Ensuring human rights in the provision of contraceptive information and services
Guidance and recommendations

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Annex B  Guideline Development Group
Annex C  Grade Summaries and Evidence Tables
Annex D  Health and human rights standards
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Annex C Grade Summaries and Evidence Tables

1. NON-DISCRIMINATION
Recommendation based on human rights standards (Annex D), no health evidence sought.

2. AVAILABILITY

Recommendation 2.1 Integration of supply chain

Date: 2013-04-11
Question: Should full intervention package vs partial intervention package be used for improve quality of family planning services?
Settings: Uganda
Bibliography:

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1 Okello et al., 2003
2 High risk of bias as different subjects were assessed at baseline and follow-up.
3 While imprecision was not serious, some assessed groups (i.e. new clients) were small, with n<300.
4 Contraceptive experience score was 0.72 for the experimental group for new clients (full intervention) and 0.71 for the control group (partial intervention), indicating little difference between the full and partial interventions.
3. ACCESSIBILITY

3.1 Comprehensive sexuality education

Author(s): P. Whyte
Date: 2013-04-10
Question: Should theory-based multi-component educational program be used in high school students?
Settings: USA - California and Texas
Bibliography:

<table>
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1 Coyle et al., 2001
2 High risk of bias due to self-report of outcome variables; no accounting for subjects lost to follow-up; and no statistical correction for multiple tests of significance. The paper argues that analyses were limited to primary and secondary hypotheses and that all other testing was considered exploratory.
3 Odds ratio based on 'multi-level' analysis using logistic or linear regression (type used for this outcome not specified). The use of condoms at last intercourse was a secondary outcome in the study, with frequency of intercourse without a condom and number of sexual partners without a condom the primary outcomes.
Quality assessment | No of patients | Effect | Quality | Importance
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Curriculum based on social cognitive theory and social inoculation theory | Control | Relative (95% CI) | Absolute |

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<td>1 Coyle et al., 2004</td>
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<sup>2</sup> High risk of bias due to use of self-report surveys for assessing outcomes; lack of participation from students who had permission to participate; high loss to follow-up of subjects.
**Question:** Should health belief model combined with social learning theory be used in adolescents aged 13-19 years?

**Settings:** USA - California and Texas

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1 Program included four areas: factual information, group discussion of factual information, group discussion of values, feelings and emotions, and discussion of decision-making and personal responsibility for one's sexual behaviour.

2 Eisen 1990

3 Only 60% of the baseline sample completed one year follow-up interviews.

4 Some analyses were based on small subgroups of the total sample (n=81) and main analyses included only 60% of those who completed follow-up.

5 For males there was no statistically significant difference in contraceptive efficiency at one year follow-up. For females there was a statistically significant advantage favouring the control group, with a contraceptive efficiency score of 6.95 for the intervention group and 12.00 for the control group (p<0.01); higher score is better.

6 For males, the use of effective contraception was greater in the control group, 65% compared to 55% in the intervention group. For females, 35% in the intervention group and 65% in the control group reported using effective contraception for their most recent intercourse.
**Question:** Should peer-led sex education vs teacher-led sex education be used in high school students?

**Settings:** UK

**Bibliography:**

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¹ Stephenson et al., 2004
² Some risk of bias given that outcomes were self-reported. The paper states that substantial bias seems improbable however no rationale for this claim is provided.
³ The paper reports n and percentage using contraception at first sex, but does not report the total N. The referenced webpages with additional tables (which may have total N) no longer exist. Therefore proportions cannot be entered in GRADE.
**Question:** Should peer-led sex education vs teacher-led sex education be used in high school students?

**Settings:** UK

**Bibliography:**

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*Stephenson et al., 2008

Some risk of bias given that outcomes were self-reported.

The paper reports n and percentage using contraception at first sex for intervention and control groups, but does not report the total N for each group. Therefore proportions cannot be entered in GRADEVERY.
## Recommendation 3.2 Removal of financial barriers

**Author(s):** P. Whyte  
**Date:** 2013-04-10  
**Question:** Should contraceptive method of choice at no cost be used in women in St. Louis region?¹  
**Settings:** USA  

### Bibliography:
- Quality assessment

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| use of long-acting contraceptive method  
¹ There is no comparison with use of contraceptives at cost.  
² Secura et al., 2010  
³ Observational study reporting only proportion who chose contraception.  
⁴ Study reports only that 67% of women who enrolled chose long-acting contraceptive methods. 2500 enrolled. No details on number assessed.

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**Question:** Should no intervention be used in male college students?¹

**Settings:** China

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¹ This study did not use an intervention. It assessed current condom use in male college students.

² Long et al., 2012

³ Paper reports that study represents only a small sample of college students and results may not be representative. In addition, results are based on retrospective data, when condom use may be best measured using daily calendars.

⁴ The paper reports only that 61.5% of subjects used a condom during their most recent sexual encounter, no Ns are provided.

⁵ Odds ratio for condom use when free condoms were available. When free reproductive health counselling was available, odds ratio for use of condoms was 1.54 (95% CI: 1.08, 2.74) compared to no counselling.
**Question:** Should contraceptive method of choice at no cost be used in women in St. Louis region?

