



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

Annexes

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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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Full intervention package	Partial intervention package	Relative (95% CI)	Absolute		
contraceptive experience of clients												
1 ¹	observational studies	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision ³	none	- ⁴	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

¹ Okuello 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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Theory-based multi-component educational program	Control	Relative (95% CI)	Absolute		
use of condoms at last intercourse (assessed with: survey)												
1 ¹	randomised trials	very serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.68 (1.02 to 2.76) ³	-	⊕⊕⊕⊕	IMPORTANT
							0%			-	LOW	

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.

Author(s): P. Whyte

Date: 2013-04-10

Question: Should curriculum based on social cognitive theory and social inoculation theory be used in school students grade 6 to 9?

Settings: USA - California

Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Curriculum based on social cognitive theory and social inoculation theory	Control	Relative (95% CI)	Absolute		
condom use at last intercourse (assessed with: survey)												
1 ¹	randomised trials	very serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	-	-	⊕⊕○○	IMPORTANT
								0%		-	LOW	

¹ Coyle et al., 2004

² 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.

Author(s): P. Whyte

Date: 2013-04-10

Question: Should health belief model combined with social learning theory be used in adolescents aged 13-19 years?¹

Settings: USA - California and Texas

Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Health belief model combined with social learning theory	Control	Relative (95% CI)	Absolute		
contraceptive efficiency (weighted composite index intended to assess consistency with which teenagers used effective methods before and after the intervention) (assessed with: interview)												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	serious ⁴	none	- ⁵	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		
use of an effective contraceptive at most recent intercourse (assessed with: interview)												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	serious ⁴	none	- ⁶	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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.

Author(s): P. Whyte

Date: 2013-04-10

Question: Should peer-led sex education vs teacher-led sex education be used in high school students?

Settings: UK

Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Peer-led sex education	Teacher-led sex education	Relative (95% CI)	Absolute		
used contraception at first sex - females (assessed with: questionnaire)												
1 ¹	randomised trials	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 0.90 (0.73 to 1.11) ³	-	⊕⊕⊕○	IMPORTANT
								0%		-	MODERATE	
used contraception at first sex - males (assessed with: questionnaire)												
1 ¹	randomised trials	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.01 (0.68 to 1.49) ³	-	⊕⊕⊕○	IMPORTANT
								0%		-	MODERATE	

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.

Author(s): P. Whyte

Date: 2013-04-10

Question: Should peer-led sex education vs teacher-led sex education be used in high school students?

Settings: UK

Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Peer-led sex education	Teacher-led sex education	Relative (95% CI)	Absolute		
used any contraception at first sex - females (assessed with: questionnaire)												
1 ¹	randomised trials	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.07 (0.88 to 1.31) ³	-	⊕⊕⊕○	IMPORTANT
								0%		-	MODERATE	
used any contraception at first sex - males (assessed with: questionnaire)												
1 ¹	randomised trials	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.04 (0.65 to 1.68) ³	-	⊕⊕⊕○	IMPORTANT
								0%		-	MODERATE	
used any contraception at last sex - females (assessed with: questionnaire)												
1 ¹	randomised trials	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.57 (1.08 to 2.29) ³	-	⊕⊕⊕○	IMPORTANT
								0%		-	MODERATE	
used any contraception at last sex - males (assessed with: questionnaire)												
1 ¹	randomised trials	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 0.66 (0.31 to 1.39) ³	-	⊕⊕⊕○	IMPORTANT
								0%		-	MODERATE	

¹ Stephenson et al., 2008

² Some risk of bias given that outcomes were self-reported.

³ 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 GRADEVIEW.

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							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Contraceptive method of choice at no cost	Control	Relative (95% CI)	Absolute		
use of long-acting contraceptive method												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ⁴	-	-	-	VERY LOW	IMPORTANT
							0%					

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.

Author(s): P. Whyte

Date: 2013-04-10

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

Settings: China

Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	No intervention	Control	Relative (95% CI)	Absolute		
condom use during most recent sexual encounter (assessed with: survey)												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ⁴	-	-	-	VERY LOW	IMPORTANT
								0%		-		
provision of free condoms (assessed with: survey)												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.98 (1.08 to 3.61) ⁵	-	VERY LOW	IMPORTANT
								0%		-		

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.

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							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Contraceptive method of choice at no cost	Control	Relative (95% CI)	Absolute		
use of long-acting contraceptive method												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ⁴	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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

Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Lady health worker program	No program	Relative (95% CI)	Absolute		
use of modern reversible contraceptive method (assessed with: survey)												
1 ²	observational studies ³	serious ⁴	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.50 (1.04 to 2.16) ⁵	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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.

