

A summative content analysis of how programmes to improve the right to sexual and reproductive health address power

Marta Schaaf ^{1,2}, Victoria Boydell ³, Stephanie M Topp ⁴, Aditi Iyer ⁵, Gita Sen,⁵ Ian Askew⁶

To cite: Schaaf M, Boydell V, Topp SM, *et al*. A summative content analysis of how programmes to improve the right to sexual and reproductive health address power. *BMJ Global Health* 2022;**7**:e008438. doi:10.1136/bmjgh-2022-008438

Handling editor Seye Abimbola

► Additional supplemental material is published online only. To view, please visit the journal online (<http://dx.doi.org/10.1136/bmjgh-2022-008438>).

Received 4 January 2022
Accepted 27 March 2022



© Author(s) (or their employer(s)) 2022. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

For numbered affiliations see end of article.

Correspondence to

Dr Marta Schaaf;
martaschaafconsult@gmail.com

ABSTRACT

Introduction Power shapes all aspects of global health. The concept of power is not only useful in understanding the current situation, but it is also regularly mobilised in programmatic efforts that seek to change power relations. This paper uses summative content analysis to describe how sexual and reproductive health (SRH) programmes in low-income and middle-income countries explicitly and implicitly aim to alter relations of power.

Methods Content analysis is a qualitative approach to analysing textual data; in our analysis, peer-reviewed articles that describe programmes aiming to alter power relations to improve SRH constituted the data. We searched three databases, ultimately including 108 articles. We extracted the articles into a spreadsheet that included basic details about the paper and the programme, including what level of the social ecological model programme activities addressed.

Results The programmes reviewed reflect a diversity of priorities and approaches to addressing power, though most papers were largely based in a biomedical framework. Most programmes intervened at multiple levels simultaneously; some of these were ‘structural’ programmes that explicitly aimed to shift power relations, others addressed multiple levels using a more typical programme theory that sought to change individual behaviours and proximate drivers. This prevailing focus on proximate behaviours is somewhat mismatched with the broader literature on the power-related drivers of SRH health inequities, which explores the role of embedded norms and structures.

Conclusion This paper adds value by summarising what the academic public health community has chosen to test and research in terms of power relations and SRH, and by raising questions about how this corresponds to the significant task of effecting change in power relations to improve the right to SRH.

BACKGROUND

Power shapes all aspects of global health: from the policies governing healthcare availability, accessibility, acceptability and quality to the health status of populations and

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Power shapes all aspects of global health: from the policies governing healthcare availability, accessibility, acceptability and quality to the health status of populations. Existing reviews on power in sexual and reproductive health (SRH) examine discrete elements of how SRH interventions address power.

WHAT THIS STUDY ADDS

⇒ We identified key trends and themes, including a prevailing focus on behaviour change strategies, and the related use of research approaches that are focused on detecting changes therein. At the same time, especially in the context of HIV and/or gender-based violence, there are many programmes that seek to effect change on multiple levels and use complicated study designs that harness epidemiological approaches to assess change.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE AND/OR POLICY

⇒ Further development of these approaches and increased programme and research attention to power relations at the community, organisational and policy/governance levels would complement the behavioural research. This should be done in a way that links research back to its purpose: producing a body of evidence that together can start to answer the question of how to shift power dynamics in favour of the right to SRH.

inequities therein. This is by no means a novel assertion. Researchers, activists and policy-makers working across contexts recognise the centrality of power for understanding global health (eg, see Gore *et al*^{1–5}). Current work builds on diverse streams of earlier theoretical and empirical work, such as explorations of the social determinants of health undertaken in the 19th century by German pathologist Rudolf Virchow and the 20th-century Indian Dalit rights leader, Dr B R Ambedkar.^{6,7} Over the past 20 years, the concept of power has

been evoked—explicitly or implicitly—in a range of multilateral agenda-setting efforts in global health, such as the WHO Commissions on Macroeconomics and Health⁸ and the Social Determinants of Health⁹ to efforts more specific to sexual and reproductive health (SRH), like the Unified Accountability Framework for the UN Secretary General’s Global Strategy for Women’s Children’s and Adolescents’ Health.¹⁰

Power operates at all levels and ultimately gets translated into what services are delivered and in what manner, who gets access and on what terms, and who is excluded. Thus, the concept of power is not only useful in understanding the current situation, but also it is regularly mobilised in programmatic efforts, including those that seek to change power relations that work to limit people’s access to or use of services. Such programmes are common in SRH, a distinct field within global health where the role of power dynamics, such as how gender relations are laden with power, has long been recognised (eg, see Boydell *et al.*^{11–14}). Programmatic efforts aiming to alter power relations in SRH involve diverse actors and encompass a wide range of approaches, like non-governmental organisation (NGO)-led efforts to empower marginalised groups, national governmental strategies to shift power dynamics within households (eg, regarding violence against women) and grassroots efforts to demand a greater role in health policy-making for particular constituencies. Yet, while power is the subject of increasing attention in research describing the status quo, as well as strategies and programmes seeking to change the status quo, it has not been deeply explored in evidence reviews. Existing reviews look only at discrete elements of how SRH interventions address power, such as how they try to shift gender norms (eg, see Ruane-McAteer *et al.*¹⁵). This gap is likely due to the breadth of the concept of power and the associated challenges in defining research questions and ensuring that findings are useful to individuals working in programme design, who may seek a more parsimonious approach.

This paper uses summative content analysis to describe how SRH programmes in low-income and middle-income countries (LMICs) described in the peer-reviewed literature explicitly and implicitly aim to alter relations of power. The focus is on *how* programmes seek to change power relations rather than *whether or not* programmes in SRH successfully change power relations. We contribute to answering a broad research question: ‘how do programmes seek to change power relations in order to promote the right to SRH?’ In this bounded paper, we address a component of that question; that is, ‘how do programmes documented in the peer-reviewed literature address power relations in order to promote the right to SRH?’

The paper is necessarily incomplete, as many efforts seeking to change power dynamics are not described in the peer-reviewed literature and others will not be responsive to our search terms. Most of what does appear in the peer-reviewed literature is research and evaluation,

rather than overarching programme descriptions. Our analysis does not address the ways that power shapes SRH programmes and research, but rather starts downstream, looking at how programmes documented in the peer-reviewed literature seek to harness or change power dynamics.

This paper focuses on LMICs. We recognise that questions related to power are also salient for high-income countries (HICs). We chose to focus on LMICs for two reasons: first, because there are several strands of global agenda setting and policy implementation related to SRH that were primarily focused on LMICs, such as the 1994 Cairo International Conference on Population and Development (ICPD) and its subsequent reviews every 5 years; second, for the most part, the programmes we review have been designed for implementation and potential replication in the LMIC context. This reflects a broader siloing between LMICs and HICs in global health, which is in itself a reflection of power dynamics in global health governance.

This summative content analysis is a first step towards summarising what has been tried, in what SRH domains it has been tried, how it was framed (eg, human rights, legal empowerment and structural interventions) and what lessons were learnt about power. The paper will lay groundwork for additional research, policy-making and action on power dynamics as a determinant of the right to SRH, including reproductive rights.

The concept of power

Power as a concept has deep and rich conceptual antecedents spanning many disciplines. Power is a complex construct, but many theories of power point to two key dimensions: power as a force that creates structures of formal and informal control, such as laws and social norms; and, second, power as a resource to be generated and mobilised for individual and collective transformation, as in self and collective efficacy, rights claiming, and empowerment.^{14 16} Social scientists often describe these two dimensions as *structure* and *agency*. Thus, power is not inherently good or bad for population health, but it is omnipresent, influencing law and policy, organisations, norms and beliefs, interpersonal relations and individual decision space.¹⁴

Research to understand how structure and agency are created, change and operate to influence health is similarly wide-ranging. This research builds mostly on theories and approaches from the social sciences, such as political science, anthropology, demography and social epidemiology, and has produced a rich evidence base examining the explicit and/or implicit role of power dynamics in phenomena such as health agenda-setting; health policy implementation; the influence of political trends on population health; and the impact of social hierarchies on health workers, health behaviours and status, access to care and quality of care received (eg, ^{12 17–23}). Such descriptive and exploratory work sheds light on why things are the way they are and how

they came to be that way. Within the confines of public health programme research, exploration of structure and agency is generally more limited, as such research is often based in a biomedical paradigm and consequently focuses on factors that are considered to be modifiable by public health actors.

Among the domains of global health, SRH has attributes that make a power lens particularly apt. Donor, governmental, organisational and individual understandings and approaches to sexuality and fertility reflect social norms and mores regarding gender roles and reproduction.^{11 12 24–26} These norms are part of the structure, influencing agency for all people engaged in SRH programme and service design, implementation and use. Structure and agency are not static. Rather, power is dynamic, and the SRH terrain is often contested, with tensions and conflict regarding SRH occurring within households and communities, within and among organisations, and within and among governments.^{11 14 26}

However, there are important areas of agreement among global and national policy-makers. At the ICPD held in Cairo in 1994, the international community coalesced around a vision of SRH that foregrounds reproductive autonomy, as opposed to population control.²⁷ Similarly, there is general consensus regarding the need to eradicate reproductive coercion and to promote equity in SRH service access, quality and outcomes.²⁷ However, factors such as gender hierarchies, political and national ideologies, and deeply held beliefs about appropriate motherhood and non-procreative sex continue to influence how public health evidence is (or is not) reflected in policies, programmes and practice.

Since the ICPD in 1994 and with the advent of unprecedented funding and global health activism accompanying the HIV pandemic, new approaches to addressing power within SRH policies, funding and programmes have been tried, often called structural interventions. The limited impact of efforts focused on individual behaviour change was emphasised by those advocating for structural interventions, which aim to change the context within which health and illness are produced, and factors at the

community, organisational (eg, health system), and law and policy levels.^{28–31}

METHODS

Since we were interested in *how* programmes seek to change power relations rather than *whether they* changed power relations, our search focused on papers that describe programmes that aim—implicitly or explicitly—to address power, even if results are not provided.

Perhaps because power is a complex and not especially bounded or discrete construct, it is not always explicitly discussed. Thus, we sought a method that would allow us to find and compare keywords and content, and to interpret the context in which those keywords and content are used.³² To achieve this, we conducted a summative content analysis. Content analysis is a qualitative approach to analysing textual data; in our analysis, peer-reviewed articles describing programmes aiming to alter power relations to improve SRH constituted the data.³³ Summative content analysis has not been widely used in global health, but among the analysis and review methodologies, its focus on summation and ability to assess what is both explicit and implicit in the text was well suited to our research question.

This summative content analysis explores two questions: (1) how do programmes that seek to change power relations try to do so? and (2) what are the reported lessons learnt from these programmes in relation to power?

As summarised in [table 1](#), search words were chosen to encompass the three concepts central to our question, namely, programme, SRH and power.