**Settings:** USA

**Bibliography:**

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</table>

1 There is no comparison with use of contraceptives at cost.
2 Peipert et al., 2012
3 Observational study reporting only proportion who use long-acting method of contraception.
4 Paper reports that 75% of participants chose a long-acting method of contraception. This is a follow-up to the Secura et al (2010) paper which reported 67% in first 2500 participants. Primary outcomes were abortions, repeat abortions and teenage births.
Recommendation 3.3 Improving access for populations with difficulties accessing services

(Evidence on rural population)

Author(s): P. Whyte
Date: 2013-03-20
Question: Should lady health worker program vs no program be used in married women?¹
Settings: Pakistan

<table>
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<th>Quality assessment</th>
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¹ Lady health workers deliver services related to child and maternal health.
² Douthwaite and Ward 2002
³ Retrospective review of data.
⁴ High risk of bias given observational nature of the study. In addition, no baseline data was collected.
⁵ Based on multivariate logistic regression analysis. The paper provided only percentages (not Ns) for the intervention and control group for proportion using modern reversible methods of contraception.
**Quality assessment** | **No of patients** | **Effect** | **Quality** | **Importance**
--- | --- | --- | --- | ---
| **No of studies** | **Design** | **Risk of bias** | **Inconsistency** | **Indirectness** | **Imprecision** | **Other considerations** | **Traditional medical practitioners to deliver family planning services** | **Control** | **Relative (95% CI)** | **Absolute** | **Quality** | **Importance**
| | | | | | | | | | | | | | |
| 1 observational studies | observational studies | serious<sup>1</sup> | no serious inconsistency | no serious indirectness | no serious imprecision | none | 508/800 (63.5%)<sup>2</sup> | 413/850 (48.6%) | - | 486 fewer per 1000 (from 486 fewer to 486 fewer) | | |
| | | | | | | | | | | | | | |

1 Kambo
2 Observational study, areas included were 'purposively' selected.
3 Greater increase in contraceptive use from baseline to follow-up in intervention group as opposed to control group. Values presented here are for follow-up.

**Quality assessment** | **No of patients** | **Effect** | **Quality** | **Importance**
--- | --- | --- | --- | ---
| **No of studies** | **Design** | **Risk of bias** | **Inconsistency** | **Indirectness** | **Imprecision** | **Other considerations** | **Delivery of improved services for health** | **Control** | **Relative (95% CI)** | **Absolute** | **Quality** | **Importance**
| | | | | | | | | | | | | | |
| 1 observational studies<sup>2</sup> | observational studies | serious<sup>1</sup> | no serious inconsistency | no serious indirectness | no serious imprecision | none | - | - | - | - | | |
| | | | | | | | | | | | | | |

1 Katende et al., 2003
2 Retrospective review of data.
3 High risk of bias as analysis is limited to facility-based information only and did not take into account other programmatic interventions that may have had an impact.
4 Paper reports that none of the measures of service delivery was significantly associated with modern method use of contraceptives among women living in rural areas.
**Author(s):** P. Whyte  
**Date:** 2013-03-20  
**Question:** Should community-based approach be used in a rural population?  
**Settings:** Pakistan  

**Bibliography:**

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<td>1</td>
<td>observational studies</td>
<td>serious</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
</tr>
</tbody>
</table>

1 Sultan et al., 2002  
2 Retrospective review of survey data.  
3 Retrospective review of data therefore limiting ability to link causal factors.  
4 Adjusted odds ratio indicating that women living within 5km of two community-based workers were significantly more likely to be using a modern contraceptive method compared to those with no access to community workers.
**Recommendation 3.4 Displaced populations**

**Author(s):** P. Whyte  
**Date:** 2013-03-28  
**Question:** Should community-based providers in emergency setting be used in refugee population?  
**Settings:** eastern Burma  
**Bibliography:**

<table>
<thead>
<tr>
<th>No of studies</th>
<th>Design</th>
<th>Risk of bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
<th>No of patients</th>
<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>observational studies</td>
<td>no serious risk of bias</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>none</td>
<td>Community-based providers in emergency setting</td>
<td>1070/2377 (45%)$^2$</td>
<td>prevalence rate ratio 1.88 (1.63 to 2.17)$^3$</td>
<td>-</td>
<td>@@@O LOW</td>
</tr>
</tbody>
</table>

1 Mullany et al., 2010  
2 This is the proportion using modern contraception at endpoint. The proportion using modern contraception at baseline was 23.9%.  
3 Comparing baseline and endpoint.
**Recommendation 3.5 Integration with HIV**

**Author(s):** P. Whyte  
**Date:** 2013-03-05  
**Question:** Should integration of HIV/AIDS services with maternal, neonatal and child health, nutrition and family planning services be used for maternal and child mortality and control HIV/AIDS epidemic?  
**Settings:** All countries  
**Bibliography:** Lindegren et al., 2012

<table>
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<th>Quality assessment</th>
<th>No of patients</th>
<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
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<td>No of studies</td>
<td>Design</td>
<td>Risk of bias</td>
<td>Inconsistency</td>
<td>Indirectness</td>
</tr>
<tr>
<td><strong>Uptake of contraception (Ethiopia)</strong></td>
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<tr>
<td>11,4</td>
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<td>no serious inconsistency</td>
<td>no serious indirectness</td>
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<td>11,7</td>
<td>observational studies</td>
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<td>no serious inconsistency</td>
<td>no serious indirectness</td>
</tr>
<tr>
<td><strong>Uptake of contraception (Malawi; HIV positive women)</strong></td>
<td></td>
<td></td>
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<tr>
<td>11,9</td>
<td>observational studies</td>
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<td>no serious inconsistency</td>
<td>no serious indirectness</td>
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<tr>
<td><strong>Couple unit of protection (CYP) calculated by dividing the total quantity uptake of each FP commodity by duration of protection provided, assuming an average of 10 acts per month (Nigeria)</strong></td>
<td></td>
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<tr>
<td>11,12</td>
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<td>no serious inconsistency</td>
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<tr>
<td><strong>Uptake of contraception (Kenya)</strong></td>
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<td>11,14</td>
<td>observational studies</td>
<td>very serious</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
</tr>
<tr>
<td><strong>Uptake of contraception (Tanzania)</strong></td>
<td></td>
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<td>11,17</td>
<td>observational studies</td>
<td>very serious</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
</tr>
</tbody>
</table>
This is the health problem identified in the systematic review. The review question this was contained under for the Guidance was “Are there interventions which, compared to baseline care (no intervention), are effective at improving equitable access to FP information and services for users or potential users”. The specific research question was “Is there evidence that integration with HIV services improves accessibility of FP services?”.

