What we know about Sexual and Reproductive Health and Rights interventions in sub-Saharan Africa

Policy and Operations Evaluation Department (IOB)

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Preface

A key function of the Policy and Operations Evaluation Department (IOB) is to inform policy makers and practitioners about what we know about what works and why in a particular area of Dutch foreign and development policy. Evidence and Gap Maps (EGM) are an important tool for making this possible: they tell us what evidence there is and where it can be found, but also where knowledge is still lacking.

Within the framework of its evaluation of the Dutch international policy on Sexual and Reproductive Health and Rights (SRHR), IOB commissioned Howard White and Anil Thota of the Campbell Collaboration to construct a map of systematic reviews of SRHR-interventions in Sub-Saharan Africa. This resulted in a map based on 368 selected systematic reviews, published between 2015 and July 2020. Paul de Nooijer, Caspar Lobbrecht, Echica van Kelle and Bart van Rijsbergen from IOB supported this process.

While the EGM shows whether there is evidence – or not – it does not tell us *what* it says about what works, and why. Therefore, we identified fourteen topics for which all available evidence was synthesized in *evidence summaries*.

This document provides background information on the Evidence and Gap Map, how it is structured and can be used and the fourteen evidence summaries.

IOB hopes that the insight they provide contributes to increased evidence-based policymaking and implementation and addressing the remaining knowledge gaps. Both the EGM and these evidence summaries were subject to IOB's regular quality control mechanisms.

Peter van der Knaap,
Director Policy and Operations Evaluation Department (IOB)

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List of abbreviations

ART	Antiretroviral treatment
EGM	Evidence and Gap Map
EmONC	Emergency obstetric and neonatal care
DART	Differentiated antiretroviral treatment
FGM	Female genital mutilation
GBV	Gender based violence
HIV	Human Immunodeficiency Virus
IOB	Policy and Operations Evaluation Department
IPV	Intimate partner violence
LGBTQI+	Lesbian, gay, bisexual, transgender, queer, intersex, and others
LMIC	Low- and middle-income country
mHealth	Mobile health
P4P	Pay-for-performance
PLHIV	People living with HIV
RCT	Randomised controlled trial
SMW	Sexual minority women
STIs	Sexually transmitted infections
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
USD	United States dollar
VCT	Voluntary counselling and testing
WLHIV	Women living with HIV

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1. Introduction and reading guide

For many years, Sexual and Reproductive Health and Rights (SRHR) have been a priority in Dutch development cooperation. The Netherlands has been funding multilateral organisations, international funds, as well as national and international NGOs working on a broad range of SRHR-related themes, from gender-based violence to sexuality education for young people. It is party to all relevant international conventions, it is a signatory to many resolutions and declarations on SRHR and active in international SRHR-diplomacy. The most recent policy document on trade and development cooperation Investing in Global Prospects - For the World, For the Netherlands (2018) - shows that SRHR is likely to remain a priority, also in emergencies and humanitarian crises.

Currently, IOB is conducting an evaluation of the Dutch policy on SRHR for the period from 2012 onwards. This evaluation aims to address the following question: *To what extent has the Netherlands contributed to the improvement of Sexual and Reproductive Health and Rights and contributed to halting the spread of HIV/AIDS in developing countries and what lessons can be learned for future policy?*

Policy relevance is one of the research areas of this evaluation and a key question to be addressed is the following: *What does the available evidence tell us about what works and what does not work in SRHR interventions in low and lower middle-income countries?*

To be able to respond, IOB contracted the Campbell Collaboration to address the following research questions:

- What evidence is available from systematic reviews about what works and what does not work, and why, in SRHR interventions in low and lower middle-income countries, especially in sub-Saharan Africa?
- What does the evidence from systematic reviews tell us about what works and what does not work for selected SRHR interventions in low and lower middle-income countries, especially in sub-Saharan Africa?

To answer these questions, the Campbell Collaboration first performed a systematic search for systematic reviews on interventions targeting SRHR. The starting point for developing the typology of interventions was the Dutch policy on SRHR – Annex 1.8 presents the specific coding framework for SRHR. The focus on sub-Saharan Africa is also based on Dutch policy.

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The protocol for the review on which this Map is based is available in Annex 1. The search only included systematic reviews and meta analyses that were published in English in the period 2015-July 2020. Both quantitative and qualitative reviews were eligible for inclusion. In addition, these reviews had to include at least one study from a low-income or lower middle-income country in sub-Saharan Africa. The review did not include individual impact evaluations.

The PRISMA diagram of the review is presented in Annex 2. It shows that after removing duplicates, the researchers identified 9,938 systematic reviews of which 9,732 were excluded after initial screening. Out of the remaining 611 full-text articles, 243 did not meet the inclusion criteria and 368 systematic reviews were eligible.

Then, the Campbell Collaboration produced an Evidence and Gap Map (EGM) of these 368 systematic reviews on SRHR. The Evidence and Gap Map is hosted on the Campbell Collaboration website and is available here.

Evidence and Gap Maps are systematic and visual presentations of the availability of rigorous evidence for a particular policy domain – in this case Sexual and Reproductive Health and Rights. The EGM consolidates what is known (and not known) about "what works" by mapping out the systematic reviews across interventions and outcomes, providing a graphical display of areas with a lot of evidence from systematic reviews and areas with gaps in the evidence.

While an EGM shows whether evidence is available – or not – it does not shed light on what the evidence says. To answer the second research question, therefore, the researchers prepared 14 evidence summaries, i.e. short briefs of the best available evidence on specific SRHR-topics. The following topics were selected based on the availability of evidence and their relevance for Dutch SRHR policy:

1. Male involvement;
2. Male engagement against IPV;
3. Early marriage prevention;
4. Financial incentives;
5. HIV stigma reduction;
6. Pay-for-performance;
7. Access to safe abortion;
8. mHealth;
9. Advocacy for WLHIV;
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The remainder of this document provides:

- Information on the set-up of the evidence and gap map and how to use it (chapter 2), e.g. in terms of how to apply filters and how to access the records and individual studies.
- The evidence summaries mentioned above (chapter 3). Each summary presents the findings and evidence gaps, gives an overview of the interventions researched, and concludes with a systematic presentation of the evidence. You can click through the different sections to see what interests you most.
- Three Annexes are provided: Annex 1 presents the Protocol for the review; Annex 2 contains the PRISMA diagram and Annex 3 gives an overview of the references used for drawing up the evidence summaries.

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2. How to use the Evidence and Gap Map

This chapter explains the structure of the SRHR Evidence and Gap Map (EGM) and how to use it.

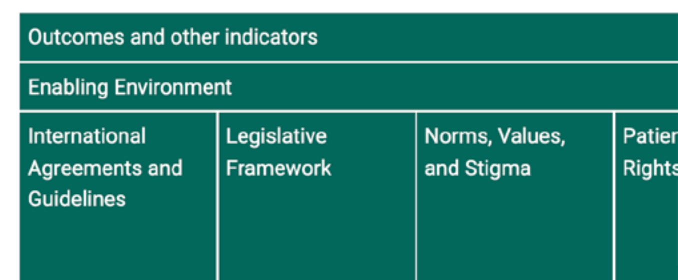
First of all, note that the EGM might be bigger than your screen and you have to use the scroll bars to view the map in its entirety. Clicking on the 'Hide Headers' button in the settings tab will reveal a larger part of the map on your screen. You can also zoom out by adjusting your browser settings. The keyboard shortcut is: hold CTRL and press the + key to zoom in, or the – key to zoom out. You can also hold CTRL and use the scroll wheel on your mouse.

On the top of the page, the EGM contains five **settings tabs**: Filters; Hide Headers; Fullscreen; About; and View Records – see picture 1.

Picture 1 – Settings Tabs

The Hide Headers, Fullscreen and About tabs are self-explanatory. The Filters and View Records tabs are explained on the next page.

In the Map, the **columns are outcomes and other indicators**, see picture 2. The **rows are SRHR intervention categories**, see picture 3.



Picture 2 – Outcome categories

Picture 3 – Intervention categories

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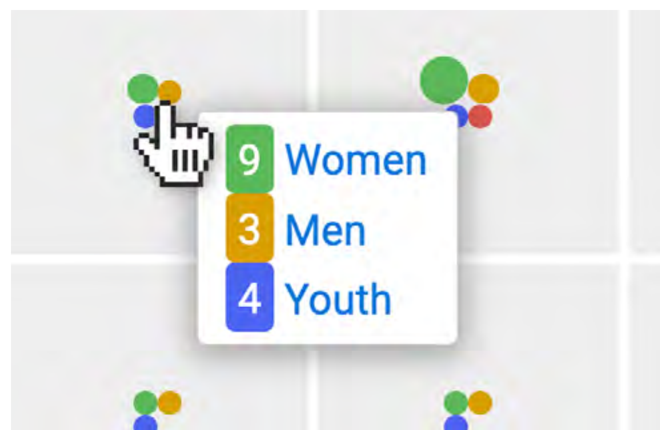
Hovering your mouse on a specific cell will show how many systematic reviews are available for that specific intervention and outcome area – see picture 4. If a cell does not contain any bubbles, there is no evidence (an evidence gap) for the specific intervention and outcome from systematic reviews.



Picture 4 – Number of systematic reviews per cell

The cells of the table contain **bubbles** with a size proportional to the number of studies reporting on the specific outcome for that intervention.[1]

There are separate bubbles for different target groups:

- Green bubbles indicate that the systematic reviews focus specifically on 'Women'
- Orange indicates a specific focus on 'Men';
- Blue indicates a specific focus on 'Youth'
- Red indicates a specific focus on 'Key populations'.[2]

Clicking on a cell leads you to a sub-page that presents the **list of systematic reviews** corresponding to an intervention and outcomes for that cell. Click on a study in the list to get publication details, relevant summaries and URL to access the review itself. It is possible to export the references of the selection of systematic reviews by clicking on the 'Download Listed References' button. This opens an RIS file, which is a bibliographic citation file and contains information such as title, author, publication date, keywords and publisher. Programmes that can open RIS files include reference tools such as Endnote, Zotero and Wandora.

1 The map has four styles: bubble, heat, mosaic and donut, which all portray the same information but in a different format. You can choose your own preferred style. The default style is bubble.
2 Key populations include sex workers, injecting drug users, men who have sex with men, and disadvantaged groups.

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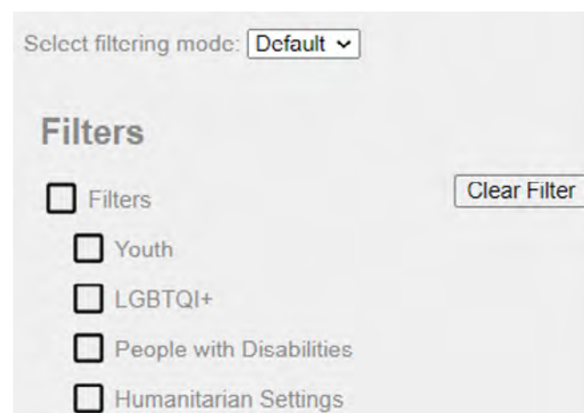
The map includes a set of filters, allowing evidence to be shown just for the selected filter. To use the Filter function, click the **settings tab 'Filters'** on the top-left of the map – see picture 1. The following filters are available and can be scrolled down and checked for selection: youth; LGBTQI+; people with disabilities; humanitarian settings; key populations; men; women; poor; 100% of studies from sub-Saharan Africa; >50% to <100% of studies from sub-Saharan Africa; <10% of studies from sub-Saharan Africa (see picture 5). Once all the relevant filters are selected, click on 'Update'.



Picture 5 - Filters

It is also possible to manually access and search the 368 systematic reviews. First, clear all filters and select 'Update'. Then, click on the **settings tab 'View Records'**. This gives you access to the publication details, relevant summaries and URLs of all systematic reviews. Now, you can manually select or deselect specific interventions and/or indicators. This allows you to, for example, select all systematic reviews that focus on a specific intervention and take all outcomes into account. In addition, you can also manually add filters by clicking on 'Filter' in the sub-page and enter your filter. Again, it is possible to export the references of the selection of systematic reviews by clicking on the 'Download Listed References' button.

3. Evidence Summaries

The evidence summaries are short briefs that synthesise the best available evidence for specific SRHR-topics. Each summary first presents the findings and evidence gaps, then gives an overview of the interventions researched, and ends with an in-depth systematic presentation of the evidence.

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3.1 Male involvement

In maternal and child health

Using the filter 'men', 59 systematic reviews in the evidence map are identified as including studies in which engaging men is used as an intervention strategy. Typically, this involves engaging males to understand the health needs of their female partners and support their access to SRH services. Five systematic reviews in the evidence map focus on the impact of male involvement interventions on maternal and child health outcomes. They are summarised here.

3.1.1 Findings and evidence gaps

Based on the five reviews on male involvement in mother and child health, the following conclusions can be drawn:

1. There is evidence that male involvement interventions in low- and middle-income countries (LMICs) can increase institutional delivery rates, skilled birth attendance and infant antiretroviral prophylaxis.
2. Findings on other maternal and child health outcomes such as antenatal care visits, birth preparedness, postnatal care and neonatal care are not consistent across studies.
3. Multicomponent interventions including different strategies to increase male involvement seem to work better than single component interventions. Strategies commonly used to increase male involvement include home visits, health education, community-based education, couple counselling, verbally encouraging women to bring their partners with them, and engaging community health workers and community leaders.

More randomised controlled trials (preferably with large samples) are needed because so far there have been few studies of certain intervention strategies to promote male involvement. For example, verbal encouragement seems to be a very effective intervention strategy but only two studies in the reviews investigated this approach. More studies on this and other approaches could increase confidence in the results.

Cost information was not reported in any of the reviews. Economic evaluations could help implementers and funders to make decisions.

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3.1.2 The interventions researched

The evidence map identified 58 systematic reviews of studies in which engaging men was used as an intervention strategy with the goal of improving various sexual and reproductive health (SRH) outcomes for women. Typically, this involves engaging males to understand the health needs of their female partners and support their access to SRH services. This summary focusses on the impact of male involvement interventions on maternal and child health outcomes.

Male involvement may be impeded by cultural and socioeconomic factors and lack of resources to address health system barriers. It is considered an important intervention in LMICs for maternal and child health and has frequently been researched. It could lead to better treatment acceptance and adherence among women and children for antenatal visits, institutional deliveries, skilled birth attendance, postnatal care and child wellness visits.

Increasing male involvement is intended to improve maternal and child health outcomes by:

- improving couple relationships, especially regarding communication and decision-making
- improving males' support for their women partners, to address demand-side barriers to accessing maternal and child health services and
- improving men's awareness and support of optimal home care practices for maternal and child health.

In turn, these three aspects will increase the use of maternal and child healthcare and lead to better health-promoting behaviours in the household and – ultimately – to improved maternal and child health outcomes. Various strategies may be involved in interventions for male involvement, such as community outreach, couple education, home visits, workplace education, counselling and mass media campaigns.

