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3ie evidence gap maps

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The EGM protocol provides all the supporting documentation for the map, including the background information for the theme of the map, and details the methods that will be applied to systematically search and screen the evidence base, extract, and analyse data, and develop the EGM report.

About this evidence gap map protocol

This report presents the protocol for a systematic search to identify and map the evidence base of impact evaluations and systematic reviews of Sexual and Reproductive Health and Rights interventions in low- and middle-income countries. The EGM will be developed by 3ie with generous support from the German Institute for Development Evaluation (DEval) and the Federal Ministry for Economic Cooperation and Development (BMZ) of the Federal Republic of Germany. The content of this report is the sole responsibility of the authors and does not represent the opinions of 3ie, its donors or its Board of Commissioners. Any errors and omissions are also the sole responsibility of the authors. Please direct any comments or queries to the corresponding author, Tomasz Kozakiewicz, at tkozakiewicz@3ieimpact.org.

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Sexual and Reproductive Health and Rights (SRHR) in Low- and Middle-Income Countries: An Evidence Gap Map

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EGM Protocol

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Acronyms

AMSHeR	African Men for Sexual Health and Rights
AIDS	Acquired immunodeficiency syndrome
BMZ	Federal Ministry for Economic Cooperation and Development (BMZ) of the Federal Republic of Germany
CRR	Centre for reproductive rights
CSC	Community score cards
CSE	Comprehensive sexuality education
CVA	Citizen's voice and action
DEval	German Institute for Development Evaluation
DID	Difference-in-difference
DSW	Deutsche Stiftung Weltbevölkerung
EGM	Evidence gap map
EPF	European Parliamentary Forum for sexual and reproductive rights
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
HIC	High income country
HIP	High Impact Practices in Family Planning
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
HS4A4A	Health Systems Advocacy for Africa
IE	Impact evaluation
ICPD	International Conference on Population and Development
IPV	Intimate partner violence
ITS	Interrupted time series
IV	Instrumental variable
L&MICs	Low- and middle-income countries
MHAF	Minority HIV/AIDS Fund
NDH	National Department of Health (Republic of South Africa)
PMTCT	Prevention of mother to child transmission
STI	Sexually transmitted infections
SBC	Social and behavioural change
SDG	Sustainable development goal
SECP	Stakeholder engagement and communication plan
SR	Systematic review
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRR	Sexual and reproductive rights
TWFE	Two-way fixed effects
TWM	Two-way Mundlak

1. Introduction

Despite a global call by the Programme of Action of the International Conference on Population and Development (ICPD, 1994) to ensure universal access to sexual and reproductive health, there remain large gaps in access and services. The 2030 Agenda for Sustainable Development affirmed the global commitment to the rights of couples and individuals to have autonomy over decisions related to their sexual and reproductive health and rights, and to have access to high quality services. And while progress has been made in expanding access to SRHR services, important challenges persist. The ability to exercise one's sexual and reproductive rights (SRR), which are also human rights, affects sexual and reproductive health (SRH), making SRHR critical to ensuring the health and well-being of the global population.

Sexual and reproductive rights are defined as "the right to control one's own body, define one's sexuality, choose one's partner, and receive confidential, respectful, and high-quality services" (Starrs et al. 2018, 2642). For a large share of the world's population, sexual and reproductive health and rights (SRHR) remain constrained in one or more dimensions. For example, only 57 per cent of women report having autonomy over SRHR-related decisions, including whether to refuse sex, make personal healthcare decisions or use contraception (UNFPA 2022d). Among other factors, low autonomy regarding SRHR decisions can be associated with unplanned pregnancies, many of which may be unwanted; and people may resort to abortions in unsafe conditions; with further myriad effects on quality of life (UNFPA 2022d). In low and middle-income countries (L&MICs) in particular, about 218 million women who do not want to become pregnant do not use a modern method of contraception; 49 per cent of pregnancies are unintended; and an estimated 35 million unsafe abortions occur every year (Sully et al. 2020).

Another clear challenge is the right to access SRHR services. As many as 4.3 billion people globally are expected to face inadequate access to SRH services during their lifetimes (Starrs et al. 2018). In L&MICs, 45 million women do not have access to adequate antenatal care (Starrs et al. 2018), while 16 million women do not receive needed care after major complications from childbirth (Sully et al. 2020) and the majority (94 per cent) of maternal deaths from preventable causes in pregnancy or childbirth occur in L&MICs (McGranahan et al. 2021). Each year worldwide, millions of people need treatment for conditions such as curable sexually transmitted infections (STIs; 350 million) or infertility (49-180 million couples), while thousands of women die from cervical cancer (266,000), a largely preventable condition (Starrs et al. 2018).

Despite these challenges, the last few decades have seen progress on some SRHR-related goals. For example, there have been improvements in contraceptive use and maternal and newborn health (Starrs et al. 2018); and declines in rates of new infections from human immunodeficiency virus (HIV) and deaths from acquired immunodeficiency syndrome (AIDS) (Minority HIV/AIDS Fund (MHAF) 2022). Based on data from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD DAC), funding disbursed for SRHR has remained stable at 7.8 billion USD in 2020, though disbursements returned to pre-2019 levels after a drop in 2019 (DSW and EPF 2022).

However, discriminatory norms and values about SRHR persist. For example, Kågesten and colleagues (2021) reported that while a majority of survey respondents in Ethiopia, Zimbabwe and Nigeria supported accessible contraception, 85% did not consider homosexuality acceptable; 33% held the view that girls who have begun menstruating are ready for marriage; 23% considered it acceptable for a husband to beat his wife; and 19% considered female genital mutilation and cutting (FGM/C) acceptable.

To some extent, rates of child marriage and gender-based violence (GBV) also reflect widely held and discriminatory social norms and values. Child marriage, or marriage before age 18, is a violation of human rights (UNICEF 2020). Yet, as of 2022, an estimated 37 per cent of women aged 20-24 had entered marriage before age 18 in West and Central Africa, while the rate was 28 per cent in South Asia (UNICEF 2022b). Women and girls who marry as adolescents are generally more likely than their unmarried counterparts to have less decision-making power within the relationship or household, including with respect to family planning, education or earning an income (UNFPA 2022d).

Worldwide, an estimated 27 per cent of women and girls aged 15 or older have experienced intimate partner violence (IPV) over their lifetime (Oram et al. 2022). The proportion of women who have experienced IPV in their lifetime is even higher in some countries; for example, rates range from 40 to above 60 per cent for some countries in Africa, Asia and the Pacific, Latin America, and Europe (Starrs et al. 2018). Exposure to IPV is associated with a range of adverse physical and mental health outcomes for women, including gynaecological problems (e.g. vaginal bleeding and infections), adverse birth outcomes, suicidal ideations, and HIV infection (Campbell et al. 2002; Guo et al. 2023; Ellsberg et al. 2008; Li et al. 2014)

The COVID-19 pandemic has exacerbated these issues in some contexts. For example, during the height of COVID-19 restrictions such as lockdowns, staff and resources were diverted from SRHR services; there was a reduction in health-seeking behaviours; and supply chain disruptions affected the availability of contraceptives (Riley et al. 2020). Even when COVID-19 lockdowns have ended, not acting quickly to improve services during the recovery

phase may entrench reduced services or worsen SRH conditions for more vulnerable or underserved populations such as people experiencing GBV (Riley et al. 2020). Other factors such as school closures and economic shocks resulting from COVID-19 have been associated with an increased risk of child marriage, with effects predicted to last into the coming decade (Yukich et al. 2021).

Research about SRHR programs has generally focused on a particular set of topics such as contraception, maternal health services, and prevention and treatment of HIV; or a specific population such as married women (Starrs et al. 2018). While there is an abundance of evidence on the effects of SRH (Warren et al. 2015) and maternal health programs in some key areas (Chersich and Martin 2017), other aspects of SRHR are under-studied. A scoping review of economic evaluations of SRHR interventions found 280 studies that addressed STIs such as HIV and AIDS, but no publications that covered sexual function and satisfaction (Kaiser et al. 2021). Gaps may also exist for evaluations of comprehensive sexuality education programs, and programs that address, infertility, reproductive cancers and STIs other than HIV (Starrs et al. 2018). In addition, there has been a call for further study of the effectiveness of SRHR interventions that engage men or people with diverse sexual orientations or gender identities (Starrs et al. 2018).

There have been previous efforts to map the SRHR evidence for people in L&MICs. For example, multiple Evidence Gap Maps (EGMs) have focused on particular SRHR topics or populations, including: social and behaviour change communication interventions to support HIV prevention, with a focus on adolescent girls and young women (Bose et al. 2023); a mapping of systematic reviews (SRs) of SRHR interventions in Sub-Saharan Africa, which identified 368 SRs that included at least one study from an L&MIC in Sub-Saharan Africa (Policy and Operations Evaluation Department (IOB) 2021); SRH interventions for persons with disabilities (Monteath-van Dok and Lagaay 2020); IPV prevention interventions (Dickens et al. 2019); SRHR interventions that address men, masculinities and gender equality (Ruane-McAteer et al. 2019); social and behaviour change communication interventions related to reproductive, maternal, newborn and child health (Portela et al. 2017); and adolescent SRH interventions (Rankin et al. 2016). This EGM will fill a gap in the current evidence base on SRHR by considering a broad range of SRHR interventions across multiple populations and L&MIC regions. For example, relevant SRHR services can include care and counselling related to family planning; sexual health and wellbeing; and reproductive, maternal and newborn health (Sully et al. 2020; UNFPA 2022e; Pillay et al. 2020; Starrs et al. 2018).

This EGM will compile existing and ongoing rigorous evidence that evaluates SRHR interventions in L&MICs. By identifying and describing the available evidence in a clear and

structured way, the EGM will facilitate access to evidence on the effects of SRHR interventions on selected SRHR-related outcomes in L&MICs for decisionmakers, researchers and the development community.

The results will be displayed on 3ie's online platform, which provides a graphical and interactive display of the evidence in a matrix framework. There will also be filters which users can apply to sort the evidence in the EGM according to different dimensions, including study design, country and population. The interactive map will be accompanied by a report addressing the key research questions, including an analysis of the characteristics of the available evidence and key trends (i.e., number of impact evaluations published over time, geography, focus on interventions and outcomes, targeted audiences).

The specific objectives of this EGM are twofold:

- Identify and describe the evidence evaluating the effects of SRHR interventions in L&MICs.
- Identify potential primary evidence gaps and synthesis gaps.

To meet these objectives, we will address the research questions shown in Table 1 by implementing best practice methodologies for systematic evidence mapping (Snilstveit et al. 2016). First, we will conduct a comprehensive search of relevant academic and grey literature sources to identify the evidence on four different domains of SRHR interventions, including: (i) SRHR policy, advocacy and health systems, (ii) social and behavioural change for the public, (iii) SRHR services, and (iv) vouchers, cash or in-kind transfers. We will map the identified studies on an intervention-outcome matrix, which provides an interactive visual display of the volume of impact evaluations and systematic reviews (SRs) in each thematic area (Saran and White 2018; Snilstveit et al. 2016; 2017; White et al. 2020). This visualization allows for easy identification of clusters of evidence related to specific interventions and outcomes, as well as absolute evidence gaps (i.e., a lack of impact evaluations) and synthesis gaps (i.e., a lack of medium or high confidence SRs). We will also examine frequencies and patterns in studies' key characteristics (e.g., the geographic distribution of evidence, study designs and interventions featured in the literature).

Table 1: EGM research questions

Research question No.	Research Question
RQ1	What is the available evidence (systematic reviews, rigorous impact evaluations, qualitative studies attempting causal inference) on the effects of Sexual and Reproductive Health and Rights interventions in L&MICs?
RQ2	What kind of activities are mainly conducted? What are the main mechanisms that interventions use to achieve their outcomes?[1]
RQ3	What are the primary and synthesis evidence gaps on the effects of Sexual and Reproductive Health and Rights interventions in L&MICs?

In this protocol, we outline details of our approach and methods for compiling an EGM of evidence on the effects of SRHR interventions on rights-related outcomes. Section 2 provides background information on SRHR definitions, goals and challenges. Section 3 summarises each of the included intervention domains and how they might affect SRHR. Section 4 provides details of the criteria for determining the inclusion of studies in the map. Finally, Section 5 outlines our literature search strategy and methods of data management and analysis.

2. Background

International consensus about how to define SRHR has evolved over time. Despite agreement among researchers and practitioners in the SRHR community that SRHR involves multiple interlinked components, previous global agreements have reflected a much narrower view of the concept. It was in this context that the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights (Guttmacher-Lancet Commission) called on the global community to embrace a more comprehensive definition of SRHR that included long unrecognized components such as personal autonomy and sexual well-being. In its widely cited 2018 report, the Guttmacher-Lancet Commission observed that SRHR has shifted from improving health or population control, to invoking human rights and empowering people to make their own choices (Starrs et al. 2018). We adopt the following broad definition of SRHR:

[1] This research question will be addressed solely by examining findings from systematic reviews appraised by the research team as having medium or high confidence in the conclusions about their effects. The findings from such studies will be disaggregated by intervention category.

> "Sexual and reproductive health care encompasses a broad range of services that ensure people can decide whether and when to have children, experience safe pregnancy and delivery, have healthy newborns, and have a safe and satisfying sexual life. These services are important investments both because they enhance individual well-being and allow people to exercise their sexual and reproductive rights, and because they have far-reaching benefits for societies and for future generations."
>
> –(Sully et al. 2020, 4)

Broadly speaking, the key dimensions of SRHR include **family planning**, such as provision of information, counselling and means of contraception; **maternal and newborn care;** such as counselling and services to prevent complications during pregnancy and following childbirth; **sexual health and wellbeing** such as counselling and STI prevention; and the **right to access services and make sexual and reproductive decisions** (Sully et al. 2020; Starrs et al. 2018; Pillay et al. 2020; DSW and EPF 2022). As adapted from the Guttmacher-Lancet Commission report, other essential programmes or services include comprehensive sexuality education, and those related to safe abortion and care; sexual and gender-based violence; reproductive cancers; and infertility (Starrs et al. 2018).

The Sustainable Development Goals for 2030 (SDGs) similarly include universal access to SRH services such as family planning, education, and integration of services at the national level under SDG 3: Ensuring healthy lives and promoting wellbeing for all (target 3.7) and universal access to SRH and reproductive rights under SDG 5: Achieve gender equality and empower all women and girls (target 5.6; United Nations 2015). The international community has also advocated for SRHR to consider the life course and circumstances for people regardless of gender, age, sexuality or gender identity, or other characteristics (UNFPA 2022e; Starrs et al. 2018; Sundewall et al. 2022b). SRHR can encompass additional sub-categories depending on the target population or other donor priorities.[2]

For L&MICs to deliver on these SDGs, researchers and experts have called for a core package of SRHR services that account for country-level funding and resource constraints (Sully et al. 2020; Starrs et al. 2018; Pillay et al. 2020; Sundewall et al. 2022b). Core services that have been reported as potentially cost-effective across L&MIC contexts include supporting contraception; antenatal, childbirth and post-natal care; and addressing major curable STIs

[2] For example, international and multilateral donors such as Gavi, the Vaccine Alliance; United Nations agencies; the Global Fund to fight AIDS, TB and Malaria; and the World Health Organization have prioritised, among other things, supporting water, sanitation and hygiene education and facilities as they relate to SRH; ending violence against women and girls; reproductive, maternal and child health, which includes the health of children from ages one month to five years; ending child marriage; and menstrual health and hygiene (DSW and EPF 2022; UNICEF 2022; UNFPA 2022b).

for all women regardless of age (Sully et al. 2020). Under the principles of Universal Health Coverage (UHC), such services should not only meet all people's needs, but should be affordable and high-quality (Pillay et al. 2020). Critical needs also exist for other areas, such as cervical cancer, IPV, the relatively high proportion of new HIV infections among young women, the SRHR needs of people in humanitarian contexts, and infertility (Sully et al. 2020). In practice, countries vary in the extent to which they deliver essential services as identified in the Guttmacher-Lancet Commission report; for example, some may not address GBV, comprehensive sexuality education or infertility, and coverage of safe abortion services vary depending on legal or social factors (Pillay et al. 2020).

Multiple barriers exist to ensuring universal SRHR, including discriminatory gender norms, limited accessibility, and public administration and financing challenges. Harmful gender norms, laws, and policies continue to impede SRHR goals such as expanding and improving quality of services (Starrs et al. 2018; Ravindran and Govender 2020). Based on preliminary reporting that the COVID-19 pandemic has disproportionately affected services for women and girls (Mittal and Singh 2020; Riley et al. 2020; Tang et al. 2020), it has been argued that support for delivery of core services should also prioritise addressing discriminatory norms and values (Kågesten et al 2021; Sundewall et al. 2022a). However, SRR can be "some of the most challenging rights to achieve … This is largely because barriers to realizing SRHR are rooted in unequal gender power relations, stigma, and entrenched social norms, with ripple effects at individual, household, community, and policy levels" (Oxfam Canada 2020, p.3). SRH treatment may also be inaccessible, of low quality, or unavailable to people based on factors such as their wealth, ethnicity, sexual orientation, gender identity, whether they are married, or age (Starrs et al. 2018). Some people may perceive stigmas or feel discouraged from seeking preventative care or treatment for SRH conditions (Starrs et al. 2018; Desrosiers et al. 2020). Additionally, public administration challenges including low government accountability, or health system challenges such as an inadequately trained workforce can constrain service delivery goals (Starrs et al. 2018; Pillay et al. 2020). Funding and finance challenges also exist, such as funding gaps in less-developed countries; or fragmented financing across public and private sectors that contribute to inefficiency, inconsistency of approach or inhibited visibility and oversight (Starrs et al. 2018; Pillay et al. 2020).

3. SRHR Interventions

The scope and framework for this EGM have been developed in consultation with the German Institute for Development Evaluation (DEval) and associated stakeholders[3], an advisory group consisting of SRHR researchers, policymakers, and practitioners as well as a subject matter expert. We will focus on a selection of four key intervention domains identified and prioritized for the EGM through the consultation process where we invited the above stakeholders to make suggestions and comment on the framework. Those are: (1) SRHR policy, advocacy and health systems; (2) Behavioural change interventions for the public; (3) SRHR services; and (4) Vouchers, cash or in-kind transfers. Within each domain there are multiple categories of interventions. These are based on the mechanisms of how they work and could relate to any topic. For example, studies from the *counselling* category could be about the prevention of STIs, GBV or both. The interactive map allows users to filter out studies based on the health topic of interest. Below we summarize key arguments about how each of the included intervention domains might address the primary needs and challenges of ensuring SRHR for all.