We selected the keywords working from articles already known to the authors to be relevant to the study objective; we then piloted and refined the search terms for programme, SRH and power. The words included in the SRH search terms were intended to capture all elements of SRH. We limited our power-related inclusion criteria to factors, activities and constructs whose relationship to power were explicitly described in the paper or implied, such as respectful maternity care and

Table 1 Search terms applied

| Programme keywords | + | Sexual and reproductive health keywords | + | Power keywords | + | MESH terms for LMICs in PubMed |
|---|---|--|---|---|---|--------------------------------|
| interven* OR programme OR project OR campaign OR advocacy OR policy OR strateg* | | Contraception OR abortion OR menstruation OR menstrual OR family planning OR condom OR STI OR HIV OR maternity OR antenatal OR prenatal OR labour OR delivery OR sexual* OR reproductive OR fertility OR cervical OR breast OR pregnancy OR “gender-based violence” OR “intimate partner violence” OR “violence against women” OR “domestic violence” | | Power OR accountability OR control OR empower* OR voice OR capabilities OR capacity OR transformative OR autonomy OR inequality OR inequity OR norms | | |

LMICs, low-income and middle-income countries; MESH, Medical Subject Headings.

Table 2 Inclusion and exclusion criteria

| Inclusion | Exclusion |
|---|---|
| Protocols and studies using any method that describes a programme or intervention, including the goals/objectives, setting, the target community or clients, and key activities | <ul style="list-style-type: none"> ▶ Reviews and commentaries. ▶ Papers with very brief descriptions that would not add value as a data source (eg, ‘an empowerment intervention using community education approaches’). |
| Programmes that address power at any level of the social ecological model | <ul style="list-style-type: none"> ▶ Programmes whose sole outcomes were health behaviours. ▶ Interventions that were reportedly based on well-known structural interventions (eg, stepping stones or image) but that did not describe any activities aiming to shift power relations. ▶ Programmes that brought in powerful actors to affect change but that did not aim to affect changes in power relations (eg, programmes that used church leaders to increase uptake of male circumcision). ▶ Articles that examined how SRH programmes unintentionally influenced power relations but that did not in themselves seek to address power (eg, a programme assessing possible increases in intimate partner violence due to a health behaviour intervention). |
| Cash transfer programmes that aimed to change power relations | <ul style="list-style-type: none"> ▶ Cash transfer programmes that aimed to address material deprivation only (eg, inability to pay school fees or to purchase food) rather than to change power relations. |

SRH, sexual and reproductive health.

reproductive autonomy. The authors had multiple discussions regarding what constituted ‘addressing power’; the final inclusion and exclusion criteria are provided in [table 2](#).

We included papers where any element of the programme met our inclusion criteria. We searched PubMed, Scopus and Academic Search Complete and, based on title and abstract and excluding duplicates, imported 342, 15 and 60 papers to Zotero for full review, respectively. We looked only at papers that were published after 1994, reflecting the watershed event of ICPD and its acknowledgement of human rights, gender equity and reproductive autonomy as germane to reproductive health and rights, population and development, as an important transition in the field. At the start of the full-review process, three authors independently assessed the same 10 studies to determine inclusion or exclusion to confirm that criteria were clear and being applied consistently. We then read the articles in their entirety, eliminating those that did not meet our criteria. At the end of this process, we had 91 articles. We did not apply criteria related to language, but our search produced only English language results.

We found that we had some papers relating to the same programme, such as protocols and results for the same programme. We linked these records, and only kept both papers where they yielded new information. For example, often the protocol had greater detail about the content of the programme, while the results paper provided information about the lessons learnt about power. In a few cases, we had two or more papers describing programmes implemented by a single NGO that were related but distinct; we classified these as separate programmes.

We then entered the articles into an extraction tool (a spreadsheet) that included basic details about the programme and lessons learnt about power as a result of the programme, if provided. We also indicated what level of the social ecological model—as defined in [figure 1](#)—the programme activities addressed. Social ecological models are used to illustrate the multiplicity of factors—including the individual, social and other structural factors—that shape health, as well as domains of intervention and change.³⁴ We included four levels in our approach to the social ecological model: individual/interpersonal, community, organisational and law/policy. Based on our background reading, we collapsed individual and interpersonal into a single level because we realised many of the interventions aimed to affect both levels through one activity, for example, training and equipping commercial sex workers to learn about sexually transmitted infections and to demand that their partners use condoms. We used the programme description and the outcome measures specified in the respective papers as a basis for deciding at which levels of the social ecological model the programme intended to intervene.

Then, we undertook a final search by looking at the citations of included papers, as well as adding papers that the authors knew would meet the inclusion criteria, but due to the heterogeneity and complexity of the construct(s), were not captured in earlier searches. Following another round of inclusion screening of the newly identified papers, we added 17 articles to our extraction table. A total of 108 articles regarding 93 different programmes were included in our analysis.

As this content analysis is summative, our analysis largely consisted of summarising the extraction tool and identifying themes. The results section is in a large part a



Figure 1 The social ecological model. NGO, non-governmental organisation.

narrative summary of what was recorded in the extraction tables. To synthesise the broad swath of ‘lessons learnt’, we grouped all lessons learnt listed in the extraction table into categories that emerged from the data, for example, ‘resistance’ and ‘stigma’.

We analysed the articles working from the premise that power dynamics could be addressed at any level, including systemic power dynamics. For example, a programme that reached a large number of people could contribute to social norm change. In our summation, we also explore the distribution of programmes within the social ecological model, including to what extent programmes address multiple levels or directly address law, policy and institutional practices.

We do recognise that, in practice, programmes are not implemented in a vacuum; they are implemented in a political economic context where other programmes, social movements and geopolitical trends shape the right to SRH. These factors outside of the programme will shape how effectively a programme effects changes in power dynamics, so it is simplistic to assert that a programme addressing one level of the social ecological model is necessarily more effective than another.

Finally, the themes emerging from the data were discussed among the first three authors and subsequently

elaborated in brief memos through an iterative process that required returning to the articles. These memos were then collapsed into broader categories and developed into the discussion section.

We ensured trustworthiness by triangulating among papers as we identified and elaborated themes and being attentive to discrepant findings. Moreover, since our intent is descriptive rather than a meta-analysis of findings, threats to validity are less of a concern.

Patient and public involvement

Because this paper is not directly related to patient care, this research was done without patient involvement. Patients were not invited to comment on the study design and were neither consulted to develop patient-relevant outcomes or interpret the results nor invited to contribute to the writing or editing of this paper for readability or accuracy.

Given the somewhat academic nature of the research question, the public were not invited to participate. However, public participation in some form might be appropriate for future work that addresses some of the gaps and tensions identified in this paper.

RESULTS

We present some basic attributes of the included papers, and then go on to present the programmes by level of the social ecological model.

Overview

For simplicity, we refer to ‘programmes’ in this paper, though some of these may have been described as ‘interventions’ or ‘efforts’ in the papers we reviewed. The papers included describe programmes undertaken in diverse regions that address different elements of SRH, and for which power functions in manifold ways. Online supplemental table 1 presents a high-level overview of the results, including the countries where the programme was implemented, the levels of the social ecological framework the programme engaged, the theoretical and other bases provided for the intervention, and the primary SRH domain of intervention.

Most of the programmes took place in Africa (n=56), with South Africa (n=15), Kenya (n=8) and Uganda (n=7) being the most represented. Twenty-nine of the programmes were in Asia, with the majority (n=24) in India. There were five programmes in Latin America and one in Eastern Europe. There were no papers regarding the Western Pacific region. In terms of SRH domains addressed, HIV prevention and services to prevent and/or support survivors of intimate partner violence (IPV) or another type of violence were the most common, with 17 interventions focused on HIV prevention only, 11 focused on HIV and IPV/other violence and 29 focused on IPV/other violence only. None of the papers focused on comprehensive abortion care. Most papers reported experimental, quasi-experimental or quantitative preapproach–postapproaches to assessing impact (n=72), and were largely based in a biomedical or positivist framework. Twenty-one papers used exclusively qualitative methods or did not report an evaluation or study but simply described a programme. Of the programmes reviewed, only two were described as a governmental effort^{35 36}; the rest were seemingly implemented by NGOs and/or universities (n=106), although these efforts typically collaborated with public sector facilities and other public sector actors. Discussion of the agency/institution implementing the programme was generally very limited, consistent with the biomedical orientation that the programme itself is an ‘exposure’, not the entity implementing the programme. On the other hand, some papers included more in-depth discussions of which organisation(s) implemented the programme, the context of the organisation and the implications for the programme.^{25 37–46}

Theoretical basis

Many of the papers did not explicitly report the theoretical basis of the programme described, but they did summarise the extant evidence base and/or describe formative research as data that informed programme design (n=34). Others referenced one or more theories or

models underlying the programme (n=39). As reflected in online supplemental table 1, many of the theoretical underpinnings were from the behavioural sciences and social cognitive theories; others used the theory of gender and power or Freirean approaches, and a few relied on diffusion or other theories focused on social networks. Many of the theory-based programmes were focused on the individual/interpersonal level, but some addressed multiple levels. Moreover, many programmes referred to multiple theories. Finally, several programmes were derived from more participatory or other bottom-up processes (n=6).

Several papers examined their study outcomes in the broader context of the evolving evidence base and theory regarding unresolved issues such as the link between IPV and women’s economic empowerment, and the combination of gender segregated and mixed gender groups in spurring change in gender norms.^{47–49}

Individual/interpersonal

Most programmes addressed more than one level of the social ecological model. Approximately, a third (n=31) of the interventions were focused on the individual/interpersonal level only, and 36 others addressed the individual/interpersonal in combination with others. Most programmes provided counselling or education sessions to individuals and/or couples, often with a role-playing component or similar activity that aimed to help participants to enact the principles taught.^{50–69}

Other counselling, training or awareness raising sessions intervening at the individual/interpersonal level aimed to change the behaviour of individuals in a position of power in a given context, including men in the community, school personnel or parents of girls.^{70–72} Regardless of the participants, programmes aiming to change the behaviour of individuals typically had some explicit content related to power dynamics, such as recognising and changing gender hierarchies,^{51 53 56 70 72–75} understanding the health impacts of gender and other power dynamics,^{73 76} human rights⁷⁷ and joint financial decision-making.⁵² To promote implementation of the lessons taught, many programmes aimed to enhance participants’ commitment and capacity to act differently in their interpersonal interactions by teaching strategies ranging from problem-solving techniques and more assertive communication^{50 51 58 60 64 73 74} to self-defence,^{61 62} and enacting positive masculinity through anger management and conflict resolution.^{53 54 56 78 79} Some of the activities were for groups convened by the project, such as groups of students in school or classes for multiple families at once, but seemingly targeted groups for reasons of efficiency, or to promote discussion about personal concerns rather than to engender any collective action or change in a community level variable.^{36 56 66 73 77–82}

Organisational

Twenty-eight programmes, just under a third of the total, addressed the organisational level. Some programmes

explicitly aimed to build organisational capacity to identify and address power dynamics and how these constrain autonomy in the context of SRH.^{83 84} The most common organisational structure addressed was health facilities. For example, several programmes entailed health facility-led efforts to engage communities in expressing their priorities regarding quality of care; some of these had an explicit health facility accountability component.^{35 37 42 85–88} Other health sector programmes aimed to create change in the way organisations operate, including health facilities^{89–92}; health and allied professional associations and other organisational stakeholders in SRH, including law enforcement^{93–95}; schools⁹⁶; and factories.⁹⁷ For example, a school-based programme in Uganda supported teachers to exercise respectful leadership, such as through the practice of non-punitive discipline.⁹⁶