Each of the reviews looked at multiple maternal and child health outcomes. While the specific outcomes assessed in each review might have slight variations, the following domains were examined: antenatal or postpartum care for women, uptake of essential maternal health services, birth and complication preparedness, birth with a skilled attendant or in a facility, maternal or newborn nutrition, care-seeking for complications or illness, maternal morbidity, and maternal, perinatal or neonatal mortality.

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3.1.3 Systematic presentation of the evidence

Aguiar and Jennings (2015) examined the effect of male partners accompanying women on antenatal visits. There were some positive effects, such as improved knowledge of danger signs, increases in institutional delivery, skilled birth attendance and higher uptake of postnatal services. However, there were inconsistent findings on other outcomes, such as birth preparedness, utilisation of antenatal care, miscarriages, birth-related outcomes (caesarean section; stillbirth), breastfeeding and newborn health. The authors concluded that better communication between couples might have motivated men to participate. Possible reasons for the lack of success of many outcomes were poor communication, late accompaniment and partner type.

Tokhi et al. (2018) similarly looked at what effect male involvement had on maternal and newborn health. This review found improvements in antenatal attendance, skilled birth attendance, institutional delivery, postpartum care, preparedness for birth and for complications, and maternal nutrition. The effects on maternal morbidity, mortality and breastfeeding were not as clear-cut. The authors concluded that these interventions improved male partner support and led to increased couple communication and joint decision-making. However, whether these interventions afforded women more autonomy was unclear.

The same group of researchers was responsible for two other reviews of the impact of male partner involvement: Takah et al. (2019) assessed the impact on institutional (hospital) delivery services to pregnant women living with HIV whereas Takah et al. (2018) assessed the impact on the uptake of infant antiretroviral prophylaxis/treatment in sub-Saharan Africa.

Takah et al. (2019) reported that involving male partners by using various strategies increased the likelihood of women delivering in hospital by 56%. They found three categories of interventions to involve male partners to be effective:

- complex community interventions with multiple components, such as community mobilisation, male community leaders, mass media – all focused on promoting male involvement (51% increase in likelihood of hospital delivery)
- complex community interventions with community health workers visiting homes and counselling couples (58% increase in likelihood of hospital delivery)
- verbally encouraging women to bring their male partners for counselling. While the effect size for verbal encouragement interventions is very large, it must be noted that the evidence comes from a small number of studies.

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Takah et al. (2018) found that male partner involvement interventions doubled the likelihood of successful uptake of infant antiretroviral prophylaxis. Specifically, psychosocial interventions (such as psychotherapy and community-based treatment) and verbal encouragement worked best in increasing the likelihood of uptake of infant antiretroviral prophylaxis: the increases were by 3.5 times and 2.4 times, respectively. The findings for complex community interventions and using invitation letters were not statistically significant. Although the reported effect estimates showed large benefit for some of these interventions, they should be interpreted with caution due to the small number of studies.

Triulzi et al. (2019) had a different scope than the other reviews. Here the authors were looking to see which intervention strategies were successful in increasing male partner involvement for pregnant women living with HIV. The review did not assess impact on actual maternal and child health outcomes.

Multicomponent interventions were generally more successful than single component interventions. The most effective multicomponent interventions included health promotion via education and healthcare worker training. Within single component interventions, home visits were the most effective.

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3.2 Male engagement against IPV

Interventions to prevent intimate partner violence (IPV)

38 systematic reviews in the evidence map focus on gender based violence (GBV). Five of these systematic reviews include studies that assess the effectiveness and characteristics of male engagement interventions to prevent intimate partner violence (IPV). These evidence from these reviews is summarised here.

3.2.1 Findings and evidence gaps

Considering the evidence from the five systematic reviews on male engagement interventions to prevent intimate partner violence, the following conclusions can be drawn:

1. Male engagement seems to be a promising intervention. There is evidence that male involvement can positively address gender inequities and ultimately prevent intimate partner violence in sub-Saharan Africa. Although many outcomes related to gender norms and reduced intimate partner violence did improve across studies, improved outcomes were not seen consistently in all studies.
2. Adding positive parenting elements to these interventions seems to be a novel idea to concurrently address intimate partner violence and child maltreatment. There is evidence from a small number of studies that suggests that this can lead to better parenting attitudes and behaviour.

The number of studies on which these findings are based is currently small and more studies with good study designs are needed to improve insight into the effectiveness of male engagement interventions. It would also be useful to ascertain the role of additional components in the effectiveness of these interventions. More economic evaluations could help implementers and policymakers make appropriate decisions.

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3.2.2 The interventions researched

Intimate partner violence includes physical, sexual and psychological violence and is a global problem. According to a recent meta-analysis, three in five women in sub-Saharan Africa have been subjected to intimate partner violence in their lifetimes and two in five are currently experiencing it in their relationships. Women are often reluctant to report intimate partner abuse and violence to others or to the authorities.

Male engagement interventions deploy gender transformative processes with the aim of improving attitudes to gender norms, reducing the social acceptability of intimate partner violence and eventually reducing the incidence of violence. The knowledge and awareness imparted should lead to improved attitudes towards gender and violence and eventually result in improved behaviour and ultimately to reduced intimate partner violence.

The initial step is community outreach to recruit males to participate in intervention activities. This is followed by intervention activities to engage the males. Intervention components can include:

- group sessions for education, skills development and counselling on violence prevention
- one-on-one sessions covering the same content
- community mobilisation that includes components such as involvement of community activists, films, posters, mass media and public meetings.

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3.2.3 Systematic presentation of the evidence

The systematic review by Casey et al. (2016) focuses on identifying gender transformative interventions that engage men as a strategy to prevent intimate partner violence. Most (80%) of the studies included were in sub-Saharan Africa. Most interventions included men and women, but some focused solely on men. Usually, trained facilitators delivered multiple sessions over several weeks. In some cases, other sexual and reproductive health topics such as HIV the prevention of sexually transmitted infections were also part of the programme.

Most studies reported improvements in gender equitable attitudes but only about half of the results were statistically significant. Similarly, most studies reported reductions in different types of intimate partner violence, but the results were statistically significant in only two studies from sub-Saharan Africa. Two studies reported a reduction in social acceptance of intimate partner violence but only one study's results were statistically significant.

Bourey et al. (2015) looked at economic or social interventions (individual or combined) for prevention of intimate partner violence in low- and middle-income countries. Male engagement interventions included social interventions such as participatory learning programmes for young men and women, community mobilisation interventions, group discussions for men and media campaigns to promote legislation against domestic violence.

Most studies reported statistically significant improvements for at least one outcome, including decreased intimate partner violence, reduced acceptability of intimate partner violence, better relationship quality and more equitable gender norms. However, most studies did not report improvements for all outcomes, i.e. only a few outcomes (sometimes just one) improved within each study.

Schwab-Reese and Renner (2018) conducted a scoping review of screening, management and treatment for intimate partner violence in low-resource settings. A small proportion of the studies reviewed included male engagement strategies similar to those in the two reviews discussed above. As with those reviews, although there were improved outcomes across studies, the findings were not consistent.

Semahegn et al. (2019) came to similar conclusions: male involvement seems a promising intervention strategy for prevention of intimate partner violence but more studies are needed to improve insight into their effectiveness and whether results are consistent.

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The scoping review by Bacchus et al. (2017) examined the impact of male involvement interventions on intimate partner violence and child maltreatment. Most of the studies were from sub-Saharan Africa. Interventions included targeting fathers and male caregivers with various activities related to intimate partner violence and maltreatment prevention, such as mentoring programmes, community awareness campaigns focused on positive parenting, group discussions to reflect on gender and parent roles, local activism, media campaigns, one-on-one counselling and home visits.

The results from the small number of studies of these programmes suggested that the outcomes were better parenting attitudes and behaviour, improved quality of relationship with female partners, less conflict and improved attitudes towards gender norms. There were even some unintended positive effects, such as reduced alcohol use. However, the review's authors warned that the results should be interpreted with care because of the small number of studies.

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3.3 Early marriage prevention

Four systematic reviews in the evidence map included studies evaluating the effectiveness of interventions in preventing early marriage. These reviews included a broad range of intervention strategies with the goal of preventing early marriage or child marriage (and improving other sexual and reproductive health (SRH) outcomes for young girls).

3.3.1 Findings and evidence gaps

Based on the evidence from the four systematic reviews on preventing early marriage, the following conclusions can be drawn:

1. Economic incentive interventions, including cash transfers, show mixed results on decreasing early marriage.
2. Longer exposure to early marriage programmes likely leads to better results.
3. It appears that better SRH outcomes can be achieved by not focusing merely on early marriage prevention. Multicomponent programmes addressing early marriage, e.g. school policies and parent participation and local community involvement, are more effective than single component interventions.
4. It is not clear precisely which intervention strategy or combination of strategies works best in preventing early marriage. We need more insight into the role of multilevel interventions, ‘boosters’ after the main programme activities end, the minimum level of participation and the combinations of programme elements needed for programme effectiveness. Fund more research in sub-Saharan Africa on early marriage prevention programmes, to enable the identification of the most effective combinations of intervention strategies.

There are some gaps in the evidence. The mixed results (i.e. some positive, some no impact, some negative) from the available sub-Saharan African studies show that more evaluations are needed.

In addition, none of the sub-Saharan Africa studies reported on age at marriage as an outcome (they reported on proportion of girls married). Having more studies report this outcome can help us better understand the impact of these interventions.

Also, cost information was sparsely reported. Economic evaluations can help implementers and funders make decisions, given that these multicomponent interventions are quite resource-intensive.

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3.3.2 The interventions researched

Early marriage affects girls and boys in low- and middle-income countries although girls are disproportionately affected (one in five versus one in 30). Nearly 12 million girls are still married in childhood every year worldwide. While numbers are generally declining, mainly due to progress in South Asia, the global burden has now shifted to sub-Saharan Africa. Of the estimated 650 million global number of girls and women in 2020 who had been married early (before the age of 18), nearly one in three was from sub-Saharan Africa. Girls face multiple adverse lifelong consequences from being married early, including reduced chances of finishing basic schooling, increased chances of experiencing domestic violence and increased chances of adolescent pregnancy and subsequent childbirth-related complications. There are consequences for society, such as continuation of intergenerational cycles of poverty.

Prevalent gender inequality, deeply rooted social beliefs, customs such as dowry, poverty, insecurity from humanitarian conflicts and societal pressure can all potentially contribute to early marriage.

Multiple intervention strategies are used to prevent early marriage, including: national-level mass media campaigns; peer mentorship programmes; life-skills programmes on health, gender and sexuality; systems for children and others to report child marriage to authorities; cash transfers (conditional or unconditional) or in-kind support (uniforms, books) to increase girls' school enrolment; training in social and financial skills and; access to medical, legal and psychosocial support.

The UNFPA-UNICEF Global Programme to End Child Marriage is an example of a multifaceted approach to tackling child marriage. It takes a rights-based approach and promotes girl education and life aspirations. It engages with households and the community at large to develop positive attitudes to girls; it also engages with governments to advocate for laws and policies that prohibit early marriage.

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3.3.3 Systematic presentation of the evidence

The systematic review by Kalamar et al. (2016) focusses exclusively on interventions to prevent early marriage. Most (six out of 11) of the studies reviewed reported positive results for reducing the proportion of girls married and increasing the age at marriage; one study reported both positive and negative results (less early marriage in girls aged 10–14 compared with controls but the opposite effect was seen for girls aged 15–19). The remaining four studies reported no statistically significant change for either outcome. Various intervention strategies had been implemented in the studies, such as conditional and unconditional cash transfers, school voucher programmes, covering school fees, providing school uniforms and books, teacher training and life-skills curricula. Many of the interventions studied included multiple components.

Results for studies from sub-Saharan Africa were inconsistent. Two studies from Malawi implementing cash transfers found a significant decrease in the proportion of girls married. Similar results were also seen in a third study from Zimbabwe, which included provision of school fees, uniforms, books and supplies. However, two studies from Kenya – one using cash transfers and the other providing school uniforms and training for teachers – found no change in this outcome. The last study from Ethiopia, which included school support and providing a life-skills curriculum for students, was the one that found positive results for girls aged 10–14 but negative results for those aged 15–19.

Shackleton et al. (2016) published a systematic review of reviews, i.e. it identifies and synthesises other systematic reviews. The report aimed to assess the effectiveness of school-based interventions that went beyond health education for better adolescent health. The authors report that the available evidence suggests that economic incentives were effective in reducing early marriage and adolescent pregnancy in low- and middle-income country settings. The results of health education interventions combined with peer education in terms of reducing age at marriage were inconsistent. Health education interventions combined with school health clinics or counselling seemed to be ineffective in reducing age at marriage. Overall, better SRH outcomes were achieved for adolescents by not focusing merely on early marriage prevention; multicomponent school-based interventions, e.g. school policies and parent participation and local community involvement, were more effective than any single component on its own.

Another systematic review of reviews, by Yount et al. (2017), looked at interventions to prevent five forms of gender-based violence (including early marriage) against girls in adolescence and early adulthood. It recognised that early marriage was a risk factor for

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gender-based violence. Within the review of reviews, four systematic reviews focusing on early marriage prevention were identified; they included 13 individual studies. The results from individual studies were inconsistent: some studies showed improvements, others worsening of outcomes and many showed the interventions had no impact.

Haberland et al. (2018) performed a systematic review that examined implementation factors for adolescent girl programmes in low- and middle-income countries. Only a few studies in this broad review reported on early marriage prevention outcomes. Some studies reported positive results for preventing early marriage but most showed no impact. Overall, the authors concluded that longer exposure to the programme and employing a multicomponent approach are likely more effective.

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3.4 Financial incentives

To improve utilisation of sexual and reproductive health services

There are 26 systematic reviews in the EGM that look at financial incentive programmes to improve utilisation of health services and products for SRH. Some reviews focus on specific economic incentives such as cash transfers, while other reviews are broader. This evidence summary presents the findings of six reviews.

3.4.1 Findings and evidence gaps

Based on the six reviews on the effects of financial incentive programmes on utilisation of health services and products for SRH, the following conclusions can be drawn:

1. Financial incentives programmes can be effective in increasing utilisation of health services and products for SRH. Cash transfers, short-term payments and vouchers can improve utilisation of health services for maternity services (antenatal care, skilled birth attendance, facility delivery, postpartum care), HIV testing and linkage to treatment, and voluntary uptake of male circumcision; they also reduce risky sexual behaviours among adolescents. However, it must be noted that findings were not universally positive for all utilisation and behaviour outcomes across all studies.
2. Cash transfer programmes might be more effective in reducing risky sexual behaviour among girls and women than among boys and men.
3. The delivery of these programmes can be improved by concurrently improving the quality of healthcare facilities, reducing bureaucratic procedures for enrolling in financial incentive programmes, using efficient mechanisms to identify eligible households and individual participants locally, and supporting transportation to health facilities, especially for maternity services.
4. There are various contextual factors that can influence the effectiveness of the programmes, such as:
   a. quality of the healthcare services provided
   b. burden for families and individuals enrolling in the programmes
   c. proper mechanisms to identify eligible participants
   d. support to overcome other barriers such as transport to healthcare facilities and opportunity costs (i.e. lost wages).

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There is a solid evidence base on the effects of financial incentives programmes on utilisation of services as outcomes. At the same time, more studies of financial incentives programmes are needed on maternal and child morbidity and mortality outcomes.