The Lindegren et al (2012) review included high, middle and low income countries as defined by the World Bank. The studies which reported on contraceptive use were conducted in low and middle income countries.

The Lindegren et al (2012) review stated that seven studies (of the 19 in the review) reported on contraceptive use. Given that the review did not include any data from the studies and instead just stated that “All seven studies that reported on contraceptive use showed positive results, with an increase in family planning use (both condom and non-condom methods) reported” this GRADE table will report each of the available studies separately. Two of the cited studies (Brou et al., 2009 and King et al., 1995) were not available and as there were no results provided in the Lindegren review, results are not presented.

Bradley et al., 2009
High risk of selection bias, lack of blinding therefore high risk of performance bias, all outcomes were self-reported, therefore high risk of reporting bias.
This is men and women combined who reported use of contraception post-intervention. The paper indicates this was a significant increase from pre-intervention, where usage was 0.1% for women and 0.8% for men.
Gillespie et al., 2009
This was the proportion of women in current sexual unions who were using contraception.
Hoffman et al., 2008
Small sample size with n=227.
Ngure et al., 2009
High risk of selection bias, lack of blinding with unclear risk of performance bias, and high risk of other bias as HIV positive women had greater visit frequency and greater contraception uptake than HIV negative women.
This OR is based on comparison of proportion of visits where non-condom contraceptive use was reported, for HIV-positive women. For HIV-negative women the OR=2.2 (95% CI: 1.4, 3.5).
Rasch et al., 2006
Adjusted OR (influence of age, marital situation, previous birth and occupation) based on comparison with those who refused HIV test (97/299; 32.9%).

Gillespie et al., 2009
This was the proportion of women in current sexual unions who were using contraception.
Hoffman et al., 2008
Small sample size with n=227.
Ngure et al., 2009
High risk of selection bias, lack of blinding with unclear risk of performance bias, and high risk of other bias as HIV positive women had greater visit frequency and greater contraception uptake than HIV negative women.
This OR is based on comparison of proportion of visits where non-condom contraceptive use was reported, for HIV-positive women. For HIV-negative women the OR=2.2 (95% CI: 1.4, 3.5).
Rasch et al., 2006
Adjusted OR (influence of age, marital situation, previous birth and occupation) based on comparison with those who refused HIV test (97/299; 32.9%).
Recommendation 3.6 Integration postpartum

Author(s): P. Whyte  
Date: 2013-03-13  
Question: Should education for contraceptive use by women postpartum be used in women following childbirth?²

Settings: US and four other countries³

Bibliography: Lopez et al., 2012

<table>
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<tr>
<th>No of studies</th>
<th>Design</th>
<th>Risk of bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
<th>No of patients</th>
<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
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<tr>
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<tr>
<td>1²</td>
<td>randomised trials</td>
<td>serious¹</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>serious²</td>
<td>none</td>
<td>170/299 (56.9%)²</td>
<td>19/301 (6.3%)³</td>
<td>-</td>
<td>63 fewer per 1000 (from 63 fewer to 63 fewer)</td>
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<tr>
<td>contraceptive use postpartum</td>
<td></td>
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<tr>
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<td>randomised trials</td>
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<td>no serious inconsistency</td>
<td>no serious indirectness</td>
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<td>117/276 (42.4%)¹⁰</td>
<td>118/291 (40.5%)</td>
<td>-</td>
<td>405 fewer per 1000 (from 405 fewer to 405 fewer)</td>
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<tr>
<td>1²</td>
<td>randomised trials</td>
<td>serious¹²</td>
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<td>no serious indirectness</td>
<td>no serious imprecision</td>
<td>none</td>
<td>-</td>
<td>-</td>
<td>OR 1.62 (1.06 to 2.50)¹³</td>
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</tr>
<tr>
<td>1³</td>
<td>randomised trials</td>
<td>serious¹⁰</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>serious¹⁰</td>
<td>none</td>
<td>53/62 (85.5%)</td>
<td>40/62 (64.5%)</td>
<td>RR 1.33 (1.07 to 1.64)</td>
<td>LOW</td>
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<tr>
<td>contraceptive use postpartum (assessed with: questionnaire and collection of pill packs)</td>
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<tr>
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<td>randomised trials</td>
<td>serious¹⁰</td>
<td>no serious inconsistency</td>
<td>no serious indirectness</td>
<td>serious¹⁰</td>
<td>none</td>
<td>4/16 (25%)</td>
<td>3/9 (33.3%)¹⁰</td>
<td>-</td>
<td>333 fewer per 1000 (from 333 fewer to 333 fewer)</td>
</tr>
</tbody>
</table>
The Lopez et al (2012) review states that of the ten included studies only five had contraceptive use as an outcome. The review did not provide any pooled analyses of the available studies. Consequently, each study is presented individually here.

Five of the studies in the Lopez et al (2012) review focused on adolescents and one on young women, the remainder did not have age limits. Of the studies focusing on adolescents, only two had contraceptive use as an outcome.

