; transmission, symptoms, and treatment of STIs; FP; and peer pressure. Sessions once per week throughout the academic year (about 9 months). The sessions were coeducational and each lasted about 45 minutes.	Pre/post-test with control; 5 intervention schools and 5 control schools (who received regular sex education program) Chi-square tests; students' t-tests; logistic regression using generalized estimating equation methods 9 months after baseline and 21 months after baseline (76% of baseline)	Knowledge of pregnancy prevention and condom use: + (not sustained at follow-up 2) Knowledge of when pregnancy occurs: - Attitudes about sexual activity: + (not sustained at follow-up 2) Attitudes about parenthood: + (not sustained at follow-up 2) Sexual initiation: 0 Use of contraception: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Maharaj, P., & Cleland, J. (2006). Condoms Become the Norm in the Sexual Culture of College Students in Durban, South Africa. *Reproductive Health Matters, 14*(28), 104–112, A10.	South Africa 3,000 male and female college students, ages 18–24	Promoting condoms for pregnancy prevention may increase condom use for safe sex among young people. Condoms promoted for pregnancy prevention.	Survey February and March 2003	Over 75% of students surveyed reported condom use at last sexual intercourse, primarily to prevent pregnancy. Almost 87% of men and 89% of women surveyed felt that condoms were part of sex. 6 focus group discussions found that condoms had become part of sex and were highly acceptable and easily accessible. If a woman requested to use of a condom, male and female respondents agreed that the man must comply. Male respondents reported being suspicious of women who agreed to unprotected sex, and many respondents reported that they would rather use condoms than jeopardize their future.
Martiniuk, A.L.C., O'Connor, K.S., & King, W.D. (2003). A cluster randomized trial of a sex education programme in Belize, Central America. *International Journal of Epidemiology, 32*(1), 131–136.	Belize (urban) n=399 adolescents ages 13–19	Responsible Sexuality Education Program based on Bandura's Social Learning Theory is a 3-hour, scripted responsible sexuality education intervention that provides a framework for adolescents' decision making in relationships and provides unbiased information about sex and sexuality.	Randomized control trial; 8 classrooms were randomized to the intervention arm and 11 classrooms to the control arm Regression analysis Time period not provided	Knowledge: + Attitudes: 0 Behavioral intent: 0
Mba, C.I., Obi, S.N., & Ozumba, B.C. (2007). The impact of health education on reproductive health knowledge among adolescents in a rural Nigerian community. *Journal of Obstetrics and Gynaecology, 27*(5), 513–517.	Nigeria (rural) n=360 students participated in both the pre- and post-tests; mean age was 14.3 years	Intervention consisted of a 3-hour workshop on STIs, HIV/AIDS, and FP.	1 intervention secondary school and 1 control secondary school Chi-square tests Same subjects interviewed 6 weeks after the workshop	Knowledge about STIs, HIV/AIDS, and FP methods: + Sexual activity: 0

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Mbizvo, M.T., Kasule, J., Gupta, V., Rusakaniko, S., et al. (1997). Effects of a randomized health education intervention on aspects of reproductive health knowledge and reported behaviour among adolescents in Zimbabwe. *Social Science & Medicine, 44*(5), 573–577.	Zimbabwe; selected urban and rural secondary schools (exact location not reported) n=1,689 males and females with a mean age of 14.5 at baseline; n=1,605 participants at 5-month follow-up	Health education program consisting of IEC materials (leaflets, pamphlets, posters) and lectures. Content: male reproductive function, sexuality, HIV/AIDS, female reproductive function, anatomy, STIs, human sexuality, unwanted pregnancy, contraception, and career goals.	Randomized control trial; 5 intervention and 3 control schools; cross-sectional samples Chi-square tests; wilcoxon two-sample tests; trend analysis 5 months after baseline	Knowledge of menstruation: + Knowledge of wet dreams: + Knowledge of pregnancy: + Knowledge of family planning: + Ever had sex: 0
Murray, N., Toledo, V., Luengo, X., Molina, R., & Zabin, L. (2000). An evaluation of an integrated adolescent development program for urban teenagers in Santiago, Chile. Unpublished Draft. Washington, DC: Futures Group.	Santiago, Chile (urban) n=4,238 male and female 7th–12th grade students	School and health facility education. Content: healthy relationships, sexuality, STIs, gender, risk-taking behaviors. Information and referrals to clinic.	Pre/post-test with control; 2 intervention and 3 control sites Life table techniques 3 rounds of data collection: baseline and 8-month and 20-month follow-up	Knowledge on human reproduction & STIs (index): + Knowledge about STIs: + Knowledge on contraception: 0 Attitudes (teen pregnancy, sexual relationships of youth): 0 Sexual activity: 0 Contraceptive use: Males: 0 Females: + Method use at last sex: 0
Rusakaniko, S., Mbizvo, M.T., Kasule, J., Gupta, V., et al. (1997). Trends in reproductive health knowledge following a health education intervention among adolescents in Zimbabwe. The *Central African Journal of Medicine, 43*(1), 1–6.	Zimbabwe (rural and urban) Baseline: n=1,689 students 5-month follow-up: n=1,605 9-month follow-up: n=1,589	Intervention package included lectures, videos, and IEC materials in the form of leaflets and pamphlets that cover male reproductive function, sexuality, STDs/AIDS; female reproductive function, anatomy, and STDs; human sexuality and responsible sexual behavior; and unwanted/unplanned pregnancy and contraception.	Randomized control trial; 8 secondary schools were randomized to receive a health education intervention and 3 (1 urban and 2 rural) were chosen to serve as controls Chi-square tests 5 months and 9 months after implementation	Knowledge of reproductive biology: + Knowledge of contraception: + Knowledge of pregnancy risk: +