Another group of programmes addressed organisations or entities that bridge the state–society intersection (meaning that they are governed by public sector and community actors), such as hospital committees or village health and sanitation committees. The desired impacts ranged from changing these organisations' behaviours regarding SRH⁹⁸ to creating new organisations or committees bridging state and society.⁹⁹

Some programmes sought to build the capacity of community-based organisations to work on a particular area related to power and SRH, such as facilitating the right to a legal remedy for sex workers who experience GBV.¹⁰⁰ One multicountry effort in Southern Africa did this on a regional level by engaging a variety of organisations, including health facilities, schools, local organisations and religious groups, with the particular constellation of groups engaged depending on the context. Specifically, the programme aimed to improve these organisations' capacity to reorient HIV prevention activities to focus more on the 'choice disabled'.⁸³

Programmes intervening at the organisational level intended to influence power dynamics that were manifest at the organisational level as well as other levels, such as in interpersonal interactions. Many of the health facility-focused programmes aimed to foster the provision of respectful (maternity) care, such as programmes aiming to improve communication between providers and patients and their families; to ensure that providers do not employ condescending, demeaning or discriminatory language; and to support community monitoring of health facilities to prevent and document disrespect.^{91 92 101 102} To effect such change, some programmes created mechanisms of communication between health providers/facilities and communities to increase health system responsiveness,^{35 44 89 103} or introduced a birth companion or care navigator to change the dynamics of power between the patient and providers.¹⁰⁴

Community

Fifty-three of the programmes—almost 60% of the total—addressed the community level; 11 of them focused solely on the community. Some of the analyses sought to compare programmes that engaged the

community with those that did not.^{89 105} Most of the community-focused activities included community mobilisation and/or dialogue.^{38 42 71 83 87 89 97 103 105–109} In some cases, this mobilisation and dialogue was described as the community component of a programme trying to impel health system responsiveness to community SRH concerns.^{37 38 42 85–87 89 103 105}

Other mobilisation efforts used community-based activities to shift community norms in ways that promote SRH equity, including through community theatre, community action groups and repeated community dialogues regarding issues such as the acceptability of IPV, gender norms and HIV stigma.^{25 47 83 95 99 100 110–114} Sometimes these efforts also aimed to promote critical consciousness using Freirean principles as a way to empower participants.⁹⁴ A few programmes sought to build community awareness and shift norms by facilitating community sharing from smaller groups that had been convened on a specific SRH issue, such as HIV or IPV prevention.^{41 45 98 115}

Many programmes endeavoured to change community norms by training opinion leaders, community action teams, community activists or ambassadors; these efforts often focused on shifting gender norms at the community level.^{44 75 113 116–119} For example, based on an analysis using John Gaventa's Powercube, a framework for analysing power that helps users to identify opportunities for mobilisation and change, the SASA programme trained ordinary community members as activists, who were then mentored to conduct various activities to engage men, women and institutions in the community.¹¹⁹ A few programmes included activities to assess impact within communities—as opposed to just changes in individual attitudes—such as by asking community members about the frequency and type of their communication relating to issues targeted by the programme,⁴⁶ or creating measures to assess community-level changes.^{120 121}

Several programmes aiming to shift power relations at the community level were implemented by grassroots organisations or other types of community-based organisations. They created and amplified demand for change by working to decrease the acceptability of domestic violence, claiming human rights for sex workers or agitating for better quality maternal health-care.^{25 37 38 40 42–44} These efforts were generally part of a longer term, iterative strategy that entailed multilevel engagement in order to effect change at multiple levels. For example, Balestra and colleagues and Dasgupta and colleagues describe a programme wherein grassroots women set their own goals related to maternal health and other issues and then collected evidence to use in their advocacy vis-a-vis local health facilities, as well as district and state managers and policy-makers.^{37 40}

Several programmes engaged the media to cover the project concerned and/or to be a channel for communicating information or ideas that were intended to effect a change in norms and power relations.^{108 122} A few projects intervening at the community level did not aim to shift community power relations per se, but rather to create

enabling conditions for changes in power dynamics at the interpersonal level, such as by raising awareness among stakeholders about the links between harmful gender norms and IPV, or between young age of marriage and maternal morbidity and mortality, and attempting to galvanise their support for change.^{90 97 102 123 124}

Public policy/governance

Seventeen of the programmes reviewed addressed the public policy/governance level; none focused exclusively on this level. Some programmes included advocacy activities aiming to foster governmental commitment to the given SRH issue, such as by ensuring the involvement of local or national government leaders or entities in programme awareness raising activities.^{25 75 95 102 110 125}

Others sought to change the ways that public sector actors operate, such as schools or medical training institutions, by changing policies.^{102 126} Civil society organisations made claims on policy-makers at the local or national level, including trying to alter the ideologies underpinning governance decisions^{37 40 43 45} or trying to hold the governmental accountable for failing to fulfil the right to SRH.¹²⁷ Some programmes run by NGOs built capacity and/or supported individuals or organisations to engage in policy-making, including through engagement in electoral politics.^{39 41 85 101–103}

Lessons learned

The papers described lessons learnt regarding programmes seeking to alter power relations in order to improve SRH. While the focus of this paper is on what the programmes did rather than the impact they had, we report on some of the key lessons presented insofar as these shed light on fundamental issues such as the combination and types of activities that comprise a programme. Not all papers reported programme results. Of those that did, many simply presented results and noted that the programme—understood as an exposure—worked or did not work. These focused on the viability of the programme theory without necessarily invoking power.

We present power-related lessons in [table 3](#), according to the key themes invoked by the papers' authors, as well as their framing of the theme. For example, some described community resistance as a barrier and discussed how they overcame it; others simply asserted that a particular approach had helped to minimise community resistance.

DISCUSSION

Nature of existing evidence about power in SRH programmes

This paper adds value by summarising what the academic public health community has chosen to test and research in terms of power relations and SRH, and by raising questions about how this corresponds to the significant task of effecting change in power relations to improve the right to SRH. We elaborate further.

The 93 programmes reviewed reflect a diversity of priorities and approaches to addressing power. Most programmes intervened at multiple levels simultaneously,

including some programmes that were described as 'structural'. The structural programmes tended to be more explicit about their objective to shift power relations, noting that an explicit power framing channelled participants' priorities towards both upstream and proximate drivers of SRH inequities (eg, see Abramsky *et al*¹¹⁶). Others addressed multiple levels using a more typical programme theory that sought to change individual behaviours and proximate drivers.

Almost all of the programmes tried to influence individual knowledge and behaviour, as well as some of the proximal structures shaping individual ability to exercise agency, such as gender relations of power in sexual encounters. The research designs used were skewed toward (quasi) experimental and quantitative preapproaches/postapproaches and measuring success in terms of individual knowledge and reported behaviour change, reflecting a prevalence of positivist evidence in addressing power in programmes.

The predominance of positivist biomedical framing and study approaches of the programmes reviewed in this study stands in contrast to the diverse and deep body of research—ranging from ethnography to political science—that analyse the ways that power shapes SRH policy, programmes and population health.^{5 128} This broader literature of descriptive cross-sectional studies typically draw on paradigms from the social sciences, such as interpretivist and constructivist framings, that can enrich biomedical research by foregrounding social relations and constellations of causes of change. Such framings are often germane to programmes that aim to shift power relations.^{129 130} By contrast, the use of traditional public health measurement approaches to assess structural change, as more typically used in the programmes reviewed in this study, entails many challenges, including how to account for complexity and context and how to create measures that detect changes in power relations.^{12 25 131–137} Programmes that seek to alter power relations might incorporate real-time learning and adaptation, and encounter uncertain trajectories of change, including pushback. Time frame and methodological limitations may undermine the effectiveness and assessment of a programme, and undercut effective scale-up or adaption and replication as the influence of social and political context is not elucidated.^{138 139} In brief, both the programmes implemented and the methods used to assess their impact likely do not correspond to the multilevel determinants of structure and agency.

On the other hand, there was a subset of articles that focused on bottom-up efforts to build agency and mobilise collective power, typically led by NGOs working at the national and subnational levels. Overall, their approach was grounded in a human rights or social movements paradigm, and the focus of research included how these programmes were part of a longer process of changing both structure and agency, rather than a time-bound effort to increase quantifiable indicators.^{25 37 39 40 43 101 140}

Table 3 Key themes and power-related lessons learnt from SRH literature

| Theme | Lesson | Papers |
|--|--|--------------------------|
| Resistance | Some programmes faced community resistance as some community members felt that the programme undermined cultural or religious tradition. Programme implementers addressed (though did not eliminate) this resistance by working with opinion leaders from the start, and in some cases, by integrating these opinion leaders into programme activities; failing to do so seemingly undermined the programme. | 46 75 95 111 151 |
| | Due to prevailing gender norms, men were reluctant to engage in programmes that addressed 'women's issues', and this was lessened by framing the programme as working on issues of community importance, as opposed to women's concerns. | 72 95 116 |
| | Many papers noted that involving men helped programmes to achieve their goals, particularly those that aimed directly or indirectly to influence gender relations of power. | 49 51 65 81 119 123 152 |
| | Engaging mothers in law was an effective way to influence gender relations of power in the household. | 76 |
| | Resistance can engender non-linear effects, as actors with power initially push back against an effort. | 45 |
| Stigma | The act of bringing stigmatised SRH issues out into the open for discussion—in small groups or at the community level—can foment a change in power relations. | 25 38 39 41 45 79 84 116 |
| | Relying on community representatives as legitimate spokespeople for stigmatised issues might help to ensure that these issues are discussed and that decision-makers listen. | 38 |
| | Open discussion of stigmatised issues (HIV in this case) may lead to increased polarisation when the issue in question is already polarised. | 122 |
| Programme exposure | Some papers speculated whether a higher 'dose' of the programme might more effectively provoke changes in power relations. | 52 53 56 57 107 151 152 |
| | Gender and other norms may limit particular groups' exposure (ie, their ability to participate) to the programme; this should be addressed in programme design. | 96 |
| Limitations of programmes addressing only individual/interpersonal levels, benefits of a multilevel approach | A multilevel intervention might be more successful in changing the power relations and other structural factors that limited the programme's success. | 48 57 70 84 |
| | Systematically addressing several levels of the health system and use of a political economy analysis buttressed programme success. Deliberately engaging stakeholders at multiple levels also gave programme implementers a clearer picture of power relations and how they play out. | 85 153 |
| | The provision or existence of high-quality material, human and other resources may be critical to enable or facilitate change, including ensuring that health providers do not perpetuate stigma. | 57 71 89 |
| | The combination of mass media messaging, community mobilisation and interpersonal engagement in informal spaces (eg, market and spontaneous community meetings) can work synergistically to shift power dynamics. However, this informal interpersonal engagement did not work in all settings, perhaps due to cultural differences | 41 46 111 113 |
| | Combining support for community activism and efforts to engage local government and service providers can support an 'enabling environment' for change. | 75 |
| Grassroots efforts | Programmes led by grassroots NGOs and activists underlined the effectiveness of collective action by the marginalised in demanding rights and shifting power relations, as well as the emancipatory potential of marginalised populations recognising their 'right to have rights'. These efforts can be more effective when collective actors confront multiple structures that 'reproduce(d)and maintai(n) their marginality' rather than just the direct determinants, ⁴⁵ p103). | 25 41 43 45 |
| | Programmes led by organisations that modelled non-hierarchical relationships with communities helped community members to perceive themselves as part of an organised effort to effect change. | 37 43 |
| | Papers regarding programmes that were not obligated to ensure programme fidelity noted that programme learning and real-time adaptation were key to ensuring the programme addressed contextual factors and changing power dynamics. | 37 40 85 87 |
| | NGO monitoring efforts must negotiate power dynamics at multiple levels, including generalised commitment from the state at higher levels of the health system, and resistance from front-line providers who feel judged. | 42 |
| | A long-term community-based advocacy programme built the political capabilities of the women participating, making it more likely that they demanded change from political, state and community actors regarding a number of issues over the medium and long terms. | 37 |
| | Lack of legislation or poor implementation of legislation undercut the programme's effectiveness. | 84 114 127 |
| Public policy/governance | | |
| SRH, sexual and reproductive health. | | |