3.1 SRHR policy, advocacy and health systems

Sexual and reproductive rights are recognized as human rights in international law, and in domestic law depending on the context (ICPD, CRR 2013). For example, 179 signatory states of the International Conference on Population and Development (ICPD) Programme of Action have committed to take legal, policy, budgetary, and other measures to advance SRHR (ICPD, CRR 2013). To operationalize human rights in health systems, these efforts require engagement from public health leaders, civil society groups and community members, as well as accurate information to gauge challenges or progress (Starrs et al. 2018; Filippi et al. 2016). If interventions can build the capacity of public health and community stakeholders to advocate for SRHR, these stakeholders can theoretically collaborate with policymakers to help shape policies and resources that reflect local priorities (HSA4A Partnership n.d.; Wemos n.d.). Meanwhile, multiple information sources contribute to building accurate data, such as health management information systems, vital registration, programme assessments and special surveys (Starrs et al. 2018; Filippi et al. 2016).

[3] German development cooperation stakeholders include but are not limited to representatives of the Federal Ministry for Economic Cooperation and Development (BMZ), German Agency for International Cooperation (GIZ), KfW Development Bank and Berlin Institute for Population and Development.

Efforts to strengthen health systems also involve building supply side capacity to adapt and deliver quality services, equitably, sustainably and at scale (Galavotti et al. 2019). Some of the practices in this group with a considerable evidence base, especially for family planning,[4] include policy implementation, domestic public financing, supply chain management, strategic social accountability and strengthening capacity for leading and managing for excellence (HIP 2022a).

Comprehensively developed, implemented and monitored policies can support services at scale, such as by supporting social insurance or other financing arrangements for health service users, and efficient domestic resource mobilization (HIP 2018; 2022a). Supply chain management improvements can potentially increase the availability of SRHR services by increasing data visibility and use, speeding up the flow of products, professionalizing the workforce, and benefitting from private sector capacity (HIP 2020). Enabling collective efforts of individuals and communities (rights holders) may also engage health sector actors in a collaborative process to identify problems, and to implement and monitor solutions to hold each other accountable for improvements in service quality and responsiveness. Challenges include stigma, harmful gender norms among providers and communities, and lack of clear guidance, authority, and knowledge of rights and entitlements at the local level (Schaaf et al. 2022). Some challenges can be overcome by linking objectives to legal accountability and budgetary expenditures to ensure that providers respond (Lince-Deroche et al. 2020; Schaaf et al. 2022)

The right to health comprises four essential elements of healthcare services (UNCESCR 2000). Services and facilities should be scientifically and medically appropriate and of the highest **quality.** They should be **available** in sufficient quantity (taking into account a country's income status) and be ethically and culturally **acceptable** (respectful of individuals, minorities, peoples, and communities, and sensitive to gender and life-cycle requirements). Finally, services and facilities need to be physically and economically **accessible,** including service information and education (IFHHRO n.d.). This is of particular importance for people whose needs have been least met by existing services or who have low uptake of services (UNFPA 2021).

Approaches that aim to improve SRHR services for adolescents, people with disabilities, people with diverse sexual orientations and other populations can include training, social and behavioural change interventions for healthcare staff to sensitize them about unique needs of

[4]High Impact Practices in Family Planning are vetted by experts against specific criteria based on demonstrated magnitude of impact on contraceptive use and consideration of other relevant outcomes such as unintended pregnancy, fertility, delay of marriage, birth spacing, or breast feeding (HIP 2022a).

diverse individuals or instituting flexible service hours or modes of delivery; among other practices[5] (Policy and Operations Evaluation Department (IOB) 2021; UNFPA 2021). Finally, apart from training of the workforce on their on-the-job activities, building capacity to lead and manage is a key prerequisite for strengthening quality, equity and cost-effective use of resources. High impact practices in this area include leadership, management, and governance capacity-building interventions often centred around an in-service training component (HIP 2022b).

With respect to maternal and newborn care, services that address common delays in care could potentially lead to improved health at the antenatal, childbirth or postnatal and postpartum stages. Common delays can include a delay in seeking care, delay in reaching a health facility, or delay in receiving professional care after reaching a health facility (Shah et al. 2020). Improved leadership and management of SRHR services could help to address structural factors, such as quality of care, that lead to delays in maternal and newborn care (Shah et al. 2020).

3.2 Social and behavioural change for the public

In the conceptual framework developed by Portela and colleagues (2017), social and behavioural change (SBC) interventions aim to strengthen the capabilities of individuals, households, communities, and health systems. To avoid overlaps between our intervention categories, we distinguish activities targeted at health system actors (captured under the intervention domain described above) from those targeted at the wider society (captured under the second intervention domain). SBC programmes primarily aimed at the public can draw from various communication channels to raise awareness or change perceptions, such as mass media (e.g. TV or radio), and approaches that aim to empower and engage community members in dialogue, such as group education, mentorship, or community mobilization (Portela et al. 2017; HIP 2022c). Using these approaches to strengthen capabilities, in turn, can in theory increase care-seeking, advocacy, and communication within couples, families and households; and better enable equitable gender dynamics, community engagement, responsive service delivery, and policies in support of SRHR goals (Portela et al. 2017). SBC interventions can focus on a range of SRHR topics; we highlight a few examples here.

Though underutilized, SBC for family planning interventions are thought to be cost-effective and can enhance related SRHR policy or services programmes (HIP 2022c). For example,

[5] Other practices might include engaging people from a given population to help deliver services. For example, community health workers.

while costs vary, Rosen and colleagues (2019) estimated that in Zambia, spending 1 USD to expand SBC interventions could save USD 2.40-5.30 when considering health care costs and loss of productivity. SBC interventions can potentially influence widely held views about sexuality, fertility, how couples communicate, awareness about the actual risk of becoming pregnant or the side effects of contraception (HIP 2022c). Encouraging dialogue and mobilizing the community could potentially lead people to advocate for their preferences within and beyond their households and proactively seek SRHR services—and could strengthen approaches for target populations such as adolescent girls (HIP 2022c; Portela et al. 2017).

SBC interventions can also contribute to programmes that aim to reduce GBV and FGM/C. For example, Tordrup and colleagues (2022) described SBC activities such as community dialogues, engagement with religious and community leaders, peer educators, and awareness campaigns that have been used with the goal of reducing FGM.

SBC interventions can also engage young people and their families in support of improving communications about sexuality and perceptions about seeking care. In a review of SRH interventions for young people, Desrosiers and colleagues (2020) described SBC approaches such as group and peer-delivery, engaging parents and community members in dialogues, group support, and sessions that aimed to build knowledge and skills. SBC approaches can potentially raise awareness and understanding about youth sexuality, reduce stigmas among young people about seeking SRH care, or improve communication within families (Desrosiers et al. 2020). SBC interventions such as education about healthy relationships or supporting constructive family engagement have also been used to help address factors that contribute to child marriage, such as perceptions about gender roles (UNFPA 2022d).

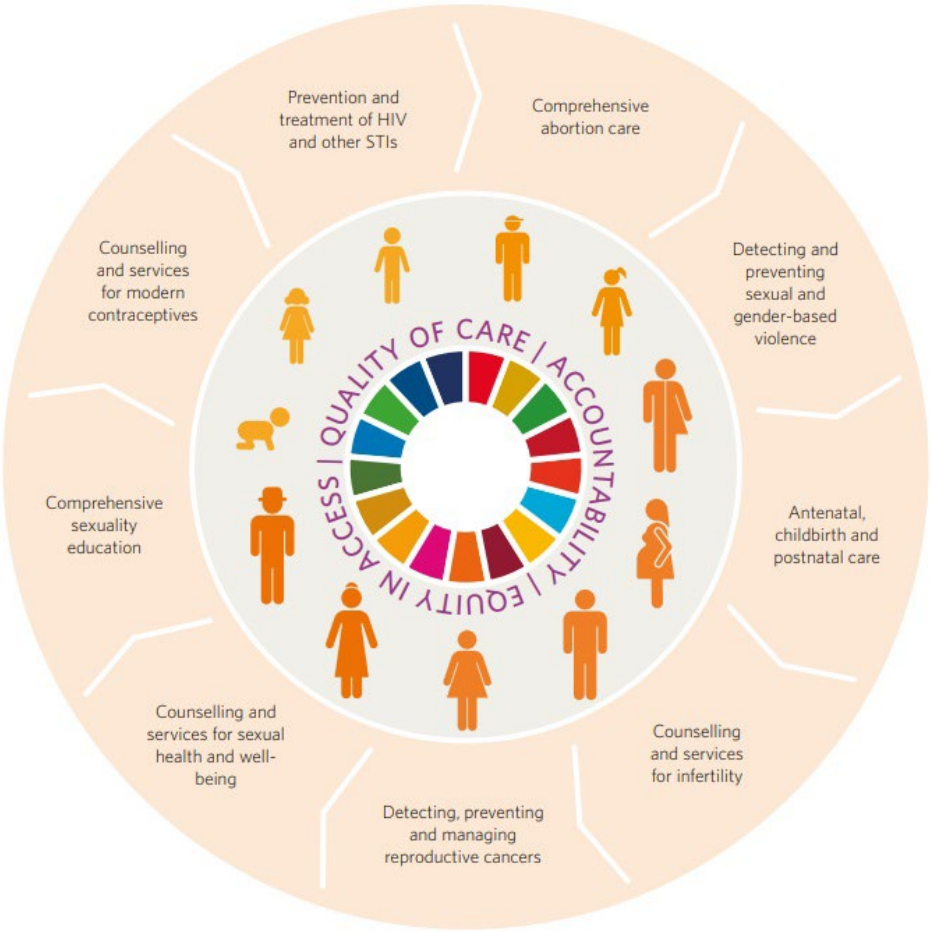
Although comprehensive sexuality education (CSE) is referred to as an essential SRHR service (see next section for a comprehensive list of such services), we are including this as a type of social and behaviour change intervention based on its primary focus on education instead of health service-based counselling (UNFPA 2022a; 2022d).

3.3 SRHR Services

To include a broad set of relevant SRHR services, we considered interventions referred to as essential in the Guttmacher-Lancet Commission report (Starrs et al. 2018) and UNFPA documentation prepared for the 2019 Nairobi Summit on ICPD25, which established shared commitments related to the ICPD Programme of Action (UNFPA 2020a). In its framing of universal access to SRHR, UNFPA (2020a) diagrammed a comprehensive set of SRHR services, as reproduced in Figure 1, below. In the context of family planning, maternal and newborn health, and sexual health and wellbeing, particular services are noted, including

comprehensive abortion care, and detection, prevention or other services related to gender-based violence, reproductive cancers and infertility.

Figure 1. Essential SRHR services



Source: UNFPA. 2020. “Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage: Background Document for the Nairobi Summit on ICPD25 - Accelerating the Promise.” UNFPA. https://www.unfpa.org/featured-publication/sexual-and-reproductive-health-and-rights-essential-element-universal-health.

Connecting people to quality care on a routine or timely basis can contribute to preventing, identifying or treating health conditions and complications before they become life-threatening, or impair quality of life (Filippi et al. 2016). Access to timely and quality care can help to explain why expanding the provision of family planning, maternal and newborn care, and sexual health services has been linked to a range of improvements in health and health behaviours (Sully et al. 2020; Watkins et al. 2017). For example, Sully and colleagues (2020) reported that expanding these services can potentially lead to substantive reductions in unintended pregnancies (68%), unsafe abortions (72%), maternal deaths (62%), newborn deaths (69%), new HIV infections for babies (88%), and could potentially eliminate cases of pelvic inflammatory disease or infertility in women resulting from chlamydia or gonorrhoea infections.

Examples of interventions could include, among others, counselling and services for multiple modern methods of contraception; safe abortion care or post-abortion care; emergency obstetric and newborn care; and prevention of STIs (UNFPA 2020b). Family planning, maternal and newborn health, and sexual health services are also considered cost-effective; for example, an estimated 1 USD spent for expanded contraceptive services could reduce costs for pregnancy or newborn care by 3 USD (Sully et al. 2020).

With the exception of clinical-based interventions such as those that aim to address specific complications during or immediately following childbirth, or abortion or post-abortion services, this EGM has a primary focus on prevention. This focus was informed by input from German development stakeholders, and to support meaningful reporting of the evidence. For the purposes of our review, prevention includes interventions that aim to reduce risks for negative health outcomes (Gilmore and McAuliffe 2013), to include counselling, screening, and involvement of community health workers, among other interventions.

In addition, because many women access SRH services during their lifetime, these services can be an entry point for early detection or prevention of GBV (Lewis et al. 2022). For example, as part of health visits, SRH providers could potentially identify survivors of GBV, deliver support or care, and connect them to other services with the aim of preventing further harm (More et al. 2017).

Relatively low-cost services to detect, prevent or manage cervical cancer could also substantively reduce mortality; cervical cancer is estimated to cause more deaths in L&MICs than complications from pregnancy (Sully et al. 2020). Since human papilloma virus (HPV) infection causes most cervical cancer cases, services such as HPV vaccination and pap smear screening in L&MICs has been linked to reducing new cases, burden or death from cervical cancer (Hull et al. 2020).

3.4 Vouchers, cash, or in-kind transfers

Another approach to increasing the use of essential health services is through demand-side financing (Ravindran and Govender 2020). While vouchers, cash or in-kind transfers could be technically classified under the social and behavioural change intervention domain, we have created a separate group for them to underline their uniqueness. The underlying assumption of these programmes is that obstacles such as transportation and food costs are too prohibitive for underserved populations, especially people living in poverty (Gupta et al. 2010). Thus, health services are underutilized. By subsidizing goods or services (e.g. through vouchers, cash transfers or asset transfers), behaviour changes are incentivized and some of

the cost of purchasing these goods or using services is offset, making them more affordable and increasing the likelihood that they are utilised by beneficiaries.

On the demand side, vouchers, a non-monetary incentive, can support access to free services, empower users, facilitate access to SRHR products in a confidential setting or motivate providers to improve quality and respond to user needs via increased income (Marie Stopes International et al. 2018). For example, voucher schemes have been found to reduce out of pocket expenses and lead to increased access to maternal health services and family planning (N. M. Bellows, Bellows, and Warren 2011; B. W. Bellows et al. 2013; Grainger et al. 2014; B. Bellows et al. 2016).

Cash transfers are another modality for demand-side financing. Cash transfers conditional on receivers' actions deemed beneficial (e.g., to give birth in a health facility) have been reported to increase the use of maternal and neonatal health services (Glassman et al. 2020; Ekezie et al. 2017) though not for family planning services (Khan et al. 2016); and their effects on health outcomes have been mixed (Ekezie et. al 2017). Other studies found perverse effects or no benefits of conditional cash transfers for people from stigmatised groups, such as scheduled castes or those without land, who faced challenges producing the necessary documents to prove their eligibility and were less likely to participate (Witter et al. 2017). In a case study from rural Tamil Nadu, India, a sizable increase in institutional deliveries in public health facilities has meant that the providers could not provide other essential SRH services, especially at primary and secondary care levels (Balasubramanian and Ravindran 2011).

Other incentives used to promote desirable behaviours can include unconditional cash transfers or asset transfers, which provide economic incentives that might discourage families from marrying off young girls. For example, in one study the provision of cooking oil was reported to be effective in reducing child marriage (Buchmann et al. 2021). In humanitarian settings, emergency cash and voucher assistance may be used. Emergency cash transfers can help women at risk of GBV or survivors of GBV escape perpetrators and find safe housing (UNFPA 2020c). Unconditional cash transfers labelled for a specific purpose (e.g. covering transport and/or dependent care costs) can reduce indirect costs related to accessing medical care or psychosocial support (UNFPA 2020c).

4. Criteria for considering studies for this map

4.1 Population

We will include studies that target any population from low- and middle-income countries (L&MIC), as defined by the World Bank (Appendix 1), for the first year of the intervention

implementation. For studies that target populations in both an L&MIC and a high-income country (HIC), we will include them if the results for the L&MIC population are analyzed and reported separately (i.e., with unique intervention and comparison groups from the L&MIC). We will exclude studies that compare the effects of an intervention group from an L&MIC to a comparison group in a HIC.

Interventions that seek to enhance the performance of a specific niche population, such as athletes, the military, astronauts or actors/models will be excluded. However, interventions targeting specific vulnerable populations (e.g., women, persons with disabilities, etc.) will be included. We will also exclude studies that evaluate programmes for migrants from L&MICs to HICs, or vice versa. Finally, we will include studies of all age groups, including those considered outside of the reproductive age (defined as 15-49 years), provided that other inclusion criteria are met.

4.2 Interventions

For a study to be eligible, it should evaluate an intervention conducting activities intended to affect Sexual and Reproductive Health and Rights (SRHR) within at least one of the intervention domains presented in Table 2. For a full list of intervention categories within each domain, refer to Appendix 2.

Table 2: Included intervention domains

Intervention domain	Description
SRHR policy, advocacy, and health systems	Interventions that aim to improve SRHR service delivery through implementation of policies, strengthening of institutions and advocating for compliance with human rights commitments.
Social and behavioural change for the public	Interventions that aim to raise awareness about SRHR, change public perceptions and behaviours through the use of social and behaviour change (SBC) techniques such as teacher-led instruction, mass and social media, mobilisation of family, peers or the wider community.
SRHR services	Provision of SRHR services such as counselling or care for the following: family planning, maternal and newborn health, comprehensive abortion care, GBV-specific services, prevention of cervical cancer, prevention of infertility, prevention of HIV and other STIs, and sexual function and satisfaction.
Vouchers, cash or in-kind transfers	Interventions that aim to drive specific SRHR-related behaviours by directly providing households with cash transfers (with or without

conditions attached), vouchers to cover direct or indirect healthcare-related costs, or desirable assets such as cooking oil.

Combining multiple SRHR services, especially if integrated in national health systems, can potentially contribute to health improvements in a cost-effective way (Lince-Deroche et al. 2020; Lince-Deroche et al. 2020; Global Financing Facility and World Bank Group 2021). Thus, while each of the above intervention domains is defined separately, studies may evaluate programmes that are delivered as part of a package of activities from two or more intervention categories (components). For studies of multicomponent interventions, as long as at least one of the components of a multicomponent intervention is included in the intervention framework and the study otherwise meets the EGM inclusion criteria, the study will be included. Depending on the nature of multi-component interventions included, the project team will adopt a suitable approach to coding these consistently in the map. The approach may include creating new intervention categories for relatively common packages of intervention components, if any are identified; determining the main intervention of focus in the study and grouping the study with others that focus on that main component; grouping all multicomponent studies together, or a combination of these approaches. The approach adopted and any associated limitations will be stated in the final report.