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Stanton, B.F., Li, X., Kahihuata, J., Fitzgerald, A.M., et al. (1998). Increased protected sex and abstinence among Namibian youth following a HIV risk-reduction intervention: a randomized, longitudinal study. *AIDS, 12*(18), 2,473–80.	Omusati and Caprivi, Namibia n=515 males and females ages 15–18; 12-month follow-up sample was 340 (66%)	Adaptation of U.S.-based "FOCUS on Kids" program, based on social cognitive theory; program called "My Future is My Choice." 14 after-school sessions with groups of 15–20 students. Sessions were 2 hours a week for 7 weeks. Content: emphasis on abstinence and safer sex practices. Facilitator training lasted 40 hours.	Randomized control trial; 10 schools with random assignment of individuals within school Chi-square tests 2-month, 6-month, and 12-month follow-up (after baseline)	Perceive could find condoms: Males: + (2&6 months) Females: + (12 mos.) Perceive could ask for condoms at clinic: 0 Believe they can put condom on: Males: 0 Females: + (2, 6, & 12 mos.) Intention to use condoms: Males 0 Females: + (2 mos.) Delay of sexual initiation: Males 0 Females: + (12 mos.) Condom use if sexually active: Males: + (2 mos.) Females: 0 Discussed past sexual relationships and other HIV risk behaviors with partners: + (2 & 6 mos.) Number of sex partners: 0 Could refuse sex without a condom: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Walker, D., Gutierrez, J.P., Torres, P., & Bertozzi, S.M. (2006). HIV prevention in Mexican schools: prospective randomized evaluation of intervention. *BMJ*, 332(7551), 1189–1194.	Morelos, Mexico n=10,954 students (at baseline), 9,371 (immediately after intervention), 7,308 (1 year after); mean age 16.7	Schools were randomized to one of three arms: an HIV prevention course that promoted condom use, the same course with emergency contraception as back-up, or the existing sex education course. The curriculum was based on teaching life skills and followed the guidelines of the United Nations Program on HIV/AIDS for effective school-based programs.	Randomized control trial; 15 schools randomly assigned to each of the intervention courses and 10 randomly assigned to control (existing course) Logistic regressions Baseline, 4 months, and 16 months after intervention began (which lasted 15 weeks)	Knowledge on EC: + (condom promotion + EC group at 16 mos.) Attitudes about condom use: + (females at 16 mos.) Condom use at last sex: + (condom promotion + EC group but only at 4 mos., not at 16 mos.) Knowledge on EC: + (condom promotion + EC group at 16 mos.) Attitudes about condom use: + (females at 16 mos.) Condom use at last sex: + (condom promotion + EC group but only at 4 mos., not at 16 mos.) Used EC: + (condom promotion + EC group but only for females at 16 mos.)
Shuey, D.A., Babishangire, B.B., Omiat, S., & Bagarukayo, H. (1999). Increased sexual abstinence among in-school adolescents as a result of school health education in Soroti district, Uganda. *Health Education Research, 14*(3), 411–419.	Soroti District, Uganda n=400 males and females, average age 13–14	Activities: 1-day sensitivity training for local leaders and headmasters; supervision of school health program; meetings with parents, teachers, and community leaders; training for "senior women" and science teachers' college in school health and AIDS curriculum.	10 students from each of the 38 primary schools selected Chi-square tests; cross tabulation 2 years after pretest	Knowledge of AIDS: 0 Communication between peers and teachers about sex:+ Perceive peers are sexually active: 0 Agree that abstinence is good: + Sexual activity: + Number of partners: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Erulkar, A. S., Ettyang, L., Onoka, C., Nyagah, F.K., & Muyonga, A. (2004). Behavior change evaluation of a culturally consistent reproductive health program for young Kenyans. *International Family Planning Perspectives, 30*(2), 58–67.	Nyeri Municipality, Kenya (treatment); Nyahururu Municipality, Kenya (control) At baseline, unmarried young people ages 10–24: n=1,544 At end line, young adults ages 10–26: n=1,865 (only respondents ages 10–24 in this analysis)	Nyeri Youth Health Project, a community-based project that uses Kikuyu tradition and well-known and respected young parents as counselors—who were trained for one month in the life skills curriculum "Life Planning Skills for Adolescents in Kenya." Used group discussions, role playing, drama, and lectures; worked with adults; and referred youth to trained service providers. Content: community, family, and individual values; adolescent development; sexuality; gender roles; relationships; pregnancy; HIV/STIs; harmful traditional practices; substance abuse; planning for the future; and children's rights and advocacy.	1 intervention municipality and 1 control municipality Logistic regression or Cox proportional hazard models 36 months	Sexual debut: Males: + (marginally significant .8) Females: 0 Secondary abstinence: Males: 0 Females: + Condom use: Males: + Females: 0 Number of sex partners: Males: 0 Females: + Communication with parents: Males: - Females: + Communication with other adults: Males & Females: +

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Pande, R., Kurz, K.H., Walia, S., MacQuarrie, K., & Jain, S. (2006). *Improving the reproductive health of married and unmarried youth in India: evidence of effectiveness and costs from community-based interventions. Final report of the Adolescent Reproductive Health Program in India* (pp. 77). New Delhi, India: International Center for Research on Women.	Aurangabad and Maharashtra, India: All unmarried adolescent girls ages 12-18, with a focus on out-of-school and working girls; in first round of program, 440 girls enrolled and 179 completed the life skills course Tigri, New Dehli: 407 girls at baseline and end line Naglamachi, New Dehli: 294 at baseline and 365 at end line	Life skills course as a 1-year program with 1-hour sessions each weekday evening. (1) Developing social and peer support for adolescent girls, (2) training adolescent girls to build skills to negotiate their environment, and (3) conducting an IEC campaign through (a) one-on-one interaction with a Swaasthya female health worker and (b) video programs on community and adolescent issues that were screened on local cable television.	