Author(s): P. Whyte

Date: 2013-03-20

Question: Should traditional medical practitioners to deliver family planning services be used in rural population?

Settings: Uttar Pradesh, Muzaffamagar District

Bibliography:

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		
use of contraceptive methods (assessed with: survey)												
1 ¹	observational studies	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	508/800 (63.5%) ³	413/850 (48.6%)	-	486 fewer per 1000 (from 486 fewer to 486 fewer)	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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.

Author(s): P. Whyte

Date: 2013-03-20

Question: Should delivery of improved services for health be used in rural population?

Settings: Uganda

Bibliography:

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		
current contraceptive use (assessed with: survey)												
1 ¹	observational studies ²	serious ³	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	- ⁴	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Community-based approach	Control	Relative (95% CI)	Absolute		
use of modern reversible method of contraception (assessed with: survey)												
1 ¹	observational studies ²	serious ³	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.74 (1.11 to 2.71) ⁴	-	⊕○○○ VERY LOW	MPORTANT
								0%		-		

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Community-based providers in emergency setting	Control	Relative (95% CI)	Absolute		
use of modern methods of contraception (assessed with: survey)												
1 ¹	observational studies	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	1070/2377 (45%) ²	-	prevalence rate ratio 1.88 (1.63 to 2.17) ³	-	⊕⊕⊕⊕ LOW	IMPORTANT
								0%		-		

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?¹

Settings: All countries²

Bibliography: Lindegren et al., 2012

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Integration of HIV/AIDS services with maternal, neonatal and child health, nutrition and family planning services	Control	Relative (95% CI)	Absolute		
uptake of contraception (Ethiopia)												
1 ^{3,4}	observational studies	very serious ⁵	no serious inconsistency	no serious indirectness	no serious imprecision	none	212/3374 (6.3%) ⁶	-	-	-	⊕000 VERY LOW	IMPORTANT
								0%		-		
uptake of contraception (Ethiopia)												
1 ^{3,7}	observational studies	very serious ⁵	no serious inconsistency	no serious indirectness	no serious imprecision	none	474/677 (70%) ^{6,8}	-	-	-	⊕000 VERY LOW	IMPORTANT
								0%		-		
uptake of contraception (Malawi; HIV positive women)												
1 ^{3,9}	observational studies	very serious ⁵	no serious inconsistency	no serious indirectness	serious ¹⁰	none	92/200 (46%) ^{5,11}	-	-	-	⊕000 VERY LOW	IMPORTANT
								0%		-		
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)												
1 ^{3,12}	observational studies	very serious ⁵	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ¹³	-	-	-	⊕000 VERY LOW	IMPORTANT
								0%		-		
uptake of contraception (Kenya)												
1 ^{3,14}	observational studies	very serious ¹⁵	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ⁶	-	OR 4.0 (3.0 to 5.3) ¹⁶	-	⊕000 VERY LOW	IMPORTANT
								0%		-		
uptake of contraception (Tanzania)												
1 ^{3,17}	observational studies	very serious ⁵	no serious inconsistency	no serious indirectness	no serious imprecision	none	172/407 (42.3%)	-	OR 1.23 (0.87 to 1.72) ¹⁸	-	⊕000 VERY LOW	IMPORTANT
								0%		-		

- ¹ 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?".
- ² 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.
- ³ 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.
- ⁴ Bradley et al., 2009
- ⁵ 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.
- ⁶ 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..
- ⁷ Gillespie et al., 2009
- ⁸ This was the proportion of women in current sexual unions who were using contraception.
- ⁹ Hoffman et al., 2008
- ¹⁰ Small sample size with n=227.
- ¹¹ The 46% is women using contraception at 1 month follow-up. At 1-week follow-up 52% were using contraception. The N of 200 accounts for those lost to follow-up and those who died during the study.
- ¹² Chabikuli et al., 2009
- ¹³ Paper reports mean monthly CYP of 38.2 following the intervention, compared to 32.3 prior to the intervention, a significant increase. these results are based on 44,589 people who attended FP clinics during the review period.
- ¹⁴ Ngure et al., 2009
- ¹⁵ 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.
- ¹⁶ 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).
- ¹⁷ Rasch et al., 2006
- ¹⁸ 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?^{1,2}