It is notable that none of the programmes described focused on abortion, although one included postabortion care in their efforts to improve respectful maternity care.¹⁰²

The right to SRH as a governmental obligation

Perhaps in part because they are empirical research on programmes to address specific health concerns and behaviours, the studies reviewed are somewhat removed from the larger question of how governments can address the power-related drivers of SRH inequities. The right to health approach is based on the assumption that the government is the ultimate duty bearer mandated to respect, protect and fulfil the right to SRH.¹⁴¹ With few exceptions, the programmes reviewed were pilots or localised efforts. To be sure, many of these efforts were intended to produce evidence that can be diffused and used by governmental and other actors developing national strategies and scaled-up programming, and these scaled up efforts may not be documented in peer-reviewed literature. Nonetheless, the extent to which pilot evidence is useable to policy-makers and actually informs governmental programmes remains an important priority for research, support and advocacy.^{139 142 143}

Relatedly, none of the programmes explicitly address the provision of SRH care within the private sector—both for profit and non-profit private actors. The private sector is a major provider of SRH services in many settings¹⁴⁴ often responsible for over half of the services provided in a country, so programmes aiming to affect power as a determinant of SRH at the organisational level should consider the role played by the private sector.

Sustainability and scale

Almost all of the programmes reviewed were led by NGOs, universities or research institutions, though they typically were implemented within the public sector. This raises questions about governmental commitment and capacity; potential for scale; and researcher commitment, ability, and incentives to study governmental efforts. In other words, there is likely both a research gap and an implementation gap. The research gaps reflects the fact that funders typically fund NGOs and universities to study programmes, including those implemented in the public sector. The implementation gap likely exists because governments are unwilling to directly confront the power dynamics that shape the right to SRH, and/or because many programmes are piloted by non-governmental actors and then not subsequently scaled up and taken over by governments. On the one hand, non-governmental actors may have greater expertise to both research and provide rights-based care, particularly to marginalised groups.¹⁴⁵ On the other hand, in many settings, the government is the only actor with the capacity to implement health programmes at scale. As a body of work, research needs to consider these questions if researchers aim to produce evidence that can influence the right to SRH over the long term and at scale.

Limitations

Our review has several limitations. First, the peer-reviewed literature is not an unbiased representation of the universe of action to address the power-related determinants of SRH. This limitation holds for almost any review of academic literature describing programme approaches, but it has specific implications for our paper. As compared with external interventions, social movement efforts are likely under-represented in the peer-reviewed global health literature, particularly in a literature search that takes an interventionist frame. At the same time, social movement efforts and grassroots advocacy on SRH are deep and long-standing, and integral to a comprehensive assessment of efforts to address power dynamics as these shape the right to SRH. Social movement and grassroots NGO action may be most significant for especially contentious SRH issues, such as abortion. Stigma relating to abortion and other issues may also contribute to their under-representation in research and, thus, in peer-reviewed literature. It is also possible that programmes that describe themselves as being transformative may in some way reinforce power relations; our summation of the article would not have detected that. As an illustration, a programme that purportedly seeks to change gendered power relations in SRH might not refer patients to abortions, even in contexts where abortion is permitted. This nuance might not come through in a peer-reviewed paper, but it would mean that the programme's impact on power relations is more partial or complex than we could learn from the paper itself. In essence, the gap between the literature and reality may be especially pertinent in the case of SRH.

Second, this analysis did not include programmes that may inadvertently affect power relations by perpetuating harmful power relations,^{22 146} or the ways that power pervades SRH agenda setting, and research and evaluation itself.^{26 147 148}

Third, much of the work that would address power as a determinant of SRH might not be explicitly related to SRH or be sensitive to the search terms we used, which combine SRH, programmes/intervention and power. For example, efforts to improve morale and job security among healthcare workers could help to lessen rude treatment of clients seeking maternal healthcare but may not be labelled as an SRH intervention. An effort to hold the government accountable for failing to deliver quality maternal health services in a national court or to change the laws related to abortion, age of consent, or the regulation sex work would address power dynamics shaping the right to SRH but would likely not be detected using search terms related to programmes.

Fourth, this analysis focuses on LMICs. There is growing recognition that truly 'global health' should indeed be global and not focus exclusively on LMICs. Indeed, the power dynamics shaping SRH may be shaped and influenced at the global level, and, even if not, have many commonalities across countries at all income levels, such as accelerating wealth inequality.¹⁴⁹ The silo between

HICs and LMICs is eroding, as it can stifle innovation, solidarity and learning.¹⁵⁰ The need to develop new, widely accepted review methodologies that can accommodate literature from all over the world—such as a stratified sampling approach—to reviewing papers is urgent.

Fifth, because we addressed such a broad topic here, we were unable to zoom in on granular issues that may be of great importance to theory development. For example, the papers revealed different theories and findings regarding the creation of peer groups to foster individual empowerment, as opposed to creating peer groups to serve as a source of social capital or a mechanism for collective mobilisation. As another example, some programmes addressed sex workers as an at-risk group that needs to be empowered with health information and prevention tools, while other programmes addressed sex workers as a group that needs health information and tools as well as avenues for rights claiming and obtaining remedies for police harassment. These approaches make different assumptions about how power dynamics shape the right to SRH.

CONCLUSION

Power and the right to SRH is a big topic. This paper looks at a significant slice of that topic—how programmes seeking to improve the right to SRH address power. Despite the limitations of our approach, we identified key trends and themes, including the prevailing focus on behaviour change strategies, and the related use of research approaches that are focused on detecting changes therein. At the same time, especially in the context of HIV and/or GBV, there are many programmes that seek to affect change on multiple levels and that use complicated study designs that harness epidemiological approaches to assess change at multiple levels. Further development of these approaches and increased programme and research attention to power relations at the community, organisational and policy/governance levels would complement the behavioural research. This should be done in a way that links research back to its purpose: producing a body of evidence that together can start to answer the question of how to shift power dynamics in favour of the right to SRH, and that is useful to decision-makers in SRH programme development.

Author affiliations

¹Independent Consultant, Brooklyn, New York, USA

²Department of Sexual and Reproductive Health and Research, WHO, Geneva, Switzerland

³School of Health and Social Care, University of Essex Faculty of Science and Health, Colchester, UK

⁴College of Public Health, Medical and Veterinary Sciences, James Cook University, Townsville, Queensland, Australia

⁵Ramalingaswami Centre on Equity and Social Determinants of Health, Public Health Foundation of India, Bangalore, India

⁶WHO, Geneva, Switzerland

Twitter Marta Schaaf @martaschaaf and Stephanie M Topp @globalstopp

Acknowledgements Veena Sriram and Kerry Scott kindly offered thought partnership and feedback on possible methods for the review.

Contributors MS, VB and SMT developed the methodology and reviewed the same 10 manuscripts to ensure the reliability of the inclusion and exclusion criteria. MS extracted the data and wrote the first draft of the paper. VB and SMT made substantial comments on the first draft, including writing new text. AI, GS and IA offered substantive input and drafted some text, particularly regarding the framing of the paper and discussion. All authors read and approved the final manuscript.

Funding This manuscript was developed with support from the United Nations Development Program (UNDP)-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP Research), a cosponsored programme executed by the WHO.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, conduct, reporting or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information.

Supplemental material This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by BMJ. BMJ disclaims all liability and responsibility arising from any reliance placed on the content. Where the content includes any translated material, BMJ does not warrant the accuracy and reliability of the translations (including but not limited to local regulations, clinical guidelines, terminology, drug names and drug dosages), and is not responsible for any error and/or omissions arising from translation and adaptation or otherwise.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>.

ORCID iDs

Marta Schaaf <http://orcid.org/0000-0002-7616-5966>

Victoria Boydell <http://orcid.org/0000-0001-5051-9167>

Stephanie M Topp <http://orcid.org/0000-0002-3448-7983>

Aditi Iyer <http://orcid.org/0000-0002-2177-0755>

REFERENCES

- Gore R, Parker R. Analysing power and politics in health policies and systems. *Glob Public Health* 2019;14:481–8.
- Narayan D. *Voices of the poor: can anyone hear us?* Washington, DC: World Bank, 2000.
- Navarro V. What we mean by social determinants of health. *Int J Health Serv* 2009;39:423–41.
- Ottersen OP, Frenk J, Horton R. The Lancet–University of Oslo Commission on global governance for health, in collaboration with the Harvard global health Institute. *The Lancet* 2011;378:1612–3.
- Storeng KT, Mishra A. Introduction. politics and practices of global health: critical ethnographies of health systems. *Glob Public Health* 2014;9:858–64.
- Mahanand J. India's pandemic response needed Ambedkar's vision of social security and public health [Internet], 2020. The Caravan. Available: <https://caravanmagazine.in/policy/indias-pandemic-response-needed-ambedkars-vision-of-social-security-and-public-health>
- McNeely IF. *"Medicine on a grand scale": Rudolf Virchow, liberalism, and the public health*. London: Wellcome Trust Centre for the History of Medicine at UCL, 2002.
- WHO. *Report of the Commission on Macroeconomics and Health—Macroeconomics and health: investing in health for economic development*. Geneva: WHO, 2001.
- WHO. *Closing the gap in a generation*. Geneva: WHO, 2008.
- Every Woman Every Child. *The Unified Accountability Framework: Supporting country-led efforts with the Global Strategy for Women's Children's and Adolescents' Health*. Geneva: Every Woman Every Child no date.