Pre/post case-control design: 4 years Baseline and end line surveys in both sites, designing each as two cross-sectional assessments: 3 years	Significant increase in knowledge and skills among the intervention group compared with the control group. Increase of 1 year to the median age of marriage. Control group was 4 times more likely to marry before age 18 than girls who fully participated in the intervention. Logistic regression showed that, at end line, participants in the skills-building modules and those exposed to the one-on-one interaction were significantly more likely to have higher perceived self-determination than girls who did not participate in these intervention elements. The one-on-one interaction also was positively associated with behavior as measured by better menstrual hygiene.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Nanda, R., Shah, A., & Satyavada, A. (2011). Investments in Adolescents can lead to better reproductive health outcomes: evidence from PRACHAR, Bihar. International Family Planning Conference, Senegal, Pathfinder International.	Bihar, India 306 young men and 307 young women randomly selected who had received the PRACHAR training intervention 306 young men and 306 young women from comparison areas who had not received intervention	RH and communication and negotiation skills training for adolescent girls and boys; "infotainment" parties for newlyweds; training for female and male change agents to conduct home visits to young married women and group meetings with young married men, parents-in-laws, and influential community members to provide information on health timing and spacing of pregnancy; and dissemination of timing and spacing messages through community-wide engagement, e.g., wall paintings and street theater to sustain norm changes.	Comparison group and intervention group Logistic regression controlling for education and case; proportional hazards regression Phase 1: 2001–2005 Phase 2: 2005–2009 Phase 3: 2009–2012	Women in intervention group were 44% less likely to be married by the time of the survey. Of those that were married, they were 39% less likely to have had a first birth at time of Thursday; they were 5 times more likely to have ever used contraception before first birth; and they were 5 times more likely to have ever used contraception after first birth.
African Youth Alliance (AYA). (2007). *Improving Health Improving Lives: AYA End of Year Programme Report*. New York, NY: UNFPA.	Ghana, Tanzania, Uganda Ghana: 3,416 youth Tanzania: 1,900 youth Uganda: 3,176 youth	Comprehensive programs for youth can improve HIV knowledge and encourage protective behavior. Comprehensive integrated program on SRH behavior that includes policy and advocacy coordination; institutional capacity building, coordination and dissemination; behavior change communication, including life planning skills and enter-education activities such as sports, dance, and rap; youth-friendly services; and integration of adolescent sexual and reproductive health with livelihood skills training.	Post-intervention analysis between intervention sites Ghana: 2001–2005 Tanzania: 2002–2005 Uganda: 2001–2005	Significant positive impact of the alliance on condom use, contraceptive use, partner reduction, and several self-efficacy and knowledge antecedents to behavior.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Levitt-Dayal, M., & Motihar, R. (2001). *Adolescent Girls in India Choose a Better Future: An Impact Assessment*. CEDPA/India.	India: peri-urban slums of New Delhi; rural Madhya Pradesh; and rural and urban slums of Gujarat n=1,693 unmarried and married women ages 15–26	Better Life Options program that seeks to empower young women to make better choices for the future. Activities: income-generating activities, formal and non-formal education, Family Life Education, vocational skills training, health education and services, public awareness creation, and advocacy. Also works with parents, community leaders, and decisionmakers to raise awareness about the need for girls' empowerment. Content: decision making, mobility, self-esteem/confidence/ empowerment, childbearing and spacing, contraceptive use, and health-seeking behavior.	1 intervention and 1 control group Risk-ratios generated from MV analyses 1–4 years after program participation	Awareness of HIV: + Age at marriage: + Completion of secondary education: + Employed and earning money: + Contraceptive use: + Utilization of ANC and PNC services: + Utilization of hospital for delivery: + Utilization of ORS for children's diarrhea: + Number of children: + Child mortality: + Children vaccinated: +
Lee-Rife, S., Malhotra, A., Warner, A., & Glinski, A.M. (2012). What Works to Prevent Child Marriage: A Review of the Evidence. *Studies in Family Planning, 43*(4), 287–303.	23 child marriage prevention studies carried out in low-income countries	Vertical programs that focused on school or incentive-based interventions. Horizontal programs that focused on working with girls to empower them with information, skills, and resources.	Systematic review of interventions aimed at reducing child marriage 1973–2009	12/23 programs examined changes in attitudes, with 6 reporting positive results. 18/23 programs measured behavior change, with 9 reporting positive results. 4 rigorous studies looking at marriage behavior, with only 1 having exclusively positive results. Discussion provides good recommendation for strengthening interventions.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Individual/A: Increase access to information on reproductive rights, contraceptive choices				
Boulay, M., Storey, J.D., & Sood, S. (2002). Indirect Exposure to a Family Planning Mass Media Campaign in Nepal. *Journal of Health Communication, 7*, 379–399.	Dang District, mid-western region of Nepal 667 women	Examine role of indirect exposure in extending the reach and effectiveness of a radio program designed to promote the use of family planning. This effect is examined in light of the Radio Communication Project (national health communication campaign) that addressed the high of unmet need for FP in Nepal starting in December 1995.	Survey questionnaire; comparison with 1996 Nepal Family Health Survey 6 months	More than half of the survey respondents, equal to those directly exposed, were exposed to the program's messages through discussions with peers. Women who had either indirect or direct exposure to the program's messages were 160% more likely to use a contraceptive method, compared with women with no exposure.