Some studies tested effectiveness based on the amount of the financial incentive, but to be able to draw robust conclusions, more studies are needed. More evaluations of the costs and cost-effectiveness of these programmes will also be useful to decision-makers and implementers.

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3.4.2 The interventions researched

Financial incentive programmes are demand-side interventions that may include cash transfers, vouchers, short-term payments and non-cash incentives such as mobile phone talk time minutes and food vouchers as a way to encourage households and individuals to access healthcare services and facilities. These programmes are targeted at households and individuals in areas with high rates of poverty and high rates of morbidity and mortality related to SRH issues. Examples of services whose uptake financial incentives can promote include antenatal care, facility deliveries, skilled birth attendance, postpartum care, HIV testing and treatment and voluntary circumcision for men.

Factors that can inhibit patients from seeking SRH services include the lack of transportation to healthcare facilities, opportunity costs, mistrust of the healthcare system and out-of-pocket expenses. Financial incentive programmes aim to reduce these barriers to care seeking, especially in areas with high rates of poverty, morbidity and mortality. By removing the barrier of costs and improving awareness of the services available, these programmes aim to increase utilisation of healthcare services, ultimately leading to better health outcomes (e.g. for reduced maternal mortality, reduced HIV morbidity).

Many different types of financial incentives have been tried out, such as:

- Cash transfers: payments are made to households or to a responsible individual within a household – typically a woman. They may be conditional (e.g. conditional on negative results for sexually transmitted infection tests) or unconditional (i.e. are made regularly, irrespective of healthcare utilisation).
- Vouchers: typically, these can be purchased in an individual's own community for redemption at a healthcare facility (e.g. pregnant women can purchase a voucher than can be redeemed for facility delivery services at a healthcare facility)
- Short-term payments: payments are made to help cover the costs of specific services (e.g. in the case of antenatal care, only for the delivery of services).
- Other incentives include non-cash items, such as mobile phone talk time minutes and food vouchers.

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3.4.3 Systematic presentation of the evidence

Cooper et al. (2020) reviewed the literature to examine the impact of cash transfer programmes in low- and middle-income countries on a broad range of health outcomes, including SRH outcomes. The review assessed whether the effectiveness of these programmes differed in relation to recipient age, socioeconomic status, gender and school enrolment. The relevant findings for programmes in sub-Saharan Africa to improve SRH outcomes are presented here.

An unconditional cash transfer programme in Kenya provided cash transfers to 1,540 households (754 controls did not receive transfers). Among younger adolescents receiving transfers, the probability of sexual debut was significantly lower than among controls. There was no difference in effectiveness between girls and boys. Four years after the programme had started, adolescent sexual behaviour (for those with at least one sexual partner) did not differ between girls and boys nor did it correlate with the size of the cash grant at baseline. The analysis also found that the programme did not influence the beneficiary's choice of partner (i.e. the age or educational background of the partner they chose).

A conditional cash transfer programme from Malawi found that after one year there was no change in sexual activity or condom use. However, men were likely to report a 9% increase in risky sexual behaviour (from baseline) while women reported a 6.7% decrease. The incidence of HIV did not differ between intervention and control groups.

A monthly unconditional cash transfer programme in South Africa to caregivers of children in low-income households found improvements in some risky sexual behaviour outcomes for girls but no improvements for boys. The outcomes that improved for girls were reduced incidence of transactional sex and relationships with much older partners (>5 years older). Other outcomes such as decline in the number of sexual partners, condom use, having sex while intoxicated or after drug use did not change.

A conditional cash transfer programme in Tanzania tried different levels of cash transfer ("high-value" versus "low-value" versus no cash transfer) conditional on negative test results for sexually transmitted infections (STIs). Although fewer people in the high-value group reported STIs than in the control group (9% versus 12%), the results were not statistically significant.

Overall, not many factors showed differential effects for cash transfer programmes on SRH, except for gender. In multiple studies, many outcomes for girls and women seemed to be better than those for boys and men.

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Cruz et al. (2017) also looked at conditional cash transfer programmes and their role in improving health outcomes for children (age 0–5 years) in low- and middle-income countries. Overall, the review found some positive improvements for immunisation rates and child morbidity. The results for child mortality and other health outcomes were inconsistent across studies.

Only one study was in sub-Saharan Africa. A cluster randomised controlled trial in Zimbabwe (Manicaland HIV/STD Prevention Project) provided conditional and unconditional cash transfers to low-income households who had orphans or were child-headed or headed by an elderly person or had an ill or disabled household member. In the conditional cash transfer group, the proportion of the children (0–4 years) with complete vaccination records was 1.8% higher than in the controls. The outcome for the unconditional cash transfer group was better: 3.1% more than controls.

Choko et al. (2018) assessed the impact of financial incentives for patients for two outcomes: linkage to HIV treatment (starting HIV treatment after diagnosis) and voluntary medical circumcision. Financial incentives included cash or non-cash incentives such as mobile phone talk time minutes, food vouchers, smart phones via a lottery and subsidised fees for health services. All studies except one were from sub-Saharan Africa.

Three of the five studies investigating linkage to HIV treatment, i.e. people accessing and continuing antiretroviral therapy, reported positive results: 26% increase for postpartum women, 42% increase for people who inject drugs and 10% increase for people testing at a clinic. However, in the remaining two studies, one among newly HIV positive patients identified in the community and another among people testing at an HIV clinic, there was no statistically significantly difference for this outcome between the intervention group and the controls.

The results for voluntary uptake of circumcision were more compelling. Overall results from four studies suggest a fourfold increase in uptake for those that received incentives compared to controls.

Swann (2018) reviewed the evidence on household economic strengthening interventions which included financial incentives for HIV testing and linkage to care. Findings from sub-Saharan African studies are summarised here.

A study in rural Malawi found that financial incentives increased the probability of people obtaining their HIV test results after getting tested with 43% compared to those that didn't receive a financial incentive. For every dollar increase in the incentive the probability increased by 9.1 percentage points. Another study, in rural Zimbabwe, found that a grocery

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item incentive led to increased couple testing for HIV (49.5% compared to 10.6% in controls). A study from Swaziland found that financial incentives given as mobile phone minutes along with health education, appointment reminders and accelerated antiretroviral therapy led to a higher linkage with healthcare within one month of HIV diagnosis. A conditional cash transfer programme (South African Disability Grant) for adults living with HIV was associated with higher reported initiation of antiretroviral therapy (64.5% versus 44.1% for those not receiving the grant).

Hurst et al. (2015) conducted a rapid review of the effectiveness of demand-side interventions in improving utilisation of maternal health services. The interventions were either financial incentives (cash transfers, vouchers) or participatory women's groups providing information in the community. The findings from the studies on financial incentives are summarised below.

Overall, the review found strong evidence of the effectiveness of these interventions in increasing utilisation of services. Two studies of financial incentives from sub-Saharan Africa were included. In a study from Kenya, women could buy vouchers for antenatal care, facility delivery services and postpartum care. The likelihood of having at least one antenatal visit increased more than sixteen-fold, delivery at a facility increased by 40% and skilled birth attendant at delivery increased by 20%.

Hunter and Murray (2017) attempted to identify the enablers and barriers that affected implementation of cash transfer and voucher programmes. Their findings from the sub-Saharan African studies are provided below.

A Child Grant Programme in Zambia provided unconditional cash transfers to households with children in three districts with the worst child morbidity and mortality outcomes. Payments were made directly to mothers. There was no effect on skilled birth attendance or antenatal care. A lack of investment in health care facilities was seen as a barrier to the effectiveness of the programme.

The SURE-P programme in Nigeria was a short-term payment scheme for women who accessed maternity services in one of the programme's many health facilities. There was no effect on skilled birth attendance or antenatal care. Factors helping to increase service usage included prompt payment, specific roles for banks and local organisations that provided information systems for the programme and the existence of other programmes that also supported maternity care services.

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Vouchers for Health in Kenya was a programme in which women living in three districts and two urban slums could purchase vouchers that could be redeemed for maternity services (including caesarean section) at accredited health facilities. The programme led to increased skilled birth attendance and facility deliveries but there was no impact on antenatal and postnatal care.

Two voucher programmes for maternity services in Uganda – Makerere University Voucher Scheme and HealthyBaby – covered antenatal care, delivery and postnatal care at public facilities and some private facilities. Some vouchers also covered transportation costs to the health facility. Both programmes led to increased facility deliveries and one programme also saw increased use of antenatal and postnatal services. Enablers for implementation were found to be covering the transport costs, reimbursing providers based on output and efficiently identifying eligible women.

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3.5 HIV stigma reduction

There were 35 systematic reviews in the evidence map in which impact on stigma was reported. The three that assessed the effectiveness of stigma reduction interventions for people with HIV are summarised here.

3.5.1 Findings and evidence gaps

Based on the evidence from the three systematic reviews, the following conclusions can be drawn:

1. HIV stigma reduction programmes are generally effective, although the reported effects are relatively small. Educational approaches and home-based counselling and treatment can be effective tools in HIV stigma reduction and in improving knowledge on HIV/AIDS.
2. Programmes for professionals, including healthcare personnel (in work settings), seem to be more effective than programmes for other types of participants.
3. Structural and community factors and population characteristics influence the effectiveness of programmes. Implementers should therefore consider the influence of these structural factors (e.g. anti-homosexuality laws, HIV testing programmes and national policies), community factors (e.g. traditional beliefs and practices, taboos and prevalence of intimate partner violence) and population characteristics (e.g. age, socioeconomic status and urban versus rural residence) for these programmes in a given setting.

Despite the large number of studies on educational approaches, there are few evaluations of regulatory laws and policies that can address HIV stigma. Cost information on these programmes is also sparse. More economic evaluations could help implementers and policymakers make appropriate decisions.

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3.5.2 The interventions researched

HIV stigma is prejudice and unfavourable attitudes against people living with HIV (PLHIV). It can lead to discrimination against PLHIV in various aspects of their lives such as healthcare, workplace settings and in the community. HIV stigma and discrimination can cause mental and emotional distress for PHLIV and lead to reduced use of healthcare services and participation in society.

HIV stigma reduction programmes use multiple types of intervention strategies in various settings, such as healthcare, workplaces and schools. Often HIV stigma reduction programmes are a combination of various strategies rather than single-component programmes.

The interventions aim not just to improve knowledge of HIV but also to change the attitudes of the public towards PLHIV. Perspective-taking and empathy are commonly promoted in these programmes, often through different types of interactions between programme participants and PLHIV, such as one-on-one conversations, group sessions, role play and games.

Intervention strategies for HIV stigma prevention programmes include:

- awareness raising to improve knowledge, attitudes and behaviours (radio, films, health education programmes, group discussions, testimonies, mobile phone messaging, etc.)
- health service provision to reduce barriers to HIV testing and services (antiretroviral therapy provision, voluntary counselling and testing (VCT), mobile and home-based VCT, etc.) and offering social and psychological support to PLHIV[1]
- community mobilisation using local counsellors to raise awareness, improve behaviours and offer health services in the community (traditional healers, youth counsellors, community health workers, local community leaders) and
- developing regulatory legislation.

1 Social and psychological support for instance included teaching coping skills to PLHIV (Thapa et al., 2018)

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3.5.3 Systematic presentation of the evidence

The large systematic review and meta-analysis by Mak et al. (2017) found that HIV stigma reduction programmes are effective: stigma can be reduced. Participants' knowledge of HIV/AIDS improved significantly for studies with or without control groups. The studies also reported improved attitudes towards PLHIV. While statistically significant, the effects were relatively small. Studies that could not be included in the main analysis also mostly reported positive results for HIV-related knowledge and a reduction in negative attitudes.

The participants were male and female members of the community, professionals, institutionalised individuals (juveniles, substance-abuse offenders) or students. In most studies, standard educational approaches like lectures and talks were used. In some programmes, PLHIV were invited as speakers to share their life experience with HIV. In some studies, a combination of approaches was used.

Programmes for healthcare professionals with multiple sessions conducted in community settings and those for healthcare personnel, conducted at their worksites, were generally more effective than such programmes for other types of participants, such as community members. The results for healthcare personnel were promising.

The review by Thapa et al. (2018) aimed to understand the mechanisms by which reducing HIV stigma resulted in greater HIV test uptake in low- and middle-income countries (LMICs). The multiple strategies identified by the review included those from studies alluded to above.

Most interventions used multiple strategies. The authors concluded that these interventions improved knowledge and reduced stigmatising attitudes and behaviour. Ultimately, this led to more uptake of HIV testing in LMICs. Factors that influenced the impact of these programmes included:

- structural factors such as anti-homosexuality laws, HIV testing programmes and national policies
- community factors such as traditional beliefs and practices, taboos and prevalence of intimate partner violence
- population characteristics such as age, socioeconomic status and urban or rural residence.

Feyissa et al. (2015) assessed the effectiveness of home-based HIV counselling and testing in reducing HIV stigma. Among programme participants, the risk of observable stigmatising behaviour in the community and the risk of PLHIV experiencing stigmatising behaviour were respectively 16% and 37% lower than in the control group.

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3.6 Pay-for-performance

Eighteen systematic reviews in the evidence map cover financing interventions to improve SRH outcomes. One of these strategies is Pay-for-performance (P4P). Four systematic reviews focus on the effectiveness of P4P interventions in improving SRH outcomes. Results from these reviews are summarised here.

3.6.1 Findings and evidence gaps

Based on the evidence from four systematic reviews on the effects of P4P on SRH outcomes, it can be concluded that the evidence is mixed and results are inconsistent.

P4P interventions implemented to improve SRH outcomes have shown a positive impact in some areas (HIV/AIDS testing and treatment) and in some process/services outcomes for maternal and child health, such as antenatal care services. On the other hand, the evidence is not convincing on P4P interventions for improving family planning services and many maternal and child health outcomes such as delivery care, postnatal care, under-fives outcomes, emergency obstetric and neonatal care (EmONC), out-of-pocket expenses and client satisfaction.

A few studies report a potential negative impact on structural outcomes related to maternal and child health services (i.e. availability of quality staff and patient perception of drug availability at health facilities) and therefore caution is warranted when implementing P4P programmes.

There are various gaps in the evidence and more research should be funded to expand the evidence base of P4P in sub-Saharan Africa:

- The overall number of available studies is small. More evaluation would improve insight into effectiveness.
- The types of P4P programmes vary significantly across studies, i.e. the amount of the incentive payment and whether it is paid to an individual healthcare provider or to a facility. Having more evaluations on the various types of payment mechanisms and scenarios would contextualise findings better.
- Many important outcomes have not been studied in P4P programme evaluations for SRH. For example, Das et al. (2016) report that impact on delivery care, EmONC, postnatal care and under-fives outcomes were not reported in the studies they reviewed.

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Given the inconsistent findings and potential negative impact found in some cases for various SRH outcomes, implementers should be wary of implementing P4P interventions. The following factors can be important when implementing P4P programmes: (1) involving health workers in establishing performance indicators and adequate incentive payments and (2) autonomy of the facilities making the payments and increased budgetary support for facilities.