Based on existing extensive research about selected interventions (see Section 1), input from German development cooperation stakeholders, advisory group members, and the subject matter expert; and to enable meaningful reporting of the evidence, we will exclude studies for selected interventions or cases:

- Population policies related to spatial distribution, urbanization, migration, or other structural factors influencing fertility and promoting work life balance will be excluded.
- For studies of maternal and newborn health interventions, we will define newborn using the World Health Organization definition of a newborn infant under 28 days of age (World Health Organization 2023). If a maternal and newborn health intervention focuses on babies or children 28 days of age or older, only the maternal health component of the intervention will be considered for relevance to the framework.
- Standalone newborn health interventions and standalone maternal nutrition or breastfeeding interventions will be excluded, unless delivered as part of package with other eligible SRHR topics (including family planning, sexual health and wellbeing, reproductive health and wellbeing such as prevention of cervical cancer or infertility, and gender-based violence).
- As adapted from integrated approaches outlined in UNFPA (2009), we will focus on SRHR packages that integrate STI and HIV prevention with other SRHR topics. With the exception of HPV prevention interventions which are considered linked to cervical

cancer prevention, standalone services to prevent HIV and other STIs will be excluded, unless delivered as part of an integrated package with other includable SRHR topics.
    - For example, HIV prevention activities such as counselling about pre-exposure prophylaxis or PMTCT of HIV would only be included if delivered with activities focused on other SRHR topics, such as family planning.
    - The same would apply to other STI programs; if an intervention solely screens the population for STIs, it would be excluded unless it is complemented with at least one other SRHR topic-focused activity, such as prevention of cervical cancer (e.g. screening for HPV).
    - Treatment for HIV (such as antiretroviral treatment to manage HIV or for PMTCT of HIV), syphilis (such as antibiotic treatment for PMTCT of syphilis), or other STIs will be excluded. However, if an intervention delivers STI treatment along with at least one other includable standalone SRHR topic (such as an includable intervention that focuses on family planning), it will be included.
- Prevention of cervical cancer, such as via counselling, screening or administration of the HPV vaccine, will be included. Prevention of reproductive cancers other than cervical cancer, and treatment for cervical or other reproductive cancers, will be excluded. The focus on cervical cancer prevention (including via HPV prevention) is based on input from German development cooperation stakeholders and the subject matter expert; findings about the importance of prevention activities such as screening or HPV vaccination to reducing incidence of cervical cancer, such as by Hull and colleagues (2020); and to enable meaningful reporting of the evidence.
- Treatment for infertility will be excluded. This approach is in line with the EGM's primary focus on prevention based on input from German development cooperation stakeholders and to enable meaningful reporting of the evidence. In addition, prevention activities for STIs, including those for which infertility could be a consequence, will be included.
- Standalone interventions that support livelihoods, such as income generation, will be excluded.
- Cash transfers for families who live in poverty with the sole aim of poverty alleviation and social protection will be excluded as they do not fit into the causal chain for SRHR interventions. Cash transfers conditional on using family planning services will be excluded on ethical grounds.
- While we aim to capture common GBV-related interventions, some of them may not find a place in our categories and may therefore be excluded. Identified examples include: economic interventions, income generation, and to a lesser degree certain

workplace/private sector interventions, social empowerment programmes, police activities and those that enforce existing laws and regulation (e.g. through legal accountability mechanisms).

4.3 Outcomes of interest

For a study to be included, its evaluation should measure at least one of the outcomes presented in Table 3. Definitions for each outcome category can be found in Appendix 3.

Table 3: Included outcomes

Outcome group	Description
Knowledge, attitudes, and norms	**Knowledge and awareness outcomes:** Measures of knowledge and awareness around SRHR, associated rights, laws, commodities, and services; includes health provider knowledge. **Attitudes and normative change:** Measures of normative change, attitudes, beliefs and perceptions around SRHR and related topics.
Behaviours	**Sexual behaviour:** Measures of initiation, frequency of and abstinence from sexual intercourse, including safe and risky sexual behaviours. **Contraception and other prevention:** Measures of use of modern technology or methods to prevent pregnancy and/or STIs. **Menstrual hygiene:** Indicators related to access or use of menstrual products and maintenance of menstrual hygiene. **Communication, support seeking and caregiver practices:** Interpersonal support and communication with and care seeking from parents, caregivers, sexual partners or community members; caregiver practices.
Availability, accessibility, acceptability and quality of services	**Availability and use:** Utilization of SRHR services, products and information by users. **Accessibility:** Measures of whether the services are accessible to all without discrimination including the extent that health professionals respect patients' rights. **Affordability:** Measures of affordability of SRHR services and products to service users. **Quality and acceptability:** Outcomes related to changes in service quality and responsiveness. **Registration:** Measures of registration for the following SRHR statistics: birth, marriage and vital registration.
Health outcomes	**Adolescent pregnancy:** Measures of adolescent fertility, pregnancy, unwanted pregnancy, age at first birth and similar indicators. **Adult fertility and infertility:** Outcomes related to fertility and infertility among adults. **Safe abortion:** Indicators related to induced termination of pregnancy.

	HIV and other STIs: Outcomes related to testing, incidence and prevalence of HIV and other STIs. **Newborn morbidity and mortality:** Measures of morbidity and mortality for newborns under 28 days of age. **Maternal morbidity and mortality:** Any measures of morbidity and mortality for mothers. **Sexual satisfaction and function:** Extent of physical, mental and emotional well-being in relation to sexuality.
Gender-based violence and harmful practices	**Child, early and forced marriage:** Indicators such as age at marriage and adolescent marriage status. **Female genital mutilation:** Incidence, prevalence or other measures of female genital removal/cutting. **Trafficking:** Incidence, prevalence or other measures signalling the use of force, fraud or coercion to exploit an individual for profit through forced labour or sexual exploitation. **Gender-based violence:** Incidence, prevalence or other measures of harmful acts directed at individuals based on their gender or sexual orientation.
Enabling environment	**Agency and empowerment:** Measures of bodily, sexual and reproductive autonomy and self-determination over one's life. **Legislative environment:** The extent to which SRHR are protected (or discriminated against) by adopting national laws and policies, and reforms of the delivery of care**.** **International norms:** Establishment of international agreements and guidelines, ratification of human rights conventions**.**

4.4 Types of studies

We will include impact evaluations and SRs that measure the effects of a relevant intervention on outcomes of interest, including both selected quantitative and qualitative study designs.

4.4.1 Impact evaluations (IEs)

We will include experimental and quasi-experimental study designs that estimate effects attributable to an intervention. This includes randomized controlled trials but also a variety of econometrical approaches such as regression discontinuity designs, instrumental variables, fixed-effect regressions, interrupted time series models, matching and synthetic control methods (for a comprehensive list refer to Appendix 4).

A study's comparison group may encompass observations that receive no intervention, are scheduled to receive it at a later stage, or benefit from an alternative condition. We will not exclude studies on the basis of the comparison condition of a control group. However, we will exclude evaluations and case studies that do not satisfy the methodological conditions described above.

4.4.2 Systematic reviews (SRs)

We will include systematic effectiveness reviews that describe the search, inclusion criteria, data collection and synthesis methods used (Snilstveit et al. 2016). Any evidence reviews, such as literature reviews, that do not adopt these methods will be excluded. We will exclude overviews of reviews and SRs that are not effectiveness reviews (i.e., that do not aim to synthesize the evidence of the effects of a relevant intervention on priority outcomes of interest), such as SRs of the barriers and facilitators to implementation of an intervention. Due to a large volume of systematic reviews that contain SRHR interventions we will apply two inclusion restrictions. First, we will only include reviews that focus on L&MICs only, or report outcomes separately for L&MICs. Second, we will not extract data on systematic reviews scored as having low confidence in their findings. A full list of such studies will be presented in the final report but will not be included in the analysis or on the map. For a checklist of additional questions that will be used to limit the number included SRs refer to Appendix 9.

4.4.3 Qualitative study designs

For certain interventions, quantitative impact evaluations can be difficult to conduct, for example, because the intervention is applied to a small number of units (White and Phillips, 2012). This typically applies to situations “when data are available for only one or several units of assignment (…)[such as a] national policy change or a capacity-building intervention in a single organisation” (White and Phillips, 2012, p. 5). For such interventions small n approaches may be more appropriate, and limiting inclusion to only quantitative impact evaluations may miss relevant studies. To ensure we identify relevant studies for all interventions, we will adopt a two-phased approach to search and inclusion where we identify interventions that are candidates for small n study designs after completion of the first round of search and screening and subsequently conduct a targeted search for additional studies for these interventions only.

Specifically, we will include qualitative studies for those interventions where we identify little or no quantitative evidence. We define this as intervention categories with less than 10 studies. This number corresponds to 1 per cent or less of all included quantitative impact evaluations within the EGM. Ten studies is also the minimum number of studies necessary to conduct a meta-regression analysis or to explore publication bias (Higgins et al., 2022). Once we identify intervention categories where gaps are evident, we will conduct a separate search which will combine search terms from this subset of intervention categories with a broad selection of qualitative and evaluation related search terms to account for the lack of standardized reporting. As ‘small n’ evaluations that attempt to establish causality are rare and can often only be identified on examining the full text, machine-learning will not be applied to this

iteration of the search (see section 5.1.2 for more information about how machine-learning will be used in combination with quantitative search terms).

We define small n studies as studies that use "available methods when n is too small to apply statistical approaches to constructing a counterfactual" (3ie, 2012). Following White and Phillips (2012) our focus is on qualitative methods that can be applied to one or a few cases which excludes Qualitative Comparative Analysis and modelling-based approaches such as general equilibrium models or systems-based evaluations. We will include qualitative studies using a theory-based methodology that could plausibly establish a causal impact of the intervention in a small n scenario. As statistical tests that measure differences in outcomes between treatment and comparison groups are not possible for less than ten observations, theory-based approaches help to elucidate the causal pathways from an intervention's inputs and activities to outputs and outcomes. They should preferably generate and verify alternative causal hypotheses, like those that operate because of other programs or existing capacities (Sharma Waddington, Umezawa, and White 2023).

As there is not always consensus about method nomenclature or definitions (the same method may have different names or the same name implemented differently), we will include all studies that present a clearly defined method and use it to examine the effects (attribution[6] or contribution[7]) of a relevant intervention on a relevant outcome. For a list of study design related criteria that need to be met by small n evaluations to be included, refer to Table 4.

A non-exhaustive list of small n evaluation methods and their definitions will be provided to screeners and coders performing data extraction for reference (refer to Appendix 4). If a method does not fit any of the definitions, it will be classified as Other under the Evaluation method filter. If the method is purely quantitative, it will be excluded unless it meets the criteria for experimental or quasi-experimental methods.

Table 4: Study design checklist for full text screening of small n papers

Question	**if NO**	**if YES**
Does the study seek to answer a **causal inference question and applies a methodology to examine the causal relationship** between an intervention and outcome? Do they describe the method or at least reference it?	**EXCLUDE – Does not apply a method to infer causation**	**MARKER – quantitative effectiveness study** should be applied here if you find a study that infers causation using

[6] We define attribution as the extent to which the observed change in outcome is the result of the intervention, having allowed for all other factors which may also affect the outcome(s) of interest (3ie, 2012)

[7] We define contribution as the effect of an intervention that is difficult to isolate from other co-occurring causal factors (Vaessen, Lemire, and Befani, 2020).

Question	if NO	if YES
You would typically look at the: *- research questions (to check if there is a causal inference question e.g. What is the effect/probability of a causal relationship of XXX on YYY? What are the necessary and sufficient intervention configurations that lead to YY?)* *- methods section (to check if there is a method described or referenced)* *- findings/conclusions (to check if it has actually been applied and the causal claim is clearly stated. For example, 'XXX caused/led to/ contributed to/impacted/affected YYY'… 'Without XXX, YYY might not have happened…'/ 'Otherwise, YYY would have not been possible... " (adapted from* Sharma Waddington, Umezawa, and White 2023*, p. 51)*		quant methods. In such cases proceed to coding it using the 'FTS Full text Screening - FTS (double) – Quant' codeset. If the study uses qualitative or mixed methods move on to the question below.
Does the study mention using one of the following **more explicit causal identification approaches:** realist evaluation, general elimination methodology, process tracing or contribution analysis? (adapted from Sharma Waddington, Umezawa, and White, p. 51 and 41)	Move on to the next step.	Move on to question 4 from the screening checklist (Appendix 7)
Is the **Theory of Change** presented (or referenced) for the intervention(s) being evaluated, that meets at least 2 of the following: "- sets out underlying intervention logic and theoretical links - outlines inputs, activities, outputs, intermediate and final intended outcomes (adapted from Sharma Waddington, Umezawa, and White 2023, p. 51)	**EXCLUDE – Implicit causal identification with no Theory of Change**	Move on to the next step.

Source: Full text screening protocol. Other screening questions were not considered relevant for this section and can be found in Appendix 7. The above questions have been adapted from a coding checklist that assesses the quality of small n methods used to evaluate the effects of Dutch official development assistance to support SRHR programming. In contrast to our map, its authors did not use the questions to determine what constitutes a small n evaluation approach.

We will not include qualitative studies that do not focus on evaluating intervention effects, such as those describing and exploring experiences, context, theory development, etc.

4.5 Other inclusion and exclusion criteria

We will also apply the following criteria when selecting studies for inclusion.

- **Language**: Studies published in any language will be included, although the search terms will be in English only.
- **Publication date**: Studies will be included if their publication date was 2014 or after. The date has been chosen based on the launch of the BMZ Initiative on Rights-based Family Planning and Maternal Health (BMZ 2013).
- **Status of studies**: We will include all studies regardless of publication status (i.e. both peer-reviewed and studies published in 'grey literature'). We will include ongoing and completed IEs, SRs, and qualitative studies that meet our inclusion criteria. For on-going studies, we will include prospective study records, protocols and trial registrations. Providing an indication of the prevalence and characteristics of on-going evaluation evidence is expected to enrich the analysis of current evidence gaps and support decision making in relation to evidence generation.

5. Methods

5.1. Search methods

To identify relevant studies for our map, we will conduct a comprehensive search for eligible studies using the standards and methods developed by Snilstveit and colleagues (2016; 2017) for compiling an Evidence Gap Map. We will adopt a systematic search strategy following guidelines for systematic literature searching (Kugley et al. 2017). We will develop a set of English search terms and apply it to a wide range of electronic academic and institutional databases and repositories. Finally, we will document the process to systematically screen, critically appraise and extract data from studies identified by the search.

5.1.1. Search strategy

To identify relevant literature, we have compiled a set of search terms which will be translated into a search strategy with support from an information specialist. An example of the search strings for one of the academic databases is presented in Appendix 5. We will adapt the strings and use variants of these terms, depending on the available search functionality, to search electronic databases, repositories, and institutional websites. We provide a list of the sources we will search in Appendix 6. To minimise the risk of publication bias, we selected a wide range of publication types, including journal articles, working and discussion papers,

conference proceedings, theses, dissertations, and institutional reports. We have identified relevant sources suggested by our information specialist, practitioners, researchers and by consulting other known related EGMs (Rankin et al. 2016, Portela et al. 2017, Dickens et al. 2019, Policy and Operations Evaluation Department (IOB) 2021).

While some websites and databases have sophisticated search functions, some do not support complex queries or allow for the export of materials. Others must be browsed by keywords or manually by clicking open records one by one. We will customise our search strategy according to each source that we search (using the website's thesaurus or keyword index if necessary to identify the appropriate vocabulary). We will document and consult approaches for targeted searches and troubleshoot problematic sources with our information specialist.

Where possible, the EGM team will contact key experts and organizations through an advisory group to identify additional studies that meet the inclusion criteria. We will also publish a blog post to identify studies that might otherwise have been missed.

5.1.2. Screening protocol

This subsection provides an overview of the processes we will adopt to systematically screen studies identified by the search. The EGM will be managed using EPPI-Reviewer (Thomas et al., 2022). This platform will be used to manage references, identify and remove duplicate studies, and screen records for inclusion using the procedures outlined below.

- **Training of screeners**: The core project team will train a team of consultants on the protocol, with a focus on understanding the subject matter and the screening process. All screeners will screen the same set of studies and will continue in the training program until an 85 per cent level of consistency is achieved in terms of their decisions to include or exclude a study at the title and abstract stage (i.e., did screeners make the decision that was consistent with the core team?). For the small n methods search the reliability threshold will be 80 per cent.
- **Title and abstract screening**: The title and abstract of all imported and de-duplicated studies will be screened by one screener, who will give a judgment of include, exclude, or unsure. A second screener will review any records marked as unsure (an approach that has been demonstrated to produce comparable results to double screening at significantly lower cost (Shemilt et al. 2016). Several exclude codes will be available to provide more information on the reasons for exclusion in each case. We will apply screening codes in a hierarchical order so that consistent comparisons can be made about why studies were excluded and at what stage in the screening process. A full list and order of codes is provided in Appendix 7.

Periodic meetings will be held by members of the core team to address studies flagged for a second opinion and make any refinements to the screening approach. The output of this process will be a set of screened studies that have been put forward for full text screening.

- **Machine learning**: We will use the machine-learning features of EPPI-Reviewer to accelerate the title and abstract screening process (O'Mara-Eves et al. 2015; Thomas et al. 2011). We will begin by screening 500-1000 random abstracts, which will serve as a training set for the construction of a classifier that assigns all remaining abstracts a probability of inclusion based on the training data. We will screen all abstracts with a probability score of 0.3 or greater. We will then screen a random sample of abstracts from the buckets with lowest probability scores (0-0.1, 0.1-0.2, 0.2-0.3) to determine if any should be included for full-text screening. If more than 1 per cent of a bucket sample is found to be includable, we will proceed to screen all abstracts from that bucket.
- **Full-text screening:** We will retrieve the full text for each study that meets all the title and abstract inclusion criteria. Two reviewers will independently examine each full text in detail against the protocol. Again, we will apply a code to each study that reflects either that the study is included, or why the study is excluded. If the reviewers are not in agreement whether to include or exclude a study a senior project team member will reconcile the decision. The output of this stage will be a set of studies deemed suitable to include in the EGM.
- **Checks for linked publications:** The project team will attempt to group publications that focus on the same intervention and study population (i.e., publications that report on the same study). This typically occurs in cases where an author group publishes more than one paper in relation to one particular study on a specific population. Descriptive information will only be extracted once for each group of linked publications, drawing on all linked publications so that extraction is as comprehensive as possible. For studies that exist on 3ie's Development Evidence Portal online platform at the time of data extraction, the record for the already-extracted title will be indicated as the main publication.

Each step in this process will be documented in detail and graphically presented in a flow chart in the final report to facilitate replication of the approach.

5.2. Data extraction and critical appraisal

We will systematically extract data from all included studies directly on 3ie's Development Evidence Portal online platform, based on the provisional data extraction tool available in Appendix 8. The data will cover the following broad areas:

- **Basic study and publication information**: This coding will focus on capturing the general characteristics of the study including authors, publication date and status, study location, intervention type, outcomes reported, definition of outcome measures, population of interest, study and programme funders, time periods for delivery and analysis.
- **Topical cross-cutting issues**: We will extract data on a number of cross-cutting issues, including equity and gender, population, health theme, democratic/autocratic context, and cost-effectiveness. A preliminary list can be found in Appendix 8.
- **Critical appraisal**: We will critically appraise all included SRs following the practices suggested by Lewin and colleagues (2009). This appraisal assesses SRs according to criteria relating to the search, screening, data extraction, and synthesis activities conducted, and covers all the most common areas where biases are introduced. We will rate each systematic review as low, medium, or high confidence drawing on guidance provided in Snilstveit and colleagues (2017). For the purposes of our search results and References section in the final report, we will include SRs rated as low quality. However, we will not include SRs rated as low quality in the analyses nor in the online map. We will not critically appraise IEs, as this is typically beyond the scope of EGMs. The tool used for this process is presented in Appendix 10.