L'Engle, K.L., Vahdat, H., Ndakidemi, E., Lasway, C., & Zan, T. (2013). Evaluating feasibility, reach and potential impact of a text message family planning information service in Tanzania. *Contraception, 87*, 251–256.	Tanzania 2,870 text message users	Mobile for Reproductive Health (m4RH) pilot; initial messages sent to users regarding contraceptive methods; second messages were questions regarding gender, age, where they learned of the program and whether the program had changed their FP use.	Text messages 10 month pilot, September 2010–June 2011	First study to provide evaluation data from pilot mobile phone program in sub-Saharan Africa. Adolescents and young adults' heaviest users; changes in FP use mentioned after using program, and changes were consistent with where users are in reproductive life cycle.
Valdes, PR., Alarcon, A.M., & Munoz, S.R. (2013). Evaluation of Informed Choice for contraceptive methods among women attending a family planning program: conceptual development; a case study in Chile. *Journal of Clinical Epidemiology, 66*(3), 302–307.	Chile 13 physicians and 1, 446 women	Study to measure the Informed Choice of contraceptive methods among women attending a family healthcare service.	Multi-method design; expert opinions and survey questionnaires Time period not provided	Women and experts agreed on key elements of importance for an informed choice tool. Provider client interactions were very important. Women deprioritized the provider asking about her reproductive intentions.
Mahamed, F., Parhizkar, S., & Raygan Shirazi, A. (2012). Impact of family planning health education on the knowledge and attitude among Yasoujian women. *Global Journal of Health Science, 4*(2), 110–118.	Yasouj city, Iran 200 women	Premarital counseling on family planning comprising 4 educational sessions.	Pre/post-tests on intervention and control groups; paired t-tests 4 weeks	Significant increases in intervention group in knowledge and attitudes toward contraceptive methods compared with control group.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Desai, J., & Tarozzi, A. (2011). Microcredit, family planning programs, and contraceptive behavior: evidence from a field experiment in Ethiopia. *Demography*, *48*(2), 749–782.	Ethiopia (rural) 133 peasant associations randomly assigned to 3 intervention groups (credit, family planning, combined) or a control group	In the first intervention group, both credit and family planning services were provided and the credit officers also provided information on family planning. In other two intervention groups, only credit or family planning services, but not both, were provided and the control group did not receive services.	Randomized control trial Baseline survey of 6,440 households in the 133 associations Follow-up survey of 6,375 households in the 133 associations 39 months	No significant difference in outcomes among groups.
Mbonye, A.K., Hansen, K.S., Wamono, F., & Magnussen, P. (2012). Barriers to contraception among HIV-positive women in a periurban district of Uganda. *International Journal of STD & AIDS*, *23*(9), 661–666.	Uganda 10,706 women	Identify barriers to contraceptive use.	Formative study	Many adolescents do not trust providers to keep information confidential. Women fear contraceptives interfere with antiretroviral treatment. Side effects and opposition by spouses were other barriers faced by women.