- 11 Boydell V, Schaaf M, George A, *et al.* Building a transformative agenda for accountability in SRHR: lessons learned from SRHR and accountability literatures. *Sex Reprod Health Matters* 2019;27:64–75.
- 12 Robinson JL, Narasimhan M, Amin A, *et al.* Interventions to address unequal gender and power relations and improve self-efficacy and empowerment for sexual and reproductive health decision-making for women living with HIV: a systematic review. *PLoS One* 2017;12:e0180699.
- 13 Sen G, Germain A, Chen LC, eds. *Population policies reconsidered*. Cambridge: Harvard Series on Population and International Health, 1994.
- 14 Sen G, Iyer A, Chattopadhyay S, *et al.* When accountability meets power: realizing sexual and reproductive health and rights. *Int J Equity Health* 2020;19:111.
- 15 Ruane-McAteer E, Gillespie K, Amin A, *et al.* Gender-transformative programming with men and boys to improve sexual and reproductive health and rights: a systematic review of intervention studies. *BMJ Glob Health* 2020;5:e002997.
- 16 Harris P, Baum F, Friel S, *et al.* A glossary of theories for understanding power and policy for health equity. *J Epidemiol Community Health* 2020;74:548–52.
- 17 Erasmus E, Gilson L. How to start thinking about investigating power in the organizational settings of policy implementation. *Health Policy Plan* 2008;23:361–8.
- 18 Grace KT, Fleming C. A systematic review of reproductive coercion in international settings. *World Med Health Policy* 2016;8:382–408.
- 19 Knibbs S, Price N. Peer education in sexual and reproductive health programming: a Cambodian case study. *Dev Pract* 2009;19:39–50.
- 20 Lehmann U, Gilson L. Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes. *Health Policy Plan* 2013;28:358–66.
- 21 Paul M, Essén B, Sariola S, *et al.* Negotiating collective and individual agency: a qualitative study of young women's reproductive health in rural India. *Qual Health Res* 2017;27:311–24.
- 22 Senderowicz L. "I was obligated to accept": A qualitative exploration of contraceptive coercion. *Soc Sci Med* 2019;239:112531.
- 23 Wachter K, Horn R, Friis E, *et al.* Drivers of intimate partner violence against women in three refugee camps. *Violence Against Women* 2018;24:286–306.
- 24 Gruskin S, Ravindran TKS. Rights-Oriented research and education (RORE) network for sexual and reproductive health: realising the ICPD 20 years later: shifting the paradigms for research and education. *Glob Public Health* 2014;9:647–52.
- 25 Menon SV, Allen NE. Community organizing and counter narratives in the response to domestic violence in India. *Am J Community Psychol* 2021;67:184–94.
- 26 Storeng KT, Palmer J, Daire J, *et al.* Behind the scenes: international NGOs' influence on reproductive health policy in Malawi and South Sudan. *Glob Public Health* 2019;14:555–69.
- 27 Brown R, Kismödi E, Khosla R, *et al.* A sexual and reproductive health and rights journey: from Cairo to the present. *Sex Reprod Health Matters* 2019;27:326–8.
- 28 Blankenship KM, Reinhard E, Sherman SG, *et al.* Structural interventions for HIV prevention among women who use drugs: a global perspective. *J Acquir Immune Defic Syndr* 2015;69 Suppl 2:S140–5.
- 29 Moore L, Chersich MF, Steen R, *et al.* Community empowerment and involvement of female sex workers in targeted sexual and reproductive health interventions in Africa: a systematic review. *Global Health* 2014;10:47.
- 30 Sommer M, Parker R. *Introduction: structural approaches in public health. in: structural approaches in public health*. New York: Routledge, 2013: 21–34.
- 31 Wamoyi J, Mshana G, Mongi A. A review of interventions addressing structural drivers of adolescents' sexual and reproductive health vulnerability in sub-Saharan Africa: implications for sexual health programming. *Reprod Health*;201413:88.
- 32 Griffiths TH. Application of summative content analysis to a postal questionnaire. *Nurse Res* 2016;23:30–6.
- 33 Hsieh H-F, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res* 2005;15:1277–88.
- 34 McLeroy KR, Bibeau D, Steckler A, *et al.* An ecological perspective on health promotion programs. *Health Educ Q* 1988;15:351–77.
- 35 Alhassan RK, Nketiah-Amponsah E, Ayano MA, *et al.* Impact of a bottom-up community engagement intervention on maternal and child health services utilization in Ghana: a cluster randomised trial. *BMC Public Health* 2019;19:791.
- 36 Govender S, Edwards S. Appreciative inquiry into lifeskills-based HIV/AIDS education in South African schools. *Afr J AIDS Res* 2009;8:115–21.
- 37 Balestra GL, Dasgupta J, Sandhya YK, *et al.* Developing political capabilities with community-based monitoring for health accountability: the case of the Mahila Swasthya Adhikar Manch. *Glob Public Health* 2018;13:1853–64.
- 38 Boydell V, Nulu N, Hardee K, *et al.* Implementing social accountability for contraceptive services: lessons from Uganda. *BMC Womens Health* 2020;20:1–12.
- 39 Chatterjee B. ActionAid's Young Urban Women programme in urban India: taking an intersectional approach to decent work, unpaid care, and sexual and reproductive health and rights. *Gender & Development* 2015;23:127–43.
- 40 Dasgupt J, Sandhya YK, Lobis S. Using technology to claim rights to free maternal health care: lessons about impact from the my health, my voice pilot project in India. *Health Hum Rights* 2015;17:135.
- 41 de Souza R. Creating "communicative spaces": a case of NGO community organizing for HIV/AIDS prevention. *Health Commun* 2009;24:692–702.
- 42 George AS, Mohan D, Gupta J, *et al.* Can community action improve equity for maternal health and how does it do so? research findings from Gujarat, India. *Int J Equity Health* 2018;17:125.
- 43 Gooptu N, Bandyopadhyay N. "Rights to Stop the Wrong": Cultural Change and Collective Mobilization—The Case of Kolkata Sex Workers. *Oxford Development Studies* 2007;35:251–72.
- 44 Mecwan S, Sheth M, Khanna R. Enhancing social accountability through adolescent and youth leadership: a case study on sexual and reproductive health from Gujarat, India. *Gender & Development* 2021;29:151–69.
- 45 Reza-Paul S, Lorway R, O'Brien N, *et al.* Sex worker-led structural interventions in India: a case study on addressing violence in HIV prevention through the Ashodaya Samithi collective in Mysore. *Indian J Med Res* 2012;135:98–106.
- 46 Starmann E, Heise L, Kyegombe N, *et al.* Examining diffusion to understand the how of Sasa!, a violence against women and HIV prevention intervention in Uganda. *BMC Public Health* 2018;18:616.
- 47 Abramsky T, Devries KM, Michau L, *et al.* Ecological pathways to prevention: how does the Sasa! community mobilisation model work to prevent physical intimate partner violence against women? *BMC Public Health* 2016;16:339.
- 48 Fleming PJ, Silverman J, Ghule M, *et al.* Can a gender equity and family planning intervention for men change their gender ideology? results from the CHARM intervention in rural India. *Stud Fam Plann* 2018;49:41–56.
- 49 McGhee S, Shrestha B, Ferguson G. "Change Really Does Need to Start From Home": Impact of an Intimate Partner Violence Prevention Strategy Among Married Couples in Nepal. *J Interpers Violence* 2019;088626051983942.
- 50 Decker MR, Wood SN, Ndira E, *et al.* Sexual violence among adolescent girls and young women in Malawi: a cluster-randomized controlled implementation trial of empowerment self-defense training. *BMC Public Health* 2018;18:1341.
- 51 Doyle K, Levitov RG, Barker G, *et al.* Gender-transformative Bandedero couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: findings from a randomized controlled trial. *PLoS One* 2018;13:e0192756.
- 52 Green EP, Blattman C, Jamison J, *et al.* Women's entrepreneurship and intimate partner violence: a cluster randomized trial of microenterprise assistance and partner participation in post-conflict Uganda (SSM-D-14-01580R1). *Soc Sci Med* 2015;133:177–88.
- 53 Hossain M, Zimmerman C, Kiss L, *et al.* Working with men to prevent intimate partner violence in a conflict-affected setting: a pilot cluster randomized controlled trial in rural Côte d'Ivoire. *BMC Public Health* 2014;14:339.
- 54 Jones D, Peltzer K, Weiss SM, *et al.* Implementing comprehensive prevention of mother-to-child transmission and HIV prevention for South African couples: study protocol for a randomized controlled trial. *Trials* 2014;15:417.
- 55 Krishnan S, Subbiah K, Chandra P, *et al.* Minimizing risks and monitoring safety of an antenatal care intervention to mitigate domestic violence among young Indian women: the Dil Mil trial. *BMC Public Health* 2012;12:943.
- 56 Maman S, Mulawa MI, Balvanz P, *et al.* Results from a cluster-randomized trial to evaluate a microfinance and peer health leadership intervention to prevent HIV and intimate partner violence among social networks of Tanzanian men. *PLoS One* 2020;15:e0230371.