Settings: US and four other countries³

Bibliography: Lopez et al., 2012

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Education for contraceptive use by women postpartum	Control	Relative (95% CI)	Absolute		
contraceptive use postpartum (assessed with: interview)												
1 ⁴	randomised trials	serious ⁵	no serious inconsistency	no serious indirectness	serious ⁶	none	170/299 (56.9%) ⁷	19/301 (6.3%) ⁸	-	63 fewer per 1000 (from 63 fewer to 63 fewer)	⊕⊕○○ LOW	IMPORTANT
								0%		-		
contraceptive use postpartum												
1 ⁹	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	117/276 (42.4%) ¹⁰	118/291 (40.5%)	-	405 fewer per 1000 (from 405 fewer to 405 fewer)	⊕⊕⊕⊕ HIGH	IMPORTANT
								0%		-		
contraceptive use postpartum (assessed with: interview)												
1 ¹¹	randomised trials	serious ¹²	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.62 (1.06 to 2.50) ¹³	-	⊕⊕○○ MODERATE	IMPORTANT
								0%		-		
contraceptive use postpartum (assessed with: interview)												
1 ¹⁴	randomised trials	serious ¹⁵	no serious inconsistency	no serious indirectness	serious ¹⁶	none	53/62 (85.5%)	40/62 (64.5%)	RR 1.33 (1.07 to 1.64)	213 more per 1000 (from 45 more to 413 more)	⊕⊕○○ LOW	IMPORTANT
								0%		-		
contraceptive use postpartum (assessed with: questionnaire and collection of pill packs)												
1 ¹⁷	randomised trials	serious ¹⁸	no serious inconsistency	no serious indirectness	serious ¹⁹	none	4/16 (25%) ²⁰	3/9 (33.3%) ²¹	-	333 fewer per 1000 (from 333 fewer to 333 fewer)	⊕⊕○○ LOW	IMPORTANT
								0%		-		

- ¹ 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.
- ² 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.
- ³ 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.
- ⁴ Saeed et al., 2008. Intervention was contraceptive counselling following birth plus an educational leaflet.
- ⁵ No information was provided regarding allocation concealment.
- ⁶ 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.
- ⁷ An additional 129 (43.1%) indicated they would start using contraception in the next 6 months.
- ⁸ An additional 153 (50.8%) indicated they would start using contraception in the next 6 months.
- ⁹ Bashour et al., 2008. Intervention was either 4 post-natal home visits or one post-natal home visit.
- ¹⁰ 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.
- ¹¹ Bolam et al., 1998. intervention included structured baseline household questionnaire, one-to-one health education at birth and 3 months later.
- ¹² 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.
- ¹³ 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.
- ¹⁴ Quinlivan et al., 2003. Intervention was five structured post-natal home visits by nurse midwives.
- ¹⁵ Unclear risk for performance bias and detection bias given no information was provided in regard to blinding.
- ¹⁶ Small N with 139 enrolled and 124 assessed.
- ¹⁷ Gilliam et al., 2004. Intervention consisted of counselling, a videotape about oral contraceptives and written material.
- ¹⁸ Unclear risk of performance bias and detection bias due to lack of information regarding blinding.
- ¹⁹ Small n with only 33 randomised and 52% had dropped out at one year follow-up.
- ²⁰ 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.
- ²¹ 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?¹