The following processes will be implemented to collect this information:

- **Develop and refine data extraction codebooks**: The draft codebook developed for this project will be reviewed and potentially refined in light of any feedback received by the EGM advisory group and insights from project implementation.
- **Data extraction training and pilot**: Coders assigned to each data extraction task will undergo theory- and practice-based training in using the tools provided. Each coding group will code a 'training set' of studies and we will assess their inter-rater reliability. We will provide additional group training as required prior to the main-stage extraction

- **Main-stage extraction**: In the case of descriptive and equity-based information, studies will be coded by one coder. In the case of critical appraisal assessments, studies will first be single coded and then reviewed by a SR methods expert. We will hold meetings periodically with coders on the project to provide support and resolve queries.
- **Quality checks**: During the data extraction phase, the project team will perform quality checks of the extracted data. In practice, a member of the core team will check the consistency of data extracted by consultants. As far as possible, checks will start at the beginning of the data extraction stage, soon after coders graduate from the data extraction training pilot. This will minimize coder drift and minimize the amount of data that need to be re-extracted by the core team.

5.3. Analysis and reporting

We will conduct a range of descriptive analyses to provide an overview of included studies across the following dimensions:

- Publication year
- Publication type
- Geography
- Study participants
- Interventions
- Outcomes
- Study type characteristics
- Results of the systematic review critical appraisal
- Equity and cross cutting themes, e.g. fragile and conflict-affected states, or if a study's methodology is sensitive to gendered inequalities
- Population, age group, mode of delivery, health topic and cost data

Where appropriate, we will consider running cross-tabs to provide a more nuanced overview of the evidence identified. We will produce the following analytical outputs:

- **Interactive EGM**: An interactive evidence gap map that visually presents the current evidence base that is categorized by coverage with respect to the predetermined intervention-outcome framework, quality and completeness. We will incorporate filters into the map to enable a more targeted use – for example, by restricting the studies to a specific evaluation method, by population or country. The map will be stored on the 3ie website and shared as a public good.
- **Presentation**: A presentation will provide an overview of the emerging findings of the EGM. This will be presented by the evaluation team and will provide an

opportunity for DEval and German development cooperation stakeholders and the advisory group to comment on the findings and to collaboratively discuss opportunities for additional analyses, presentation of results and implications. It will be designed such that it can be used by DEval and BMZ for internal learning purposes.

- **EGM technical report**: The EGM technical report will include an overview of the method, Theory of Change for each intervention domain, and the key results of the EGM. This report will present a set of research and policy implications. Analytical details will be provided in technical annexes. The technical report will be published by 3ie and shared as a public good.
- **EGM policy brie**f: We will provide a high-level summary of the results with primary focus on answering the research questions specified in Section 1 using non-technical language.

5.4. Timeline

The approximate date for submission of the EGM report is November 2023. All final analytical outputs will be published on 3ie's Development Evidence Portal.

5.5. Engagement and communication plan

3ie will share the results of the EGM with DEval, development cooperation stakeholders from Germany and the wider international development community. To ensure the results of the project accurately reflect the policy and research needs of key stakeholders we will aim to:

- Identify an EGM advisory group: The project team, in collaboration with DEval, will engage with key stakeholders with practical and academic expertise in the SRHR field. 3ie will set up an advisory group with the aim of providing pro-bono support to the project at several key stages of the project. These stages include developing the project protocol, reviewing the search results produced, reviewing and interpreting emerging findings, and developing and optimizing the analytical outputs produced to aid evidence uptake and use. A list of advisory group members can be found in Appendix 11.
- Develop a Stakeholder Engagement and Communication Plan (SECP): By drafting such a plan we aim to ensure that findings from the EGM are effectively disseminated to the appropriate audiences in an engaging and accessible format. This plan will include a provisional analysis of key stakeholder groups, focusing on

their relevant interests and the extent to which 3ie and/or DEval have access to them, and an assessment of what the most value-added EGM project outputs might be to aid evidence uptake and use. The SECP will be refined if necessary as additional information needs or dissemination opportunities are identified by the project team, advisory group or DEval.

6. Review information

6.1 Acknowledgements

We are grateful for the feedback provided by Dr. Tasnim Azim, our subject matter expert. The authors also wish to thank Audrey Portes who organized feedback from internal and external experts, Constanza Gonzalez Parrao and Tasnim Azim who provided inputs to near final versions of the protocol.

6.2 Contributions of authors

• Framework development: Framework development was led by Tomasz Kozakiewicz (TK) and Lina Khan (LK) with support from Shannon Shisler (SS) and Birte Snilstveit (BS).

• Protocol Development: Protocol development was led by TK and LK with support from SS and BS.

• Search Strategy: The search strategy was developed by Sarah Young and supported by TK, LK and Megha Bhattacharyya (MB).

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6.3 Declarations of interest

No conflict of interest to declare.

6.4 Plans for updating EGM

At the time of publication, there were no plans in place for updating the EGM.

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Appendices

Appendix 1: List of included countries

World Bank income status classification

Low- and middle-income countries (L&MICs)

Afghanistan	Dominican Rep.	Liberia	Serbia
Albania	Ecuador	Libya	Sierra Leone
Algeria	Egypt, AR	Macedonia, FYR	Solomon Islands
Angola	El Salvador	Madagascar	Somalia
Armenia	Eritrea	Malawi	South Africa
Azerbaijan	Ethiopia	Malaysia	South Sudan
Bangladesh	Fiji	Maldives	Sri Lanka
Belarus	Gabon	Mali	St. Lucia
Belize	Gambia, The	Marshall Islands	St. Vin. & Gren.
Benin	Georgia	Mauritania	Sudan
Bhutan	Ghana	Mexico	Suriname
Bolivia	Grenada	Micronesia, FS	Swaziland
Bosnia & Herzegovina	Guatemala	Moldova	Syrian Arab Rep.
Botswana	Guinea	Mongolia	Tajikistan
Brazil	Guinea-Bissau	Montenegro	Tanzania
Bulgaria	Guyana	Morocco	Thailand
Burkina Faso	Haiti	Mozambique	Timor-Leste
Burundi	Honduras	Myanmar	Togo
Cambodia	India	Namibia	Tonga
Cameroon	Indonesia	Nauru	Tunisia
Cape (Cabo) Verde	Iran, I.S.	Nepal	Turkey
Central African Rep.	Iraq	Nicaragua	Turkmenistan
Chad	Jamaica	Niger	Tuvalu
China	Jordan	Nigeria	Uganda
Colombia	Kazakhstan	Pakistan	Ukraine
Comoros	Kenya	Pap. New Guinea	Uzbekistan
Congo, DR	Kiribati	Paraguay	Vanuatu
Congo, Republic	Korea, Dem. Republic	Peru	Vietnam
Costa Rica	Kosovo	Philippines	W. Bank & Gaza
Côte d'Ivoire	Kyrgyz, Republic	Rwanda	Yemen, Republic
Cuba	Lao PDR	Samoa	Zambia
Djibouti	Lebanon	São Tomé & Prin.	Zimbabwe
Dominica	Lesotho	Senegal	

Former low- and middle-income countries

Czechoslovakia	Mayotte (High income: 1990)	Serbia and Mont	Yugoslavia
Gibraltar (High income: 2009-2010)	Netherlands Antilles (High income: 1994-2009)	USSR	

Transitional countries

Name	L&MIC period	High-income country period
American Samoa	1990-present	1987-1989
Antigua and Barbuda	1987-2001; 2003-2004; 2009-2011	2002; 2005-08; 2012-present
Argentina	1987-2013; 2015-16; 2018-present	2014; 2017
Aruba	1991-1993	1987-1990; 1994-present
Bahrain	1990-2000	1987-1989; 2001-present
Barbados	1987-1988;1990-99; 2001;2003-05	1989; 2000; 2002; 2006-pres
Chile	1987-2011	2012-present
Croatia	1992-2007; 2016	2008-2015; 2017-present
Cyprus*	1987	1988-present
Czech Republic	1992-2005	2006-present
Equatorial Guinea	1987-2006; 2015-present	2007-2014
Estonia	1991-2005	2006-present
Guam	1990-1994	1987-1989; 1995-present
Greece*	1987-1995	1996-present
Hungary	1987-2006; 2012-2013	2007-2011; 2014-present
Isle of Man	1990-2001	1987-1989; 2002-present
Latvia	1991-2008; 2010-2011	2009; 2012-present
Lithuania*	1991-2011	2012-present
Macao (SAR)	1987-1993	1994-present
Malta	1987-1988; 1990-1997;1999; 2001	1989; 1998; 2000; 2002-pres.
Mauritius	1987-2018; 2020-present	2019
Nauru	2016-2018	2015; 2019-present
New Caledonia	1987-1994	1995-present
Northern Mariana Islands	1992-1994; 2002-2006	1995-2001; 2007-present
Oman	1987-2006	2007-present
Palau	1987-2015	2016-present
Panama	1987-2016; 2020-present	2017-2019
Poland*	1987-2008	2009-present
Portugal	1987-1993	1994-present
Puerto Rico	1987-1988; 1990-2001	1989; 2002-present
Republic of Korea	1987-1994; 1998-2000	1995-1997; 2001-present
Romania	1987-2018; 2020-present	2019
Russia	1991-2011; 2015-present	2012-2014
Seychelles	1987-2013	2014-present
Slovak Republic*	1992-2006	2007-present
Slovenia	1992-1996	1997-present
Saudi Arabia	1990-2003	1987-1989; 2004-present
St. Kitts and Nevis	1987-2010	2011-present
Trinidad and Tobago	1987-2005	2006-present
Uruguay	1987-2011	2012-present
Venezuela	1987-2013; 2015-present	2014

High-income countries

Andorra	Faeroe Islands	Kuwait	St. Martin- French
Australia	Finland	Liechtenstein	Sweden
Austria	France	Luxembourg	Switzerland
Bahamas	French Polynesia	Monaco	Taiwan
Belgium	Germany	Netherlands	Turks & Caicos Isl

Bermuda	Greenland	New Zealand	Untd Arab Emir.
Brunei Darussalam	Hong Kong (SAR)	Norway	United Kingdom
Canada	Iceland	Qatar	United States
Cayman Islands	Ireland	San Marino	Virgin Islands- US
Channel Islands	Israel	Singapore	
Curacao	Italy*	St. Martin (Dutch)	
Denmark	Japan	Spain*	

Source: World Bank Country and Lending Groups – World Bank Data Help Desk 2023

Appendix 2: List of included interventions and sub-categories of interventions

Intervention domain	Intervention category	Definition
SRHR policy, advocacy and health systems	Policy advocacy	Advocacy directed at shaping a system of courses of action (or inaction), regulatory measures, legislative acts, judicial decisions and funding priorities concerning a particular SRHR issue (AMSHeR 2018). Advocacy interventions can make use of the following targeted actions: • radio, television broadcasts, social media engagements, documentaries, news articles, issuing press releases, invitations to media, distributing materials such as pamphlets, booklets or manuals providing relevant information • meetings with government officials, attending public hearings, responses to proposed legislation, organise demonstrations, sit-ins • issuing shadow reports to provide alternative views of the progress of government and donor financial commitments or compliance with human rights standards at high-level meetings • filing complaints using national, regional and global accountability mechanisms
	Policies and laws	Population policies and laws enacted by a local or national government or workplace implemented with the goal of affecting public or private delivery of essential SRHR services.* Following O'Reilly (2017) we define a policy as a set of standard operating procedures that were consistently applied and written or codified in some manner. To be included, the policy or law has to be intentionally related to SRHR. Policies directly related to SRHR can facilitate access or serve as barriers, such as: • strive to remove barriers to accessible and affordable SRHR services (e.g., eliminating third party authorization, mandating free antenatal care, contraception, safe abortion services, comprehensive sexuality education, HPV vaccination, etc) • create barriers to prevent and respond to rights violations (e.g., GBV, sex-selective abortion) If a policy is related to SRHR indirectly it will be excluded.
	Healthcare financing schemes	Financing arrangements through which people obtain SRHR services (OECD,EU, and WHO 2011). Interventions include direct payments by households for services

Intervention domain	Intervention category	Definition
		and goods (e.g. fee-for-service) and third-party financing arrangements including the following: • government schemes (may include cost sharing) • social health insurance or compulsory private insurance • other schemes financed by non-profit institutions or enterprises, Compulsory Medical Saving Accounts, voluntary health insurance schemes. The financing schemes above can be financed through revenue generation strategies such as domestic resource mobilization (High Impact Practices in Family Planning (HIPs) 2018), social insurance contributions, and voluntary prepayments. Studies that measure effects of such would also be included.
	Civil registration and vital statistics systems	Civil registration and vital statistics (CRVS) systems that aim to register all births and deaths, issue birth and death certificates, compile and disseminate vital statistics, including cause of death information; and potentially enable verifiability of age and family relationship information. CRVS systems may also record marriages and divorces (WHO n.d.). The following activities would be included: • provision of integrated systems • digitisation and standardisation • institutional capacity building
	Supply chain and logistics activities	Supply chain management organizes SRHR product supply chain players: procurers, manufacturers, shippers, distributors, warehouses, facilities, and service providers—in a system that aims to ensure timely delivery of products from the port to warehouses, service delivery points and communities (High Impact Practices in Family Planning (HIPs) 2018). The following activities would be included: • supply chain assessments that aim to increase data visibility and use for continuous improvement (e.g. for HPV vaccines) • consolidation of supply chains to match distribution to consumption, including with the use of technology • capitalising on private sector capacity (e.g. by outsourcing transport and distribution to private companies)
	Social accountability	Activities that operate at the subnational level, where the community and health facility intersect, and engage communities and health sector actors in a collaborative process to jointly identify problems, implement, and monitor solutions with the aim of accountability for the quality and responsiveness of SRHR services (High Impact

Intervention domain	Intervention category	Definition
		Practices in Family Planning (HIP) 2022d; Schaaf and Khosla 2021). The following approaches and their modifications would be included: • Community Score Cards (CSC) that monitor the quality of community-based public services through focus groups – particularly marginalized groups (Pekkonen 2012; CARE n.d.) • social audits that measure the degree to which services and local development projects have the staff and inputs required under local law (TAP Network n.d.); may culminate in public hearings and could be referred to as Community-Based Performance Monitoring if combined with CSC • Citizen Voice and Action (CVA) that consists of CSC + social audits + repeatable cycles to increase accountability, and can facilitate extending beyond the local level (Walker 2018)
	Provider capacity building and service adjustments	Building capacity of providers through adjustments to existing services, social and behavioural change interventions, training, job aids and other technical assistance to deliver essential SRHR services.* Service adjustments can also include updates to facilities or processes with the aim of improving SRHR services delivery, such as integrating HPV vaccine delivery with other services or enabling school-based delivery (Whitworth et al. 2021; Morgan et al. 2022). Capacity building and service adjustments could be directed at providers from the following sectors: • health service frontline staff, such as midwives or administrators, including those managing family planning services (e.g., training, routine screening for reproductive coercion, or introducing or expanding skilled birth attendants to existing maternal and newborn facilities) • justice and security sector staff (e.g. training police officers to identify warning signs of intimate partner violence, introducing women's police stations, documentation or referrals to create safe homes) • education sector staff such as teachers or administrators (e.g., introducing youth-friendly SRHR services at schools) • community-based providers such as community health workers and other volunteer or community-based staff.
Social and behavioural change for the public	Mass and social media campaigns	Interventions that employ mass media (for example, radio and television) and social media that aim to promote essential SRHR services among the public through consistent, high-quality messages on advertisements, talk shows, service announcements, etc.* Mass and social media campaigns aim to create social and behavioural change (e.g., to prevent GBV or to prevent GBV and STIs) by "providing

Intervention domain	Intervention category	Definition
		accurate information, building self-efficacy, and promoting attitudes and social norms that support healthy sexual and reproductive behaviours" (High Impact Practices in Family Planning (HIP) 2017; UNFPA 2022c).
	Social marketing	Using marketing concepts based on behaviour change theory, market research and consumer insight with the aim of tailoring health information, products and services to consumer's needs, values and preferences (HIP 2021). Social marketing strategies use marketing concepts including: • product design • appropriate pricing • sales and distribution • multiple communication forms that reinforce and complement each other such as advertising, social franchising, public relations, internet communication, community mobilisation, counselling, print and electronic materials, and network marketing (e.g. social norm marketing to prevent GBV). All forms communicate the same content associated with the "product" (Portela et al. 2017).
	SRHR education, including Comprehensive Sexuality Education	Education on at least one of the below SRHR-related topics; or that specifically refers to the Comprehensive Sexuality Education curriculum, which is a holistic rights-based approach that aims to impart knowledge, skills, attitudes or values related to the below topics (UNFPA 2022d): • Relationships, gender, sexuality and sexual behaviour, SRH, SRR, and human development (Braeken and Cardinal 2008; UNFPA 2022; Policy and Operations Evaluation Department (IOB) 2021) • Gender equality education, mentoring, or training with the aim of addressing GBV, related practices such as FGM/C or child marriage (UNICEF 2022a) or trafficking. Components can include: self-efficacy, critical thinking and decision-making, assertive communication, gender interactions and negative gender roles, identifying emotions, life skills training to promote development of positive masculinity, skill-building related to GBV prevention (including harassment or assault) such as de-escalation, negotiation and self-defence (Baiocchi et al. 2017), discussion of rape myths and self-protection (UNFPA 2022c), and bystander interventions at educational institutions and community service. • Menstrual health and hygiene (UNFPA 2022b)