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3.6.2 The interventions researched

P4P is financial compensation intended to incentivise provision of care and services in terms of quality as well as efficiency. If healthcare providers achieve predetermined results (quality of care or health outcomes) then the providers receive additional payments. P4P can be focused on various levels of the health system, such as individual healthcare providers, healthcare facilities and large institutions. P4P strategies to improve health outcomes have been tried out in high-income countries and in low- and middle-income countries.

P4P attempts to incentivise behaviour change by offering payments that reward healthcare provider performance, which then leads to better quality and more efficient healthcare delivery. Only changing the behaviour of healthcare providers might not be sufficient and other demand-side barriers (e.g. healthcare services being too expensive) potentially also play an important role. Therefore, to succeed, P4P interventions might have to address multiple barriers. Other factors that may influence the effectiveness of P4P interventions include professional fulfilment, social status, skill level, availability of treatment resources and organisational constraints.

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3.6.3 Systematic presentation of the evidence

Das et al. (2016) examined P4P in the context of improving the quality of maternal and child healthcare in low- and middle-income countries. The review found only a small number of studies on this topic. These reported a diversity of performance measurements and payment mechanisms for quality of care – which made it difficult to compare results across studies. Generally, P4P programmes made payments to healthcare providers or facilities when they met pre-specified volume and quality of maternal and child health services delivered. Payment was made either to individuals or facilities. Examples of the amounts paid: 5% of physicians' salaries in the Philippines; 275% times the base salary of primary healthcare facility staff in Egypt; and monthly payments of USD200–USD4,000 to facilities in DRC.

Maternal and child health-related performance indicators for payments included measures such as completeness of medical records, patient satisfaction, waiting times, combination of service volume and quality, clinical competence scores of physicians, facility caseload, utilisation of services and adherence to national standards and protocols.

The review found a mix of positive outcomes and some negatives in the evidence, though not always for the same outcomes across studies. Overall, there were slightly negative results for structural outcomes such as availability of qualified staff in clinics and hospitals, provider knowledge and patient perception of drug availability. P4P was found to have a positive effect on the quality of health services such as antenatal care provided but had little to no impact on maternal and neonatal health outcomes, out-of-pocket expenses and client satisfaction. The studies reviewed did not investigate impact on delivery care, EmONC, postnatal care and under-fives outcomes. In summary, P4P interventions led to promising improvements in multiple outcomes but the results were not consistent across studies. Further, some outcomes were negative.

Suthar et al. (2017) assessed P4P interventions as a strategy for improving HIV/AIDS service delivery. The review included four studies from sub-Saharan Africa. P4P was found to:

- significantly improve testing coverage for pregnant women (by 29%) and for couples (by 11%) but not for individuals (no difference)
- significantly improve antiretroviral coverage for pregnant women (by 55%), infants (by 92%) and other adults (by 74%)
- significantly reduce treatment dropouts (by 16%) and treatment failure rates (failure 55% less likely).

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The authors state that these results suggest that P4P could improve HIV service access and quality, but that to better understand its impact, more insight was needed into the other factors in the health system.

Blacklock et al. (2016) systematically reviewed the impact of P4P interventions on family planning services. The reported results on the effectiveness of P4P interventions in improving family planning coverage were inconsistent. Two studies reported an increase in the use of modern family planning methods and two others reported increased subscriber and coverage rates for family planning. But eight studies showed no impact on family planning use or prevalence. When the authors looked at outcomes for equity, financial protection, satisfaction with care received, quality of services and organisation of services, the results were also inconsistent. Given these findings it was difficult to conclude whether P4P is a reliable strategy to improve uptake of family planning services.

Patel (2018) conducted a systematic review to look at how P4P interventions worked and what factors were important for implementation. She found that the P4P interventions varied considerably in their design and implementation: for example, there could be large differences across programmes in the amount of the P4P incentive payment or the performance indicators which trigger a payment. This made comparisons across these programmes challenging. The author identified the following factors as important when implementing P4P programmes: engagement of health workers, getting their input on performance indicators, determining what is considered an attractive financial incentive, independence of the facilities making the payments and increased budgetary support for facilities.

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3.7 Access to safe abortion

Ten systematic reviews in the evidence map provide information on abortion-related interventions or on barriers and facilitators to seeking abortion services. Three of them assess the effectiveness of interventions to make abortion safer. Findings from these reviews are summarised here.

3.7.1 Findings and evidence gaps

Based on the three reviews on effectiveness of interventions to make abortion safer, the following conclusions can be drawn:

1. There is no evidence base on interventions to improve access to safe abortion in sub-Saharan Africa.
2. There is some evidence that task-shifting surgical abortion services to mid-level non-physician providers (from sub-Saharan Africa) is equivalent in effectiveness and safety to services provided by physicians. However, the small number of studies warrants caution in employing this strategy without further research.
3. There is also some qualitative evidence on patient/client preferences for targeted digital interventions sent to mobile devices by their healthcare providers (typically via text messages).

Currently, too few studies from sub-Saharan Africa are available for robust conclusions to be drawn on effectiveness. Interventions and research should be tailored to adolescents and youth, since they are more likely to use informal sector abortions, which can lead to severe complications.

More studies are needed on interventions that address other barriers to accessing abortion services, such as lack of awareness among women about the legal status of abortion where they live and the negative attitudes and beliefs of healthcare providers towards abortion.

Also, more studies are needed on task-shifting of abortion services to mid-level providers such as midwives and nurses. Cost information and cost-effectiveness analyses would also be useful to implementers.

A final implication from the reviews is that it is important to implement measures to protect the privacy and confidentiality of patients when interventions are digital.

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3.7.2 The interventions researched

Abortion may be medical, i.e. induced by medically prescribed drugs, or surgical – manual vacuum aspiration and dilation and evacuation. Abortions can be safe when evidence-based medical or surgical methods are used. An abortion is unsafe when conducted by an untrained person or in an unsafe environment. Unsafe abortions can lead to severe complications and even death, while also affecting mental, physical and emotional health in the long term.

Globally, three in ten pregnancies are terminated by abortion, but 45% of all abortions are unsafe and most take place in low- and middle-income countries. In Africa, three out of every four abortions are unsafe. Various factors push women to seek abortions from the informal sector: stigma; socioeconomic status; restrictive laws; lack of awareness of the legal status of abortion or of where to access abortion services; perceived costs; healthcare providers' beliefs and negative attitudes regarding abortion; and misinformation in the community.

Multiple intervention strategies are available to improve access to safe abortion, including:

- legislation and policies that remove restrictions on abortions
- raising women's awareness of available legal abortion services through mass media campaigns, community mobilisation activities, stigma reduction programmes and other methods
- tailoring interventions to adolescents and youth, such as youth-friendly reproductive health clinics or mHealth interventions for outreach, education and support
- mHealth interventions that can provide health information, appointment reminders, advice and support to women and adolescent girls confidentially and privately
- education and training for healthcare providers to address any negative attitudes or beliefs about abortion that they might have
- shifting medical and surgical abortion services tasks from physicians to mid-level providers such as midwives and nurses to improve access to safe abortion and reduce costs.

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3.7.3 Systematic presentation of the evidence

The systematic review by Barnard et al. (2015) assessed whether training or authorising mid-level providers (midwives, nurses, non-physician providers) to perform first trimester abortions resulted in abortions that were as safe and effective as when performed by physicians. While task-shifting abortion services to mid-level providers could improve access to abortion services for women and could be cost-effective, not many countries have authorised this and so the review found limited evidence. The evidence found came from a mix of high-income and low- and middle-income countries (with only one sub-Saharan African study).

For medical abortions (these were not reported on in the sub-Saharan African study), the risk of failure was similar for physicians and mid-level providers. For surgical abortions performed by mid-level providers, the risk of failure was 2.25 times greater than that associated with physicians. However, the risk of complications was similar for the two groups and the combined risk for failure and surgical complications was statistically similar for both groups. The authors noted that because of the low quality of evidence, the results should be interpreted with caution.

The sole study from sub-Saharan Africa (from South Africa) compared mid-level service providers and physicians in terms of the safety outcomes for manual vacuum aspiration (a type of surgical abortion). All mid-level providers had received government-accredited training in abortion services. 1,160 women presenting for an induced abortion were randomised to either a physician or a mid-level provider. The rate of complications was 1.4 per 100 patients for mid-level providers and 0 for doctors: this difference was not statistically significant.

Lassi et al. (2016), a broad systematic review, identified interventions implemented in low- and middle-income countries that aimed to increase skilled birth attendance through improving human resources in management systems, policy, finance, education, partnership and leadership .

Only two studies assessed interventions that shifted abortion services to a mid-level provider or trained healthcare staff to provide better abortion and other obstetric services. The results from the study from South Africa have already been mentioned above, when discussing the systematic review by Barnard et al. (2016). For the other study, from Ethiopia, it was unclear whether the results reported were attributable to providing abortion services.

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Ames et al. (2019), a qualitative evidence synthesis, examined patient perceptions and experiences with targeted digital communication via mobile devices for various sexual and reproductive, maternal, newborn, child and adolescent health issues.

With respect to abortion, clients felt vulnerable to issues of privacy and confidentiality. Some stated a preference for neutral language and tailored content, with attention paid to timing and frequency. Issues reported included poor access to cell phones, either because of problems with network coverage or because they were unable to afford mobile devices or data, or because their devices were controlled by others (e.g. a husband or father). Language barriers and costs of accessing messages also affected use.

The content, the delivery channels and the source of the messages were all important factors for clients. Clients preferred the content to include the latest information, solutions to the current health issue and advice on other health issues.

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3.8 mHealth

Interventions for sexual and reproductive health among adolescents and young people

Using the filter 'youth' 23 systematic reviews in the evidence map are identified as including studies on mHealth and technology based interventions. From these reviews, four focus on the SRH effects of mHealth interventions specifically. The findings from these reviews are summarised below.

3.8.1 Findings and evidence gaps

Based on the evidence from the reviews on mHealth interventions, the conclusion can be drawn that there is no compelling evidence that mHealth interventions can contribute to achieving SRH outcomes for adolescents and young people in sub-Saharan Africa. There are not enough studies from sub-Saharan Africa and the results from the few studies available are far from compelling.

Avoid implementing mHealth interventions to promote SRH in adolescents and young people in sub-Saharan Africa unless it is within the context of a research study. More studies of mHealth interventions are needed with the following features:

- studies in low-income countries
- studies from different geographical, demographic and socioeconomic settings in sub-Saharan Africa
- experimental study designs (including RCTs)
- reporting on multiple SRH outcomes
- studies of different mHealth technologies, such as text messages, app-based or social media-based
- reporting on programme costs and cost effectiveness

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3.8.2 The interventions researched

The increased use of mobile phones and, more recently, of smart phones in sub-Saharan Africa has created an opportunity for mHealth: mobile health interventions. These interventions use technology and mobile phone penetration, especially among adolescents and young people, to deliver information and services on sexual and reproductive health (SRH) issues. mHealth interventions make it possible for messages to be delivered to individuals on their personal devices and offer them confidentiality on sensitive topics.

mHealth interventions to improve SRH outcomes for adolescents and young people are intended to supplement traditional sexuality education curricula in the classroom. They typically include sending general sexual health promotion texts directly to adolescents, who are also able to ask their own questions via text messages. This offers personalised interactions while maintaining privacy and confidentiality. The ease with which adolescents can be reached and can themselves access resources via their mobile phones make mHealth an attractive intervention. mHealth interventions can also be used to provide treatment reminders, test results and counselling.

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3.8.3 Systematic presentation of the evidence

The systematic review by L'Engle et al. (2016) examines the effectiveness of mobile phone interventions on adolescent SRH outcomes. My far the most studies looked at interventions that used text messages, mostly for health promotion interventions where adolescents could ask questions on different SRH topics or would receive 'push' notifications with useful information on these topics. In addition to health promotion interventions, text messages were also used for health education (typically to supplement an in-person health education programme), screening and follow-up (texting test results to reduce time to treatment for sexually transmitted infections), counselling by healthcare providers (for youth living with HIV, or for advising young women on contraceptives) and to help patient adherence with treatments (such as antiretroviral therapy).

Of the 35 studies included, almost all were from high income countries; only three were from sub-Saharan Africa. Two of the latter – one from Tanzania and one from Kenya – provided information on contraceptives to young people via text message. The Tanzanian study reached 2,870 unique users with nearly 5,000 queries. Younger users (<19 years) tended to ask more questions on contraceptive methods than older users (>40 years). The Kenyan study reached close to 5,000 unique users. Condoms and natural family planning information (a form of birth control that does not use pills or devices) were the most frequently accessed content. One in five users also used the digital to locate clinics. Users stated that they liked the simple language in the messages and the confidentiality offered by mobile phones. The third study was from the Democratic Republic of Congo, where young people called into a radio programme with their SRH concerns. 15–24-year-olds asked the most questions. Given that there were so few studies and little information on effectiveness, it is difficult to draw conclusions about the effectiveness of these mHealth interventions in sub-Saharan Africa.

Wadham et al. (2019) conducted a systematic review to assess the effectiveness of new digital media interventions such as social networking sites, web pages and text messaging in improving SRH outcomes for adolescents and young people. Overall, nearly two-thirds of the studies included used web-based platforms and nearly half focused on HIV prevention; over 20 of the studies were conducted in industrialised countries. Some studies reported a statistically significant improvement in knowledge on prevention of HIV and other STIs. Only one in five studies reported favourable outcomes for condom use after intervention.

Widman et al. (2018) performed a meta-analysis that looked at technology-based interventions for youth

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and their impact on condom use and abstinence. The study found that in the intervention groups, condom use and abstinence improved statistically significantly compared to in the controls, although the size of the effect was small. There were also significant improvements for sexual health knowledge, safer sex norms and attitudes. Effects did not vary by age, gender, country of study, the dose used in the intervention or whether the intervention was tailored to participants. Short-term effects (<6 months) were stronger than longer-term effects.

Importantly, the reviews by Wadham et al. (2019) and Widman et al. (2018) both found only one study (Ybarra et al., 2013) from sub-Saharan Africa. In that study, 366 school students in Uganda were randomised to either an internet-based sexuality education programme (5–6 one-hour online modules of tailored sexuality education modules over five weeks) or to a standard HIV information programme offered at school. A large majority of students found the online programme useful and easy to navigate. They also felt that they had gained skills to keep them healthy. Two-thirds stated that there was too much content on sex and condoms. However, the main outcome measures of condom use and abstinence were not significantly different between the intervention and control groups.

The authors also noted many barriers to continuing the programme in the long term, such as poor access to technology, conflicting school schedules and lack of internet use by participants.

Gabarron and Wynn (2016) conducted a broad review on the use of social media for sexual health promotion. Since social media interventions were fairly new at that time, not many studies had adopted a theoretical framework or a robust study design. The authors reported that nearly a quarter of studies reported promising outcomes but pointed out that as research on social media interventions was so new, the findings should be interpreted with caution.

Only four of the 51 studies included were from sub-Saharan Africa and only one of them focused explicitly on young people. The review noted that the intervention reached over 2,000 people, but the results at outcome level were not clear-cut.