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)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-abortion family planning counselling	Control	Relative (95% CI)	Absolute		
repeat abortions												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	serious ⁴	none	7/276 (2.5%)	15/281 (5.3%)	-	53 fewer per 1000 (from 53 fewer to 53 fewer) ⁵	⊕○○○ VERY LOW	IMPORTANT
								0%		-		
repeat unplanned pregnancy - modern contraception												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	serious ⁴	none	42/276 (15.2%)	96/281 (34.2%)	OR 3.38 (2.16 to 5.29)	295 more per 1000 (from 187 more to 391 more)	⊕○○○ VERY LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods (assessed with: interview)												
1 ⁶	observational studies	very serious ⁷	no serious inconsistency	no serious indirectness	no serious imprecision	none	378/456 (82.9%) ³	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods at 6 months post intervention (assessed with: interview)												
1 ⁹	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious ¹⁰	none	121/123 (98.4%)	86/123 (69.9%)	RR 1.41 (1.25 to 1.58)	287 more per 1000 (from 175 more to 406 more)	⊕⊕⊕○ MODERATE	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods (assessed with: interview)												
1 ^{11,12}	observational studies	very serious ¹³	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods (assessed with: interview)												
1 ¹⁴	observational studies	very serious ¹⁵	no serious inconsistency	no serious indirectness	no serious imprecision	none	979/1009 (97%) ¹⁶	-	-	-	⊕○○○	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Post-abortion family planning counselling	Control	Relative (95% CI)	Absolute		
repeat abortions									0%	-	VERY LOW	
acceptance and/or use of contraceptive methods (assessed with: review of procedure logbooks)												
1 ¹⁷	observational studies	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	3492/4462 (78.3%) ¹⁸	-	-	-	⊕⊕⊕⊕ LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods (assessed with: interview)												
1 ¹⁹	observational studies	serious ²⁰	no serious inconsistency	no serious indirectness	no serious imprecision	none	271/315 (86%) ²¹	-	-	-	⊕⊕⊕⊕ VERY LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods (assessed with: interview with physicians, 'perusal' of client records, interview with patients)												
1 ²²	observational studies	very serious ²³	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	-	-	⊕⊕⊕⊕ VERY LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods												
1 ²⁴	observational studies	very serious ²⁵	no serious inconsistency	no serious indirectness	no serious imprecision ²⁶	none	-	-	-	-	⊕⊕⊕⊕ VERY LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods (assessed with: interview)												
1 ^{27,28}	observational studies					none	-	-	-	-	⊕⊕⊕⊕ VERY LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods												
1 ²⁹	observational studies	very serious ³⁰	no serious inconsistency	no serious indirectness	no serious imprecision	none	487/524 (92.9%) ³¹	-	-	-	⊕⊕⊕⊕ VERY LOW	IMPORTANT
								0%		-		
acceptance and/or use of contraceptive methods (assessed with: interview)												
1 ³²	observational studies	very serious ³³	no serious inconsistency	no serious indirectness	no serious imprecision	none	495/521 (95%) ³⁴	-	-	-	⊕⊕⊕⊕ VERY LOW	IMPORTANT
								0%		-		

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

- ³ 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.
- ⁴ For most outcomes the number of events was less than 300 (GRADE threshold rule of thumb value).
- ⁵ Calculated by GRADE - no relative or absolute effects provided in the paper.
- ⁶ Ministry of Health Burkina Faso 1988
- ⁷ 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.
- ⁸ 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.
- ⁹ Ferreira et al., 2011
- ¹⁰ Total N less than 300.
- ¹¹ Diaz et al.
- ¹² 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 denominators are entered, the percentage alone cannot be entered. The Ns in this study cannot be determined from the information provided in the paper.
- ¹³ 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.
- ¹⁴ Mahomed et al., 1997
- ¹⁵ 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.
- ¹⁶ There is no control group, and no relative or absolute effects in regard to before-after intervention differences were provided.
- ¹⁷ Otsea et al., 2011
- ¹⁸ There is no comparator group and no relative or absolute difference relative to pre and post-program differences.
- ¹⁹ Rasch et al., 2004
- ²⁰ The study does not account for patients lost to follow-up; follow-up time varied from one to six months.
- ²¹ There is no control group; study does not provide any assessment of relative or absolute effects, just the percentages.
- ²² Rogo et al., 1998
- ²³ 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.
- ²⁴ Solo et al., 1999
- ²⁵ 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.
- ²⁶ Number of patients using the different models is unknown.
- ²⁷ Thapa et al., 2004
- ²⁸ 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.
- ²⁹ Rasch et al., 2005
- ³⁰ 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.
- ³¹ 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%).
- ³² Rasch et al., 2007
- ³³ 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.
- ³⁴ 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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mobile outreach service delivery	Control	Relative (95% CI)	Absolute		
discontinuation of intrauterine device												
1 ¹	observational studies	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ³	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mobile outreach service	Control	Relative (95% CI)	Absolute		
discontinuation of IUD												
1 ¹	observational studies	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ²	-	-	-	⊕⊕○○ LOW	IMPORTANT
								0%		-		

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mobile outreach service for IUD	Control	Relative (95% CI)	Absolute		
discontinuation of IUD												
1 ¹	observational studies ²	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	151/1348 (11.2%)	-	-	-	⊕⊕⊕⊕ LOW	IMPORTANT
								0%		-		

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Community-based approach	Control	Relative (95% CI)	Absolute		
use of modern reversible method of contraception (assessed with: survey)												
1 ¹	observational studies ²	serious ³	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	OR 1.74 (1.11 to 2.71) ⁴	-	⊕⊕⊕⊕ VERY LOW	
								0%		-		

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self assessment and/or peer review of providers	No self assessment or peer review	Relative (95% CI)	Absolute		
clients' rating of satisfaction												
1 ¹	observational studies	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ³	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Balanced counselling strategy	Control	Relative (95% CI)	Absolute		
family planning use rates												
1 ¹	observational studies	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ²	-	-	-	⊕⊕⊕	IMPORTANT
							0%				LOW	

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Improvement of client-provider interactions	No intervention	Relative (95% CI)	Absolute		
satisfaction with clinic services												
1 ¹	observational studies	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ³	-	-	-	⊕⊕⊕	IMPORTANT
							0%				VERY LOW	

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.