Intervention domain	Intervention category	Definition
	Social groups and clubs	Groups and clubs that aim to offer safe spaces where children, youth or adults can meet friends, engage in discussions, access informational materials, seek help, or participate in training and sports. The primary goal of these groups is to provide social support or an access point for information and care related to SRHR (Rankin et al. 2016).
	Peer education and mentorship	Interventions that use peers (of the same age group or slightly older than participants) as intervention facilitators. Peers can engage in the following: provide training or instruction, disseminate information, mentoring, or refer and accompany participants to health centres (Rankin et al. 2016). For example, this could include mentoring by boys of a slightly older age to their younger peers to prevent dating violence.
	Family mobilisation and dialogue	Interventions that work with families with the aim of changing knowledge, attitudes and behaviours of parents or to encourage dialogue on SRHR topics within a family. Typically, interventions in this category aim to improve the frequency and quality of parent-child communication about sensitive topics, such as risky sexual behaviours. Other topics include caregiver decision-making, monitoring of dependents, and general awareness and knowledge training for families (Rankin et al. 2016). Fatherhood and parenting programs (e.g. home visitation, couple education) to prevent GBV would also be included in this category (UNFPA 2022c).
	Community mobilisation and dialogue	Interventions [excluding those from the *social accountability* category] that assist local groups in clarifying and expressing their needs and objectives and in taking collective action to attempt to meet them (USAID/ACCESS 2007; UNHCR, n.d.) Activities in this intervention category encompass: • developing ongoing dialogue with religious/traditional actors, community leaders and community members (e.g. to raise awareness about topics such as HPV vaccines and PMTCT of HIV/syphilis) • assisting in creating an environment in which individuals can empower themselves to address their own and their community's SRHR needs (e.g. bystander interventions that engage the community in GBV prevention or local advocacy) • identifying and supporting the creative potential of communities to develop a variety of strategies and approaches (e.g. drama and music) • assisting in linking communities with external resources

Intervention domain	Intervention category	Definition
SRHR Services	Counselling	Provision of counselling in the form of discussion between health service users and providers with the aim of helping health service users make informed decisions or cope with stresses and concerns (NDH South Africa 2019), on one or more of the following topics: • family planning and modern methods of contraception, including topics such as birth spacing; and can be part of maternal care during pregnancy, immediate/post-partum period, and post-pregnancy/abortion • prevention of cervical cancer, including the HPV vaccine • sexuality and sexual wellbeing (e.g. acknowledging sexual desire and function) • infertility • prevention of STIs including HIV, if delivered with other SRHR topics • identifying, preventing or receiving care for GBV or related practices such as FGM/C • maternal and newborn health, including nutrition, breastfeeding support or healthy behaviours, PMTCT of HIV or syphilis, or identifying or providing care for postpartum depression or anxiety. Counselling interventions focused solely on maternal and newborn nutrition or breastfeeding; or solely on PMTCT of HIV of syphilis to be included if delivered with other SRHR topics. Counselling interventions focused solely on newborn care (without a maternal health topic) to be excluded.
	Screening and assessment	Screening and assessment services with the aim of diagnosing conditions within: • sexual health, including screening for sexual function and wellbeing, and STIs including HIV if delivered with other SRHR services • reproductive health, such as screening for infertility or cervical cancer/HPV • maternal and newborn health, to detect or prevent STIs or other conditions during pregnancy or during the postpartum period. For example, can include use of ultrasonography, or biodegradable mat to support detection of haemorrhage (Wilcox et al. 2017); or assessment for postpartum depression and anxiety.
	Maternal and newborn care	Specialised provider care for: • Prevention and treatment of complications as adapted from identified gaps (Chersich and Martin 2017): - post-partum haemorrhage: administration of uterotonic agents with the aim of prevention or treatment, such as oxytocin, misoprostol, prostaglandin,

Intervention domain	Intervention category	Definition
		ergometrine, carbetocin (World Health Organization 2012; Gallos et al. 2018); cord management (e.g. late cord clamping) and uterine massage (World Health Organization 2012; Hofmeyr, Abdel-Aleem, and Abdel-Aleem 2013). - pre-eclampsia or eclampsia: calcium supplementation, administration of magnesium sulfate and other anticonvulsants, interventionist or expectant care for severe pre-eclampsia before term, induction of labour for pre-eclampsia at term (WHO 2011). • Care for newborns under 28 days of age if delivered in combination with at least one of the above components. Could include: detection and management of neonatal opthalmic conditions, comprehensive eye examination, immediate drying after birth, routine assessment and immediate essential newborn care including kangaroo skin to skin contact, warming under radiant heater, intramuscular vitamin K, hygienic cord care using chlorhexidine (World Health Organization 2017).
	Safe abortion services	Delivery of termination of pregnancy (TOP) services and post-abortion care including equipment and infrastructure with the aim of ensuring safe abortion and care (Policy and Operations Evaluation Department (IOB) 2021).
	Community health workers and home visits	Interventions that use community health workers and home visits by healthcare professionals for service delivery (Rankin et al. 2016) that are used to support any of the essential SRHR services* such as family planning, reproductive and sexual health and wellbeing, maternal or newborn care and cervical cancer/HPV prevention. Prevention of STIs including HIV would be included if delivered with other SRHR topics. Community health worker interventions focused solely on maternal and newborn nutrition or breastfeeding to be included if delivered with other SRHR topics.
	mHealth and technology-based interventions	Medical and public health practice supported by the use of mobile or web-based technologies and software applications with the aim of improving access or use of SRHR services* (Onukwugha et al. 2022). This involves the use of mobile phones, tablets, patient monitoring devices, personal digital assistants (PDAs) and other wireless devices, while interventions can include reminders of upcoming health appointments, HPV vaccination or prescription pick-ups via SMS (Portela et al. 2017).

Intervention domain	Intervention category	Definition
	Provision of SRH products	Provision of one or more of the following SRH products regardless of the modality of distribution or payments: • contraceptives defined as devices, sexual practices, chemicals, drugs or surgical procedures used to intentionally prevent conception (Jain and Muralidhar 2011) • self-testing kits (e.g., for STIs) defined as simple rapid diagnostic tests wherein an individual collects their own specimen (oral fluid or blood) to perform the test and interprets the result, often in a private setting, alone or with a person they trust (WHO 2018) • menstrual hygiene products (e.g., sanitary pads, tampons, cups or cloths) defined as products used to catch menstrual flow (UNICEF 2019) • medical supply kits defined as a collection of medicines, supplies or instruments packaged together with the aim of conducting a healthcare task (Aleman et al. 2017), e.g. emergency reproductive health (IARH) kits for humanitarian settings
Vouchers, cash, or in-kind transfers	Cash transfers	The provision of repeated or one-off assistance in the form of money, either physical currency/cash or e-cash to individuals, households or communities (CaLP, n.d.). Cash payments explicitly designed as incentives for SRHR related behaviour change, which are distinct from transfers with the sole aim of poverty alleviation and social protection (Stoner et al. 2021). They could be: • unconditional (provided without obligation) • labelled (with an intended purpose) • conditional upon receiver's actions (e.g. to give birth in a health facility or attend antenatal visits)
	Vouchers	A printout, token or e-voucher that can be exchanged for a specified amount or value of goods denominated either as a cash value (e.g., 100 KSH) or predetermined commodities or services (e.g. transportation from A to Z, ultrasound examination), or a combination of value and commodities (CaLP, n.d.). They can be redeemed at preselected retail outlets or health service centres. Vouchers are a restricted form of transfer but the degree of restriction/flexibility often varies. Other terms could be used interchangeably, such as stamps, or coupons.
	In-kind transfers (excluding SRH products)	Provision of desirable goods [excluding those from the *provision of SRH products* category], explicitly designed as incentives for SRHR related behaviour change (e.g., food such as cooking oil or school supplies to encourage girls not to marry early).

*As adapted from the Guttmacher-Lancet Commission report, essential services include counselling and care for the following: SRHR education including comprehensive sexuality education; contraceptives; maternal and newborn care; safe abortion and care; prevention of STIs including HIV; sexual and gender-based violence; cervical cancer; infertility; and sexual function and satisfaction (Starrs et al. 2018).

Appendix 3: List of included outcome types and sub-categories of outcomes

Outcome group	Outcome category	Definition	Example indicators
Knowledge, attitudes and norms	Knowledge and awareness	Public: Knowledge or awareness around SRHR, and associated rights, laws, health services, commodities, etc. SRHR service providers: knowledge related to service delivery expertise, roles or processes	Knowledge of menstruation and hygiene; Knowledge of HIV and other STI transmission mechanisms; Awareness of gender rights; Understanding pregnancy risk and how to prevent pregnancy; Understanding rights to decide if, when and with whom to have sex; provider knowledge such as content expertise or awareness of service delivery changes
	Attitudes and normative change	Measures of normative change, attitudes, beliefs and perceptions around SRHR and related topics.	Attitudes towards use of family planning and beliefs about it; Beliefs about gender norms, violence or FGM/C; Attitudes towards accessing SRHR services, mobility or son preference
Behaviours of the public	Sexual behaviour	Measures of initiation, frequency of, or abstinence from sexual intercourse. This category includes measures of safe sexual behaviours or risky sexual behaviours (Rankin et al. 2016).	Number of sexual partners; Experience of transactional sexual behaviours; Age of first sexual intercourse
	Contraception and other prevention	Use of modern technology or method to prevent pregnancy and/or STIs; could include female and male sterilisation; intrauterine devices; hormonal implants, injections, and pills; male and female condoms and other supply methods; modern fertility awareness methods and emergency contraception pills (World Health Organization 2020).	Use of condoms; Use of contraceptive pills or emergency contraceptive pills;
	Menstrual hygiene	Indicators related to menstrual hygiene such as access to or use of sanitary pads and washing habits (Rankin et al. 2016).	Use of safe menstrual products; Responses regarding washing habits

Outcome group	Outcome category	Definition	Example indicators
	Communication, support seeking and caregiver practices	Measures of interpersonal support and communication with or support-seeking from parents, caregivers, sexual partners or community members; and caregiver practices.	Marital contraceptive communication; willingness to seek support; Caregiver practices
Availability, accessibility, acceptability and quality of services	Availability and use	Measures of: -use of SRHR services such as, for example, antenatal visits, STI treatment, uptake of HPV vaccine; uptake of family planning counselling, skilled attendance at birth, or giving birth in a health facility (Glassman et al. 2013). - institutional availability of personnel, infrastructure, equipment, diagnostic capacity, and medicines and commodities (World Health Organization 2013), to support SRHR service delivery and use.	Closest SRHR services provider to respondent; Number of times SRHR services have been accessed by respondent in certain timeframe; Surgeries or procedures undergone for genital mutilation/ cutting repair; Availability of essential medicines
	Accessibility	This category includes measures of accessibility; and the extent that health professionals respect the basic human rights of the people they treat or care for (Palm et al. 2020). Outcomes could relate to one of the following rights in relation to SRHR (WHO 1994): - Right to equitable and non-discriminatory access to health services - Right to respect, dignity, integrity and non-discrimination - Right to privacy and confidentiality - Right to information related to health services, health status, treatment options and informed consent	Proportion of health facilities that are physically accessible without using stairs; Acts of disrespect and abuse during childbirth; Reponses regarding whether respondent was informed of possible side-effects before medical procedures or medication; Proportion of young people who have access to unbiased SRHR education and information
	Affordability	Measures of how affordable SRHR products and services are to users, for example measures of ability of service users to pay for services. This is different from information on intervention cost which is captured in the Cost data filter.	Cost of admission at hospital; Average diagnostic test prices; portion of income spent on health-related expenses
	Quality and acceptability	Outcomes related to service quality and acceptability such as satisfaction with health service (Aninanya et al.	Rating of care received before, during and after delivery

Outcome group	Outcome category	Definition	Example indicators
		2015). Outcomes can be measured to reflect quality of care, responsiveness or patient-centredness of the provider (e.g., through client exit interviews or provider perspectives) or of the health facility experience (e.g., wait times, cleanliness of rooms). Measures of the quality of abortion or post-abortion services would fall under the 'Safe abortion' category.	
	Registration	Measures of registration for key SRHR statistics such as birth, marriage and vital registration.	Share of programme participants whose marriage was registered
Health outcomes	Adolescent pregnancy	Measures of fertility, pregnancy, unwanted pregnancy, first birth and similar indicators for adolescents (Rankin et al. 2016).	Age at first birth; Whether respondents wanted to get pregnant at the time they got pregnant
	Adult fertility and infertility	Any measure of fertility or infertility among adults or general population without a specific focus on adolescents.	Total fertility rate; Responses to questions regarding miscarriages;
	Safe abortion	Any measure of induced termination of pregnancy (Rankin et al. 2016).	Pregnancy ended in abortion; Whether medical professional performed the abortion procedure; Method of abortion;
	HIV and other STI testing and incidence	Outcomes directly related to testing, incidence and prevalence of HIV, HPV and other STIs	HIV (or other STI) testing frequency; Incidence of HIV (or other STI); Early diagnosis, HIV status disclosure
	Maternal morbidity and mortality	Any measure of mortality for mothers or morbidity defined as conditions that are attributed to or aggravated by pregnancy and childbirth which have a negative impact on the woman's wellbeing and/or functioning (NICHD No date).	Maternal deaths; Complications from unsafe abortion; Complications from unsafe pregnancy (cardio- vascular problems, high blood pressure, infections, blood clots, bleeding, anaemia, depression and anxiety)
	Newborn morbidity and mortality	Any measure mortality or morbidity for newborns under 28 days of age.	Infant mortality rate; Number of children of respondent who were born alive but died in infancy

Outcome group	Outcome category	Definition	Example indicators
	Sexual function and satisfaction	Extent of physical, emotional and mental well-being in relation to sexuality, including the ability to have pleasurable sexual experiences (WHO n.d.)	Extent of interest in or desire for sex; extent of physical comfort during sex; ability to become aroused; ability to achieve orgasm or erection; satisfaction with sexual life
Gender-based violence and harmful practices	Child, early and forced marriage	Measures such as age at marriage or adolescent marital status. Would include dowry and marriage-related indicators.	Age at first marriage; Responses to whether dowry (or any related payments in the form of gifts) was made; Relation to their spouse before marriage (if related)
	Female genital mutilation/cutting	Incidence, prevalence or other measures of partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons.	Proportion of women who report having undergone FGM/C
	Trafficking	Incidence, prevalence or other measures signalling the use of force, fraud or coercion to exploit an individual for profit through forced labour or sexual exploitation.	Case reports of trafficking for sex work
	Gender-based violence	Incidence, prevalence or other measures of harmful acts directed at an individual based on their gender or sexual orientation. This encompasses a broad range of forms of physical, sexual and psychological violence including but not limited to: IPV including domestic violence; sexual harassment and abuse; acid throwing; honour killings (OECD 2022; Amin et al., n.d., 26) or reproductive coercion (Tarzia and Hegarty 2021).	Lived experiences and frequency of GBV/IPV registered cases of sexual assault; Reporting of acid attacks; Rate of violent crime against same sex couples; Share of women who report their partner did not wear a condom when they wanted them to wear one
Enabling environment	Agency and empowerment	Process through which an individual acquires the ability to access SRHR resources, make independent choices, and achieve preferences that align with their own values and objectives with respect to their bodily, sexual and reproductive autonomy and self-determination. This can be measured either through the observation of a set of behaviours that demonstrate an increased access to resources within a household, agency and achievements, or through self-reported perception of someone's own empowerment (e.g. self-efficacy in negotiating sexual	Responses to adolescents' perceived level of confidence to request or buy a condom/other contraceptive by themselves; Whether a woman requires permission from household elders or husband to seek medical attention for herself; decision-making power in family-planning decisions (including sterilization procedures); decision-making powers regarding sexual activities (power to say

Outcome group	Outcome category	Definition	Example indicators
		preferences). This can also include measures of the extent that people require permission (e.g., from spouse or family members) to act on preferences, such as to seek healthcare, pursue education, engage in social activities, etc.	"no" or act on preferences regarding contraceptive use).
	Legislative environment	Measures of the extent of protection or discrimination that is codified in SRHR-related laws and policies, and in the reforms surrounding these. Measures can include: - legal, administrative or financial restrictions that prevent rights holders from free and equal enjoyment of their SRR, their SRH including patients' rights. - the extent that policies account for SRHR: responsiveness to demographic changes or population trends; existence of mechanisms through which SRH service users can provide feedback, claim rights, register complaints, seek redress.	Number of countries with laws and regulations that guarantee full and equal access to women and men aged 15 years and older to access SRHR services; Equal access to abortion for married and unmarried women; Criminalisation of same sex relationships; De-criminalisation of marital rape; Bans/restrictions on contraception; Extent that a policy is considered youth-friendly; extent that a policy incorporates grievance redressal mechanisms
	International norms	Establishment of international agreements and guidelines, ratification of human rights conventions.	Ratification of human rights conventions; Establishment of guidelines

Appendix 4: Details of included study designs

4.1 Quantitative study designs

We will include IEs that use one of the following quantitative study designs, which are widely used to evaluate intervention effectiveness (Aloe et al. 2017; Reeves, Wells, and Waddington 2017).

1. Randomised evaluations with assignment at the individual, household, community or other cluster level, and quasi-randomised mechanisms using prospective methods of assignment such as alternation. This includes randomised trials where units are deliberately assigned to treatment and control groups for the purposes of research, and “natural experiments” where units are exposed to the treatment via some other random mechanism.
2. Natural experiments with clearly defined intervention and comparison groups which exploit apparently random natural variation in assignment (such as a lottery) or random errors in implementation, etc. Natural experiments that approximate randomised evaluations, regression discontinuity designs, or interrupted time series designs will be categorized as such.
3. Regression discontinuity designs, where assignment is based on a threshold measured before intervention, and the study uses regression to model the assignment process.
4. Studies controlling for time-invariant unobservable confounding, including difference-in-differences (DID), two-way fixed-effects models (TWFE), and two-way Mundlak regressions (TWM).
    a. DiD models will include an interaction term between a time and intervention variable in a regression model. They may also regress an intervention variable on an outcome variable measuring the changes in outcomes over time or present a t-test comparing changes in outcomes over time between an intervention and control group.
    b. TWFE regressions must include time fixed-effects and unit fixed-effects at the level of the intervention (or lower). For example, if the intervention varies at a village level, it must include either village fixed-effects or fixed-effects of a smaller unit, such as households.
    c. TWM models should be synonymous with the approach described by (Wooldridge 2021). This includes correlated random-effects and pooled OLS regression models that control for unit-specific time averages and time-period specific cross-sectional averages.
5. Interrupted time series (ITS) models, with or without a contemporaneous comparison group and with sufficient observations to establish a trend and control for effects on outcomes due to factors other than the intervention (such as seasonality).
6. Weighting and matching approaches which control for observable confounding, including non-parametric approaches (e.g., statistical matching, covariate matching, coarsened-exact

matching, propensity score matching) and parametric approaches (e.g., propensity-weighted multiple regression analysis).

7. Synthetic control approaches.
8. Instrumental variable (IV) approaches such as two-stage least squares procedures.
9. Endogenous treatment-effects models, endogenous switching regression, and other methods synonymous to the Heckman two step model.

We will exclude before-after studies without a comparison group or cross-sectional studies that do not attempt to control for selection bias or confounding. We will also exclude studies that only use simulation or forecast models, ex-ante impact assessments or scenario analyses, and studies that only examine willingness-to-pay for goods, services, process and business models.

4.2 Qualitative study designs

White and Phillips (2012) describe qualitative approaches that explicitly address causal identification, incorporate a theory of change and aim to "establish beyond reasonable doubt how an outcome or a set of outcomes occurred" (p. 7). The table below presents four methods that White and Phillips (2012) report as having the potential to address attribution of cause and effect in small n scenarios. The table also includes an illustrative list of other methods that can be used to answer causal inference questions in small n scenarios as identified by White and Phillips (2012) and other authors. The list is by no means exhaustive.