There were ten studies included in the Lopez et al (2012) review, six conducted in the USA, one in each of Australia, Nepal, Pakistan and Syria.

Saeed et al., 2008. Intervention was contraceptive counselling following birth plus an educational leaflet. No information was provided regarding allocation concealment.

Intervention consisted of one 20 minute informal counselling session and a one page pamphlet on contraceptive methods. The Lopez et al (2012) review downgraded the study due to low intervention quality.

An additional 129 (43.1%) indicated they would start using contraception in the next 6 months.

Intervention consisted of one 20 minute informal counselling session and a one page pamphlet on contraceptive methods. The Lopez et al (2012) review downgraded the study due to low intervention quality.

An additional 153 (50.8%) indicated they would start using contraception in the next 6 months.

Bashour et al., 2008. Intervention was either 4 post-natal home visits or one post-natal home visit.

There were two intervention groups in this trial. The first, with 4 intervention visits had 42.2% of subjects using contraception. The second group, with one intervention visit, had 37% (107/289) using contraception.

Saeed et al., 2008. Intervention was contraceptive counselling following birth plus an educational leaflet. No information was provided regarding allocation concealment.

Subjects and health educators were not blinded. There was also a high loss to follow-up, with 25% lost to follow-up at 3 months and 27% at 6 months.

There were three experimental and one control group in this study. The three experimental groups received either health education immediately after birth and 3 months postpartum (group A), health education at birth only (group B), health education at 3 months (group C). The control group (group D) received no health education. The paper compared groups A and B combined to groups C and D combined and that is the odds ratio presented here. No proportions of patients in each group using contraception can be presented in GRADE because the paper did not provide the number assessed in each group, only the overall N assessed. The paper also compared groups A and C versus groups B and D. This produced an OR of 0.86 (95% CI: 0.58, 1.35) for the comparison of contraceptive use at 6 months. There were no comparisons of the experimental groups versus the control group alone.

Bolam et al., 1998. intervention included structured baseline household questionnaire, one-to-one health education at birth and 3 months later.

There were three experimental and one control group in this study. The three experimental groups received either health education immediately after birth and 3 months postpartum (group A), health education at birth only (group B), health education at 3 months (group C). The control group (group D) received no health education. The paper compared groups A and B combined to groups C and D combined and that is the odds ratio presented here. No proportions of patients in each group using contraception can be presented in GRADE because the paper did not provide the number assessed in each group, only the overall N assessed. The paper also compared groups A and C versus groups B and D. This produced an OR of 0.86 (95% CI: 0.58, 1.35) for the comparison of contraceptive use at 6 months. There were no comparisons of the experimental groups versus the control group alone.

Quinlivan et al., 2003. Intervention was five structured post-natal home visits by nurse midwives.

Unclear risk for performance bias and detection bias given no information was provided in regard to blinding.

Small N with 139 enrolled and 124 assessed.

Gilliam et al., 2004. Intervention consisted of counselling, a videotape about oral contraceptives and written material.

Unclear risk of performance bias and detection bias due to lack of information regarding blinding.

Small n with only 33 randomised and 52% had dropped out at one year follow-up.

These are proportions of women still using oral contraceptives at one year. Another 8 had switched to other methods of contraception. The paper provides the Ns but the percentages reported in the paper are based on the total number of subjects (n=25) instead of by group, as calculated by GRADE.

These are proportions of women still using oral contraceptives at one year. Another 3 had switched to other methods of contraception. The paper provides the Ns but the percentages reported in the paper are based on the total number of subjects (n=25) instead of by group, as calculated by GRADE.
Recommendation 3.7 Integration with post abortion and abortion services

Author(s): P. Whyte
Date: 2013-03-05
Question: Should post-abortion family planning counselling be used for women in low-income countries?

Settings: low-income countries

Bibliography: Tripney et al., 2013 (The Tripney review does not offer any pooled results nor does it provide adequate detail to enter any relevant results into GRADE. Therefore the individual studies were used)

<table>
<thead>
<tr>
<th>Quality assessment</th>
<th>No of patients</th>
<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
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<td>Design</td>
<td>Risk of bias</td>
<td>Inconsistency</td>
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</tr>
<tr>
<td>repeat unplanned pregnancy - modern contraception</td>
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<td>observational studies</td>
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</tr>
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<td>acceptance and/or use of contraceptive methods (assessed with: interview)</td>
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<td>observational studies</td>
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<td>observational studies</td>
<td>very serious⁴</td>
<td>no serious inconsistency</td>
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<td>acceptance and/or use of contraceptive methods (assessed with: interview)</td>
<td>1⁷,²⁴</td>
<td>observational studies</td>
<td>very serious⁴</td>
<td>no serious inconsistency</td>
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<td>Effect</td>
<td>Quality</td>
<td>Importance</td>
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</tr>
<tr>
<td>Post-abortion family planning counselling</td>
<td>Control</td>
<td>Relative (95% CI)</td>
<td>Absolute</td>
<td></td>
</tr>
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<td>0%</td>
<td>-</td>
<td></td>
<td>VERY LOW</td>
</tr>
<tr>
<td>acceptance and/or use of contraceptive methods (assessed with: review of procedure logbooks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 17 | observational studies | no serious risk of bias | no serious inconsistency | no serious indirectness | no serious imprecision | none | 3492/4462 (78.3%)
| | | | | | | 0% | - | - | @@@@ LOW | IMPORTANT |
| acceptance and/or use of contraceptive methods (assessed with: interview) | | | | |
| 19 | observational studies | serious | no serious inconsistency | no serious indirectness | no serious imprecision | none | 271/315 (86%)
| | | | | | | 0% | - | - | @@@@@ VERY LOW | IMPORTANT |
| acceptance and/or use of contraceptive methods (assessed with: interview with physicians, 'perusal' of client records, interview with patients) | | | | |
| 19 | observational studies | very serious | no serious inconsistency | no serious indirectness | no serious imprecision | none | - |
| | | | | | | 0% | - | - | @@@@@ VERY LOW | IMPORTANT |
| acceptance and/or use of contraceptive methods | | | | |
| 14 | observational studies | very serious | no serious inconsistency | no serious indirectness | no serious imprecision | none | - |
| | | | | | | 0% | - | - | @@@@@ VERY LOW | IMPORTANT |
| acceptance and/or use of contraceptive methods (assessed with: interview) | | | | |
| 17,28 | observational studies | | none | - | - | - | - | @@@@@ VERY LOW | IMPORTANT |
| acceptance and/or use of contraceptive methods | | | | |
| 17 | observational studies | very serious | no serious inconsistency | no serious indirectness | no serious imprecision | none | 487/524 (92.9%)
| | | | | | | 0% | - | - | @@@@@ VERY LOW | IMPORTANT |
| acceptance and/or use of contraceptive methods (assessed with: interview) | | | | |
| 12 | observational studies | very serious | no serious inconsistency | no serious indirectness | no serious imprecision | none | 495/521 (95%)
| | | | | | | 0% | - | - | @@@@@ VERY LOW | IMPORTANT |