Individual B/: Empower, through education and training about reproductive health, self-esteem, rights, life-skills, and interpersonal communication				
Crissman, H.P., Adanu, R.M., & Harlow, S.D. (2012). Women's sexual empowerment and contraceptive use in Ghana. *Studies in Family Planning*, *43*(3), 201–212.	Ghana 2,104 women	Investigate the relationship between sexual empowerment and contraceptive use using 5 variables from the DHS about sex and power and report of use of contraceptives.	Secondary analysis of DHS survey data	Sexual empowerment of individuals was significantly associated with contraceptive use, even after variables such as wealth and education were taken into account.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Bawah, A. (2002). Spousal communication and family planning behavior in Navrongo: a longitudinal assessment. *Studies in Family Planning, 33*(2), 185–194.	Kassena-Nankana District, Navrongo, Northern Ghana 5,288 women surveyed in 1995 7,561 women surveyed in 1997	Using models and surveys, establish whether an association exists between spousal discussion of family planning and contraceptive use.	Analysis for 3 stages: (1) use preliminary cross-sectional probit model to examine factors associated with contraceptive use in 1997; (2) employ longitudinal analysis after linking 1995 and 1997 data sets and analyze data according to spousal-discussion status; use contraceptive use in 1997 as variable function of discussion status in 1995; (3) use model to test for reverse causation 1995 first survey; 1997 second survey	Cross-sectional and longitudinal analysis suggests that husband-wife communication about FP strongly predicts contraceptive use, even when controlling for other factors. When testing reverse causation, spousal discussion promotes contraceptive use, not the reverse.
Saleem, S., & Isa, M.A. (2004). Facilitating inter-spousal communication for birth spacing—a feasibility study on Pakistani couples for policy implications. *Journal of the Pakistan Medical Association, 54*(4), 182–186.	Karachi, Lahore, and Quetta, Pakistan 72 married couples	Interviews conducted with married couples who were either nonusers of modern methods or users of traditional methods. Behaviors negotiated where (1) discuss benefits of birth spacing with spouse, (2) discuss specific methods of family planning and decide on the most appropriate one, and (3) initiate use of a modern temporary method of family planning. Total of 4 interviews with couples.	Behavioral trials conducted (formative research method in which researcher and participants negotiate behavior that participant agrees to try for a specific amount of time; behaviors assessed through periodic reviews) July–October 2000	Out of 72 couples, 38 reported failure to discuss with their spouse; women-initiated discussions were not as favorable as men-initiated discussions. After second interview, 28 couples were successful in discussion selection of FP methods; 24 couples chose and used a method.
Kamal, S.M., & Islam, M.A. (2012). Inter-spousal communication on family planning and its effect on contraceptive adoption in Bangladesh. *Asia-Pacific Journal of Public Health, 24*(3), 506–521.	Bangladesh 10,996 ever married women	Analyze data to investigate the relationship between interspousal communication and family planning usage.	Secondary analysis of 2007 DHS	Strong association between talking with husband about family planning and use of contraceptives.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Sternberg, P., & Hubley, J. (2004). Evaluating men's involvement as a strategy in sexual and reproductive health promotion. *Health Promotion International, 19*(3), 389–396.	24 studies on men's involvement in SRH promotion.	Studies that considered men's role in HIV/STI prevention, unwanted pregnancy prevention, promotion of safe motherhood, fatherhood, and stopping violence against women were considered for the review. Articles had to be published in a peer-reviewed journal and be targeted at adult, heterosexual men.	Systematic review Time period not provided	24 papers were identified; found that there were substantial gaps in the topic areas, especially around how male involvement affected women's empowerment and men's own well-being.
Hussein, S., Nar, M.A., Moustafa, R. & Petraglia. (2011). Behavior change communication model for male decision-influencers in family planning promotion. International Conference on Family Planning, Senegal, Pathfinder International.	Underserved areas of Upper and Lower Egypt 179 clinics Baseline interviews in Lower Egypt: 1,200; 1,199 post intervention Baseline interviews in Upper Egypt: 6,158; 6,148 post intervention	Takamol project to address male populations as agents in FP decision making through a BCC intervention model combining religious leaders, community leaders, and agricultural extension workers to educate and engage men about FP and gender issues. Intervention also aimed to encourage acceptance of FP through targeted interpersonal and communication and small group interactions and by extension, creating enabling home environments for discussion of birth spacing and FP methods between husbands and their wives.	Baseline and end line (1 year after community activities ended) Household surveys March 2006–April 2011	After intervention, men were more open to discussing FP and birth spacing with their wives; 60% of women in Upper Egypt reported having discussions about FP post-intervention, compared with 48% baseline. In Lower Egypt, women who had discussions with their husbands were almost twice as likely to be using a contraceptive method as those who did not; in Upper Egypt, women were almost four times more likely.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Odeyemi, K.A., & Ibude, B.E. (2011). Promoting Male Participation in Family Planning in Rural Nigeria: A community based intervention. International Conference on Family Planning, Senegal. Department of Community Health, University of Lagos.	Nigeria (rural communities of Ilepa and Iyesi, South West) 200 men	Assessment of knowledge, attitudes, and practices of FP among men. Conducted a community-based program/intervention and determined its impact on men's knowledge and participation in FP. Intervention and control areas; intervention area had a 4-week FP health education program (health belief model).	Quasi-experimental design Multistage sampling technique in the intervention area (Ilepa) and control (Iyesi) Baseline and end line data collected through interviews Time period not provided	Spousal communication improved from 15% to 27%; joint decision making increased from 16.3% to 53.2%; positive perception of women who use contraception increased from 14% to 79%.
Hartmann, M., Gilles, K., Shattuck, D., Kerner, B., & Guest, G. (2012). Changes in couples' communication as a result of a male-involvement family planning intervention. *Journal of Health Communication, 17*(7), 802–819.	Malawi 400 men	5 visits from a male motivator to share information about contraceptives.	Quasi-experimental design 6 months	The male motivator intervention was effective at increasing contraceptive use; further evaluation showed that increased communication was a pathway by which the change occurred. The qualitative responses highlight some prevailing gender norms of men and the lead decisionmakers, but overall, the communication seemed to help the women and the couples.