Method	Description
Methods with the potential to address attribution of cause and effect in small n scenarios (White and Phillips, 2012)	
Realist evaluation	This approach sets out to answer questions related to what works, for whom, how, to what extent and in which circumstances. The aim is to identify underlying mechanisms that elucidate 'how' the outcomes were caused by the intervention and the influence of context (White and Phillips 2012). Interventions are considered a test of an implicit theory detailing how the mechanisms initiated by a program should cause desired outcomes. This theory, coupled with research on the context, is then mapped out in a series of mini-theories called Context, Mechanism and Outcome (CMOs) which explain how different potential combinations of contexts and mechanisms could deliver outcomes. CMOs cannot be observed directly. They must be hypothesized and tested as to whether they function as intended or not. A systematic analysis revises CMO configurations so that only those that show a causal influence remain.
General elimination methodology	This approach sets out for each cause to identify a sequence of events and necessary conditions, and rule out alternative explanations of observed results based on which of them are present and which are not (White and Phillips 2012). For a given event a list of potential causes is constructed, each with its own conditions which would be present when a cause is effective. The approach focuses on selectively gathering evidence, such as the primary facts needed to address the question. Establishing the absence of factors listed for each possible cause eliminates the alternative causes, leaving only those that show a causal link.
Process tracing	Evidence is used to generate multiple, preferably rival hypotheses about how the intervention connects to an outcome. These are then overturned or substantiated (White and Phillips 2012). If not already set out, a program's implicit theory of

Method	Description
	change is identified as one of several possible potential causal explanations. Each theory of change has its own hypotheses of what should hold true if a theory is true or false and an explicit chronology of events. Stakeholders systematically identify evidence to check if it supports the hypothesised causal chains.
Contribution analysis	Drawing from a detailed theory of change, evidence is collected to assess the extent that the intervention did or did not contribute to observed outcomes, along with any relevant context or other explanatory factors (Befani and Mayne 2014; White and Phillips 2012; Sharma Waddington, Umezawa, and White 2023). Sufficient evidence and explanation should be provided to construct a plausible narrative of whether and the extent that the intervention contributed, if at all, to each stage of the causal chain, and to address information gaps.
Other methods that can be used to answer causal inference questions in small n scenarios	
Contribution tracing	This approach combines process tracing and bayesian updating approaches to assess the extent that an intervention or other plausible causes have contributed to observable change, and to numerically rate the confidence of these claims (HM Treasury 2020; Befani and Stedman-Bryce 2017). As part of this participatory approach, stakeholders develop a theory of change and contribution claims and identify what evidence is needed to validate claims.
Qualitative Impact Assessment Protocol (QuIP)	This approach draws on narratives from a sampled group of beneficiaries to assess the extent that beneficiaries perceive outcomes occurring in line with the theory of change and would attribute outcomes to the intervention (Remnant and Avard 2016; Sharma Waddington, Umezawa, and White 2023).
Outcome harvesting	As part of a participatory process, programme implementers and beneficiaries collect and review evidence over time to determine if the outcomes detailed in the theory of change have occurred (HM Treasury 2020; Sharma Waddington, Umezawa, and White 2023). Stakeholders then substantiate whether outcomes can be attributed to the intervention, and if so, explore how the intervention contributed to the outcomes.
Outcome mapping	Programme implementers specify intervention goals, partners and intended change for target actors and plan and implement monitoring and evaluation, with the aim of assessing the extent that outcomes can be attributed to particular programme activities (White and Phillips 2012). Data collection can include tracking of relationships among partners and other actors, programme activities, and organisational practices.
Bayesian updating	Bayesian updating involves estimating probabilities about claims of contribution to observations as a means to assess the credibility of evidence or confidence in conclusions (HM Treasury 2020; Befani and Stedman-Bryce 2017). Stakeholders estimate probabilities for hypothetical claims being true before collecting evidence and probabilities for the evidence being found if the claim is true or false. The process aims to make evaluation assumptions transparent and subject to scrutiny or challenge.
Method for Impact Assessment of Programs and Projects (MAPP)	This approach focuses on identifying effects from the intervention and other possible factors on beneficiaries' quality of life, including positive and negative effects and whether effects were intended; and the possible reasons for these effects (White and Phillips 2012). Stakeholders such as programme staff, beneficiaries and non-programme participants would use various tools to compile and quantify information.
Success Case Method	With this method, the evaluation team defines the intended positive outcomes of an intervention and the criteria for successful or unsuccessful outcomes for beneficiaries (White and Phillips 2012). Evaluators develop information collection tools to identify successful and unsuccessful cases with beneficiaries and identify possible reasons for outcomes, including whether successful cases can be attributed to the intervention (if coupled with other approaches to assess rival hypotheses for observed outcomes).
Most significant change	This approach aims to systematically gather information from a sample of beneficiaries over time about important changes in their lives since the start of

Method	Description
	intervention, including positive and negative change, and beneficiaries' views about why those changes may have occurred (White and Phillips 2012). Programme implementers review stories periodically, select stories that they assess as representing the most significant change from change stories collected, and may verify stories with direct observation or other information.
Participatory impact assessment (PIA)	In this approach, programme implementers engage with a sample of intervention beneficiaries and other stakeholders such as those who did not participate in the programme to identify primary factors that have led to changes in people's lives; categorize whether factors are intervention-related or not, and assess the importance of identified factors to change (Catley et al. 2013). Methods for assessing information and attribution to the intervention would be tested, and programme implementers can take steps to cross-check testimonial information.
Participatory impact pathways analysis (PIPA)	Stakeholders develop a theory of change, identify and analyse the problems that the intervention aims to address, and map relationships among actors and steps needed to realise outcomes (Alvarez et al. 2010). Programme implementers should also collaborate to review how project components fit together, develop monitoring & evaluation indicators to monitor change and re-assess outcomes in the theory of change based on what they find during programme implementation.
Multiple Lines and Levels of Evidence (MLLE)	This approach can be used to assess whether an intervention could plausibly cause outcomes of interest, especially in scenarios where extensive technical data is available such as for environmental interventions with ecological outcomes (Rogers and Macfarlan n.d.). Evaluators would consider a) multiple types of evidence, such as data from multiple sources and contexts, and b) multiple levels of evidence, such as the cause being shown to precede an effect or consistent association found between the intervention and outcome across multiple contexts. Stakeholders such as those with expertise in the field would assess the credibility of evidence.

Appendix 5: Search strategy and quantitative search terms

Database/Platform: Science Citation Index and Social Science Citation Index (Web of Science)

Date: March 25, 2023

String name	String details
1 Sexual and reproductive health rights	**TS=(((reproductive OR sexual OR maternal OR neonatal OR antenatal OR prenatal OR menstrual OR menstruation OR fertility OR pregnan* OR "post-partum" OR postpartum OR newborn* OR infant OR infertility OR "cervical cancer" OR hpv OR "human papilloma virus" OR "human papillomavirus") NEAR/3 (right* OR discriminat* OR antidiscriminat* OR "anti-discriminat*" OR health OR hygiene OR dignity OR equalit* OR equity OR equitable OR equities OR inequalit* OR inequit* OR care OR services)) OR ((body OR bodily) NEAR/2 (autonomy OR integrity)) OR ((abortion* OR contraception OR condom* OR contraceptive*) NEAR/3 (use OR service* OR access* OR care OR law OR policy)) OR (pregnancy NEAR/1 prevent*) OR "family planning" OR ((“sexually transmitted” OR HIV OR syphilis) NEAR/5 prevent))**
2 Policies and laws	TS=(policy OR policies OR law OR laws OR (legal* NEAR/3 (mandate* OR act)) OR regulat* OR "standard operating procedure*")
3 Healthcare financing schemes	TS=((health* NEAR/2 financ* NEAR/2 scheme*) OR (health AND ("fee-for-service" OR (cost NEAR/2 shar*) OR co-payment*)) OR ("third-party" NEAR/2 (financ OR ("health* insurance" NEAR/2 scheme))) OR "compulsory medical saving account*")
4 Policy advocacy activities	TS=(((consumer* or patient* OR right*) NEAR/2 (advoca*)) OR ("human right*" NEAR/3 (comply OR compliance)) OR "shadow report*" OR (complaint* NEAR/3 "accountability mechanism*"))
5 Civil registration and vital statistics systems	TS=(((vital NEAR/2 statist*) OR (civil NEAR/2 regist*) OR ((birth OR death OR marriage) AND certificate*)) AND (system OR digiti* OR standardi* OR (institution* NEAR/2 capacity NEAR/2 building)))
6 Supply chain and logistics activities	TS=((("supply chain*" OR "distribution system*") NEAR/5 (assessment OR consolidation OR streamlin*)) OR (outsourc* NEAR/3 (transport* OR private)) OR (logistics NEAR/3 "management information system*"))
7 Social accountability and community engagement	TS=(((communit* OR social OR citizen* OR public) NEAR/2 ("report* card*" OR audit* OR engag* OR scorecard* OR "score card*" OR accountab* OR watchdog* OR democrati* OR responsibility OR obligation* OR (performance NEAR/2 monitor*))) OR "public hearing*" OR "citizen voice" OR "people power")
8 Provider capacity building and service adjustments	TS=((("behavio* change*" OR "capacity building" OR training OR "job aid*" OR educat* OR "technical assistance" OR (service* NEAR/1 adjust*)) NEAR/5 ("service provider*" OR staff OR administrator* OR manager* OR worker* OR staff OR "police officer*" OR teacher* OR educator* OR midwife OR midwives)) OR ((referral* OR document*) AND violence AND service*) OR ("youth-friendl*" NEAR/1 service*))
9 Mass and social media campaigns	TS=(((mass NEAR/1 (media OR communication)) OR "social media" OR internet OR blog* OR facebook OR twitter OR instagram OR podcast* OR broadcast* OR audiovisual OR film* OR movie* OR edutainment OR (information NEAR/2 disseminat*) OR marketing OR advert* OR telecommunicat* OR email OR e-mail OR "electronic mail" OR hotline* OR radio OR television OR TV OR phone* OR telephon* OR mobiles OR campaign* OR boards OR newspaper* OR magazine* OR brochure* OR leaflet* OR pamphlet* OR cinema* OR "product design*" OR sales OR "consumer behavio$r*" OR "social franchis*" OR "public relations"))
10 Social marketing	TS=("social franchis*" OR "social marketing" OR (("product design" OR "appropriate pricing" OR (sales NEAR/1 distribution) OR "public relation*") AND (((responsive OR respond) NEAR/1 consumer) OR (behavio* NEAR/1 change*) OR (behavio* NEAR/1 change*))))
11 Social groups and clubs	TS=("social group*" OR club* OR "social organization*" OR "social organisation*" OR "safe space*" OR "support group*" OR "discussion

	group*" OR ((group* OR club*) NEAR/2 (care OR friend* OR peer* OR (information* NEAR/1 (access* OR material*)) OR sport*)))
12 **Peer education and mentorship**	TS=(peer* NEAR/1 (volunteer* OR counsel* OR support OR intervention* OR educat* OR mentor* OR facilitat* OR disseminat* OR referral*))
13 **Family mobilisation and dialogue**	TS=((family OR families OR parent* OR mother* OR father* OR caregiver*) NEAR/3 (participat* OR involv* OR engage* OR motivat* OR mobilis* OR mobiliz* OR outreach OR dialog* OR communicat* OR (awareness NEAR/1 rais*)))
14 **Community mobilisation and dialogue**	TS=((consumer* OR patient* OR communit*) NEAR/3 (participat* OR involv* OR engage* OR motivat* OR mobilis* OR mobiliz* OR outreach OR dialog*))
15 **Cash transfer programmes**	TS=(((financial OR cash OR pay* OR monetary OR money OR "e-cash") NEAR/3 (transfer* OR measure* OR incentive* OR reward* OR allowance* OR gain* OR credit* OR benefit* OR conditional OR unconditional)) OR subsidies OR subsidy OR subsidiz* OR subsidis*)
16 **Vouchers**	TS=(voucher* OR "e-voucher*" OR stamp* OR coupon*)
17 **In-kind transfers**	TS=(("in-kind" OR "cooking oil") NEAR/2 (transfer*))
18 **mHealth and technology-based interventions**	TS=("technology-based" OR "mobile health" OR mhealth OR m-health OR e-health* OR ehealth* OR "electronic health" OR "mobile technol*" OR ((mobile OR smartphone OR smart-phone OR phone OR software) NEAR/3 (app*)) OR MMS OR "multimedia messaging service*" OR SMS OR "short messag* service*" OR "text messag*" OR "voice messag*" OR "interactive voice response" OR IVR)
19 **Community health workers and home visits**	TS=(((house* OR home) NEAR/2 (call* OR visit*)) OR ((lay OR voluntary OR volunteer* OR untrained OR unlicensed OR nonprofessional* OR "non professional*") NEAR/2 (worker* OR attendant* OR aide OR aides OR support* OR person* OR helper* OR carer* OR caregiver* OR "care giver*" OR consultant* OR assistant* OR staff OR visit* OR midwife OR midwives)) OR "health extension worker*" OR (trained NEAR/3 (volunteer* OR "health worker*" OR mother*)) OR ((community OR village*) NEAR/3 ("health worker*" OR "health care worker*" OR healthcare)) OR (community NEAR/3 (volunteer* OR aide OR aides OR support)) OR ((birth OR childbirth OR labor OR labour) NEAR/0 (attendant* OR assistant*)) OR (home NEAR/0 (care OR aide OR aides OR nursing OR support OR intervention* OR treatment OR visit*)))
20 **Maternal and newborn care**	TS=(((child* OR infant* OR newborn* OR neonatal OR perinatal OR maternal OR mother*) NEAR/2 (care OR service*)) OR ((((postpartum OR "post-partum") NEAR/0 (haemorrhage OR hemorrhage)) OR "pre-eclampsia" OR eclampsia OR "uterine prolapse") NEAR/1 (prevent*)))
21	#2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19 OR #20 OR #21
22	#1 AND #21
23 **Counselling**	TS=((sex OR sexual* OR reproductive OR fertility OR infertility OR family OR pregnan* OR "post-partum" OR postpartum OR prenatal OR antenatal OR postnatal OR "post-natal" OR "post-pregnancy" OR marital OR marriage OR gender OR domestic OR maternal OR mother* OR contraceptive OR "cervical cancer" **O**R hpv OR "human papilloma virus" OR "human papillomavirus" OR victim* OR abortion OR breastfeed*) NEAR/3 (counseling OR counselling OR "psychosocial support" OR "psycholog* therapy" OR psychotherapy))
24 **Screening and assessment**	TS=((("sexual health" OR "sexual wellbeing" OR "sexual well-being" OR STI OR "sexually transmitted" OR HIV OR "reproductive health" OR fertil* OR infertil* OR "cervical cancer" **O**R hpv OR "human papilloma virus" OR "human papillomavirus" OR "maternal health" OR "newborn health") NEAR/2 (screen* OR assess*)))
25 **Safe abortion services**	TS=((abortion* OR "post-abortion") NEAR/5 (service* OR access* OR infrastructure OR facility OR facilities OR equipment))

26 **Provision of SRH products**	TS=(((condom* OR contracepti* OR ((STI OR HIV OR "sexually transmitted" OR pregnancy) NEAR/1 (test OR tests OR "self-test*" OR "home test*")) OR "menstrual hygiene product*" OR tampon* OR "sanitary pad*") NEAR/3 (provision OR provid* OR distribut*)) OR "supply kit*" OR (emergency NEAR/2 kit*))
27 **SRHR education, including Comprehensive Sexuality Education**	TS=(((sex NEAR/2 (educat* OR ed OR curriculum)) OR (((domestic OR partner OR spous* OR marital OR marriage) NEAR/2 (violence OR abuse OR forced)) OR "violence against girls" OR "violence against adolescent girls" OR "violence against women" OR IPV OR "interpartner violence" OR "inter-partner violence" OR "intimate partner violence" OR "gender equality" OR "gender inequality" OR "gender role*" OR "gender attitude*" OR "gender value*" OR "child marriage" OR "menstrual health" OR "self-defense" OR "self-defence" OR "genital mutilation" OR "genital cutting" OR "female circumcision" OR fgm OR ((sexual OR sex) NEAR/2 (violence OR coercion OR consent OR forced OR unwanted OR consensual OR nonconsensual OR non-consensual OR behavio$r* OR harass* OR assault* OR traffic*)) OR "gender-based violence" OR GBV)) NEAR/3 (educat* OR training OR knowledge OR skills OR values OR attitudes OR "critical thinking" OR "decision making" OR communication* OR aware* OR perception* OR self-efficacy OR prevent* OR intervention* OR measur* OR responsib* OR "de-escalat*" OR negotiat*))
28	#23 OR #24 OR #25 OR #26 OR #27
29	TS=((sexual OR reproductive) NEAR/2 ("rights"))
30 **All interventions**	#22 OR #28 OR #29
31 **LMIC**	TS=(afghanistan or albania or algeria or "american samoa" or angola or "antigua and barbuda" or antigua or barbuda or argentina or armenia or armenian or aruba or azerbaijan or bahrain or bangladesh or barbados or "republic of belarus" or belarus or byelarus or belorussia or byelorussian or belize or "british honduras" or benin or dahomey or bhutan or bolivia or bosnia or herzegovina or botswana or bechuanaland or brazil or brasil or bulgaria or "burkina faso" or "burkina fasso" or "upper volta" or burundi or urundi or "cabo verde" or "cape verde" or cambodia or kampuchea or "khmer republic" or cameroon or cameron or cameroun or "central african republic" or "ubangi shari" or chad or chile or china or colombia or comoros or "comoro islands" or "iles comores" or mayotte or congo or zaire or "costa rica" or "cote d'ivoire" or "cote d' ivoire" or "cote divoire" or "cote d ivoire" or "ivory coast" or croatia or cuba or cyprus or "czech republic" or czechoslovakia or djibouti or "french somaliland" or dominica or "dominican republic" or ecuador or egypt or "united arab republic" or "el salvador" or "equatorial guinea" or "spanish guinea" or eritrea or estonia or eswatini or swaziland or ethiopia or fiji or gabon or "gabonese republic" or gambia or "georgia (republic)" or georgian or ghana or "gold coast" or gibraltar or greece or grenada or guam or guatemala or guinea or "guinea bissau" or guyana or "british guiana" or haiti or hispaniola or honduras or hungary or india or indonesia or timor or iran or iraq or "isle of man" or jamaica or jordan or kazakhstan or kazakh or kenya or korea or kosovo or kyrgyzstan or kirghizia or kirgizstan or "kyrgyz republic" or kirghiz or laos or "lao pdr" or "lao people's democratic republic" or latvia or lebanon or "lebanese republic" or lesotho or basutoland or liberia or libya or "libyan arab jamahiriya" or lithuania or macau or macao or macedonia or madagascar or "malagasy republic" or malawi or nyasaland or malaysia or "malay federation" or "malaya federation" or maldives or "indian ocean" or mali or malta or micronesia or kiribati or "marshall islands" or nauru or "northern mariana islands" or palau or tuvalu or mauritania or mauritius or mexico or moldova or moldovian or mongolia or montenegro or morocco or ifni or mozambique or "portuguese east africa" or myanmar or burma or namibia or nepal or "netherlands antilles" or nicaragua or niger or nigeria or oman or muscat or pakistan or panama or "new guinea" or paraguay or peru or philippines or philipines or phillipines or phillippines or poland or "polish people's republic" or portugal or "portuguese republic" or "puerto rico" or romania or russia or "russian federation" or ussr or "soviet union" or "union of soviet socialist republics" or rwanda or ruanda or samoa or "pacific islands" or polynesia or "samoan islands" or "navigator island" or "navigator