- 57 Manyapelo T, Van den Borne B, Ruiters RAC, *et al.* Effectiveness of a health behavioural intervention aimed at reduction of risky sexual behaviours among young men in the KwaZulu-Natal Province, South Africa. *Int J Environ Res Public Health* 2019;16:16.
- 58 Pallitto C, Garcia-Moreno C, Stöckel H, *et al.* Testing a counselling intervention in antenatal care for women experiencing partner violence: a study protocol for a randomized controlled trial in Johannesburg, South Africa. *BMC Health Serv Res* 2016;16:630.
- 59 Raj A, Saggurti N, Battala M, *et al.* Randomized controlled trial to test the RHANI wives HIV intervention for women in India at risk for HIV from husbands. *AIDS Behav* 2013;17:3066–80.
- 60 Saggurti N, Nair S, Silverman JG, *et al.* Impact of the RHANI wives intervention on marital conflict and sexual coercion. *Int J Gynaecol Obstet* 2014;126:18–22.
- 61 Sarnquist C, Omondi B, Sinclair J, *et al.* Rape prevention through empowerment of adolescent girls. *Pediatrics* 2014;133:e1226–32.
- 62 Sarnquist C, Kang JL, Amuyunzu-Nyamongo M, *et al.* A protocol for a cluster-randomized controlled trial testing an empowerment intervention to prevent sexual assault in upper primary school adolescents in the informal settlements of Nairobi, Kenya. *BMC Public Health* 2019;19:834.
- 63 Schuler SR, Nanda G, Ramirez LF, *et al.* Interactive workshops to promote gender equity and family planning in rural communities of Guatemala: results of a community randomized study. *J Biosoc Sci* 2015;47:667–86.
- 64 Smith Fawzi MC, Siril H, Larson E, *et al.* Healthy options: study protocol and baseline characteristics for a cluster randomized controlled trial of group psychotherapy for perinatal women living with HIV and depression in Tanzania. *BMC Public Health* 2020;20:80.
- 65 Speizer IS, Zule WA, Carney T, *et al.* Changing sex risk behaviors, gender norms, and relationship dynamics among couples in Cape town, South Africa: efficacy of an intervention on the dyad. *Soc Sci Med* 2018;209:95–103.
- 66 Taylor M, Jinabhai C, Dlamini S, *et al.* Effects of a teenage pregnancy prevention program in KwaZulu-Natal, South Africa. *Health Care Women Int* 2014;35:845–58.
- 67 Wechsberg WM, Luseno WK, Lam WKK, *et al.* Substance use, sexual risk, and violence: HIV prevention intervention with sex workers in Pretoria. *AIDS Behav* 2006;10:131–7.
- 68 Wechsberg WM, Krupitsky E, Romanova T, *et al.* Double jeopardy—drug and sex risks among Russian women who inject drugs: initial feasibility and efficacy results of a small randomized controlled trial. *Subst Abuse Treat Prev Policy* 2012;7:1.
- 69 Yore J, Dasgupta A, Ghule M, *et al.* CHARM, a gender equity and family planning intervention for men and couples in rural India: protocol for the cluster randomized controlled trial evaluation. *Reprod Health* 2016;13:14.
- 70 Peltzer K, Simbayi L, Banyini M, *et al.* HIV risk reduction intervention among medically circumcised young men in South Africa: a randomized controlled trial. *Int J Behav Med* 2012;19:336–41.
- 71 Schwandt HM, Underwood C. Engaging school personnel in making schools safe for girls in Botswana, Malawi, and Mozambique. *Int J Educ Dev* 2016;46:53–8.
- 72 van den Berg W, Hendricks L, Hatcher A, *et al.* 'One man can': shifts in fatherhood beliefs and parenting practices following a gender-transformative programme in eastern Cape, South Africa. *Gen Dev* 2013;21:111–25.
- 73 Harvey S, Lees S, Mshana G, *et al.* A cluster randomized controlled trial to assess the impact on intimate partner violence of a 10-session participatory gender training curriculum delivered to women taking part in a group-based microfinance loan scheme in Tanzania (MAISHA CRT01): study protocol. *BMC Womens Health* 2018;18:55.
- 74 Jemmott JB, O'Leary A, Jemmott LS, *et al.* Effect of a behavioral intervention on Perpetrating and experiencing forced sex among South African adolescents: a secondary analysis of a cluster randomized trial. *JAMA Netw Open* 2018;1:e181213.
- 75 Stern E, Niyibizi LL. Shifting perceptions of consequences of IPV among beneficiaries of Indashyikirwa: an IPV prevention program in Rwanda. *J Interpers Violence* 2018;33:1778–804.
- 76 Krishnan S, Subbiah K, Khanum S, *et al.* An intergenerational women's empowerment intervention to mitigate domestic violence: results of a pilot study in Bengaluru, India. *Violence Against Women* 2012;18:346–70.
- 77 Muthengi E, Austrian K. Cluster randomized evaluation of the Nla project: study protocol. *Reprod Health* 2018;29:15:218.
- 78 Baiocchi M, Omondi B, Langat N, *et al.* A Behavior-Based intervention that prevents sexual assault: the results of a Matched-Pairs, cluster-randomized study in Nairobi, Kenya. *Prev Sci* 2017;18:818–27.
- 79 Hoang T-A, Quach TT, Tran TT. 'Because I am a man, I should be gentle to my wife and my children': positive masculinity to stop gender-based violence in a coastal district in Vietnam. *Gender & Development* 2013;21:81–96.
- 80 Aaro LE, Mathews C, Kaaya S, *et al.* Promoting sexual and reproductive health among adolescents in southern and eastern Africa (prepare): project design and conceptual framework. *BMC Public Health* 2014;14:54.
- 81 Newmann SJ, Rocca CH, Zakaras JM, *et al.* Does integrating family planning into HIV services improve gender equitable attitudes? results from a cluster randomized trial in Nyanza, Kenya. *AIDS Behav* 2016;20:1883–92.
- 82 Ssewamala FM, Bermudez LG, Neilands TB, *et al.* Suubi4Her: a study protocol to examine the impact and cost associated with a combination intervention to prevent HIV risk behavior and improve mental health functioning among adolescent girls in Uganda. *BMC Public Health* 2018;18:693.
- 83 Andersson N, Cockcroft A, Thabane L, *et al.* HIV prevention in favour of the choice-disabled in southern Africa: study protocol for a randomised controlled trial. *Trials* 2013;14:274.
- 84 Shaikh S, Mburu G, Arumugam V, *et al.* Empowering communities and strengthening systems to improve transgender health: outcomes from the Pehchan programme in India. *J Int AIDS Soc* 2016;19:20809.
- 85 Butler N, Johnson G, Chiweza A, *et al.* A strategic approach to social accountability: Bwalo forums within the reproductive maternal and child health accountability ecosystem in Malawi. *BMC Health Serv Res* 2020;20:1–16.
- 86 Gullo S, Galavotti C, Sebert Kuhlmann A, *et al.* Effects of a social accountability approach, care's community score card, on reproductive health-related outcomes in Malawi: a cluster-randomized controlled evaluation. *PLoS One* 2017;12:e0171316.
- 87 Mafuta EM, Dieleman MA, Essink L, *et al.* Participatory approach to design social accountability interventions to improve maternal health services: a case study from the Democratic Republic of the Congo. *Glob Health Res Policy* 2017;2:1–16.
- 88 Steyn PS, Boydell V, Cordero JP, *et al.* Rationale and design of a complex intervention measuring the impact and processes of social accountability applied to contraceptive programming: CaPSAI project. *Gates Open Res* 2020;4:26.
- 89 Fabbri C, Dutt V, Shukla V, *et al.* The effect of report cards on the coverage of maternal and neonatal health care: a factorial, cluster-randomised controlled trial in Uttar Pradesh, India. *Lancet Glob Health* 2019;7:e1097–108.
- 90 Falb KL, Tanner S, Ward L, *et al.* Creating opportunities through mentorship, parental involvement, and safe spaces (COMPASS) program: multi-country study protocol to protect girls from violence in humanitarian settings. *BMC Public Health* 2016;16:231.
- 91 Kerrigan D, Mbwambo J, Likindikoki S, *et al.* Project Shikamana: community Empowerment-Based combination HIV prevention significantly impacts HIV incidence and care continuum outcomes among female sex workers in Iringa, Tanzania. *J Acquir Immune Defic Syndr* 2019;82:141–8.
- 92 Walton A, Kestler E, Dettinger JC, *et al.* Impact of a low-technology simulation-based obstetric and newborn care training scheme on non-emergency delivery practices in Guatemala. *Int J Gynaecol Obstet* 2016;132:359–64.
- 93 Abramsky T, Devries K, Kiss L, *et al.* A community mobilisation intervention to prevent violence against women and reduce HIV/AIDS risk in Kampala, Uganda (the Sasa! study): study protocol for a cluster randomised controlled trial. *Trials* 2012;13:96.
- 94 Lippman SA, Pettifor A, Rebombo D, *et al.* Evaluation of the Tsima community mobilization intervention to improve engagement in HIV testing and care in South Africa: study protocol for a cluster randomized trial. *Implement Sci* 2017;12:9.
- 95 Wagman JA, Namatovu F, Nalugoda F, *et al.* A public health approach to intimate partner violence prevention in Uganda: the share project. *Violence Against Women* 2012;18:1390–412.
- 96 Devries KM, Knight L, Allen E, *et al.* Does the good schools toolkit reduce physical, sexual and emotional violence, and injuries, in girls and boys equally? A cluster-randomised controlled trial. *Prev Sci* 2017;18:839–53.
- 97 Al Mamun M, Parvin K, Yu M, *et al.* The HERrespect intervention to address violence against female garment workers in Bangladesh: study protocol for a quasi-experimental trial. *BMC Public Health* 2018;18:512.
- 98 Tripathy P, Nair N, Mahapatra R, *et al.* Community mobilisation with women's groups facilitated by accredited social health activists (ASHAs) to improve maternal and newborn health in underserved