1 There are 3 identified papers that do not provide any relevant information and cannot be entered into GRADE given the characteristics of the papers. McLaurin et al., 1995 is a paper which describes issues around post-abortion care and lists a number of recommendations made by a working group regarding private and public abortion services. There are no interventions described in this paper, nor any subjects, nor any results. The Maila et al (1997) paper describes post abortion care instituted in Nepal in 1995 and states that acceptance of family planning has been high, at 70%. There is no indication of the number of patients involved. The paper also stated that family planning "generally has involved counselling of both husband and wife", but it also states that counselling was provided to all patients. The Postabortion family planning November 2012 paper describes aspects of a number of programs and summarises the proportion of women receiving contraception before and after family planning services were 'strengthened' across countries. Entering these results into GRADE is not possible.

2 Johnson et al., 2002
Study only included women who wanted to postpone their next pregnancy for at least two years. This would suggest potential for increased interest or use of family planning. 

For most outcomes the number of events was less than 300 (GRADE threshold rule of thumb value).

Calculated by GRADE - no relative or absolute effects provided in the paper.

Ministry of Health Burkina Faso 1988

There is no indication the patients interviewed before and after the intervention are the same - the paper reports 300 patients were interviewed prior to the intervention and 456 after the intervention.

There was no control group in this study, hence no results. The paper did not provide any relative or absolute effects for the pre- and post-intervention differences - only the proportion using a family planning method was reported.

Ferreira et al., 2011

Total N less than 300.

Diaz et al.

No results from this study can be entered into GRADE. The paper provides only the average number of women seen for post-abortion complications at 3 hospitals and then provides the percentage accepting contraception at 3 different time points by type of contraception (percentages range from 4.3% to 39.0%). GRADE requires that numerators and dominators are entered, the percentage alone cannot be entered. The Ns in this study cannot be determined from the information provided in the paper.

Observational study involving program instituted at 3 hospitals. There appears to be some inconsistency between the actual programs at each hospital and the authors mention repeatedly differing levels of 'acceptance' in the different areas.

Mahomed et al., 1997

There is potential for bias given that the N does not seem to be consistent - there are more patients presented post-intervention than prior to intervention. In addition, there is no control group.

There is no control group, and no relative or absolute effects in regard to before-after intervention differences were provided.

Otsea et al., 2011

There is no comparator group and no relative or absolute difference relative to pre and post-program differences.

Rasch et al., 2004

The study does not account for patients lost to follow-up; follow-up time varied from one to six months.

There is no control group; study does not provide any assessment of relative or absolute effects, just the percentages.

Rogo et al., 1998

No indication of how many physicians actually participated. Only result provided in terms of contraceptive acceptance or use was that between 12.5% and 100% of clients left the facility with a family planning method. No details on type of method or whether it was actually used was provided.

Solo et al., 1999

Study used three different family planning models, ie who delivered and where the family planning services were delivered varied. The only results relative to use of contraceptives was the proportion of patients who left the hospital with a contraceptive method, which was identified as 82% for model 1 (FP services provided on gynecological ward by staff), 63% for model 2 (FP services provided on gynecological ward by maternal and child health staff) and 75% for model 3 (FP services provided in maternal and family planning clinic by staff). Ns of patients in each model, either exposed to it or providing results, are not provided. Commencement of programs varied across models and sites as well.

Number of patients using the different models is unknown.

Thapa et al., 2004

This study assessed manual vacuum aspiration (MVA) services in Nepal, comparing them to abortion services offered in the main operation theatre. As such, it does not directly address post-abortion family planning counselling, although patients received some counselling. It does provide the proportion of MVA patients using contraceptives at 6 weeks following abortion, which was 53.5%. The paper indicates this was on the basis of 85 subjects. The paper states that 529 cases were treated in the MVA unit, and the n=85 represents only 16% of patients. The paper states that 83.6% of the MVA group appeared for the 6 week follow-up, so the disparity in Ns is not clear.

Rasch et al., 2005

It appears that slightly different counselling programs were offered across hospitals. There is no comparison with use of contraception prior to counselling for the women included, therefore it is difficult to assess impact of the program.