Barker, G., Ricardo, C., & Nascimento, M. (2007). Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions (pp. 76). Geneva: World Health Organization.	Worldwide 58 evaluation studies	Analysis of evaluation studies of interventions with men and boys in sexual and reproductive health. Interventions were rated on their gender approach as being gender-neutral, gender-sensitive, or gender-transformative.	Online literature review, expert meetings, contacts at key organizations, and analysis of previous literature reviews 2007	Programs were rated as effective, promising, or unclear.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Sood, S., Sengupta, M., Mishra, P.R., & Jacoby, C. (2004). 'Come gather around together': an examination of radio listening groups in Fulbari, Nepal. *Gazette, 66*(1), 63–86.	Nepal (rural): Fulbari VDC (intervention); Parbatipur VDC (control) n=408	Radio Communication Project combines mass media messages, distance education, interpersonal communication, and counseling training programs featuring workshops, radio-based health worker training in FP, and a national drama.	Pre/post-test with control; 3 groups Group 1: radio program + the listening groups (n=204) Group 2: radio program only (n=73) Group 3: no exposure (n=131) Logistic regressions; service statistics were also collected from the sub-health posts 2001	Knowledge of FP (spontaneous recall of 5 or more methods): + (Group 1 & 2) Discussed FP with spouse: + (Group 1 only) Discussed FP with others: + (Group 1 & 2) Current use of any modern method: + (Group 1 only) Approval of FP: 0 Recommending method: 0 Future use: 0
Shattuck, D., Kerner, B., Gilles, K., Hartmann, M., et al. (2011). Encouraging contraceptive uptake by motivating men to communicate about family planning: the Malawi Male Motivator Project. *American Journal of Public Health, 101*(6), 1089–1095.	Mangochi Province, Malawi 400 men from 257 villages; 397 participants for baseline and 289 for post-intervention	Evaluation of Malawi Male Motivator intervention, which incorporated activities related to information on modern FP methods and locally available resources; motivation to act on knowledge and implement FP practices; and behavior skills related to FP such as communication skills and skills for correct condom use. Intervention arm and control arm.	Baseline and post-intervention surveys 197 participants randomized into intervention arm and 200 placed in control arm In-depth interviews with subset of participants 2008	Contraceptive use increased significantly in the intervention and control groups after the intervention (slightly greater in intervention group). Increased ease and frequency of communication, with couples being the only significant predictors of uptake.
Nanda, R. Shah, A., & Daniel, E. (2011). Involving men to increase family planning: case of Rural Bihar, India. International Conference on Family Planning, Senegal, Pathfinder International.	Bihar, India 3,532 married women and men	Phase I communication interventions included home visits, training for young couples, group meetings conducted by male communicators, and infotainment sessions. Phase 2 baseline survey was conducted in 2006 in selected intervention areas from Phase 1. This study examines the relationship between exposure of men to PRACHAR communication activities and contraceptive use.	Cross-sectional survey; bivariate analysis and logistic regression controlling for parity, women's education and standard of living Phase 1: 2001–2005 Phase 2: 2005–2009 Phase 3: 2009–2012	Compared to couples where neither had been exposed to PRACHAR communication activities and contraceptive use, the odds of currently using contraceptive methods were highest when both partners were exposed. Exposure of men alone to interventions is more effective than exposure of women only, which may reflect men's greater decision-making power.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Ha, B.T., Jayasuriya, R., & Owen, N. (2005). Increasing male involvement in family planning decision making: trial of a social-cognitive intervention in rural Vietnam. *Health Education Research, 20*(5), 548–556.	Hai Phong Province, Vietnam (2 rural communes) 651 married men in 12 villages	Impact of a stage-targeted intervention aimed at influencing men's motivational readiness to accept IUD use as a contraceptive method.	Quasi-experimental; 6 intervention villages and 6 control villages Baseline and end line	Significant positive movement in men's stage of readiness for IUD use by their wife occurred in intervention group. No significant changes in control. Compared to control group, intervention group showed higher pros and lower cost and higher self-efficacy for IUD use by their wife as a contraceptive method.
Nyako, Z., Yusuf, S., Seguan, T., Airede, L., Ishola, G., & Otolorin, E. (2011). Use of Male Birth Spacing Motivators to Mobilize Communities for Family Planning Acceptance in Northern Nigeria. International Conference on Family Planning, Senegal, MCHIP Nigeria.	Nigeria (northwest states of Kano, Katsina, and Zamfara) 7,981 men	Male education and involvement in FP. Training of male birth spacing motivators to counsel men and religious and traditional leaders on the benefits of healthy timing and spacing of pregnancies; IEC intervention.	March 2010–January 2011	247 male birth spacing motivators trained; 19.5% contraceptive acceptance rate in the project area is much higher than 3% CPR found in region.