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3.9 Advocacy for WLHIV

Interventions using rights and advocacy approaches to address gender and power imbalance for women living with HIV (WLHIV)

Thirty systematic reviews in the evidence map reported on 'women's agency/ empowerment' as an outcome. Only one review specifically assessed interventions using a rights and advocacy approach and focussed on women living with HIV. Findings from this review are summarised below.

3.9.1 Findings and evidence gaps

There is little evidence that interventions using rights and advocacy approaches to positively influence gender and power imbalance for women living with HIV are effective in sub-Saharan Africa.

One systematic review demonstrated some positive effects of the interventions on condom use and reduced incidence of some STIs. The findings on other SRH outcomes, such as condom self-efficacy, sexual communication self-efficacy, relationship power and HIV status disclosure to a partner were mixed[2]. Most studies in the review concerned a setting in the United States.

Given the inconsistent results for self-efficacy and power-related outcomes, it is important through future research to identify the most effective combination of intervention components, the intensity needed, the various modes of delivery that would be useful and the applicability of findings to different settings.

More evaluations are needed of empowerment-promoting interventions for women living with HIV, especially from sub-Saharan Africa. The review did not include information on costs. Knowing more about programme costs and budgetary impact could help implementers and policymakers when planning.

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2 Self-efficacy refers to an individual's belief in his or her capacity to execute behaviors necessary to produce specific performance attainments.

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3.9.2 The interventions researched

Gender is the conventional mix of roles, behaviours and norms assigned by society. Gender power imbalance is reflected in personal relationships, in the household, in professional relationships and in the community; women are adversely affected.

The imbalance of power in intimate relationships and in the household can make women vulnerable and can curtail their power to make decisions about finances, relationships and sexual choices. These inequalities impede women's rights and prevent them from being able to meet their sexual and reproductive health needs.

Intimate partner violence (which includes physical, sexual and psychological violence) is often a consequence of the gender and power imbalance. A recent meta-analysis reported that three in five women from sub-Saharan Africa have experienced intimate partner violence at some time in their lifetimes and two in five are currently facing it in their relationships. Power imbalances can cause women to be reluctant to report intimate partner abuse and violence.

There are many different intervention strategies to address gender inequities. One is through a rights and advocacy approach that seeks to promote women's empowerment – i.e. to build the capacity of individuals or groups to be able to make choices and subsequently to undertake preferred actions. These interventions focus on increasing women's self-efficacy and autonomy/agency. The next step is improved sexual and reproductive health (SRH) choices and rights (SRHR) which lead to better health outcomes.

Such interventions generally include cognitive behavioural therapy or adaptations of it specific to the intervention context (e.g. to improve negotiation skills) and motivational interviewing. The interventions are usually carried out by trained personnel such as nurses or social workers, or by peers and facilitators from the community. Multiple sessions are often held, commonly one-on-one or in small groups.

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3.9.3 Systematic presentation of the evidence

The systematic review by Robinson et al. (2017) assesses the impact of interventions aimed at addressing unequal gender and power relations and to improve self-efficacy and empowerment on decision-making on SRH among women living with HIV. The effectiveness of these interventions was assessed by examining the following outcomes:

- self-efficacy or empowerment for condom use, termination of pregnancy, birth spacing, childbearing and other SRH outcomes (e.g. self-efficacy in condom use is a person's confidence in their ability to buy condoms, negotiate their use with a partner and to actually use them during intercourse)
- SRH behaviours, such as condom use, contraceptive use and disclosure of HIV status to partners
- SRH outcomes, such as sexually transmitted infections (STIs) and pregnancy.

The studies were from the US and sub-Saharan Africa. The African studies were of interventions adapted from US-based interventions in an attempt to adapt successful intervention models to other contexts. Interventions were delivered in small groups or one-on-one sessions to women living with HIV. Facilitators varied across studies and included nurses, psychologists, trained group facilitators, peers and social workers. Intervention components included interactive group sessions, interactive videoconferencing and computer sessions, peers undertaking SRH education in group sessions, individual mentoring and sessions with small groups of pregnant women.

The incidence of STIs decreased and condom use increased in most of the studies that reported these outcomes, suggesting a promising role for intervention programmes of this type. While some outcomes improved in some studies, the gains were not consistent across all studies. It is furthermore important to note that the range of outcomes measured by the included studies was narrow, with the majority measuring condom use. Only a few studies measured other SRH outcomes, or more proximal outcomes such as empowerment and self-efficacy. Consequently, it is difficult to assess the impact of the interventions on women's self-efficacy or empowerment, and to understand the association between empowerment and SRH outcomes.

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3.10 Advocacy for SRH

Incorporating advocacy approaches within interventions to improve sexual and reproductive health outcomes

116 systematic reviews focus on rights, advocacy, policy or legislation, but several of these reviews mostly focus on scoping or address barriers. In total, six reviews provide insight into the effects of advocacy approaches on different aspects of SRH, such as improving maternal health, preventing gender-based violence and eradicating female genital mutilation (FGM). The findings from these reviews are summarised below.

3.10.1 Findings and evidence gaps

There are only very few studies on advocacy approaches reporting on SRH outcomes. Based on the studies that are available, the following conclusions can be drawn:

1. There is no evidence that advocacy interventions alone effectively improve SRHR outcomes. There is insufficient reporting of SRH outcomes in studies of advocacy interventions and too little context-specific information is given. Currently, very few studies report on effectiveness or cost-effectiveness. It is important, therefore, that these interventions are evaluated using robust study designs.
2. Legislation alone is not sufficient to change knowledge and attitudes towards FGM. To be effective, legislation needs to be complemented by a combination of active strict enforcement, political support and local involvement, as well as advocacy at grassroots level.
3. Advocacy interventions can potentially be an important component within multicomponent, multilevel interventions to improve SRHR outcomes. There are some examples of success from embedding advocacy approaches within larger multifaceted interventions. Consider also involving multiple stakeholders in advocacy interventions. Think of other factors that increase engagement with stakeholders, such as forming local committees, implementing accountability mechanisms, monitoring progress, giving feedback to healthcare providers, promoting a rights-based approach towards women's SRH and providing consistent information in the community.
4. To increase effectiveness of advocacy interventions, consider the specific needs of the women receiving the intervention and tailor intervention content and implementation accordingly. Ideally, involve women in the design, execution and evaluation of the intervention.

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3.10.2 The interventions researched

Advocacy interventions to improve sexual and reproductive health (SRH) outcomes aim to promote the empowerment of women. Advocates champion women's SRHR and provide support to give them access to SRH services and products.

Advocacy can be delivered one-on-one or in group settings. It can be the sole intervention but is typically part of a multicomponent, multilevel approach to improve SRHR outcomes. Advocates provide guidance and support to women and can also help them navigate resources for, among others, healthcare services, financial and legal aid, housing and counselling. They may be members of the women's community or come from outside, and they have varied backgrounds; for instance, they may be community health workers, activists, peers, lawyers or social workers.

Advocacy takes a rights-based approach to improve women's knowledge and attitudes regarding their own SRHR needs. It aims to improve women's confidence to take decisions about their own health and to improve accountability. Advocacy efforts also engage with members of the household (husbands, mothers-in-law), the healthcare system and the broader community (village leaders).

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3.10.3 Systematic presentation of the evidence

Two related systematic reviews (George et al., 2015 and George and Branchini, 2017) assessed interventions to promote awareness of the right to maternity care services. Below, the findings from both reviews are summarised together.

Among the multiple intervention strategies used to promote awareness of rights were: regular public meetings; meetings with healthcare staff; campaigns using posters, leaflets or audio presentations; creating report cards to monitor the experiences of pregnant women; community charters; and – working closely with local leaders – accountability targets related to maternal services. In other cases, health volunteers were involved and made home visits to pregnant women, involving members of the household such as husbands and mothers-in-law, and creating birth preparedness plans for women. Interventions were mostly incorporated within larger initiatives of establishing accountability mechanisms, community monitoring, advocacy and responsive service delivery. These multicomponent and multilevel interventions adapted to the local context were intended to bring together stakeholders to achieve attitudinal change. However, only four studies (only one of which was in sub-Saharan Africa) actually evaluated the impact on the use of maternity care services. These studies generally found that use of antenatal care increased, and so did the delivery of healthcare facilities.

Outcomes related to human rights (in terms of availability, acceptability and quality of care) and the capacity of rights holders and duty bearers also generally improved; however, comparisons are difficult because the studies used different measures.

In the facilities that received the intervention, workers' absence rates were 13% lower than in the control facilities. As a result of the activities to increase accountability (report cards, community meetings, etc.), the environment at the intervention facilities improved significantly in terms of the condition of floors, walls, furniture and odour. Waiting times reduced and in intervention facilities the use of equipment increased by 20% compared to in the control facilities. The authors reported that demand-driven mechanisms such as community monitoring were more important than supply-side mechanisms (such as provider assessment); they attributed intervention success largely to community monitoring tools and knowledge of health management committee roles and duties. The effect of posters on rights and obligations seemed to be less important. Overall, health worker knowledge about patients' rights remained poor but was higher in intervention facilities than in the control facilities. In intervention

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areas, dormant local health committees became active again. Discussing healthcare staff performance at local council meetings, using suggestion boxes and providing information on available free services seemed to make a difference.

In the broad systematic review by Martin Hilber et al. (2016) on interventions to strengthen accountability to improve maternal and newborn health in sub-Saharan Africa, the interventions most relevant to advocacy are those relating to 'political and democratic accountability'. They included a mix of the following: engagement with civil society organisations, with patients and professional associations, and with political activists advocating for accountability from government ministries on maternal and newborn health; the use of laws and policies to improve accountability; monitoring national progress towards achieving international targets; and the use of a rights-based approach to influence action. The authors do not provide outcome measures but conclude that advocacy efforts were most effective when multiple stakeholders were involved.

Rivas et al. (2019) conducted a systematic review to better understand how advocacy interventions helped abused women and reported that women and advocates agreed on which factors were important for advocacy interventions: knowledge and awareness on abuse, women's rights, and resources for help; support for accessing other services; proper risk assessments for continued abuse; and a plan to avoid future abuse. The duration, personnel involved (social workers, nurses, psychologists) and settings (healthcare, women's shelters) varied greatly among advocacy interventions. Trust in the advocate was vital and was boosted by shared life experiences (also being a victim of abuse or having a similar ethnic background).

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3.11 Sexuality education

Comprehensive sexuality education and contraceptive use

The evidence map contains 24 systematic reviews of comprehensive sexuality education of safe and proper contraceptive use, though some of them are broader in scope. The findings of five systematic reviews directly focussing on the relationship relationship between comprehensive sexuality education and contraceptive use and SRH outcomes are presented here.

3.11.1 Findings and evidence gaps

Based on the evidence from five reviews on the effects of comprehensive sexuality education programmes on contraceptive use and SRH outcomes, the following conclusions can be drawn:

1. The evidence that comprehensive sexuality education programmes are effective in increasing contraceptive use in sub-Saharan African is mixed at best. While some studies from sub-Saharan Africa report positive results for condom use, others report no impact. Similarly, comprehensive sexuality education programmes don't seem to reduce STIs, including HIV, in sub-Saharan Africa.
2. To improve comprehensive sexuality education programmes' effectiveness for contraceptive use it may be necessary to combine them with other health services and include other out-of-school components. Community-based activities such as information campaigns, social clubs and group activities could supplement school-based programmes.
3. Sexuality education programmes that address the gender or power context seem more likely to be effective than similar programmes that do not.

There are still some gaps in the evidence. To start, more evaluations of these interventions are needed in sub-Saharan Africa settings as many studies are from high income countries. Furthermore, the available evidence is focused on condom use. More studies are needed to assess impact on other contraceptive use, including emergency contraception.

Given the state of the evidence, comprehensive sexuality programma should be implemented with caution. It is also important to support further research on these interventions so that the picture of effectiveness becomes clearer.

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3.11.2 The interventions researched

Traditional sex education on 'the facts of life' has generally been replaced by comprehensive sexuality education which goes beyond information, helping young people to explore and nurture positive values regarding their sexual and reproductive health. This new approach was developed partly in response to the proven ineffectiveness of abstinence programmes. It is expected that the more comprehensive approach to sexuality education will lead to positive sexual and reproductive health (SRH) outcomes.

Comprehensive sexuality education interventions are typically delivered to adolescents in school (usually secondary or high school) by trained teachers or facilitators via lectures or presentations, informational literature and activities such as group discussions, role play, dramas, songs, films, counselling and quiz and essay competitions. In some cases there are community-based interventions on sexuality education. Such interventions may include peer-led programmes, youth-friendly health services and involvement of parents and members of the community.

These interventions provide adolescents with information on topics such as sexual health, safe sexual practices, transmission of HIV and other sexually transmitted infections and preventing teen pregnancy. The knowledge received is intended to impact adolescents' attitudes and behaviour, leading to better decision-making on sexual behaviour, sexual partners, sexual debut, contraceptive use and, ultimately, to lead to better SRH outcomes such as reduced unwanted pregnancy and reduced incidence of HIV and STIs.

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3.11.3 Systematic presentation of the evidence

Sani et al. (2016) conducted a systematic review and meta-analysis that included 31 different school-based comprehensive sexuality education interventions from sub-Saharan Africa. Approximately four out of five studies had been implemented in secondary schools and high schools; the rest had been carried out in primary and elementary schools. Four of the 31 studies included activities outside of school and in the community (e.g. at health centres). The target groups were girls and boys. A few studies also included condom distribution.

The interventions were mostly delivered by teachers and other students (peer educators). Others involved included health educators, physicians, volunteers, nurses and other health staff. Training was routinely provided to these facilitators.

Across the 31 interventions there was no evidence that sexual health education interventions reduced STIs, including HIV. The analysis did show some effects on self-reported condom use: in the short term (less than six months) the probability of condom use increased by 62% in the randomised control trial (RCT) studies. In the longer term, the size of the effect from RCT studies fell to 40% (6–10 months) and 22% (over 10 months).

The authors concluded that successful comprehensive sexuality education interventions included other health services, had an out-of-school element and were implemented as intended.

Haberland (2015) examined whether including gender and power content in comprehensive sexuality education programmes affected SRH outcomes such as HIV and STI rates, teen pregnancy and childbearing.

Most studies in her review were from high-income countries; only five of the 22 studies were from sub-Saharan Africa. Settings for these programmes included schools (most common), clinics and the community. Some programmes included girls only, others included both girls and boys (there were no studies on boys only). At the core of almost all studies were interactive, student-centred, skills-based teaching approaches that encourage critical thinking and participation. Some interventions added more components, such as service learning, community awareness raising, vouchers for health services, job support, sports, academic support and art projects.

Nearly half of the programmes included gender and power in the curriculum. To be classified as such, Haberland (2015) stipulated that curricula had to include at least one explicit lesson, topic or activity covering an aspect of gender or power in sexual

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relationships—for example, how harmful notions of masculinity and femininity affect behaviors, are perpetuated and can be transformed; rights and coercion; gender inequality in society; unequal power in intimate relationships; fostering young women's empowerment; or gender and power dynamics of condom use.