This percentage was for women in urban Tanzania. The results for rural Tanzania were 172 of 242 women being provided with a contraceptive method (71%).

Rasch et al., 2007

There is high risk of bias given the observational nature of the study and the lack of any comparison to use of contraception prior to counselling.

95% left the hospital ward with a contraceptive method. The female condom was accepted by 201 of 521 women (39%) and used by 158 of 521 (30%).
Recommendation 3.8 Mobile services

Author(s): P. Whyte
Date: 2013-04-10
Question: Should mobile outreach service delivery be used in women?
Settings: Pakistan
Bibliography:

<table>
<thead>
<tr>
<th>No of studies</th>
<th>Design</th>
<th>Risk of bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
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<th>No of patients</th>
<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
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<tr>
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</tr>
<tr>
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<td>no serious indirectness</td>
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<td></td>
<td>-</td>
<td>0%</td>
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</tbody>
</table>

1 Azmat et al., 2013
2 Interviews were retrospective in nature and therefore recall bias may occur; also data was self-reported.
3 19.4% discontinued IUD use at 10 months (95% CI: 16.3, 22.5).

Author(s): P. Whyte
Date: 2013-04-10
Question: Should mobile outreach service be used in women fitted with IUDs and implants?
Settings: Ethiopia, Myanmar, Pakistan, Sierra Leone, Vietnam
Bibliography:

<table>
<thead>
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<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
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<td></td>
<td>-</td>
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</tr>
</tbody>
</table>

1 Eva and Ngo 2010
2 Percentage discontinuing at 8 months was: for implant: 5.7% in Ethiopia and 6.2% in Sierra Leone; for IUD: 16.9% in Sierra Leone, 20.9% in Myanmar, 18.9% in Pakistan and 2.3% in Viet Nam.
### Author(s): P. Whyte
### Date: 2013-04-10
### Question: Should mobile outreach service for IUD be used in women?
### Settings: Philippines
### Bibliography:

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</table>

1 Ngo and Pernito 2010
2 Retrospective review of data.
One year discontinuation rates of IUD among mobile clinic users

### Author(s): P. Whyte
### Date: 2013-03-20
### Question: Should community-based approach be used in a rural population?
### Settings: Pakistan
### Bibliography:

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<tr>
<td>use of modern reversible method of contraception (assessed with: survey)</td>
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<td></td>
<td></td>
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<td>1 observational studies</td>
<td>serious</td>
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<td>no serious indirectness</td>
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</tr>
</tbody>
</table>

1 Sultan et al., 2002
2 Retrospective review of survey data.
3 Retrospective review of data therefore limiting ability to link causal factors.
4 Adjusted odds ratio indicating that women living within 5km of two community-based workers were significantly more likely to be using a modern contraceptive method compared to those with no access to community workers
**Recommendation 3.9 Elimination of third party authorization**
Based on human rights standards (Annex E), no health evidence search

**Recommendation 3.10 Elimination of parental notification**
Based on human rights standards (Annex E), no health evidence search

### 4. ACCEPTABILITY

**Recommendation 4.1 Counselling interventions**

**Author(s):** P. Whyte  
**Date:** 2013-04-11  
**Question:** Should self-assessment and/or peer review of providers vs no self-assessment or peer review be used in service providers?  
**Settings:** Indonesia  
**Bibliography:**

<table>
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<th>Inconsistency</th>
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<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
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<td>clients' rating of satisfaction</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No self assessment or peer review</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Relative (95% CI)</td>
<td></td>
<td></td>
<td>Absolute</td>
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<td></td>
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</tr>
</tbody>
</table>

1 Kim et al., 2000  
2 Authors note that quality improvements cannot be related to outcome behaviours such as continued contraceptive use.  
3 Paper reports that in the self-assessment intervention group there were significant increases in client satisfaction with provider attentiveness (4.3 to 4.4) and with needs met (4.1 to 4.3) on a non validated scale. The paper does not provide any statistical results supporting the claim of ‘significant increases’.
Author(s): P. Whyte  
Date: 2013-04-11  
Question: Should balanced counselling strategy be used in physicians and social workers?  
Settings: Guatemala  
Bibliography:

<table>
<thead>
<tr>
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<th>No of patients</th>
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<td>Balanced counselling strategy</td>
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<td>Absolute</td>
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<th>Risk of bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
<th>Improvements with clinic services</th>
<th>No intervention</th>
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<th>Absolute</th>
<th>Quality</th>
<th>Importance</th>
</tr>
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<td>-</td>
<td>0%</td>
<td>LOW</td>
<td>IMPORTANT</td>
</tr>
</tbody>
</table>

1 Leon et al., 2003  
2 The paper provided only graphs with use rates and values could not be ascertained. The paper stated that family planning use rates were inconsistent with the hypothesis of the study - that continuation in family planning would increase following improvements in quality of care. Instead, use of family planning appeared to decrease.

Author(s): P. Whyte  
Date: 2013-04-11  
Question: Should improvement of client-provider interactions vs no intervention be used in women?  
Settings: Egypt  
Bibliography:

<table>
<thead>
<tr>
<th>Quality assessment</th>
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<th>Effect</th>
<th>Quality</th>
<th>Importance</th>
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</thead>
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<td>Absolute</td>
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<th>Indirectness</th>
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</table>

1 Nawar et al., 2004  
2 Risk of attrition bias as slightly less than half of women returned to clinics at follow-up visits.  
3 Paper reports that at 7 month follow-up 72% in the intervention group were satisfied with clinic services compared to 55% in control group. At 13 month follow-up, 81% in intervention group and 61% in control group were satisfied.
**Quality assessment**

<table>
<thead>
<tr>
<th>No of studies</th>
<th>Design</th>
<th>Risk of bias</th>
<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
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<td>30/47 (63.8%)</td>
<td>16/47 (34%)</td>
<td>-</td>
<td>340 fewer per 1000 (from 340 fewer to 340 fewer)</td>
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</tr>
</tbody>
</table>

1 Additional communication skills training program in addition to regular education.
2 Yazdi et al., 2008
3 Authors state that outcome assessment in regard to client satisfaction is limited given a wide range of questionnaires was not used.
4 Number of clients (n=47) in both intervention and control groups) is small.