Individual/C: Foster demand for high-quality services and supplies through IEC/BCC and empower individuals to demand their rights be respected, protected, and fulfilled				
Gupta, N., Katende, C., & Bessinger, R. (2003). Associations of Mass Media Exposure with Family Planning Attitudes and Practices in Uganda. *Studies in Family Planning, 34*(1), 19–31.	Uganda (12 districts: Jinja, Kampala, Kamuli, Kasese, Luwero, Masaka, Masindi, Mbarara, Nakasongola, Ntungamo, Rakai, and Sembabule) Sub-samples of 2, 316 women and 663 men in project's districts	Evaluation of Delivery of Improved Services for Health project in Uganda. The project's intervention strove to increase service use and change behavior related to reproductive and maternal and child health. Project provided training, strengthening of support systems, and communication activities. This evaluation examines differences in use of modern contraceptives and intention to use a method prior and after implementation of a BCC campaign.	Evaluation design included multivariate regression analyses and used data sources from 3 household surveys conducted between 1995 and 1999 in the project districts 1995–1999	Substantial increases over time in the use of modern contraceptive methods among women and men living in the target areas. Exposure to BCC messages was associated with increased contraceptive use and intention to use.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Kane, T., Gueye, M., Speizer, I., Pacque-Margolis, S., & Baron, D. (1998). The impact of a family planning multimedia campaign in Bamako, Mali. *Studies in Family Planning, 29*(3): 309–323.	Bamako, Mali Pre-intervention baseline 824 men and women; post-intervention survey 868 men and women	Modern and Traditional Media to Promote FP in Mali project evaluation—evaluate exposure and impact of campaign's television and radio FP messages. 4 television plays, 4 short television spots, and 2 recorded songs containing FP messages.	Quasi-experimental design with separate baseline and post-intervention surveys; multivariate analysis Mass media campaign was in 1993; baseline November–December 1992 and post-intervention survey July–August 1993	Statistically significant increases in proportion of men and women who stated they had seen FP message on TV or heard on radio; substantial rise in proportion of married women using modern contraceptives in Bamako observed in 6-month period between baseline and post-intervention (from 12% to 15%).
Luck, M., Jarju, E., Nell, D.M., & George, M.O. (2000). Mobilizing demand for contraception in rural Gambia. *Studies in Family Planning, 31*(4), 325–335.	The Gambia (3 primary healthcare circuits in the North Bank Division) 420 women respondents residing in the 3 circuits	Follow-up to earlier studies that examined impact on contraceptive prevalence of a community-based family planning program that included both interventions to improve availability of services and interventions to mobilize demand for contraception. The objective of the follow-up was to determine whether low-cost demand mobilization interventions alone would bring about increased contraceptive prevalence, even in the absence of improved availability of FP services.	Circuit 1: demand-mobilization + improved availability consisted of 6 villages Circuit 2: demand-mobilization-only consisted of 5 villages Circuit 3: the control circuit, consisted of 4 villages 2 different approaches used, Kabilo and Imam meetings; demand-mobilization used the two components; the improved-availability only used one Kabilo approach had a community health nurse train a woman of the circuit to participate in health subcommittee and they would then make visits to other women in own kabilo to promote improved health practices Imam meetings were used in demand-mobilization Baseline survey for all 3 circuits conducted in May–June 1994, and follow-up survey conducted in May 1995	Baseline nonusers of modern contraceptives living in 2 treatment circuits were more than 2 times more likely than baseline nonusers living in control circuit to use a modern method at follow-up. No statistical difference in results were found between the demand-mobilization and improved availability intervention compared with the demand-mobilization only. No evidence was offered regarding significant impact of Imam meetings on women's beliefs about Islam and FP. Kabilo approach contributed to an increased rate of contraceptive use observed in the intervention circuits following its implementation.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Kincaid, D.L. (2000b). Mass media, ideation, and behavior: a longitudinal analysis of contraceptive change in the Philippines. *Communication Research, 27*(6), 723–763.	Philippines Intact panel of 1,253 married women ages 15–49	National Communication Campaign of 1995/1996 (NCC-95/96) used 6 method-specific TV spots developed for the first campaign and added 4 new ones (2 to promote breastfeeding and injectables and 2 others to involve men in decisions about FP).	Longitudinal design with lagged variables and comparable measures at Time 1 Conditional change regression analysis; structural equation modeling 6 months	Knowledge of modern contraceptive methods: + Attitudes toward the practice of FP: + Attitudes toward contraceptive methods: + Discussion of FP with one's husband: + Discussion of FP with other women: + Advocacy of FP to others: + Exposure to campaign: + Intention and contraceptive use: +
Valente, T., & Saba, W. (2001). Campaign exposure and interpersonal communication as factors in contraceptive use in Bolivia. *Journal of Health Communication, 6*(4): 303–322.	Bolivia (7 largest cities) 2,818 married women (interviews/surveys)	Evaluation of National Reproductive Health Program mass media campaign and its impact on contraceptive use.	Use of 3 waves of cross-sectional surveys and panels Multiple regression models run to determine degree of association between the outcome variables and substantive ones controlling for demographic characteristics Cross-sectional surveys Baseline February 1994 Phase 1 March–Oct 1994; 1st follow-up: Nov 1994 Phase 2 March–July 1996; 2nd follow-up August 1996 Panel information Baseline September 1995 Phase 1 Sept–Jan 1996; 1st follow-up February 1996 Phase 2, March–July 1996; 2nd follow-up August 1996	Positive attitudes (rather than knowledge) were the first step in behavior change sequence since attitude scores were higher and more strongly positively associated with initiation of use; interpersonal communication is strongly and positively associated with behavior change.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Snyder, L.B., Diop-Sidibe, N., & Badiane, L. (2003). A meta-analysis of the effectiveness of family planning campaigns in developing countries. Paper presented at the Health Communication Division of the International Communication Association Annual Conference.	Meta-analysis of 39 studies that included outcomes of interest	Family planning and reproductive health community campaigns conducted by Johns Hopkins Center for Communication Programs.	Effect sizes were calculated using a difference statistic 1986–2001	On average, the greatest campaign effect for men and women was on knowledge of modern family planning methods (r = .15). There were also positive effects for partner communication about family planning (r = .10), approval of family planning (r = .09), behavioral intentions (r = .07), and use of modern methods of family planning (r = .07).