Eight of the ten studies that included gender and power content in their curricula reported significant improvements in at least one of unintended pregnancy, childbearing or STI outcomes. At the same time, only two of the twelve of studies without gender and power in the curriculum reported similar improvements in outcomes.

The results for contraceptive use were not clear-cut. Only three studies from sub-Saharan Africa reported on this outcome and their results were inconsistent. One study reported increased self-efficacy in condom use or going to a clinic to obtain contraceptives; a second study reported improvements in some measures of condom use, while the third study found no impact on condom use.

Another important finding from the review was that clinic-based programmes fared better than school-based programmes.

The Cochrane systematic review by Mason-Jones et al. (2016) looked at school-based interventions and their effect on preventing HIV, STIs and pregnancy in adolescents. Male condom use was assessed as a secondary outcome.

Most of the studies reviewed were from sub-Saharan Africa. Three types of interventions were identified: SRH education programmes; incentive-based programmes to encourage school attendance; and a combination of both.

The SRH education programmes comprised multiple sessions delivered in school to adolescents on topics related to preventing HIV, STIs and pregnancy. The different curricula focused on improving knowledge and skills around sexual health issues, delaying sexual debut, reducing sexual risk-taking, abstinence until marriage, improving the quality of sexual relationships and better use of health services. The interventions were delivered by teachers, peers or adult facilitators in the form of lectures, group sessions, role play, games, comic workbooks and brainstorming sessions. Some interventions also had community components such as parent involvement, health clubs, interschool competitions, annual health weeks and youth-friendly SRH services.

The review found that SRH education programmes had no impact on the primary outcomes or on male condom use.

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Another Cochrane systematic review, by Lopez et al. (2016), was on the effectiveness of school-based interventions to improve contraceptive use in adolescents. Most studies were from high-income countries; only one study came from sub-Saharan Africa. The single study, from South Africa, reported some positive findings on condom use. Generally, however, the quality of the evidence used for this systematic review was too limited to draw robust conclusions.

Denford et al. (2016) systematically reviewed 37 systematic reviews of school-based interventions to improve sexual health. Overall, the review concluded that abstinence-only interventions were ineffective in reducing risky sexual behaviour. Comprehensive sexuality education interventions, especially those focusing on HIV prevention and school-based clinics, could effectively improve knowledge, attitudes, behaviour and health outcomes.

Most of the reviews referred to in this review-of-reviews were of studies from high-income countries. From the few reviews in sub-Saharan Africa, the results on condom use or other contraceptive use seemed to be inconsistent. Some reviews reported positive findings while others reported no impact from these interventions on contraceptive use in sub-Saharan Africa.

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3.12 Costs and cost-effectiveness

Of management and planning interventions to improve sexual and reproductive health outcomes

15 systematic reviews in the evidence map included studies of management and planning interventions, four of which were economic evaluations and, thus, focused on costs and cost effectiveness. The findings from these reviews are summarised below.

3.12.1 Findings and evidence gaps

Economic evaluations are not carried out as frequently as effectiveness studies. As a result, the cost-effectiveness of SRH programmes often remains unclear. Even in the existing economic studies, the reporting on various cost domains is not always complete. To be of maximum utility, economic evaluations should aim to report on all costs incurred by a given programme.

Providing more information on programme costs and cost-effectiveness can help policymakers in decision making. Comprehensive economic evaluations should be supported to complement effectiveness research on interventions. Long-term economic evaluations are also needed to get a better sense of cost-effectiveness, cost savings and cost benefits.

Based on the evidence provided by the economic evaluations on management and planning interventions in SRH, the following conclusions on cost-effectiveness can be drawn:

1. The economic evidence suggests that, in sub-Saharan African settings, differentiated antiretroviral (DART) programmes can be more cost-saving than standard antiretroviral treatment (ART) programmes. The average saving per patient per year across studies was USD 67.
2. Interventions that integrate family planning services within HIV programmes for women living with HIV are generally effective and are a cost-effective method of preventing unintended pregnancy and perinatal HIV transmission.
3. Performance-based financing, health insurance schemes and quality improvement initiatives to improve maternal and child health outcomes can be cost-effective in low- and middle-income settings.

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3.12.2 The interventions researched

The World Health Organization's Framework for Action considers six building blocks of the health system:

- service delivery;
- health workforce;
- information;
- medical products, vaccines and technologies;
- financing;
- and leadership and governance (stewardship).

Interventions for strengthening health systems (e.g. management and planning intervention approaches) are targeted at these aspects to improve outcomes for patients and the community.

Given that these interventions are implemented at organisational level, an important consideration for decision-makers is programme costs. Decision-makers also want to know the return on investment, i.e. the value of the improved SRH outcomes gained for the money invested. This summary covers the costs and cost-effectiveness of management and planning interventions to improve SRH outcomes.

Management and planning interventions aim to improve the organisation of the healthcare system and can include elements such as improving delivery of services and products. Examples relevant to SRH include the integration of family planning services into facilities that provide HIV care to women living with HIV.

Systematic reviews of economic evaluation summarise studies of individual interventions that include programme costs (preferably itemised); estimates of cost-effectiveness are summarised to gain insight into these parameters across multiple studies. Examples of the measures used to estimate cost-effectiveness are quality-adjusted life year (QALY) gained or disability-adjusted life year (DALY) averted.

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3.12.3 Systematic presentation of the evidence

Nugent et al. (2019), a systematic review that examined the costs and cost-effectiveness of integrating screening and care for non-communicable diseases into HIV programmes in low- and middle-income countries, considered five non-communicable diseases: hypertension, diabetes, hyperlipidaemia, cervical cancer and depression. The authors reported that the available evidence on the economics of these interventions was limited.

A small number of studies reported on costs of integrating screening for cervical cancer, cardiometabolic disorders (e.g. high blood pressure, diabetes, dyslipidaemia, obesity) and depression. No economic evaluations were found on integrating care for non-communicable diseases (treatment, adherence, retention) within an HIV programme.

Screening for hypertension and diabetes and related risk factors was found to be integrated within community-based HIV testing programmes. The per person cost of adding this screening ranged from 6% to 30% of the cost of HIV testing programmes in the community. In one such programme, the SEARCH platform implemented in Kenya and Uganda, the cost per person for hypertension and diabetes screening added USD 1.14 to the USD 20.10 cost of the HIV programme (an increase of 6%). Cervical cancer screening costs ranged from USD 3.24 to USD 54.34, depending on screening strategy. Since the authors found little reliable information on cost-effectiveness, they did not draw conclusions.

Roberts et al. (2019) published a systematic review of studies of the costs of differentiated antiretroviral (DART) programmes in sub-Saharan Africa. These programmes, which tailored delivery of antiretroviral therapy to clients based on their specific context, change the provider, intensity, location or frequency of services in accordance with the needs of different population groups. The DART models in sub-Saharan Africa can be group-based or delivered to individuals. They may be based in healthcare facilities, using existing infrastructure, or in the community (closer to clients). Examples of DART programmes include multi-month prescribing, task shifting (e.g. shifting a task from a nurse in a healthcare facility to a community health worker in the client's neighbourhood), community drug distribution points and adherence clubs.

The review found that most DART models with cost information in sub-Saharan Africa were facility-based and most studies were from Uganda. The range of yearly cost per patient (excluding drugs) in the programme was wide: from USD 27 to USD 889 (2018 USD). The economic evidence suggests that these programmes were cost-saving, i.e. DART programmes

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cost less than standard antiretroviral treatment (ART) programmes in sub-Saharan Africa. The average saving per patient per year across the studies was USD 67. As the largest driver of costs was personnel, DART programmes which frequently employed task shifting and reduced the number of visits to healthcare facilities could save costs, though savings can be reduced by increased utilisation of services in DART programmes and higher overhead costs.

The economic review of family planning interventions in low- and middle-income countries by Zakiyah et al. (2016) examined nine studies, three of which were economic evaluations of integrating family planning services within HIV services in sub-Saharan Africa. These three analyses looked at the impact of integrating family planning services with HIV services to prevent unintended pregnancy among HIV-positive women and to prevent HIV transmission from mothers to babies. The three studies generally found that integrating family planning services with HIV services was effective in improving the outcomes of interest and was cost-effective.

In their broad systematic review of the cost-effectiveness of health system strengthening interventions intended to improve maternal and child health outcomes in low- and middle-income countries, Zeng et al. (2017) found that performance-based financing (P4P), health insurance and quality improvement interventions were all cost-effective in improving these outcomes. The authors pointed out the diversity of implementation approaches for improving maternal and child health outcomes. They called for better economic reporting, more long-term economic analyses and for the synergy of supply-side and demand-side intervention strategies to be considered.

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3.13 SRH in humanitarian settings

Using the filter 'humanitarian settings', the evidence map contains ten systematic reviews. Four of these reviews focus on identifying effective interventions to improve sexual and reproductive health (SRH). Results from these four reviews are summarised below.

3.13.1 Findings and evidence gaps

The limited quality of the evidence on SRH in humanitarian settings probably reflects the difficulty of planning intervention studies with robust study designs in humanitarian settings and makes it rather unclear what works and what does not. However, certain intervention strategies that have been implemented have had some promising results.

More studies with good study designs are needed and it is important to support more research on various intervention strategies in humanitarian settings for SRH for adult women and adolescent girls. Even if random controlled trials are not feasible or ethical in humanitarian settings, quasi-experimental study designs could be tried; specifically, studies are needed on abortion services, fistula care and prevention of mother-to-child transmission of HIV, in LGBTQI+ populations and in people with disabilities. Cost information and cost-effectiveness analyses would also be useful for implementers.

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3.13.2 The interventions researched

A UNFPA report on the world population in 2015 estimated that nearly 26 million women and girls (ages 15–49) had sought humanitarian assistance because of armed conflicts, disease outbreaks or natural disasters. Humanitarian settings account for three in five preventable maternal deaths and approximately half of under-fives and neonatal deaths. Women and girls are also vulnerable to sexual and gender-based violence in these settings.

Interventions to improve SRH outcomes in humanitarian settings are a broad range of strategies implemented singly or multiply. Most are similar to those employed in non-humanitarian settings within SRH domains. There are interventions to improve individuals' knowledge, attitude and behaviour via health education, comprehensive sexuality education and information campaigns. Changes in behaviour will subsequently lead to better SRH outcomes.

Other examples of interventions come from strengthening the health system, e.g. by using community health workers for health promotion, training healthcare staff, integrating multiple services such as HIV testing and family planning, organising healthcare delivery via teams and subsidising the costs of health services. Other ways of engaging individuals include home visits, peer mentors and literacy and life skills development programmes.

Of special interest are the interventions focused on adolescents and young people living in humanitarian settings. Some of the unique ways implementers have tried to improve outcomes in these settings are creating an adolescent-friendly environment through flexible service hours for services, training healthcare personnel on the specific needs of adolescents and involving adolescents and young people in running the programme.

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3.13.3 Systematic presentation of the evidence

Two systematic reviews assessed the available evidence on effectiveness of SRH interventions in humanitarian settings: Singh et al. (2018) updated the findings from Warren et al. (2015), using a more recent literature search.

Seventeen of the 29 studies included in the 2018 review were conducted in humanitarian settings in sub-Saharan Africa. 24 studies were from areas affected by armed conflict while the rest came from settings affected by natural disasters or a combination of both. Of the 29 studies, ten assessed the effectiveness of interventions for pregnancy, maternal and newborn health, six included family planning interventions, five focused on HIV or sexually transmitted infections, three looked at prevention of gender-based violence, one focused on preventing mother-to-child transmission of HIV and the remaining four studies addressed multiple areas e.g. family planning and maternal and newborn health, family planning and abortion care. Because of the variation in the interventions evaluated and the study design used, the results from the studies are presented narratively in the review.

The authors of both reviews concluded that there was strong evidence for the effectiveness of the following interventions in improving a range of SRH outcomes in humanitarian settings:

- home visits
- peer-led education and counselling
- training activities for lower-level healthcare personnel
- community health workers to promote SRH services
- using a three-tiered network of providers – e.g. traditional birth attendants provide antenatal services and assist during delivery, health workers provide antenatal care and family planning products and maternal health workers oversee workers in the first two tiers and attend deliveries
- integrating SRH services within HIV programmes/ services
- engaging men in the community to reduce intimate partner violence.

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The reviews found moderate evidence for the effectiveness of the following interventions:

- transport-based referral systems that facilitate access to services
- community-based education on SRH
- delivering injectable contraceptives via community health workers
- general literacy programmes (not necessarily focused on SRH)
- birth preparedness interventions
- using treated bed nets for pregnant women to prevent malaria and subsequent anaemia
- subsidised healthcare for refugees.

Because of too few studies, there was little to no evidence on interventions for:

- treatment for fistulae
- abortion services.

Jennings et al. (2019) also systematically reviewed the evidence on SRH interventions in humanitarian settings but with a focus on adolescents and young people.

Of the 14 studies included, nine were on sub-Saharan Africa and most were conducted in areas affected by armed conflict. All studies targeted adolescents for the interventions; most studies focused on the prevention of unwanted pregnancies and transmission of HIV and other sexually transmitted infections. A small number of studies included interventions to prevent sexual and gender-based violence and mortality and morbidity among mothers and newborns. There were no studies on topics such as abortion services, fistula care and prevention of mother-to-child transmission of HIV. Neither were there studies focused on LGBTQI+ populations or people with disabilities.

As in the previous reviews, the results were reported narratively because of the heterogeneous nature of the studies included. Most studies reported outcomes on utilisation of services and change in knowledge and attitudes, but the number of studies reporting change in behaviour or risk was small. Nearly all studies reported positive changes in one or more SRH outcomes (mostly for knowledge and attitudes). Half of the studies also reported at least one SRH outcome that showed no change, and one study reported a negative impact from the intervention (in terms of a decrease in the number of family planning clients).

The authors highlighted that implementers – typically these are large international organisations such as UNFPA, WHO and Save the Children working with local authorities and funded by large foundations and international governments – have tried out various intervention strategies. These included adolescent-friendly spaces, involvement of peers, school-based programmes and actively involving young people in intervention activities. However, the available

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evidence remains limited due to inadequate reporting of outcomes and to issues with study design. It is therefore challenging to identify which intervention strategies work for this population in humanitarian settings.

A systematic review by Noble et al. (2019) looked at interventions to reduce gender-based violence and support the empowerment of adolescent girls in humanitarian settings. The review found only three studies targeted at girls aged 10–18, all from sub-Saharan Africa.

The interventions included components such as providing safe spaces for adolescent girls, providing them with livelihood skills training, mentoring, social support, peer learning and training sessions on gender-based violence prevention, reproductive health and financial literacy. Although there were some promising results, such as better engagement in livelihood activities, social assets (female friends, mentors), financial literacy, decision-making and self-efficacy, they were not consistent across studies. The small number of available studies and issues with study quality mean that it is unclear whether these types of interventions are truly effective.

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3.14 Barriers for LGBTQI+ persons

Barriers to accessing healthcare for LGBTQI+ persons

Using the filter 'LGBTQI+', the evidence map contains twelve systematic reviews. Seven of the reviews included studies that focused on identifying barriers for LGBTQI+ populations or on interventions looking to improve outcomes for them. Three systematic reviews from this group focus on characterising barriers that LGBTQI+ persons face while accessing healthcare. Their findings are summarised below.