- areas of Jharkhand and Orissa: study protocol for a cluster-randomised controlled trial. *Trials* 2011;12:182.
- 99 Settergren SK, Mujaya S, Rida W, *et al*. Cluster randomized trial of comprehensive gender-based violence programming delivered through the HIV/AIDS program platform in Mbeya region, Tanzania: Tathmini GBV study. *PLoS One* 2018;13:e0206074.
- 100 Beattie TS, Isac S, Bhattacharjee P, *et al*. Reducing violence and increasing condom use in the intimate partnerships of female sex workers: study protocol for Samvedana plus, a cluster randomised controlled trial in Karnataka state, South India. *BMC Public Health* 2016;16:660.
- 101 Grilo Diniz CS, Rattner D, Lucas d'Oliveira AFP, *et al*. Disrespect and abuse in childbirth in Brazil: social activism, public policies and providers' training. *Reprod Health Matters* 2018;26:19–35.
- 102 Warren CE, Ndwiga C, Sripad P, *et al*. Sowing the seeds of transformative practice to actualize women's rights to respectful maternity care: reflections from Kenya using the consolidated framework for implementation research. *BMC Womens Health* 2017;17:69.
- 103 Saggurti N, Atmavilas Y, Porwal A, *et al*. Effect of health intervention integration within women's self-help groups on collectivization and healthy practices around reproductive, maternal, neonatal and child health in rural India. *PLoS One* 2018;13:e0202562.
- 104 Austad K, Chary A, Martinez B, *et al*. Obstetric care navigation: a new approach to promote respectful maternity care and overcome barriers to safe motherhood. *Reprod Health* 2017;14:148.
- 105 Woelk GB, Kieffer MP, Walker D, *et al*. Evaluating the effectiveness of selected community-level interventions on key maternal, child health, and prevention of mother-to-child transmission of HIV outcomes in three countries (the ACCLAIM project): a study protocol for a randomized controlled trial. *Trials* 2016;17:88.
- 106 Bapolisi WA, Ferrari G, Blampain C, *et al*. Impact of a complex gender-transformative intervention on maternal and child health outcomes in the eastern Democratic Republic of Congo: protocol of a longitudinal parallel mixed-methods study. *BMC Public Health* 2020;20:51.
- 107 Lippman SA, Neilands TB, MacPhail C, *et al*. Community mobilization for HIV testing uptake: results from a community randomized trial of a Theory-Based intervention in rural South Africa. *J Acquir Immune Defic Syndr* 2017;74 Suppl 1:S44–51.
- 108 MacDonald L, Jones L, Thomas P, *et al*. Promoting male involvement in family planning in Vietnam and India: HealthBridge experience. *Gender & Development* 2013;21:31–45.
- 109 More NS, Das S, Bapat U, *et al*. Community resource centres to improve the health of women and children in informal settlements in Mumbai: a cluster-randomised, controlled trial. *Lancet Glob Health* 2017;5:e335–49.
- 110 Beattie TS, Bhattacharjee P, Isac S, *et al*. Supporting adolescent girls to stay in school, reduce child marriage and reduce entry into sex work as HIV risk prevention in North Karnataka, India: protocol for a cluster randomised controlled trial. *BMC Public Health* 2015;15:292.
- 111 Chatterji S, Stern E, Dunkle K, *et al*. Community activism as a strategy to reduce intimate partner violence (IPV) in rural Rwanda: results of a community randomised trial. *J Glob Health* 2020;10:010406.
- 112 Das M, Verma R, Ghosh S, *et al*. Community mentors as coaches: transforming gender norms through cricket among adolescent males in urban India. *Gender & Development* 2015;23:61–75.
- 113 Pettifor A, Lippman SA, Selin AM, *et al*. A cluster randomized-controlled trial of a community mobilization intervention to change gender norms and reduce HIV risk in rural South Africa: study design and intervention. *BMC Public Health* 2015;15:752.
- 114 Wagman JA, Gray RH, Campbell JC, *et al*. Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort. *Lancet Glob Health* 2015;3:e23–33.
- 115 Jewkes R, Nduna M, Levin J, *et al*. A cluster randomized-controlled trial to determine the effectiveness of stepping stones in preventing HIV infections and promoting safer sexual behaviour amongst youth in the rural eastern Cape, South Africa: trial design, methods and baseline findings. *Trop Med Int Health* 2006;11:3–16.
- 116 Abramsky T, Devries K, Kiss L, *et al*. Findings from the Sasa! study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda. *BMC Med* 2014;12:122.
- 117 Gibbs A, Corboz J, Shafiq M, *et al*. An individually randomized controlled trial to determine the effectiveness of the women for women international programme in reducing intimate partner violence and strengthening livelihoods amongst women in Afghanistan: trial design, methods and baseline findings. *BMC Public Health* 2018;18:164.
- 118 Kajula L, Balvanz P, Kilonzo MN, *et al*. Vijana Vijiweni II: a cluster-randomized trial to evaluate the efficacy of a microfinance and peer health leadership intervention for HIV and intimate partner violence prevention among social networks of young men in Dar ES Salaam. *BMC Public Health* 2016;16:113.
- 119 Kyegombe N, Abramsky T, Devries KM, *et al*. The impact of Sasa!, a community mobilization intervention, on reported HIV-related risk behaviours and relationship dynamics in Kampala, Uganda. *J Int AIDS Soc* 2014;17:19232.
- 120 Mmbaga EJ, Kajula L, Aaro LE, *et al*. Effect of the prepare intervention on sexual initiation and condom use among adolescents aged 12–14: a cluster randomised controlled trial in Dar ES Salaam, Tanzania. *BMC Public Health* 2017;17:322.
- 121 Mueller V, Peterman A, Billings L, *et al*. Exploring impacts of community-based legal aid on Intra-household gender relations in Tanzania. *Fem Econ* 2019;25:116–45.
- 122 Creel AH, Rimal RN, Mkandawire G, *et al*. Effects of a mass media intervention on HIV-related stigma: 'Radio Diaries' program in Malawi. *Health Educ Res* 2011;26:456–65.
- 123 Halim N, Steven Mzilangwe E, Reich N, *et al*. Together to end violence against women in Tanzania: results of a pilot cluster randomized controlled trial to evaluate preliminary effectiveness of interpersonal and community level interventions to address intimate partner violence. *Glob Public Health* 2019;14:1653–68.
- 124 Kapadia-Kundu N, Storey D, Safi B, *et al*. Seeds of prevention: the impact on health behaviors of young adolescent girls in Uttar Pradesh, India, a cluster randomized control trial. *Soc Sci Med* 2014;120:169–79.
- 125 Christofides NJ, Hatcher AM, Pino A. A cluster randomised controlled trial to determine the effect of community mobilisation and advocacy on men's use of violence in periurban South Africa: study protocol. *BMJ Open* 2018;23:e017579.
- 126 Prakash R, Beattie TS, Javalkar P, *et al*. The Samata intervention to increase secondary school completion and reduce child marriage among adolescent girls: results from a cluster-randomised control trial in India. *J Glob Health* 2019;9:010430.
- 127 Odallo B, Opondo E, Onyango M. Litigating to ensure access to quality maternal health care for women and girls in Kenya. *Reprod Health Matters* 2018;26:123–9.
- 128 Shiffman J, Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *Lancet* 2007;370:1370–9.
- 129 Aston T, Roche C, Schaaf M. Monitoring and evaluation for thinking and working politically. *Evaluation* 2021;13563890211053028.
- 130 Sriram V, Topp SM, Schaaf M, *et al*. 10 best resources on power in health policy and systems in low- and middle-income countries. *Health Policy Plan* 2018;33:611–21.
- 131 Heymann J, Levy JK, Bose B, *et al*. Improving health with programmatic, legal, and policy approaches to reduce gender inequality and change restrictive gender norms. *Lancet* 2019;393:2522–34.
- 132 Mandal M, Muralidharan A, Pappa S. A review of measures of women's empowerment and related gender constructs in family planning and maternal health program evaluations in low- and middle-income countries. *BMC Pregnancy Childbirth* 2017;17:342.
- 133 Salam RA, Faqqah A, Sajjad N, *et al*. Improving adolescent sexual and reproductive health: a systematic review of potential interventions. *J Adolesc Health* 2016;59:S11–28.
- 134 Schaaf M, Cant S, Cordero J, *et al*. Unpacking power dynamics in research and evaluation on social accountability for sexual and reproductive health and rights. *Int J Equity Health* 2021;20:1–6.
- 135 Semahegn A, Torpey K, Manu A, *et al*. Are interventions focused on gender-norms effective in preventing domestic violence against women in low and lower-middle income countries? A systematic review and meta-analysis. *Reprod Health* 2019;16:93.
- 136 Shahmanesh M, Patel V, Mabey D, *et al*. Effectiveness of interventions for the prevention of HIV and other sexually transmitted infections in female sex workers in resource poor setting: a systematic review. *Trop Med Int Health* 2008;13:659–79.
- 137 Taft A, Small R. Preventing and reducing violence against women: innovation in community-level studies. *BMC Med* 2014;12:155.
- 138 Barbrook-Johnson P, Castellani B, Hills D, *et al*. Policy evaluation for a complex world: practical methods and reflections from the UK centre for the evaluation of complexity across the nexus. *Evaluation* 2021;27:4–17.
- 139 Hartmann M, Khosla R, Krishnan S, *et al*. How are gender equality and human rights interventions included in sexual and reproductive health programmes and policies: a systematic review of existing research foci and gaps. *PLoS One* 2016;11:e0167542.

- 140 Bukenya B. From social accountability to a new social contract? the role of NGOs in protecting and empowering PLHIV in Uganda. *J Dev Stud* 2016;52:1162–76.
- 141 Committee on Economic, Social and Cultural Rights. General Comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International covenant on economic, social and cultural rights) United nations. Available: <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuW1a0Szab0oXTdlmn sJZZVQfQejF41Tob4CvjJeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7 N8TLm%2BP3HJPzjHySkUoHMavD%2Fpyfcp3Ylzig> [Accessed Jun 2021].
- 142 Chandra-Mouli V, Ferguson BJ, Plesons M, *et al.* The Political, Research, Programmatic, and Social Responses to Adolescent Sexual and Reproductive Health and Rights in the 25 Years Since the International Conference on Population and Development. *J Adolesc Health* 2019;65:S16–40.
- 143 Starrs AM, Ezeh AC, Barker G, *et al.* Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *The Lancet* 2018;391:2642–92.
- 144 Ravindran TKS, Govender V. Sexual and reproductive health services in universal health coverage: a review of recent evidence from low- and middle-income countries. *Sex Reprod Health Matters* 2020;28:1779632.
- 145 McDonough A, Rodríguez DC. How donors support civil society as government accountability advocates: a review of strategies and implications for transition of donor funding in global health. *Global Health* 2020;16:110.
- 146 Cole MS, Boydell V, Hardee K, *et al.* The extent to which performance-based financing programs' operations Manuals reflect Rights-Based principles: implications for family planning services. *Glob Health Sci Pract* 2019;7:329–39.
- 147 Cottingham J. Historical note: how bringing women's health advocacy groups to who helped change the research agenda. *Reprod Health Matters* 2015;23:12–20.
- 148 Schaaf M, Kapilashrami A, George A, *et al.* Unmasking power as foundational to research on sexual and reproductive health and rights. *BMJ Glob Health* 2021;6:e005482.
- 149 McGovern T, Schaaf M, Battistini E, *et al.* From bad to worse: global governance of abortion and the global Gag rule. *Sex Reprod Health Matters* 2020;28:54–63.
- 150 Abimbola S. On the meaning of global health and the role of global health journals. *Int Health* 2018;10:63–5.
- 151 Pettifor A, Lippman SA, Gottert A, *et al.* Community mobilization to modify harmful gender norms and reduce HIV risk: results from a community cluster randomized trial in South Africa. *J Int AIDS Soc* 2018;21:e25134.
- 152 Gupta J, Falb KL, Lehmann H, *et al.* Gender norms and economic empowerment intervention to reduce intimate partner violence against women in rural Côte d'Ivoire: a randomized controlled pilot study. *BMC Int Health Hum Rights* 2013;13:46.
- 153 Iyer A, Sen G, Sreevathsa A. Deciphering Rashomon: an approach to verbal autopsies of maternal deaths. *Glob Public Health* 2013;8:389–404.

| Study Author(s) | Title | Country | Individual, interpersonal | Organizational | Community | Public Policy/governance | Theory* | SRH domain |
|--|--|-----------------------------|---------------------------|----------------|-----------|--------------------------|---|------------------------|
| ·Yore, Dasgupta, Ghule, et al. ·Fleming, Silverman, Ghule, et al. | ·CHARM, a gender equity and family planning intervention for men and couples in rural India: protocol for the cluster randomized controlled trial evaluation ·Can a Gender Equity and Family Planning Intervention for Men change men's gender ideology?: Results from the CHARM cluster randomized controlled trial in rural India | India | √ | | | | Existing public health evidence base | HIV and contraception |
| Woelk, Kieffer, Walker et al. | Evaluating the effectiveness of selected community-level interventions on key maternal, child health, and prevention of mother-to-child transmission of HIV outcomes in three countries (the ACCLAIM Project): a study protocol for a randomized controlled trial | Swaziland, Uganda, Zimbabwe | √ | | √ | | Existing public health evidence base | HIV |
| Wingood, Reddy, Lang et al. | Efficacy of SISTA South Africa on sexual behavior, HIV stigma and relationship control among isiXhosa women in the Western Cape Province, South Africa: Results of a Randomized Controlled Trial | South Africa | √ | | | | Adaptation of a well documented intervention from the US that was based on Social Cognitive Theory and the Theory of Gender and Power | HIV and IPV prevention |
| Wechsberg, Krupitsky, and Romanova et al. | Double jeopardy—drug and sex risks among Russian women who inject drugs: initial feasibility and efficacy results of a small randomized controlled trial | Russia | √ | | | | Adaptation of a well documented intervention from the US that was based on Empowerment Theory and Social Cognitive Theory | HIV prevention |