Rogers, E.M., Vaughan, P.W., Ramadhan, M.A., Swalehe, N.R., et al. (1999). Effects of an entertainment-education radio soap opera on family planning behavior in Tanzania. *Studies in Family Planning, 30*(3), 193–211.	Tanzania Five annual surveys of about 2,750 households in the comparison and the treatment areas A sample of new family planning adopters in 79 health clinics	Radio soap opera program, Twende na Wakati (Let's be modern/let's control our lives), was broadcasted on 7 mainland stations of Radio Tanzania. An eighth station broadcasted alternative programming from 1993–1995; its listenership served as a comparison area. The program was designed based on a values grid containing 57 statements, such as not favoring male children over female children and encouraging couples to use FP methods.	7 intervention areas and 1 comparison area Regression models; ANOVA Strength of evidence: medium 1993–1995	Knowledge of FP: 0 Attitudes toward FP (measured by self-efficacy): + Attitudes toward FP (measured by ideal number of children): 0 Attitudes toward FP (measured by ideal age at marriage for women): + Attitudes toward FP (measured by approval of FP): + Discussed FP with spouse: + Contraceptive use: + Currently pregnant: 0

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
Guilkey, D.K., & Hutchinson, P.L. (2011). Overcoming methodological challenges in evaluating health communication campaigns: evidence from rural Bangladesh. *Studies in Family Planning, 42*(2), 93–106.	Bangladesh (urban and rural areas at Paribarik Shastha Clinics) 12,754 women in 2001 and 8,718 women in 2003	Smiling Sun Communication Campaign—multichannel campaign that disseminated important health-related messages and promoted health services. 26-episode TV drama series covering a variety of health topics including reproductive health and family planning (birth spacing, long-term contraceptive methods, etc.). This is an evaluation of the intervention that measured the impact of the campaign.	2-stage cluster sampling procedure based on a sampling frame Control for endogenous program placement and addressed potential endogeneity of self-reported campaign exposure in health-behavior equations by estimating a set of exposure, contraceptive-use, and antenatal-care equations by full information maximum likelihood Fieldwork July–September 2011, June and September 2003	Only 12% of women reported seeing the Smiling Sun logo on television.
Van Rossem, R., & Meekers, D. (2007). The reach and impact of social marketing and reproductive health communication campaigns in Zambia. *BMC Public Health, 7*, 352.	Zambia	Social marketing campaigns promoting condom use on TV and the radio.	National survey data analysis 6 months, retrospective message recall	Men who had high exposure to media about condom use were 1.48 times more likely to have ever used a condom and 1.23 times more likely to have used a condom at last sex.
Decat, P., Zhang, W., Delva, W., Moyer, E., et al. (2012). Promoting contraceptive use among female rural-to-urban migrants in Qingdao, China: a comparative impact study of worksite-based interventions. *European Journal of Contraception Reproductive Health Care, 17*(5), 363–372.	Qingdoa, China n=1,218	A standard intervention of distribution of brochures, free condoms, and informative postings in the workplace. The intensive intervention added a hotline that offered SRH counseling, VIP cards for reduced priced reproductive health services, visits by health providers including lectures, consultations, and peer education.	Quasi-experimental design 18 months	The intensive intervention increased contraceptive use among childless migrants older than age 22.

Reference	Location/Sample	Intervention Description	Design/Methods and Period of Observation	Results
FOCUS on Young Adults and CARE International-Cambodia. (2000). *Impact of an Adolescent Reproductive Health Education Intervention Undertaken in Garment Factories in Phnom Penh, Cambodia*. Cambodia: CARE International.	Phnom Penh, Cambodia 1,072 mostly female (92%) factory workers with a mean age of 20	Reproductive health education provided to young garment factory workers using a Participatory Learning and Action approach.	Pre/post-test with control; Chi-square tests 18 months after baseline	Knowledge of STI/HIV/AIDS: 0 Knowledge of contraceptive method: + Knowledge of the risks of pregnancy: + Discussed condoms with friends: + Worry about getting AIDS: 0 Knowledge of modes of HIV/AIDS prevention: 0 Knowledge of condom source: 0

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