3.14.1 Findings and evidence gaps

Based on the three systematic reviews focusing on characterising barriers that LGBTQI+ persons face while accessing healthcare, the following conclusions can be drawn:

1. LGBTQI+ persons experience many barriers while accessing healthcare, such as stigma, denial of care and even abuse. LGBTQI+ persons are often hesitant to disclose their sexual identity to healthcare providers for fear of judgement and receiving low quality care. This leads to avoidance of the healthcare system, leading to poor overall health outcomes for this group.
2. Healthcare providers' own beliefs, education level and knowledge affect their attitudes and behaviour towards LGBTQI+ persons. This identifies a potential area for developing interventions to improve the knowledge, attitudes and behaviour of healthcare personnel in their treatment of LGBTQI+ persons.
3. The criminalisation of consensual same-sex relationships that is codified in law in many African countries is a major factor that negatively impacts societal norms relating to LGBTQI+ persons.

While one of the three reviews in this summary focused on African LGBTQI+ populations, the number of African studies in the other two reviews is small. More studies on specific barriers for LGBTQI+ persons in sub-Saharan Africa are needed so that interventions can be customised to the setting.

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3.14.2 The barriers researched

LGBTQI+ persons face many challenges in accessing healthcare. Enduring societal norms and subsequent stigma can hinder them from feeling safe within society at large, including within the healthcare system. Although decriminalising consensual same-sex relationships is picking up pace in many parts of the world, over 60 countries and territories continue to criminalise them. In many parts of sub-Saharan Africa, anti-gay laws, often with severe punishments, are in force, making it all the more challenging for LGBTQI+ persons to access healthcare safely. Some healthcare providers might have preconceived notions about LGBTQI+ issues, leading to discrimination.

It is important to identify specific barriers, characterise the environment for LGBTQI+ persons to access healthcare services and find areas of intervention to overcome these barriers.

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3.14.3 Systematic presentation of the evidence

Muller and Hughes (2016) conducted a systematic review to characterise the experiences and issues faced by sexual minority women (SMW) in Southern Africa. SMW surveyed in the studies were mostly in their twenties and came from different racial and socioeconomic backgrounds. The SMW were reluctant to use healthcare services and to disclose their sexual orientation in institutional settings (schools, healthcare) and often suffered hateful and even violent events in silence. The most common health issues for the SMW were sexually transmitted infections (including HIV), mental health and sexual violence. Poor healthcare provider knowledge, lack of sexual health information among SMW along with the role of organised religion contributed to social exclusion of SMW. The review also highlights the impact of restrictive laws that criminalise consensual same-sex relationships in many parts of sub-Saharan Africa. The authors argue that these laws have had a large influence on societal norms, leading to increased stigma and victimisation of LGBTQI+ persons.

In their systematic review, Brooks et al. (2018) explored sexual orientation disclosure in healthcare by LGBTQI+ persons. Most of the 31 studies in the review were in high-income countries but two were from sub-Saharan Africa. The review identified four themes for barriers to and facilitators for disclosing sexual orientation to healthcare providers: the moment of disclosure; the expected outcome of disclosure; the healthcare professional; and the environment/setting of disclosure. The most prominent factors identified were the perceived relevance of revealing sexual orientation to healthcare providers; the skills and language used by healthcare personnel; and worry that revealing sexual orientation would lead to negative judgement and poor care.

Ayhan et al. (2016) aimed to systematically identify discrimination experiences for LGBTQI+ persons. Almost all the studies included in this systematic review were from high-income countries; only one study was from sub-Saharan Africa. LGBQTI+ persons reported stigma, denial/refusal of healthcare, and abuse (verbal and physical). Healthcare providers' attitudes towards LGBTQI+ were influenced by knowledge, education, religion and beliefs. The review's authors call for more education interventions such as seminars, workshops and interactions with LGBTQI+ persons that target healthcare providers, in addition to LGBTQI+-friendly policies to improve the healthcare environment.

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1.1 PICOS

Population

The population of interest are females and males living in low- and lower-middle income countries in sub-Saharan Africa.

Interventions

The interventions are those intended to affect Sexual and Reproductive Health and Rights. Our starting point for developing a typology of interventions was the strategy of the Dutch Ministry of Foreign Affairs, which were subsequently modified during piloting. The final categories are (the full list of sub-categories is in Annex 1.8):

- Enabling environment for SRHR (e.g. youth engagement in decision-making, and advocacy and legislation)
- Improving access to information (e.g. media campaigns, and comprehensive sexuality education)
- Health systems strengthening (e.g. financing and private sector involvement)
- Health services availability, access and quality (e.g. clinics and community health workers, and SRH supply chain and logistics)
- Socio-economic interventions (e.g. cash transfers and education, where these have an explicit intent to affect SRHR)

Comparison

We will include reviews, which have both active and passive comparisons where applicable, that is where the comparison gets an alternative treatment (active) or no intervention (passive).

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Indicators

The indicators are organized into the following categories (see Annex 1.8 for a detailed list):

- Barriers and facilitators and implementation issues
- Intervention costs
- Enabling environment (e.g. norms and values)
- Knowledge, attitudes and practice
- Health services
- SRHR outcomes (e.g. maternal health and mortality and early marriage)

Study designs

The evidence and gap map will only include systematic reviews that are in English and published in 2015 or later. In addition, these reviews must include at least one study from a low-income or lower middle-income country in sub-Saharan Africa.

Both quantitative and qualitative reviews are eligible for inclusion.

Filters

We will code the following to act as filters in the Evidence and Gap Map:

- Youth
- LGBTQI+
- People with disabilities
- Humanitarian settings
- Key populations (including sex workers, injecting drug users, men who have sex with men, and disadvantaged groups)
- Men
- Women
- Poor and disadvantaged

These filters represent the priority target groups in the Dutch SRHR-policy.

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1.2 Search

The primary search will be conducted on PubMed, supplemented by the Cochrane Library. The search string for PubMed is shown in Annex 1.6. Supplementary searches for unpublished reviews on specific topics will be conducted in Google Scholar using the search string "[Topic]" AND "systematic review"; for example "sexuality education" AND "systematic review". We will also hand search selected journals and websites. Journals searched will be BMJ Sexual & Reproductive Health, Frontiers in Reproductive Health, International Perspectives on Sexual and Reproductive Health, Perspectives on Sexual and Reproductive Health, Reproductive Health, Sexual & Reproductive HealthCare, and Sexual and Reproductive Health Matters. Websites will include Guttmacher Institute, Marie Stopes International, PLAN, UNFPA, and WHO.

1.3 Screening and coding

Development of screening and coding forms

The screening and coding forms will be developed through a consultative piloting process involving IOB staff and other stakeholders within the Ministry of Foreign Affairs. The final forms resulting from this process are contained in Annexes 1.7 and 1.8 respectively. The coding form in Annex 1.8 is also the framework for the map, and is presented here with the definitions used.

Process

Screening is a two-stage process: title and abstract, followed by full text. Screening and coding of all studies will be done independently by two people.

Screening and coding will be conducted using the EPPI Reviewer software. The data file can be exported from EPPI Reviewer as a JSON file to import into EPPI Mapper to generate the interactive EGM. This is an html file that can be posted online.

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1.4 Critical appraisal of included studies

For critical appraisal we will use AMSTAR 2, which is the adaptation of AMSTAR for reviews including non-experimental studies (see https://www.bmj.com/content/358/bmj.j4008).

1.5 Analysis and presentation of results

The results will be presented in two ways: an evidence and gap map, and evidence summaries of selected topics based on included reviews.

Evidence and gap map

The online evidence and gap map will display the available studies as a matrix with interventions as row headings and outcomes as column headings. The studies may be filtered by various characteristics (e.g. target group) to only show studies for that filter.

The will be interactive, so the user can click on any cell, or row or column heading, to get a list of the studies it contains. They may then click on any study to access the record for that study and the full text if in the public domain (and abstract if not).

Evidence summaries

The evidence summaries will be reviews of reviews. Using the map we will, in consultation with IOB staff, identify 14 topics for which there are relevant reviews in scope and produce a short narrative review (evidence summary) based on these reviews. The summaries will describe the issue or condition, the intervention(s), the included reviews and their findings in a narrative summary format. They will shed light on the reasons for (in)effectiveness of certain interventions, as well as the (in)effectiveness of specific interventions for certain sub-groups and to identify critical conditions for effectiveness of SRHR-interventions in developing countries.

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Stakeholder engagement

The key stakeholders are IOB staff who have been engaged in piloting and topic selection for the summaries. IOB staff have consulted more broadly within the ministry of Foreign Affairs and organized a stakeholder engagement meeting.

Planned use of the map and summaries

The results from this study can help the Ministry of Foreign Affairs – in particular the department responsible for SRHR – in moving towards more evidence-based programming. It will also help to identify knowledge gaps that can inform and direct further research activities. Finally, IOB will use the results of the study for the broader SRHR evaluation.

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1.6 Search strings for PubMed

((“reproductive health”[MeSH Terms] OR “reproductive health services”[MeSH Terms]) OR “sexual abstinence”[MeSH Terms]) OR “sexual behavior”[MeSH Terms]) OR “pregnancy in adolescence”[MeSH Terms]) OR “pregnant women”[MeSH Terms]) OR “ambulatory care facilities”[MeSH Terms]) OR “ambulatory care facilities”[MeSH Terms]) OR “abortion, legal”[MeSH Terms]) OR “abortion, criminal”[MeSH Terms]) OR “postnatal care”[MeSH Terms]) OR “prenatal diagnosis”[MeSH Terms]) OR “prenatal care”[MeSH Terms]) OR “women s health services”[MeSH Terms]) OR “women s health”[MeSH Terms]) OR “sexual behavior”[MeSH Terms]) OR “maternal behavior”[MeSH Terms]) OR “maternal mortality”[MeSH Terms]) OR “infant mortality”[MeSH Terms]) OR “child health services”[MeSH Terms]) OR “infant health”[MeSH Terms]) OR “maternal-child health centers”[MeSH Terms]) OR “child health”[MeSH Terms]) OR “child health services”[MeSH Terms]) OR “hiv”[MeSH Terms]) OR “anti-hiv agents”[MeSH Terms]) OR “anti-retroviral agents”[MeSH Terms]) OR “antiretroviral therapy, highly active”[MeSH Terms]) OR “sexually transmitted diseases”[MeSH Terms]) OR “sexually transmitted diseases”[MeSH Terms]) OR “marriage”[MeSH Terms]) OR “marriage”[MeSH Terms]) OR “circumcision, female”[MeSH Terms]) OR “violence”[MeSH Terms]) OR (((“interpersonal”[All Fields] OR “interpersonality”[All Fields]) OR “interpersonally”[All Fields]) AND “violence”[MeSH Terms])) OR “domestic violence”[MeSH Terms]) OR “spouse abuse”[MeSH Terms]) OR “breast feeding”[MeSH Terms]) OR “breast feeding”[MeSH Terms]) OR “contraceptive agents”[MeSH Terms]) OR “contraceptive agents”[MeSH Terms]) OR “ambulatory care facilities”[MeSH Terms]) OR “sex education”[MeSH Terms]) OR “family planning services”[MeSH Terms]) OR “sex education”[MeSH Terms]) OR “condoms”[MeSH Terms]) OR “unsafe sex”[MeSH Terms]) OR ((“unsafe”[All Fields] OR “unsafely”[All Fields]) AND ((((((((((((((“abort”[All Fields] OR “aborted”[All Fields]) OR “aborter”[All Fields]) OR “aborters”[All Fields]) OR “aborting”[All Fields]) OR “abortion s”[All Fields]) OR “abortion, induced”[MeSH Terms]) OR (“abortion”[All Fields] AND “induced”[All Fields])) OR “induced abortion”[All Fields]) OR “abortion”[All Fields]) OR “abortions”[All Fields]) OR “abortive”[All Fields]) OR “abortively”[All Fields]) OR “abortives”[All Fields]) OR “aborts”[All Fields]))) OR ((((((((((((“emerge”[All Fields] OR “emerged”[All Fields]) OR “emergence”[All Fields]) OR “emergences”[All Fields]) OR “emergencies”[MeSH Terms]) OR “emergencies”[All Fields]) OR “emergency”[All Fields]) OR “emergent”[All Fields]) OR “emergently”[All Fields]) OR “emergents”[All Fields]) OR “emerges”[All Fields]) OR “emerging”[All Fields]) AND ((((“obstetric”[All Fields] OR “obstetrically”[All Fields]) OR “obstetrics”[MeSH Terms]) OR “obstetrics”[All Fields]) OR “obstetrical”[All Fields]) AND “care”[All Fields])) OR ((((((((((((((“sexual behavior”[MeSH Terms] OR (“sexual”[All Fields] AND “behavior”[All Fields])) OR “sexual behavior”[All Fields]) OR “sexual”[All Fields])

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OR “sexually”[All Fields]) OR “sexualities”[All Fields]) OR “sexuality”[MeSH Terms]) OR “sexuality”[All Fields]) OR “sexualization”[All Fields]) OR “sexualize”[All Fields]) OR “sexualized”[All Fields]) OR “sexualizing”[All Fields]) OR “sexuals”[All Fields]) AND ((“reproductive health”[MeSH Terms] OR (“reproductive”[All Fields] AND “health”[All Fields])) OR “reproductive health”[All Fields]))) AND ((“meta-analysis”[Publication Type] OR “review”[Publication Type]) OR “systematic review”[Publication Type])) AND ((((((((((((((((((((((((((((((((((((((“adolescent”[MeSH Terms] OR “adolescent”[MeSH Terms]) OR “young adult”[MeSH Terms]) OR “child”[MeSH Terms]) OR “adult”[MeSH Terms]) OR “adolescent”[MeSH Terms]) OR “women”[MeSH Terms]) OR “poverty”[MeSH Terms]) OR “disabled persons”[MeSH Terms]) OR “mentally disabled persons”[MeSH Terms]) OR “disabled children”[MeSH Terms]) OR “gender identity”[MeSH Terms]) OR “homosexuality”[MeSH Terms]) OR “homosexuality, female”[MeSH Terms]) OR “homosexuality, male”[MeSH Terms]) OR “sexual and gender minorities”[MeSH Terms]) OR “bisexuality”[MeSH Terms]) OR “transgender persons”[MeSH Terms]) OR “refugees”[MeSH Terms]) OR “transients and migrants”[MeSH Terms]) OR “transients and migrants”[MeSH Terms]) OR “sex workers”[MeSH Terms]) OR “drug users”[MeSH Terms]) OR “vulnerable populations”[MeSH Terms]) OR “lgbtq”[All Fields]) OR “lgbt”[All Fields]) OR “female”[MeSH Terms]) OR “adolescent”[MeSH Terms]) OR “relief work”[MeSH Terms]) OR “community health workers”[MeSH Terms]) OR “women s rights”[MeSH Terms]) OR “maternal health”[MeSH Terms]) OR “africa south of the sahara”[MeSH Terms]) OR ((((“poverty”[MeSH Terms] OR “poverty”[All Fields]) OR (“low”[All Fields] AND “income”[All Fields])) OR “low income”[All Fields]) AND (((“countries”[All Fields] OR “country”[All Fields]) OR “country s”[All Fields]) OR “countrys”[All Fields]))) OR (((“middle”[All Fields] OR “middles”[All Fields]) AND ((“income”[MeSH Terms] OR “income”[All Fields]) OR “incomes”[All Fields])) AND (((“countries”[All Fields] OR “country”[All Fields]) OR “country s”[All Fields]) OR “countrys”[All Fields]))) OR “lmic”[All Fields]) OR (“low”[All Fields] AND (“middle”[All Fields] OR “middles”[All Fields]) AND ((“income”[MeSH Terms] OR “income”[All Fields]) OR “incomes”[All Fields]))) OR ((((“altruism”[MeSH Terms] OR “altruism”[All Fields]) OR “humanitarianism”[All Fields]) OR “humanitarian”[All Fields]) OR “humanitarians”[All Fields])) AND ((“meta-analysis”[Publication Type] OR “review”[Publication Type]) OR “systematic review”[Publication Type]))) AND ((“legislation as topic”[MeSH Terms] OR “social values”[MeSH Terms]) OR “social distance”[MeSH Terms]) OR “human rights”[MeSH Terms]) OR “human rights abuses”[MeSH Terms]) OR “civil rights”[MeSH Terms]) OR “sex education”[MeSH Terms]) OR “education”[MeSH Terms]) OR “teaching”[MeSH Terms]) OR “community health workers”[MeSH Terms]) OR “community health centers”[MeSH Terms]) OR “community health services”[MeSH Terms]) OR “community health workers”[MeSH Terms]) OR “health education”[MeSH Terms]) OR “mass media”[MeSH Terms]) OR “health promotion”[MeSH Terms]) OR “community health planning”[MeSH Terms]) OR “health systems agencies”[MeSH