**Recommendation 4.2 Follow-up**

Based on human rights standards (Annex D), no health evidence search
## 5. QUALITY

**Recommendation 5.1 Quality assurance processes**

**Author(s):** P. Whyte  
**Date:** 2013-04-11  
**Question:** Should national adolescent friendly clinic initiative vs control clinics be used in adolescents?[^1]  
**Settings:** South Africa  
**Bibliography:**

<table>
<thead>
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<th>Effect</th>
<th>Quality</th>
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<td><strong>Design</strong></td>
<td><strong>Risk of bias</strong></td>
<td><strong>Inconsistency</strong></td>
<td><strong>Indirectness</strong></td>
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</table>

[^1]: The national adolescent friendly clinic initiative (NAFCI) was based on a quality triangle including defining quality, improving quality and measuring quality. Quality was defined as standards of adolescent friendly services and the standards and criteria were developed on the basis of established characteristics and attributes of adolescent-friendly services. Measuring quality was done using a self-audit process and external assessment. Improving quality included forming teams in each clinic, with externally trained facilitators to support the team.

[^2]: Dickson et al., 2007

[^3]: Paper notes risk of selection bias, lack of statistical power due to small number of clinics (11 experimental, 11 control) and lack of adolescent clients at some clinics (simulations were performed instead of actual client-provider interactions).

[^4]: The paper reports that the average clinic score of all experimental clinics was 79.9% compared to the control group clinics at 60.9% (p=0.005).
**Author(s):** P. Whyte  
**Date:** 2013-04-11  
**Question:** Should improvement of client-provider interactions vs no intervention be used in women?  
**Settings:** Egypt  
**Bibliography:**

<table>
<thead>
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<th>Quality assessment</th>
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<th>Effect</th>
<th>Quality</th>
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<td>Improvment of client-provider interactions</td>
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<td>Absoute</td>
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</tr>
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<td>No intervention</td>
<td>Relative (95% CI)</td>
<td>Absoute</td>
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<tr>
<td>Satisfaction with clinic services</td>
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<th>Inconsistency</th>
<th>Indirectness</th>
<th>Imprecision</th>
<th>Other considerations</th>
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<td>-</td>
<td>-</td>
<td>-</td>
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<td>IMPORTANT</td>
</tr>
</tbody>
</table>

| | | | | | | | | | | | | |

¹ Nawar et al., 2004  
² Risk of attrition bias as slightly less than half of women returned to clinics at follow-up visits.  
³ Paper reports that at 7 month follow-up 72% in the intervention group were satisfied with clinic services compared to 55% in control group. At 13 month follow-up, 81% in intervention group and 61% in control group were satisfied.

**Recommendation 5.2 Management of Long acting contraceptives**  
Based on human rights standards (Annex E), no health evidence search

**Recommendation 5.3 Provider training**  
Based on human rights standards (Annex E), no health evidence search

**6. INFORMED DECISION MAKING**  
Recommendations 6.1 and 6.2 are based on human rights standards (Annex D). No health evidence search conducted.

**7. PRIVACY AND CONFIDENTIALITY**  
Recommendations 7.1 is based on human rights standards (Annex D). No health evidence search conducted.
8. PARTICIPATION

Recommendation 8.1

Author(s): P. Whyte  
Date: 2013-03-10  
Question: Should local initiatives program be used in residents of northern India?  
Settings: India

<table>
<thead>
<tr>
<th>Quality assessment</th>
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<td>no serious indirectness</td>
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</table>

1 The study assessed local initiatives programs in three areas in India - the slums of Kolkata, Punjab and Himachal Pradesh and Uttarakhal.

2 The proportions using contraception at baseline and at the end of the programs were presented. The paper states that all three locations in the study ended the project with contraceptive use near or above 60%. The paper provides no numbers indicating how many individuals made up the result proportions. The paper also states that this usage of contraception represents a 78% increase in contraceptive use on average. It is not clear how this increase was calculated.

3 Paxman et al., 2005

4 The baseline measures in this study were taken 3 months after the programs had commenced. The methods used across the three locations of the study varied, limiting the ability to combine results.
**Author(s):** P. Whyte  
**Date:** 2013-03-10  
**Question:** Should empowerment of female community health volunteers be used in married women of reproductive age?  
**Settings:** Nepal  
**Bibliography:**

<table>
<thead>
<tr>
<th>No of studies</th>
<th>Design</th>
<th>Risk of bias</th>
<th>Inconsistency</th>
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<th>Imprecision</th>
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<td>188/241 (78%)&lt;sup&gt;3&lt;/sup&gt;</td>
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<td>-</td>
<td>-</td>
<td>⚫⚫⚫⚫</td>
<td>VERY LOW</td>
<td>IMPORTANT</td>
</tr>
</tbody>
</table>

<sup>1</sup> Shrestha 2002  
<sup>2</sup> Sample size assessed was small with n=241.  
<sup>3</sup> This represented a significant increase over baseline, when none of the subjects used contraception.
9. ACCOUNTABILITY

Recommendation 9.1 and 9.2 are based on human rights standards (Annex D).
An evidence search on performance based financing resulted in one low quality study. The need for research on the effectiveness of performance based financing’s impact on contraceptive availability and human rights was noted.