Author(s): P. Whyte

Date: 2013-04-11

Question: Should communication skills training program vs no training program be used in healthcare providers?¹

Settings: Iran

Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Communication skills training program	No training program	Relative (95% CI)	Absolute		
client satisfaction												
1 ²	randomised trials	serious ³	no serious inconsistency	no serious indirectness	serious ⁴	none	30/47 (63.8%)	16/47 (34%)	-	340 fewer per 1000 (from 340 fewer to 340 fewer)	⊕⊕○○ LOW	IMPORTANT
								0%		-		

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	National adolescent friendly clinic initiative	Control clinics	Relative (95% CI)	Absolute		
overall clinic score (assessed with: interview)												
1 ²	observational studies	serious ³	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ⁴	0%	-	-	⊕○○○ VERY LOW	IMPORTANT

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Improvement of client-provider interactions	No intervention	Relative (95% CI)	Absolute		
satisfaction with clinic services												
1 ¹	observational studies	serious ²	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ³	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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?¹

Settings: India

Bibliography:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Local initiatives program	Control	Relative (95% CI)	Absolute		
increase in contraceptive use² (assessed with: survey)												
1 ³	observational studies	very serious ⁴	no serious inconsistency	no serious indirectness	no serious imprecision	none	-	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

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

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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Empowerment of female community health volunteers	Control	Relative (95% CI)	Absolute		
use of contraceptives												
1 ¹	observational studies	no serious risk of bias	no serious inconsistency	no serious indirectness	serious ²	none	130/241 (53.9%) ³	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		
satisfaction with consultation												
1 ¹	observational studies	no serious risk of bias	no serious inconsistency	no serious indirectness	serious ²	none	188/241 (78%)	-	-	-	⊕○○○ VERY LOW	IMPORTANT
								0%		-		

¹ Shrestha 2002

² Sample size assessed was small with n=241.

³ 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:

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Financing to a for-profit company to provide family planning services	Control	Relative (95% CI)	Absolute		
number of family planning clients												
1 ¹	observational studies ²	no serious risk of bias	no serious inconsistency	no serious indirectness	no serious imprecision	none	- ³	-	-	-	⊕⊕⊕	IMPORTANT
							0%			-	LOW	

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

Human Right	Recommendations to States Relevant to Family Planning
The Right to Consent to Marriage and to Equality in Marriage	<p>Ensure the right to “freely to choose a spouse and to enter into marriage only with their free and full consent” (1).</p> <p>Remove any requirements for spousal consent in order to access family planning services (2).</p>
The Right to Education	<ul style="list-style-type: none"> • “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	<ul style="list-style-type: none"> • 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).
The Right to Health	<ul style="list-style-type: none"> • “Develop and implement programmes that provide access to sexual and reproductive health information and services, including for adolescents” (11).

Human Right	Recommendations to States Relevant to Family Planning
	<ul style="list-style-type: none"> • Ensure the availability, accessibility, acceptability and quality of family planning information and services (12). • [Ensure that available family planning methods] “provide accessible, complete, and accurate information about various family planning methods, including their health risks and benefits, possible side effects and their effectiveness in the prevention of the spread of HIV/AIDS and other sexually transmitted diseases” (13). • Ensure that “health facilities, goods and services [including family planning] must be accessible to all, especially the most vulnerable or marginalized sections of the population in law and in fact without discrimination on any of the prohibited grounds” (14).
The Right to Information and Freedom of Expression	<ul style="list-style-type: none"> • “Ensure that women and men have information and access to the widest possible range of safe and effective family-planning methods in order to enable them 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • “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).
The Right to Participate in the Conduct of Public Affairs and the Right to	<ul style="list-style-type: none"> • 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).

Human Right	Recommendations to States Relevant to Family Planning
Free, Active and Meaningful Participation	<ul style="list-style-type: none"> • 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)
The Right to Privacy	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • “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	<ul style="list-style-type: none"> • 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).