	islands" or "sao tome and principe" or "saudi arabia" or senegal or serbia or seychelles or "sierra leone" or slovakia or "slovak republic" or slovenia or melanesia or "solomon island" or "solomon islands" or "norfolk island" or "norfolk islands" or somalia or "south africa" or "sri lanka" or ceylon or "saint kitts and nevis" or "st. kitts and nevis" or "saint lucia" or "st. lucia" or "saint vincent and the grenadines" or "saint vincent" or "st. vincent" or grenadines or sudan or suriname or surinam or "dutch guiana" or "netherlands guiana" or syria or "syrian arab republic" or tajikistan or tadjikistan or tadzhikistan or tadzhik or tanzania or tanganyika or thailand or siam or "timor leste" or "east timor" or togo or "togolese republic" or tonga or trinidad or tobago or tunisia or turkey or turkmenistan or turkmen or uganda or ukraine or uruguay or uzbekistan or uzbek or vanuatu or "new hebrides" or venezuela or vietnam or "viet nam" or "middle east" or "west bank" or gaza or palestine or yemen or yugoslavia or zambia or zimbabwe or "northern rhodesia" or "global south" or africa or magreb or maghrib or sahara or "west indies" or "indian ocean islands" or caribbean or "central america" or "latin america" or "south and central america" or "south america" or "asia, central" or "central asia" or "asia, northern" or "north asia" or "northern asia" or "asia, southeastern" or "southeastern asia" or "south eastern asia" or "southeast asia" or "south east asia" or "asia, western" or "western asia" or "europe, eastern" or "east europe" or "eastern europe" or "developing country" or "developing countries" or "developing nation$" or "developing population$" or "developing world" or "less developed countr*" or "less developed nation$" or "less developed population$" or "less developed world" or "lesser developed countr*" or "lesser developed nation$" or "lesser developed population$" or "lesser developed world" or "under developed countr*" or "under developed nation$" or "under developed population$" or "under developed world" or "underdeveloped countr*" or "underdeveloped nation$" or "underdeveloped population$" or "underdeveloped world" or "middle income countr*" or "middle income nation$" or "middle income population$" or "low income countr*" or "low income nation$" or "low income population$" or "lower income countr*" or "lower income nation$" or "lower income population$" or "underserved countr*" or "underserved nation$" or "underserved population$" or "underserved world" or "under served countr*" or "under served nation$" or "under served population$" or "under served world" or "deprived countr*" or "deprived nation$" or "deprived population$" or "deprived world" or "poor countr*" or "poor nation$" or "poor population$" or "poor world" or "poorer countr*" or "poorer nation$" or "poorer population$" or "poorer world" or "developing econom*" or "less developed econom*" or "lesser developed econom*" or "under developed econom*" or "underdeveloped econom*" or "middle income econom*" or "low income econom*" or "lower income econom*" or "low gdp" or "low gnp" or "low gross domestic" or "low gross national" or "lower gdp" or "lower gnp" or "lower gross domestic" or "lower gross national" or lmic or lmics or "third world" or "lami countr*" or "transitional countr*" or "emerging economies" or "emerging nation$")
32 **LMIC**	TS=(afghan or afghans or afghani or albanian$ or algerian$ or "american samoan$" or angolan$ or antiguan$ or barbudan$ or argentine$ or argentinian$ or argentinean$ or armenian$ or aruban$ or azerbaijani$ or bahraini$ or bangladeshi$ or bangalees or bajan$ or belarusian$ or byelorussian$ or belizean$ or beninese$ or bhutanese or bolivian$ or bosnian$ or botswana or batswana or brazilian$ or brasilian$ or bulgarian$ or burkinabe or burkinese or burundian$ or "cape verdean$" or "cabo verdean$" or cambodian$ or khmer or cameroonian$ or "central african$" or chadian$ or chilean$ or chinese or colombian$ or comorian$ or congolese or "costa rican$" or ivorian$ or croatian$ or cuban$ or cypriot$ or czech$ or djiboutian$ or dominican$ or ecuadorian$ or egyptian$ or salvadoran$ or "equatorial guinean$" or equatoguinean$ or eritrean$ or estonian$ or swazi$ or swati$ or ethiopian$ or fijian or gabonese or gabonaise or gambian$ or georgian$ or ghanaian$ or gibraltarian$ or greek$ or grenadian$ or guamanian$ or guatemalan$ or guinean$ or "bissau guinean$" or guyanese or haitian$ or honduran$ or hungarian$ or indian$ or indonesian$ or iranian$ or iraqian$ or iraqi$ or manx or jamaican$ or jordanian$ or kazakhstani$ or kenyan$ or kirabati or

	kirabatian$ or "north korean$" or korean$ or kosovar$ or kosovan$ or kyrgyz* or lao or laotian$ or latvian$ or lebanese or lesothan$ or lesothonian$ or mosotho or basotho or liberian$ or libyan$ or lithuanian$ or macanese or macedonian$ or malagasy or madagascan$ or malawian$ or malaysian$ or maldivian$ or malian$ or maltese or marshallese$ or mauritanian$ or mauritian$ or mexican$ or micronesian$ or moldovan$ or mongolian$ or mongol or montenegrin$ or moroccan$ or mozambican$ or burmese or myanma or namibian$ or nauruan$ or nepali or nepalese or "netherlands antillean$" or nicaraguan$ or nigerien$ or nigerian$ or "northern mariana islander$" or mariana$ or omani$ or pakistani$ or palauan$ or panamanian$ or "papua new guinean$" or paraguayan$ or peruvian$ or philippine$ or philipine$ or phillipine$ or phillippine$ or filipino$ or filipina$ or polish or pole or poles or portuguese or "puerto rican$" or romanian$ or russian$ or "soviet people" or "soviet population" or rwandan$ or rwandese or ruandan$ or ruandese or samoan$ or "sao tomean$" or santomean$ or "saudi arabian$" or saudi$ or senegalese or serbian$ or montenegrin$ or seychellois or seychelloise$ or "sierra leonean$" or slovak$ or slovene$ or "solomon islander$" or somali$ or "south african$" or "south sudanese" or "sri lankan$" or ceylonese or kittitian$ or nevisian$ or "saint lucian$" or vincentian$ or sudanese or surinamese$ or syrian$ or tajik$ or tajikistani$ or tanzanian$ or tanganyikan$ or thai or timorese$ or togolese or tongan$ or trinidadian$ or tobagonian$ or tunisian$ or turk$ or turkish or turkmen$ or tuvaluan$ or ugandan$ or ukrainian$ or uruguayan$ or uzbek$ or vanuatu* or venezuelan$ or vietnamese or yemeni$ or yemenite$ or yemenese or yugoslav$ or yugoslavian$ or zambian$ or zimbabwean$ or african$ or asian$ or "pacific islander$" or "latin american$" or "central american$" or "south american$" or caribbean$ or "west indian$" or iberoamerican$ or "middle eastern" or "middle eastern*")
33 **LMIC**	#31 OR #32
34 **Study design**	TS=((match* NEAR/2 (propensity or coarsened or covariate or neighbo$r)) or "propensity score" or ("difference* in difference*" or "difference-in-difference*" or "differences-in-difference*" or "double difference*") or (quasi-experiment* or "quasi experiment*") or (estimator and evaluat*) or ("instrumental variable*" or (IV NEAR/2 (estimation or approach))) or (Heckman NEAR/3 (model* or approach*)) or ((two-stage or "two stage") NEAR/3 (control* or function* or "least squares")) or "regression discontinuity" or "time series" or counterfactual or "segment* regression" or (non NEAR/2 participant*) or ((control or comparison) NEAR/2 (group* or condition* or area* or village* or household* or intervention)) or (panel* NEAR/2 (data or household* or model*)) or ((exploit* or "tak* advantage") NEAR/3 (variation* or variety or exogen* or heterogen*)) or (econometric NEAR/2 (model* or adjust*)) or (select* NEAR/2 (bias* or self)))
35	TS=((experiment* NEAR/2 (design or study or research or evaluation or evidence or vary or varies or variation)) or ((random or randomi?ed or randomly) NEAR/2 (trial or assign* or treatment or control* or allocat* or experiment* or vary or varies or variation or choose or chose*)))
36	TS=((impact$ or effect*) NEAR/2 (evaluat* or assess or assessing or assessment or analyze or analyse or analyzing or analysing or analysis or analytical or estimate or estimating or estimation or cause or causal))
37	TS=("program* evaluation" or "project evaluation" or "evaluation research" or "natural experiment*" or "program* effectiveness" or "outcome assessment" or "evaluation study" or "field experiment")
38	TS=((Systematic* or synthes*) NEAR/3 (research or evaluation* or overview or finding* or thematic* or report or descriptive or explanatory or narrative or meta* or review* or data or literature or studies or evidence or map or mapping or quantitative or study or studies or paper or impact or impacts or effect* or compar*))
39	TS=("Meta regression" or "meta synth*" or "meta-synth*" or "meta analy*" or "metaanaly*" or "meta-analy*" or "metanaly*" or "Metaregression" or "Meta-regression" or "Methodologic* overview" or "pool* analys*" or "pool* data" or "Quantitative* overview" or "research integration")

40	TS=((effectiveness or effects or systemat* or synth* or integrat* or gap or methodologic* or quantitative or evidence or literature or rapid or scoping) NEAR/3 (review or map))
41	#34 OR #35 OR #36 OR #37 OR #38 OR #39 OR #40
All study design	
42	#30 AND #33 AND #41
32	Limit to Science Citation Index and Social Science Citation Index
33	Limit to 2011-present

Appendix 6: Table of databases, repositories and websites

List of electronic databases, repositories and websites we will search

Academic databases:

- Medline (Ovid)
- Science Citation Index and Social Science Citation Index (Web of Science)
- Scopus (Elsevier)
- APA PsycInfo (Ovid)
- Global Health (Ovid)
- Communication & Mass Media Complete (EBSCO)
- ERIC (Ovid)
- Gender Studies Database (EBSCO)
- International Political Science Abstracts (Ovid)
- EBSCO Discovery Service (RePEc, World Bank e-Library)
- Africa-Wide Info (EBSCO)

Specialist organisations:

Name	URL
Asian Pacific Institute on Gender-based Violence	https://www.api-gbv.org/
Centre for Research & Education on Violence Against Women & Children (CREVAWC)	https://www.learningtoendabuse.ca/index.html
The Equality Institute	https://www.equalityinstitute.org/
Governance and Social Development Resource Centre (GSDRC)	http://www.gsdrc.org/document-library/
Health Evidence	http://www.healthevidence.org/
African GBV Prevention Network	http://preventgbvafrica.org/understandingvaw/vaw-resources/
Interagency Gender Working Group (IGWG)	http://www.igwg.org/
Population Council	https://knowledgecommons.popcouncil.org/focus_sexual-health-repro-choice/
International Center for Research on Women (ICRW)	http://www.icrw.org/
Sexual Violence Research Initiative (South Africa)	http://www.svri.org/documents/svripublications
BRIDGE Global Resources	http://www.bridge.ids.ac.uk/globalresources?theme_filter=C1672
National Online Resource Centre on Domestic Violence	http://vawnet.org/
Minnesota Center Against Violence and Abuse (MINCAVA)	https://www.cehd.umn.edu/ssw/centers/mincava/
Social Care Online	http://www.sciesocialcareonline.org.uk/?q=violence+gender+ evaluation
Interagency Youth Working Group: Resources	https://www.fhi360.org/explore/content?f[0]=type%3Aresource
Health Communication Capacity Collaborative	https://healthcommcapacity.org/urban-youth-evidence-synthesis/
Health Systems Evidence	https://www.healthsystemsevidence.org/
Very Young Adolescent (VYA) Sexual and Reproductive Health Resource Library	https://toolkits.knowledgesuccess.org/toolkits/very-young-adolescent-sexual-and-reproductive-health-clearinghouse/research-6
Center for Health Market Innovations	https://healthmarketinnovations.org/document-library
Oxfam Library	https://oxfamilibrary.openrepository.com/
Child and Youth Finance International	https://childfinanceinternational.org/#publications

Name	URL
UNFPA Evaluation Database	https://www.unfpa.org/evaluation/database
WHO Global Indicus Medicus	https://www.globalindexmedicus.net/
Guttmacher Institute	https://www.guttmacher.org/global/all
MSI Reproductive Choices	https://www.msichoices.org/news-and-insights/resources/
PLAN International	https://plan-uk.org/resources

Other international development organisations and related websites:

Name:	URL
Abdul Latif Jameel Poverty Action Lab (J-Pal)	https://www.povertyactionlab.org/evaluations
African Development Bank (AfDB)	https://idev.afdb.org/en/page/evaluations
Asian Development Bank (ADB)	https://www.adb.org/documents/series/impact-evaluation-studies
Campbell Collaboration Evidence Portal	https://www.campbellcollaboration.org/component/jak2filter/?Itemid=1352&issearch=1&isc=1&category_id=101&ordering=publishUp
Centre for Effective Global Action (CEGA)	https://cega.berkeley.edu/our-research/
Cochrane systematic review library	https://www.cochranelibrary.com/search
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	https://mia.giz.de/esearcha/browse.tt.html
Policy and Operations Evaluation Department (IOB) Netherlands	https://english.iob-evaluatie.nl/publications
German Institute for Development Evaluation (DEval)	https://www.deval.org/en/publications https://rie.deval.org/rigorous-evidence-database
Innovations for Poverty Action (IPA)	https://www.poverty-action.org/search-studies ; https://www.poverty-action.org/publications
Inter-American Development Bank (IDB)	https://publications.iadb.org/en/publications
International Initiative for Impact Evaluation (3ie)	https://developmentevidence.3ieimpact.org/
National Bureau of Economic Research (NBER) – Working Papers	https://www.nber.org/
Norwegian Agency for Development Cooperation (NORAD)	https://www.norad.no/en/toolspublications/publications/
Overseas Development Institute (ODI)	https://odi.org/en/publications/
Registry of International Development Impact Evaluations (RIDIE)	https://ridie.3ieimpact.org/
Social Science Research Network	https://www.ssrn.com/index.cfm/en/
Swedish International Development Cooperation Agency (SIDA)	https://www.sida.se/en/publications
USAID Development Experience Clearinghouse (DEC)	https://dec.usaid.gov/dec/content/evaluations.aspx
World Bank	https://documents.worldbank.org/en/publication/documents-reports/documentlist
World Bank – Independent Evaluation Group (IEG)	https://ieg.worldbankgroup.org/ieg-search

Appendix 7: Details of process for selection of studies

We will exclude studies based on a prioritization and sequential exclusion approach (Saif-Ur-Rahman et al. 2022) with exclusion criteria presented as a series of questions to the screeners arranged in a sequential order. We present an example in the table below.

Priority order	Question	Excluded if the answer is
1.	Does the study evaluate an intervention, policy, program, project?	No
2.	Are participants living in an excluded high-income country at the time the intervention began?	Yes
3.	Does the study include a study design that is consistent with the map's inclusion criteria?	No
4.	Has the study been published prior to the year 2014?	Yes
5.	Does the study include an intervention that is consistent with the map's inclusion criteria?	No
6.	Does the study include an outcome that is consistent with the map’s inclusion criteria?	No

Notes: If insufficient information is available to confidently answer a question, screeners will proceed to the next question without excluding the study.

Appendix 8: Provisional data extraction form

Draft extraction protocol

Code	Subcode *(filters that will appear in online map noted in parentheses)*	Description
Basic information	Title	
	Study status	
	Language	
Author Information	Author Name	
	Author Affiliation Institution	
	Author Affiliation Institution Department	
	Author Affiliation Country	
Publication Information	Publication outlet	
	Publication outlet Other	
	Journal Volume	
	Journal Issue	
	Pages	
	Year of Publication	
	DOI	
	Abstract	
	Open access	
	Publication Type	
	Publication URL	
Sector Information	Sector name	
	Sub-sector name	
	World Bank first theme	
	World Bank first sub-theme	
	Primary OECD DAC Code	
	Secondary OECD DAC Code	
	CRS-Voluntary Code (*map filter)*	Select the CRS or voluntary code associated with the intervention. This is restricted by the selection for the DAC5 code in the previous field.