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Terms]) OR "public-private sector partnerships"[MeSH Terms]) OR "private sector"[MeSH Terms]) OR "public-private sector partnerships"[MeSH Terms]) OR "community-based health insurance"[MeSH Terms]) OR "healthcare financing"[MeSH Terms]) OR "social responsibility"[MeSH Terms]) OR "motivation"[MeSH Terms]) OR ("cash"[All Fields] AND ((((((("transfer"[All Fields] OR "transferability"[All Fields]) OR "transferable"[All Fields]) OR "transfered"[All Fields]) OR "transfering"[All Fields]) OR "transferred"[All Fields]) OR "transferring"[All Fields]) OR "transfers"[All Fields]))) OR "telemedicine"[MeSH Terms]) OR "mobile applications"[MeSH Terms]) OR "medical informatics"[MeSH Terms]) OR (("telemedicine"[MeSH Terms] OR "telemedicine"[All Fields]) OR "mhealth"[All Fields])) OR "methods"[MeSH Terms]) OR (((((("intervention s"[All Fields] OR "interventions"[All Fields]) OR "interventive"[All Fields]) OR "methods"[MeSH Terms]) OR "methods"[All Fields]) OR "intervention"[All Fields]) OR "interventional"[All Fields])) OR ((((((((("effect"[All Fields] OR "effecting"[All Fields]) OR "effective"[All Fields]) OR "effectively"[All Fields]) OR "effectiveness"[All Fields]) OR "effectivenesses"[All Fields]) OR "effectives"[All Fields]) OR "effectivities"[All Fields]) OR "effectivity"[All Fields]) OR "effects"[All Fields])) OR (("barrier"[All Fields] OR "barrier s"[All Fields]) OR "barriers"[All Fields])) OR ((((((((("facilitate"[All Fields] OR "facilitated"[All Fields]) OR "facilitates"[All Fields]) OR "facilitating"[All Fields]) OR "facilitation"[All Fields]) OR "facilitations"[All Fields]) OR "facilitative"[All Fields]) OR "facilitator"[All Fields]) OR "facilitator s"[All Fields]) OR "facilitators"[All Fields])) OR (((((((("implementability"[All Fields] OR "implementable"[All Fields]) OR "implementation"[All Fields]) OR "implementation s"[All Fields]) OR "implementational"[All Fields]) OR "implementations"[All Fields]) OR "implementer"[All Fields]) OR "implementers"[All Fields]) OR "implemention"[All Fields]))) OR "costs and cost analysis"[MeSH Terms]) OR "cost-benefit analysis"[MeSH Terms]) OR "cost-benefit analysis"[MeSH Terms]) OR "delivery of health care"[MeSH Terms]) OR "maternal health services"[MeSH Terms]) OR "reproductive health services"[MeSH Terms]) AND (("meta-analysis"[Publication Type] OR "review"[Publication Type]) OR "systematic review"[Publication Type]))

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1.7 Screening tool

	Lead author	
	Year	
1.	Is the study in English?	No>>Exclude (stop) Yes>>2
2.	Is the study published in 2015 or later?	No>>Exclude (stop) Yes>>3
3.	Is the study a systematic review? (To be systematic the study needs a comprehensive search strategy with an explicit inclusion and exclusion criteria, systematically screen, code, analyze and report studies).	No>>Exclude (stop) Yes>>4
4.	Is it a review of an intervention or interventions to improve sexual and reproductive health and rights? (The review may be of effectiveness, barriers and facilitators or costs)	No>>Exclude (stop) Yes>>5
5.	Does the review include at least one study from a low- or lower-middle-income country in sub Saharan Africa?*	No>>Exclude Yes>>Include
	Overall (Include if Yes to all the above)	

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1.8 SRHR Coding Framework

Publication
Lead author
Year of publication

Interventions		**Definitions**
Enabling environment for SRHR	Global initiatives	Support given to SRHR-related global institutions and partnerships, international advocacy and agreements, and conventions.
	Rights, advocacy and legislation	Rights-based and advocacy activities undertaken to influence either public opinion, government action or legislation.
	Youth engagement in decision-making	Engagement of youth in decision-making in a way which is voluntary, transparent, respectful, safe and rights-based.
	Youth-focused environment for SRHR services and interventions	Designing and implementing interventions and services focused on SRHR needs of youth and adolescents.
Improving access to information	Comprehensive sexuality education	Comprehensive sexuality education provides age-appropriate information, in school or out of school, includes scientifically accurate information about human development, anatomy and reproductive health, as well as information about contraception, childbirth and sexually transmitted infections (STIs). Source: https://www.unfpa.org/comprehensive-sexuality-education
	Community-based information campaigns	Community-based approaches to disseminating information including community meetings, working with community leaders, theatre, town criers, and home visitation
	Media campaigns	Information campaigns in traditional media including posters and flyers as well as social media

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Interventions		Definitions
Health systems strengthening	Management and planning	Interventions that aim to improve management and planning practices for SRHR services
	Financing	Different financing strategies to improve SRHR services
	Private sector involvement	Involvement of private sector entities both non-profit and for-profit in SRHR interventions
	Training for health administrators and workers	Training of health service providers and administrators from the formal and informal health sector. Example health care workers: community workers, traditional healers, pharmacists; Example health care administrators: managers, CEOs, board members
	Accountability and community engagement	Establishing processes to improve transparency and accountability for SRHR services in consultation with the community
Health services availability, access and quality	Clinics and community health workers	Facilities and services provided at the community level including the involvement of community health workers (CHWs)
	Sexual and reproductive health products	Provision of SRHR-related products such as contraceptives and condoms
	SRH supply chain and logistics	Interventions aimed at improving supply chain and logistics for SRHR health products
	Safe abortion	Delivery of safe abortion services (includes equipment/infrastructure for safe abortion)
	Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH)	Provision of comprehensive care to meet the reproductive health needs of women and the health needs of children
	STI/HIV testing and treatment (inc. ART)	Testing and treatment programmes for HIV and other STIs
	mHealth and technology-based interventions	Use of technology to facilitate delivery and increase reach of SRHR interventions

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Interventions		Definitions
Socio-economic interventions	Cash transfers and other economic incentives	Interventions that provide economic incentives both financial and in-kind to improve SRHR outcomes
	Life skills and livelihoods	Any support to livelihoods delivered with the intention of affecting reproductive choices, and life skills training which can help support informed choices and better livelihoods
	Education and literacy interventions	Support to education and literacy delivered with the intention of affecting reproductive choices

Indicators	Definitions
Barriers and facilitators and implementation	SRHR systematic reviews or individual studies within intervention-focused systematic reviews that provide information on either barriers or facilitators to accessing SRHR services or on implementation aspects of SRHR interventions
Intervention cost	SRHR systematic reviews or individual studies within intervention-focused systematic reviews that provide information on costs, cost-effectiveness or cost-benefit estimates.

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Effectiveness		Definitions
Enabling environment	International agreement and guidelines Legislative framework Norms, values and stigma Patient's dignity and rights Women's agency and empowerment	This list includes all the effectiveness outcomes that will be coded from SRHR systematic reviews and individual studies within reviews. These outcomes are indicators of effectiveness, i.e., how well an intervention works (or not) in improving SRHR outcomes.
Knowledge, attitudes and practice	SRHR knowledge and attitudes Safe sex and sexual behaviour	
Health services	Availability, accessibility and use of health services and products Quality of health services and products Safe, proper use of contraceptives HIV treatment cascade Safe delivery and safe abortion	
SRHR outcomes	Adolescent pregnancy and births Fertility and infertility Breastfeeding Gender-based violence Early marriage Under-five morbidity and mortality Maternal health and mortality HIV/AIDS/STIs	

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FILTERS	Example	Link
Youth	L'Engle et al. (2016) "Mobile phone interventions for adolescent sexual and reproductive health: A systematic review"	https://pediatrics.aappublications.org/content/138/3/e20160884.long
LGBTQI+	Klein et al. (2018) "Providing quality family planning services to LGBTQIA individuals: A systematic review"	https://www.sciencedirect.com/science/article/abs/pii/S0010782418300015
People with disabilities	Horner-Johnson et al. (2019) "Contraceptive knowledge and use among women with intellectual, physical, or sensory disabilities: A systematic review"	https://www.sciencedirect.com/science/article/abs/pii/S1936657418302103
Humanitarian settings	Singh et al. (2018) "Evaluating the effectiveness of sexual and reproductive health services during humanitarian crises: A systematic review"	https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0199300
Key populations (including sex workers, injecting drug users, men who have sex with men, and disadvantaged groups)	Rinaldi et al. (2018) "Cost effectiveness of HIV and sexual reproductive health interventions targeting sex workers: A systematic review"	https://resource-allocation.biomedcentral.com/track/pdf/10.1186/s12962-018-0165-0
Men	Altshuler et al. (2016) "Male partners' involvement in abortion care: A mixed-methods systematic review"	https://onlinelibrary.wiley.com/doi/abs/10.1363/psrh.12000
Women	Ivanova et al. (2018) "A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa"	https://www.mdpi.com/1660-4601/15/8/1583/htm
Poor	Systematic Review: The use of vouchers for reproductive health services in developing countries: systematic review	https://onlinelibrary.wiley.com/doi/full/10.1111/j.1365-3156.2010.02667.x

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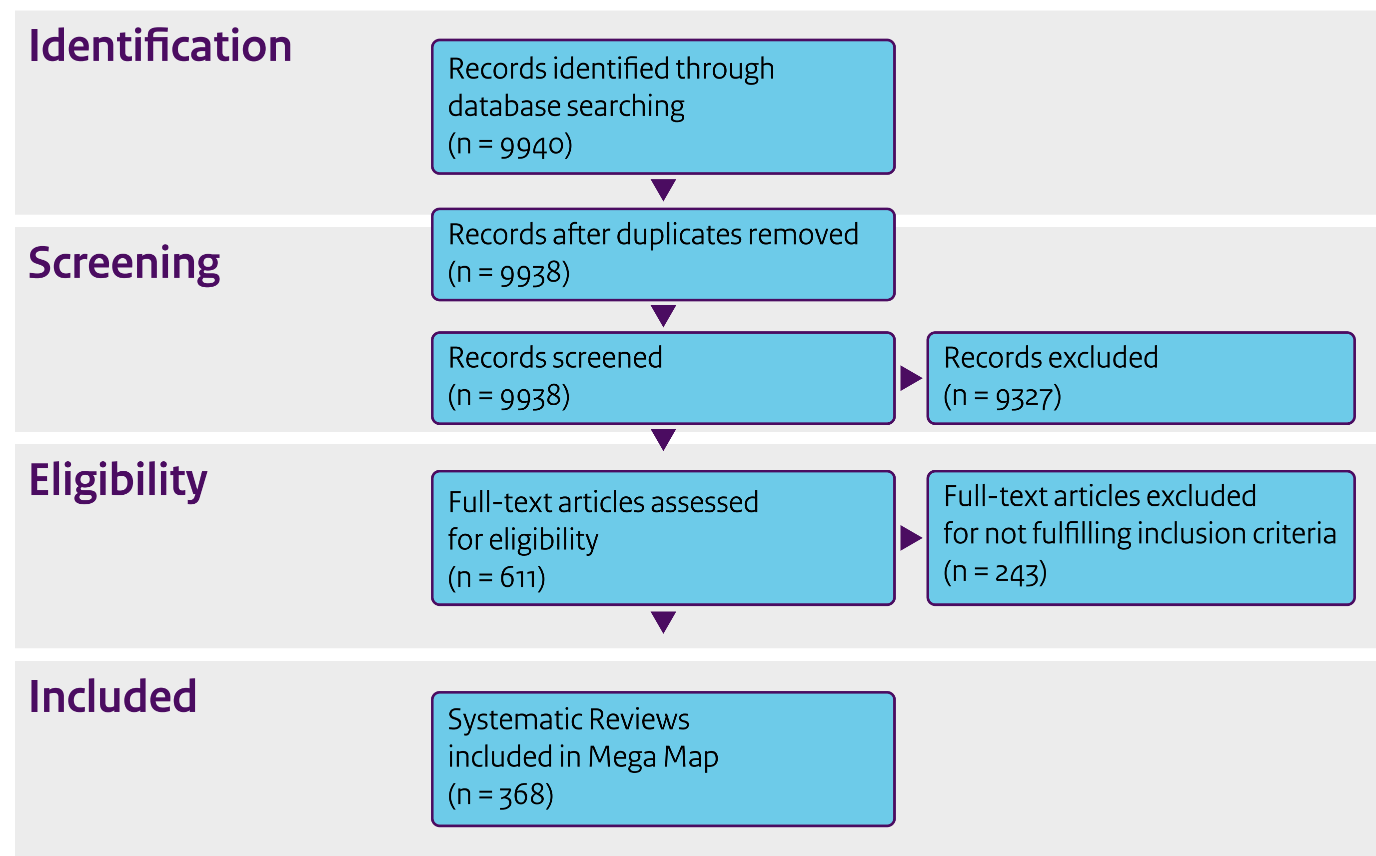
Annex 2 – PRISMA diagram[1]

Mega Map of Systematic Reviews and Meta-Analyses on Sexual Reproductive Health and Rights (SRHR) Interventions in sub-Saharan Africa (2015-2020).
(Search was for reviews published up to July 2020)



1 From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097. For more information, visit www.prisma-statement.org.

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