Author(s): P. Whyte
Date: 2013-04-11
Question: Should financing to a for-profit company to provide family planning services be used?
Settings: Kenya
Bibliography:

<table>
<thead>
<tr>
<th>No of studies</th>
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</table>

1 Chee et al., 2003
2 Cost-effectiveness analysis.
3 The number of family planning clients was 2846 between 1995 and 2000. This included 449 who were new family planning acceptors and 2397 who were previous users. The paper did not assess contraceptive use - focus was on cost-effectiveness. Using the outcome of couple years of protection (CYP) the analysis indicated that the intervention would produce family planning outcomes at no or low cost ($0.00 to $4.11). The cost per new acceptor ranged from $0.00 to $17.95. the paper concludes that providing financing to a for-profit company to provide family planning services can be a cost-effective way to increase new family planning acceptors.
### Annex D Health and human rights standards

<table>
<thead>
<tr>
<th>Human Right</th>
<th>Recommendations to States Relevant to Family Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Right to Consent to Marriage and to Equality in Marriage</td>
<td>Ensure the right to “freely to choose a spouse and to enter into marriage only with their free and full consent” (1). Remove any requirements for spousal consent in order to access family planning services (2).</td>
</tr>
</tbody>
</table>
| The Right to Education | • “Family planning services should be situated within comprehensive sexual and reproductive health services and should encompass sexuality education, including counselling” (3).  
• Ensure women’s rights “to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” (4).  
• Provide “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning” (5). |
| The Right to Equality and Non-Discrimination | • Take “all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning” (6).  
• Ensure that states “take all appropriate measures to eliminate discrimination against disadvantaged women regarding access to health care, including family planning information, counselling, and services” (7).  
• Ensure that states “report on measures taken to eliminate barriers that women face in gaining access to health care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women’s access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport” (8).  
• “Ensure access to quality health care services” [including family planning], for all women, including adolescent girls, which are delivered in a way that “ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality, and is sensitive to her needs and perspectives” (9).  
• Ensure “the equal participation of women and men in all areas of household responsibilities, including family planning”… “should be promoted and encouraged by governments” (10). |
<p>| The Right to Health | • “Develop and implement programmes that provide access to sexual and reproductive health information and services, including for adolescents” (11). |</p>
<table>
<thead>
<tr>
<th>Human Right</th>
<th>Recommendations to States Relevant to Family Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Right</td>
<td>Recommendations to States Relevant to Family Planning</td>
</tr>
</tbody>
</table>
| The Right to Information and Freedom of Expression              | • “Ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods in order to exercise free and informed choice” (15).  
• Provide accessible, comprehensive information on family planning to make options clear to individuals… “In order to make an informed decision about safe and reliable contraceptive measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services, as provided in article 10 (h) of the Convention” (16). |
| The Right to Liberty and Security of Person                      | • Ensure that “no one shall be subjected to arbitrary or unlawful interference with privacy, family, home or correspondence”, [including in decisions relating to family planning] (17).  
• Ensure “no one shall be subjected… to unlawful attacks on his honour and reputation” [for any decisions pertaining to family planning] (18).                                                                                                                                                                                                 |
| The Right to Life                                                | • Ensure “the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance” (19).                                                                                                                                                                                                 |
| The Right Not to be Subjected to Torture or Other Cruel, Inhuman, or Degrading Treatment or Punishment                | • “Ensure that measures are taken to prevent coercion in regard to fertility and reproduction” (20).  
• Ensure the “right to make decisions concerning reproduction” [including family planning] free of discrimination, coercion and violence, as expressed in human rights documents” (21).                                                                                                                                                                                                       |
<p>| The Right to Participate in the Conduct of Public Affairs and the Right to                                          | • Ensure free, active and informed participation of individuals in decision-making related to family planning … “Reproductive health care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization, and evaluation of services” (22).                                                                                                                                         |</p>
<table>
<thead>
<tr>
<th>Human Right</th>
<th>Recommendations to States Relevant to Family Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free, Active and Meaningful Participation</td>
<td>• Ensure that “special efforts [are] made to emphasize men’s shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning…” (23)</td>
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| The Right to Privacy                                                      | • Ensure that “accessibility of information [will] not impair the right to have personal health data treated with confidentiality” [including information pertaining to family planning] (24).  
  • Ensure that “all health facilities, goods and services [including family planning] are “designed to respect confidentiality and improve the health status of those concerned” (25).  
  • “The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services” (26). |
| The Right to Decide the Number and Spacing of Children                   | • Ensure the “same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights” (27).  
  • Ensure that “Compulsory sterilization or abortion” [pertaining to family planning does not occur as it] “adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children” (28).  
  • Ensure that “decisions to have children or not, while preferably made in consultation with spouse or partner, must not” …“be limited by spouse, parent, partner or Government” (29). |
| The Right to be Free from Practices that Harm Women and Girls            | • “Ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalized groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence” (30). |
| The Right to be Free from Violence                                        | • Ensure that states “take appropriate and effective measures to overcome all forms of gender-based violence,” [including sexual violence and all other forms of violence pertaining to family planning] (31).  
  • Ensure “the enactment and effective enforcement of laws and the formulation of policies, including health care protocols” [and family planning programs] “to address violence against women and abuse of girl children and the provision of appropriate health services” (32).  
  • “Undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights” (33). |


28. See reference 19

29. See reference 27