Code	Subcode *(filters that will appear in online map noted in parentheses)*	Description
	Primary DAC Code (additional)	
	Secondary DAC Code (additional)	
	CRS-Voluntary Code (additional)	
	UN sustainable development goals	
	Other topics	
	First year of intervention	
	Equity focus	
	Equity dimension	
	Equity description	
	Keywords	
Transparency Information	Primary Dataset availability	
	Primary Dataset Location	
	Primary Dataset URL	
	Primary Dataset Format	
	Secondary Dataset Disclosure	
	Secondary Dataset Name	
	Secondary Dataset Location	
	Additional Dataset Info	
	Analysis code availability	
	Stat Code Format	
	Stat Code Format - Other	
	Study Materials Availability	
	Study Materials	
	Study Materials - Other	
	Registration	
	Pre-reg Location	
	Pre-reg Location - Other	

Code	Subcode *(filters that will appear in online map noted in parentheses)*	Description
	Pre-reg URL	
	Pre-analysis plan	
	Ethics approval	
Geographic information	Continent name (*map filter)*	Select the continent/region in which the study was conducted: ● East Asia and Pacific ● Europe and Central Asia ● Latin America and Caribbean ● Middle East and North Africa ● North America ● South Asia ● Sub-Saharan Africa ● Multi-continent (select this if more than 15 countries across multiple continents, and no disaggregated effects provided for each country) If multiple continents, add in new row
	Country name (*map filter)*	Select the countries in which the study was conducted (drop down menu). There is a multi-country option for situations when there are more than 15 countries, and no disaggregated effects provided for each country.
	Country income level (*map filter)*	Automatically indicates income level when country name selected. It is the country's World Bank Income level status based on the year from the First Year of Intervention field, or if empty than the Year of publication.
	FCV country (*map filter)*	Automatically indicates FCV status when country name selected. It is the country's World Bank Fragility, Conflict and Violence classification based on the year from the First Year of Intervention field, or if empty than the Year of publication.
Methods information	Evaluation Design	
	Evaluation Method (*map filter)*	If Experimental then select: Randomised controlled trial If Quasi-experimental then select: Regression Discontinuity Design (RDD) Fixed effects (incl. difference-in-differences) Instrumental variable (IV) estimation Statistical matching Interrupted time series (ITS) Synthetic controls

Code	Subcode *(filters that will appear in online map noted in parentheses)*	Description
		If Qualitative then select: Realist evaluation General elimination methodology Process tracing Contribution analysis Contribution tracing Qualitative impact assessment protocol (QuIP) Outcome harvesting Outcome mapping Bayesian updating Method of impact assessment of programs and projects (MAPP) Success case method Most significant change Participatory impact assessment (PIA) Participatory impact pathways analysis (PIPA) Multiple Lines and Levels of Evidence (MLLE) Other
	Mixed Method	
	Additional Methods 1	
	Additional Methods 2	
	Unit of Observation	
Funding/ Implementing agency Information	Project Name	
	Implementation Agency Name	
	Implementation Agency Category	
	Program Funding Agency Name	
	Program Funding Agency Category	
	Research Funding Agency Name	
	Research Funding Agency Category	
Intervention information	Intervention	
	Intervention Description	

Code	Subcode *(filters that will appear in online map noted in parentheses)*	Description
Outcome Information	Outcome	
	Outcome Description	
Other	Population (*map filter)*	Which population does the intervention or study focus on? Select one or more of the following: ● Women or girls ● Men or boys ● Sexual minorities (LGBTI+): lesbian, gay, bisexual, transgender, queer, and intersex (persons) or other sexual and gender identities affected by the issues faced by the LGBTQI community ● People living in poverty ● People living in rural areas ● People living in informal settlements ● Indigenous peoples ● Religious or ethnic minorities ● People with disabilities ● Displaced populations and migrants ● Sex workers ● People who inject drugs ● People living with HIV • Survivors of GBV • Unspecified
	Age group (*map filter)*	Which age group does the intervention focus on or target? Select one or more of the following: • All ages • All infants and children (0 – 9 years) • Early adolescents (10-14 years) • Adolescents and youth (15-24 years) • All adults (25-and above) • Unspecified
	Marital status (*map filter)*	Which population does the intervention focus on or target? Select one or more of the following: • All • Married • Unmarried • Unspecified

Code	Subcode *(filters that will appear in online map noted in parentheses)*	Description
	Mode of delivery or setting (*map filter)*	In which mode or setting is the intervention delivered? Select one or more of the following: • Self-care • Peer-administered services • Male involvement • Religious/traditional leaders • Mobile outreach • Health facility • Education facility • None, other or unspecified
	SRHR topic (*map filter)*	Which SRHR topic does the intervention or study focus on? Select one or more of the following: • SRHR education, including comprehensive sexuality education • Contraceptives and family planning • Maternal and newborn care • Safe abortion and post-abortion care • STIs including HIV • Sexual and gender-based violence • Cervical cancer • Infertility • Sexual function and satisfaction
	Cost data (additional analysis)	Do the authors provide any measures of the cost of implementing the intervention? • Yes • No
	Theory of change (additional analysis)	Do authors report explicitly using a theory of change to inform their programming and analysis? • Yes • No
	Theory of change – page numbers	

Appendix 9: Additional screening checklist for systematic reviews

To be included, a systematic review must meet all 6 criteria below:

Item No.	Screening or exclusionary questions	Response and direction	EPPI exclude code
1	Is the publication date 2014 or after?	If no, then exclude	Exclude - Published before 2014
2	Is the study clearly described as a systematic review and/or meta-analysis?	If no, then exclude	Exclude - Not a quantitative effectiveness study:
3	Does the review focus on L&MICs only, or report outcomes separately for L&MICs?	If no, then exclude	Exclude - High-income country
4	Does the review clearly search for studies that measure the effect of a program, policy or intervention on outcomes? Note: Feasibility or acceptability studies are not accepted	If no, then exclude	Exclude - Not a quantitative effectiveness study
5	Does the review describe methods used for search, screening, data extraction, and synthesis?	If no, then exclude	Exclude - Study design: minimum reporting requirement not met
6	Does the review report outcomes that are related to one or more outcomes categories of this EGM?	If no, then exclude	Exclude: others (provide info)
If studies meet the above criteria, they will be included, and we will proceed to the quick check for fatal flaws. If any of the below items are not met, they are automatically scored as low confidence and a full appraisal will not be conducted.			
	Were the criteria used for deciding which studies to include in the review clearly reported? Did the authors specify: a) Participants/population/setting b) Intervention (s) c) Outcome (s) d) Types of studies	If no, score low confidence	
	Is the search reasonably comprehensive? - No restriction of inclusion based on publication status Grey and unpublished studies included? - Sufficient number of databases searched Did they search in at least two databases (one source of grey literature and one of academic)?	If no, score low confidence	
	a) Do authors report independent duplicate screening at full text (or equivalent, e.g., use of ML	If no, score low confidence	

Item No.	Screening or exclusionary questions	Response and direction	EPPI exclude code
	classifiers or screening to reliability)?		
	b) Do authors report independent duplicate data extraction (or equivalent, e.g. training to reliability)?	If no, score low confidence	
	c) Do authors report conducting a risk of bias assessment using suitable criteria?	If no, score low confidence	
	d) If authors have an appropriate RoB, do they make clear which evidence is at low risk for bias, and report evidence separately for low RoB studies?	If no, score low confidence	

Appendix 10: Systematic review critical appraisal tool

Table below presents a checklist for making judgements about how much confidence to place in a systematic review of effects. This checklist has been adapted from the Supporting the Use of Research Evidence (SURE) Collaboration guides (Lewin et al. 2009).

Question	Criteria
Section A: Methods used to identify, include and critically appraise studies	
A.1 Were the criteria used for deciding which studies to include in the review reported? Did the authors specify: ▪ Types of studies ▪ Participants/ settings/ population ▪ Intervention(s) ▪ Outcome(s)	Yes; partially; no; can't tell Coding guide - check the answers above YES: All four should be yes NO: All four should be no PARTIALLY: Any other
A.2 Was the search for evidence reasonably comprehensive? Were the following done: ▪ Language bias avoided (no restriction of inclusion based on language) ▪ No restriction of inclusion based on publication status ▪ Relevant databases searched (Minimum criteria: All reviews should search at least one source of grey literature such as Google; for health: Medline/ Pubmed + Cochrane Library; for social sciences IDEAS + at least one database of general social science literature and one subject specific database) ▪ Reference lists in included articles checked ▪ Authors/experts contacted	Yes; partially; no; can't tell Coding guide - check the answers above: YES: All five should be yes PARTIALLY: Relevant databases and reference lists are both reported NO: Any other
A.3 Does the review cover an appropriate time period? Is the search period comprehensive enough that relevant literature is unlikely to be omitted?	Yes; can't tell (only use if no information about time period for search); no; unsure Coding guide: YES: Generally, this means searching the literature at least back to 1990 NO: Generally, if the search does not go back to 1990 CAN'T TELL: No information about time period for search Note: With reference to the above – there may be important reasons for adopting different dates for the search, e.g. depending on the intervention. If you think there are limitations with the timeframe adopted for the search which have not been noted and justified by the authors, you should code this item as a

Question	Criteria
	NO and specify your reason for doing so in the comment box below. Older reviews should not be downgraded, but the fact that the search was conducted some time ago should be noted in the quality assessment. Always report the time period for the search in the comment box.
A.4 Was bias in the selection of articles avoided? Did the authors specify: ▪ Independent screening of full text by at least 2 reviewers ▪ List of included studies provided ▪ List of excluded studies provided	Yes; partially; no Coding guide: YES: All three should be yes, although reviews published in journals are unlikely to have a list of excluded studies (due to limits on word count) and the review should not be penalized for this. PARTIALLY: Independent screening and list of included studies provided are both reported NO: All other. If list of included studies provided, but the authors do not report whether or not the screening has been done by 2 reviewers review is downgraded to NO.
A.5 Did the authors use appropriate criteria to assess the quality and risk of bias in analyzing the studies that are included? ▪ The criteria used for assessing the quality/ risk of bias were reported ▪ A table or summary of the assessment of each included study for each criterion was reported ▪ Sensible criteria were used that focus on the quality/ risk of bias (and not other qualities of the studies, such as precision or applicability/external validity). “Sensible” is defined as a recognized quality appraisal tool/ checklist, or similar tool which assesses bias in included studies. Please see footnotes for details of the main types of bias such a tool should assess.	Yes; partially; no Coding guide: YES: All three should be yes PARTIALLY: The first and third criteria should be reported. If the authors report the criteria for assessing risk of bias and report a summary of this assessment for each criterion, but the criteria may be only partially sensible (e.g. do not address all possible risks of bias, but do address some), we downgrade to PARTIALLY. NO: Any other

Question	Criteria
A.6 Overall – how much confidence do you have in the methods used to identify, include and critically appraise studies? Summary assessment score A relates to the five questions above. High confidence applicable when the answers to the questions in section A are all assessed as 'yes' Low confidence applicable when any of the following are assessed as 'NO' above: not reporting explicit selection criteria (A1), not conducting reasonably comprehensive search (A2), not avoiding bias in selection of articles (A4), not assessing the risk of bias in included studies (A5) Medium confidence applicable for any other – i.e. section A3 is assessed as 'NO' or can't tell and remaining sections are assessed as 'partially' or 'can't tell'	**Low confidence** (limitations are important enough that the results of the review are not reliable) **Medium confidence** (limitations are important enough that it would be worthwhile to search for another systematic review and to interpret the results of this review cautiously, if a better review cannot be found) **High confidence** (only minor limitations)
Section B: Methods used to analyze the findings	
B.1 Were the characteristics and results of the included studies reliably reported? Was there: ▪ Independent data extraction by at least two reviewers ▪ A table or summary of the characteristics of the participants, interventions and outcomes for the included studies ▪ A table or summary of the results of all the included studies	Yes; no; partially; not applicable (e.g. no included studies) Coding guide: YES: All three should be yes PARTIALLY: Criteria one and three are yes, but some information is lacking on second criteria. No: None of these are reported. If the review does not report whether data was independently extracted by 2 reviewers (possibly a reporting error), we downgrade to NO. NOT APPLICABLE: if no studies/no data
B.2 Are the methods used by the review authors to analyze the findings of the included studies clear, including methods for calculating effect sizes if applicable?	Yes; partially; no; not applicable Coding guide: YES: Methods used clearly reported. If it is clear that the authors use narrative synthesis, they don't need to say this explicitly. PARTIALLY: Some reporting on methods but lack of clarity NO: Nothing reported on methods NOT APPLICABLE: if no studies/no data

Question	Criteria
B.3 Did the review describe the extent of heterogeneity? Did the review ensure that included studies were similar enough that it made sense to combine them, sensibly divide the included studies into homogeneous groups, or sensibly conclude that it did not make sense to combine or group the included studies? Did the review discuss the extent to which there were important differences in the results of the included studies? If a meta-analysis was done, was the I^2, chi square test for heterogeneity or other appropriate statistic reported? If no statistical test was reported, is a qualitative justification made for the use of random effects?	Yes; partially; no; not applicable Coding guide: YES: First two should be yes, and third category should be yes if applicable should be yes PARTIALLY: The first category is yes NO: Any other NOT APPLICABLE: if no studies/no data
B.4 Were the findings of the relevant studies combined (or not combined) appropriately relative to the primary question the review addresses and the available data? How was the data analysis done? ▪ Descriptive only ▪ Vote counting based on direction of effect ▪ Vote counting based on statistical significance ▪ Description of range of effect sizes ▪ Meta-analysis ▪ Meta-regression ▪ Other: specify ▪ Not applicable (e.g. no studies or no data) How were the studies weighted in the analysis? ▪ Equal weights (this is what is done when vote counting is used) ▪ By quality or study design (this is rarely done) ▪ Inverse variance (this is what is typically done in a meta-analysis) ▪ Number of participants (sample size) ▪ Other: specify ▪ Not clear ▪ Not applicable (e.g. no studies or no data) Did the review address unit of analysis errors? ▪ Yes - took clustering into account in the analysis (e.g. used intra-cluster correlation coefficient) ▪ No, but acknowledged problem of unit of analysis errors ▪ No mention of issue ▪ Not applicable - no clustered trials or studies included	Yes; partially; no; not applicable (e.g. no studies or no data); can't tell. Coding guide: YES: If appropriate table, graph or meta-analysis AND appropriate weights AND unit of analysis errors addressed (if appropriate). PARTIALLY: If appropriate table, graph or meta-analysis AND appropriate weights AND unit of analysis errors not addressed (and should have been). NO: If narrative OR vote counting (where quantitative analyses would have been possible) OR inappropriate reporting of table, graph or meta-analyses. NOT APPLICABLE: if no studies/no data CAN'T TELL: if unsure (note reasons in comments below)
B.5 Does the review report evidence appropriately?	Yes; partially; no; not applicable Coding guide:

Question	Criteria
The review makes clear which evidence is subject to low risk of bias in assessing causality (attribution of outcomes to intervention), and which is likely to be biased, and does so appropriately Where studies of differing risk of bias are included, results are reported and analyzed separately by risk of bias status	YES: Both criteria should be fulfilled (where applicable) NO: Criteria not fulfilled PARTIALLY: Only one criterion fulfilled, or when there is limited reporting of quality appraisal (the latter applies only when inclusion criteria for study design are appropriate) NOT APPLICABLE: No included studies Note on reporting evidence and risk of bias: For reviews of effects of 'large n' interventions, experimental and quasi-experimental designs should be included (if available). For reviews of effects of 'small n' interventions, designs appropriate to attribute changes to the intervention should be included (e.g. pre-post with assessment of confounders)
B.6 Did the review examine the extent to which specific factors might explain differences in the results of the included studies? Were factors that the review authors considered as likely explanatory factors clearly described? Was a sensible method used to explore the extent to which key factors explained heterogeneity? ▪ Descriptive/textual ▪ Graphical ▪ Meta-analysis by sub-groups ▪ Meta-regression ▪ Other	Yes; partially; no; not applicable Coding guide: YES: Explanatory factors clearly described and appropriate methods used to explore heterogeneity PARTIALLY: Explanatory factors described but for meta-analyses, sub-group analysis or meta-regression not reported (when they should have been) NO: No description or analysis of likely explanatory factors NOT APPLICABLE: e.g. too few studies, no important differences in the results of the included studies, or the included studies were so dissimilar that it would not make sense to explore heterogeneity of the results

Question	Criteria
B.7 Overall - how much confidence do you have in the methods used to analyze the findings relative to the primary question addressed in the review? Summary assessment score B relates to the five questions in this section, regarding the analysis. High confidence applicable when all the answers to the questions in section B are assessed as 'yes'. Low confidence applicable when any of the following are assessed as 'NO' above: critical characteristics of the included studies not reported (B1), not describing the extent of heterogeneity (B3), combining results inappropriately (B4), reporting evidence inappropriately (B5). Medium confidence applicable for any other: i.e. the "Partial" option is used for any of the 6 preceding questions or questions and/or B.2 and/ or B.6 are assessed as 'no'.	**Low confidence** (limitations are important enough that the results of the review are not reliable) **Medium confidence** (limitations are important enough that it would be worthwhile to search for another systematic review and to interpret the results of this review cautiously, if a better review cannot be found) **High confidence** (only minor limitations)
Section C: Overall assessment of the reliability of the review	
C.1 Are there any other aspects of the review not mentioned before which lead you to question the results?	▪ Additional methodological concerns – only one person reviewing ▪ Robustness ▪ Interpretation ▪ Conflicts of interest (of the review authors or for included studies) ▪ Other ▪ No other quality issues identified
C.2 Are there any mitigating factors which should be considered in determining the reviews reliability?	▪ Limitations acknowledged ▪ No strong policy conclusions drawn (including in abstract/ summary) ▪ Any other factors

C.3 Based on the above assessments of the methods how would you rate the reliability of the review?

<u>Low confidence in conclusions about effects</u>:

<u>Medium confidence in conclusions about effects</u>:

The systematic review has the following limitations...

<u>High confidence in conclusions about effects</u>:

If applicable: The review has the following minor limitations... Coding guide:

High confidence in conclusions about effects: high confidence noted overall for sections A and B, unless moderated by answer to C1.

Medium confidence in conclusions about effects: medium confidence noted overall for sections A or B, unless moderated by answer to C1 or C2.

Low confidence in conclusions about effects: low confidence noted overall for sections A or B, unless moderated by answer to C1 or C2.

Limitations should be summarized above, based on notes from Sections A, B and C.

Appendix 11: EGM advisory group details

The advisory group members for this EGM are the following:

- Erin DeGraw, Plan International
- Christine Galavotti, Bill & Melinda Gates Foundation
- Margaret Greene, Equimundo
- Holo Hachonda, Independent consultant
- Lisa Haddad, Population Council
- Malayah Harper, EngenderHealth
- Mary Beth Hastings, FP2030
- Laura Laski, The Partnership for Maternal, Newborn & Child Health (PMNCH)
- Monica Onyango, Boston University's School of Public Health
- Imane Sene, USAID
- Catherine Todd, Independent consultant
- Carey Walovich, Chemonics

Terms of reference for an EGM advisory group

Authors of 3ie evidence gap maps (EGM) and systematic reviews establish stakeholder advisor groups to help them determine the parameters of their proposed research and to provide inputs throughout the process. The input from the advisory group helps to ensure that the final product is policy relevant, meets the needs of different end users, and has an audience of policy and practice actors that understand the product and that are interested in using the findings. The involvement of advisory group members from different organizations and regions of the world can also help to support the dissemination of the final product to a broad audience.

Members of the advisory group can be policymakers, practitioners, influencers, researchers, and other stakeholders with an interest in the EGM. Members of the advisory group will be asked to provide inputs on various aspects of the EGM throughout the research process. The role is voluntary. The total time commitment is not likely to exceed two days. The tasks of the advisory group members may include:

- Advise on key decisions regarding the scope of the EGM, including refining the intervention and outcome framework.
- Define key concepts.
- Suggest relevant background literature and studies for inclusion.
- Participate in up to 3 teleconferences for the duration of the research (e.g., scoping stage; draft protocol; draft EGM report).
- Provide written comments on draft protocol and draft EGM report.
- Help the team draw the policy implications from the EGM findings. This can involve participating in a brainstorm/focus group meeting to review the lessons and implications of the EGM in terms of policy and practice.
- Assist the study team with policy engagement. This can involve advising the team on key stakeholders with whom to communicate to build interest in and understanding of the EGM, contribute to developing a communication and uptake plan, facilitate engagement with key audiences and communicate findings.