1. *CEDAW Convention on the Elimination of Violence Against Women. Article 16 (B)*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
2. *CEDAW General recommendation no. 21 Article 16 (1b) of the Convention on the Elimination of Discrimination Against Women*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
3. *CRC General Comment no. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art 24 of the International Convention on the Rights of the Child.)* New York, UN Committee on the Rights of the Child, 2013. (UN Doc. CRC/C/GC/15)
4. *CEDAW Convention on the Elimination of Violence Against Women. (Introduction)*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
5. *CEDAW Convention on the Elimination of Violence Against Women. Article 10 (h)*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
6. *CEDAW Convention on the Elimination of Violence Against Women. Article 12 (1)*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
7. *CEDAW General recommendation no. 21 Article 16 (1) of the Convention on the Elimination of Discrimination Against Women*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
8. *General Comment no. 14 Article 12.2 (a). The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. New York, UN Committee on Economic, Cultural, and Social Rights (CESCR), 2000. (UN Doc. E/C.12/2000/4)
9. *CEDAW General recommendation no. 24 Article 12 (1) of the Convention on the Elimination of Discrimination Against Women*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 20th Session 1999.
10. *Report of the International Conference on Population and Development. Chapter VII, Action 4.26*. Cairo, 5-13 September 1994.
11. *General Comment no. 14 Article 12.2 (a). The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*. New York, UN Committee on Economic, Cultural, and Social Rights (CESCR), 2000. (UN Doc. E/C.12/2000/4)
12. *CEDAW General recommendation no. 24 Article 12 (1) of the Convention on the Elimination of Discrimination Against Women*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
13. *Report of the International Conference on Population and Development. Chapter VII, Action 7.23 (b)*. Cairo, 5-13 September 1994.
14. *General Comment no. 14 Article 12. The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social, and Cultural Rights)*. New York, UN Committee on Economic, Cultural, and Social Rights (CESCR), 2000. (UN Doc. E/C.12/2000/4)
15. *Report of the International Conference on Population and Development. Chapter VII, Action 7.23 (a)*. Cairo, 5-13 September 1994.
16. *CEDAW General recommendation no. 19 Article 16 (1)(e) of the Convention on the Elimination of Discrimination Against Women*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 11th Session 1992.
17. *Article 17 of the International Covenant on Civil and Political Rights (CCPR)*. New York, UN Human Rights Committee, 1976.
18. *See reference 17.*

19. *CEDAW General recommendations for government action no. 13 (c)*. International Convention on the Elimination of Discrimination Against Women. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
20. *CEDAW General recommendation no. 19 Article 16 (and 5) of the Convention on the Elimination of Discrimination Against Women*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 11th Session 1992.
21. Report of the International Conference on Population and Development. Chapter V, Action 7.7. Cairo, 5-13 September 1994.
22. Report of the International Conference on Population and Development. Chapter VII, Action 7.3. Cairo, 5-13 September 1994.
23. Report of the International Conference on Population and Development. Chapter VII, Action 4.27. Cairo, 5-13 September 1994.
24. General Comment no. 14 Article 12 (b). The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). New York, UN Committee on Economic, Cultural, and Social Rights (CESCR), 2000. (UN Doc. E/C.12/2000/4)
25. *See reference 24.*
26. General Comment no. 14 Article 12 (no. 23). The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). New York, UN Committee on Economic, Cultural, and Social Rights (CESCR), 2000. (UN Doc. E/C.12/2000/4)
27. *CEDAW Convention on the Elimination of Violence Against Women. Article 16 (1) (e)*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 1979.
28. *See reference 19*
29. *See reference 27*
30. General Comment no. 14, Specific Legal Obligation no. 34. The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). New York, UN Committee on Economic, Cultural, and Social Rights (CESCR), 2000. (UN Doc. E/C.12/2000/4)
31. *CEDAW General recommendation no. 19 Article 16 (and article 5) of the Convention on the Elimination of Discrimination Against Women*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 11th Session 1992.
32. *CEDAW General recommendation no. 24 Article 12 (1) (12b) of the Convention on the Elimination of Discrimination Against Women*. New York, UN Committee on the Elimination of Discrimination Against Women (CEDAW), 13th Session 1994.
33. General Comment no. 14 Article 12 (no. 21). The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). New York, UN Committee on Economic, Cultural, and Social Rights (CESCR), 2000. (UN Doc. E/C.12/2000/4)