| | | | | | | | | |
|--|--|--------------|---|---|---|---|--|---|
| Wechsberg, Luseno, and Lam et al. | Substance Use, Sexual Risk, and Violence: HIV Prevention Intervention with Sex Workers in Pretoria | South Africa | √ | | | | Adaptation of a well documented intervention from the US that was based on Empowerment Theory and Social Cognitive Theory | HIV and IPV prevention |
| Walton, Kestler, Dettinger, et al. | Impact of a low-technology simulation-based obstetric and newborn care training scheme on non-emergency delivery practices in Guatemala | Guatemala | √ | √ | | | Based on pilot project from Mexico | Respectful maternity care |
| Wagman, Namatovu, Kiwanuka et al Wagman, Gray, Campbell, et al. | A Public Health Approach to Intimate Partner Violence Prevention in Uganda: The SHARE Project Effectiveness of an integrated intimate partner violence and HIV prevention intervention in Rakai, Uganda: analysis of an intervention in an existing cluster randomised cohort | Uganda | √ | √ | √ | √ | the Transtheoretical Model (TTM) of behavior change used to design the intervention, as was the existing public health evidence base | IPV and other violence prevention and/or support |
| van den Berg, Hendricks, Hatcher, et al. | One Man Can': shifts in fatherhood beliefs and parenting practices following a gender-transformative programme in Eastern Cape, South Africa | South Africa | | | | √ | Existing public health evidence base | HIV prevention and IPV and/or other violence prevention and support |
| Tripathy, Nair, Sinha, et al. Tripathy, Nair, Mahapatra et al. | Effect of participatory women's groups facilitated by Accredited Social Health Activists on birth outcomes in rural eastern India: a cluster-randomised controlled trial Community mobilisation with women's groups facilitated by Accredited Social Health Activists (ASHAs) to improve maternal and newborn health in underserved areas of Jharkhand and Orissa: study protocol for a cluster-randomised controlled trial | India | √ | √ | √ | | Followed principles of participatory learning and action | Maternal and newborn health |
| Taylor, Jinabhai, Dlamini et al. | Effects of a Teenage Pregnancy Prevention Program in KwaZulu-Natal, South Africa | South Africa | √ | | | | I-Change Model | Teen pregnancy prevention |

| | | | | | | | | |
|--|---|--------------|---|---|---|---|---|--|
| Stern and Niyibizi | Shifting perceptions of consequences of IPV among beneficiaries of Indashyikirwa: An IPV prevention programme in Rwanda | Rwanda | √ | | √ | √ | Paolo Friere's conscientization | IPV and/or other violence prevention and/or support |
| Starmann, Heise, Kyegombe et al. | Examining diffusion to understand the how of SASA!, a violence against women and HIV prevention intervention in Uganda | Uganda | | | √ | | Ecological model of violence | HIV and IPV prevention |
| Ssewamala, Bermudez, and Neilands et al. | Suubi4Her: a study protocol to examine the impact and cost associated with a combination intervention to prevent HIV risk behavior and improve mental health functioning among adolescent girls in Uganda | Uganda | √ | | | | Existing public health evidence base | HIV prevention and mental health |
| Speizera, Zuleb, and Carney, et al. | Changing sex risk behaviors, gender norms, and relationship dynamics among couples in Cape Town, South Africa: Efficacy of an intervention on the dyad | South Africa | √ | | | | Existing public health evidence base | HIV prevention |
| Fawzi, Siril, and Larson et al. | Healthy Options: study protocol and baseline characteristics for a cluster randomized controlled trial of group psychotherapy for perinatal women living with HIV and depression in Tanzania | Tanzania | √ | | | | Problem solving therapy, Cognitive behavioral therapy, existing public health evidence base | mental health |
| More, Das, Bapat et al. | Community resource centres to improve the health of women and children in Mumbai slums: study protocol for a cluster randomized controlled trial | India | √ | | √ | | Existing public health evidence base | IPV and/or other violence prevention and/or support; MCH |
| Settergren, Mujaya and Rida et al. | Cluster randomized trial of comprehensive gender-based violence programming delivered through the HIV/AIDS program platform in Mbeya Region, Tanzania: Tathmini GBV study | Tanzania | √ | √ | √ | | Socioecological approach to violence, building on SASA, Men As Partners, CoupleConnect | IPV and/or other violence prevention and/or support |

| | | | | | | | | |
|---|---|---------------------------------|---|--|---|--|---|--|
| Schwandt and Underwood | Engaging school personnel in making schools safe for girls in Botswana, Malawi, and Mozambique | Botswana, Malawi and Mozambique | ✓ | | ✓ | | Paulo Freire's conscientization | HIV prevention and IPV and/or other violence prevention and support |
| Schuler, Nanda, Ramirez and Chen | Interactive workshops to promote gender equity and family planning in rural communities in Guatemala: results of a community randomized study | Guatemala | ✓ | | | | Ecological framework of social and behaviour change communication (SBCC) and existing public health evidence base | MCH |
| Sarnquist, Omondi, Sinclair, et al. Sarnquist, Kang, and Amuyunzu-Nyamongo et al. | Rape Prevention Through Empowerment of Adolescent Girls -A protocol for a cluster-randomized controlled trial testing an empowerment intervention to prevent sexual assault in upper primary school adolescents in the informal settlements of Nairobi, Kenya | Kenya | ✓ | | | | social learning theory, health belief model, existing public health evidence base | IPV and/or other violence prevention and/or support |
| Sandøy, Mudenda, and Zulu et al. | Effectiveness of a girls' empowerment programme on early childbearing, marriage and school dropout among adolescent girls in rural Zambia: study protocol for a cluster randomized trial | Zambia | ✓ | | ✓ | | existing public health evidence base | HIV prevention; IPV and/or other violence prevention and/or support; teen pregnancy prevention |
| Saggurti, Nair, Silverman Raj, Saggurti, Battala, et al | Impact of the RHANI Wives intervention on marital conflict and sexual coercion -Randomized Controlled Trial to Test the RHANI Wives HIV Intervention for Women in India at Risk for HIV from Husbands | India | ✓ | | | | Social Cognitive Theory and the Theory of Gender and Power | IPV and/or other violence prevention and/or support |

| | | | | | | | | |
|--|--|--------------|---|---|---|---|---|---|
| Reza-Paul, Lorway, and O'Brien et al. | Sex worker-led structural interventions in India: a case study on addressing violence in HIV prevention through the Ashodaya Samithi collective in Mysore | India | √ | | √ | √ | community led response, not explicitly based on a theory | IPV and/or other violence prevention and/or support |
| Prakash, Beattie, Javalkar et al | The Samata intervention to increase secondary school completion and reduce child marriage among adolescent girls: results from a cluster randomised control trial in India | India | √ | | | √ | Theory of Change developed with stakeholders | child marriage |
| Pettifor, Lippman, and Selin et al. Pettifor, Lippman, Gottert et al. | A cluster randomized-controlled trial of a community mobilization intervention to change gender norms and reduce HIV risk in rural South Africa: study design and intervention Community mobilization to modify harmful gender norms and reduce HIV risk: results from a community cluster randomized trial in South Africa | South Africa | | | √ | | Existing public health evidence base | HIV prevention |
| Peltzer, Simbayi, Banyini and Kekana | HIV Risk Reduction Intervention Among Medically Circumcised Young Men in South Africa: A Randomized Controlled Trial | South Africa | √ | | | | Information–Motivation–Behavioural Skills Model | HIV prevention and IPV and/or other violence prevention and support |
| Pallitto, García-Moreno, Stöeck et al. | Testing a counselling intervention in antenatal care for women experiencing partner violence: a study protocol for a randomized controlled trial in Johannesburg, South Africa | South Africa | √ | | | | existing public health evidence base | IPV and other violence prevention and/or support |
| Newmann, Rocca, Zakaras et al. | Does Integrating Family Planning into HIV Services Improve Gender Equitable Attitudes? Results from a Cluster Randomized Trial in Nyanza, Kenya | Kenya | √ | | | | Nothing mentioned | contraception |
| Muthengi and Austrian | Cluster randomized evaluation of the Nia Project: study protocol | Kenya | | √ | | | Lloyd's typology of competencies | Adolescent SRH |
| Mueller, Peterman, Billings, and Wineman | Exploring impacts of community-based legal aid on intrahousehold gender relations in Tanzania | Tanzania | | | | √ | legal, institutional, and social learning or norms theories | IPV and other violence prevention and/or |

| | | | | | | | | |
|---|--|--------------------------------|---|--|---|---|--|---|
| | | | | | | | | support |
| Aarø, Mathews, Kaaya et al. Mmbaga, Kajula, Aarø et al. | ·Promoting sexual and reproductive health among adolescents in southern and eastern Africa (PREPARE): project design and conceptual framework ·Effect of the PREPARE intervention on sexual initiation and condom use among adolescents aged 12–14: a cluster randomised controlled trial in Dar es Salaam, Tanzania | South Africa, Uganda, Tanzania | √ | | √ | | existing public health evidence base, the SATZ project, which is based in part on social cognitive models. | Adolescent SRH |
| Menon and Allen | Community Organizing and Counter Narratives in the Response to Domestic Violence in India | India | √ | | √ | √ | Grabe and Dutt (2019) | IPV and/or other violence prevention and/or support |
| Miller, Das, Tancredi, et al. | Evaluation of a Gender-Based Violence Prevention Program for Student Athletes in Mumbai, India | India | | | √ | | Social Cognitive Theory | IPV and/or other violence prevention and/or support |
| Manyaapelo, Van den Borne, Ruiter | Effectiveness of a Health Behavioural Intervention Aimed at Reduction of Risky Sexual Behaviours among Young Men in the KwaZulu-Natal Province, South Africa | South Africa | √ | | | | Theory of Planned Behavior | HIV prevention |
| Maman, Mulawa, and Balvanz et al. | Results from a cluster-randomized trial to evaluate a microfinance and peer health leadership intervention to prevent HIV and intimate partner violence among social networks of Tanzanian men | Tanzania | √ | | | | Social network theory | HIV prevention and IPV and/or other violence prevention and support |
| MacDonald, Jones, Thomas et al. | Promoting male involvement in family planning in Vietnam and India: HealthBridge experience | Vietnam and India | | | √ | | Existing public health evidence base | HIV prevention and IPV and/or other violence prevention |

| | | | | | | | | |
|---|---|--------------|---|---|---|--|---|---|
| | | | | | | | | and support |
| -Lippman, Pettifor, Rebombo et al. -Lippman, Neilands, MacPhail, et al. | -Evaluation of the Tsima community mobilization intervention to improve engagement in HIV testing and care in South Africa: study protocol for a cluster randomized trial -Community Mobilization for HIV Testing Uptake: Results From a Community Randomized Trial of a Theory-Based Intervention in Rural South Africa | South Africa | √ | √ | √ | | Community mobilization theory | HIV prevention |
| -Krishnan, Subbiah, and Khanum et al. -Krishnan, Subbiah, Chandra and Srinivasan | -An Intergenerational Women's Empowerment Intervention to Mitigate Domestic Violence: Results of a Pilot Study in Bengaluru, India -Minimizing risks and monitoring safety of an antenatal care intervention to mitigate domestic violence among young Indian women: The Dil Mil trial | India | √ | | | | Social cognitive theory in combination with Heise's application of the social-ecological theory of behavior to violence against women | IPV and other violence prevention and/or support |
| Kerrigan, Mbwambo, Likindikoki, et al. | Project Shikamana: Community Empowerment-Based Combination HIV Prevention Significantly Impacts HIV Incidence and Care Continuum Outcomes Among Female Sex Workers in Iringa, Tanzania | Tanzania | √ | √ | | | Existing public health evidence base | HIV prevention |
| Kapadia-Kundu, Storey, Safi et al. | Seeds of prevention: The impact on health behaviors of young adolescent girls in Uttar Pradesh, India, a cluster randomized control trial | India | √ | | √ | | Existing public health evidence base particularly health belief models | Adolescent SRH |
| Kajula, Balvanz, Kilonzo et al. | Vijana Vijiweni II: a cluster-randomized trial to evaluate the efficacy of a microfinance and peer health leadership intervention for HIV and intimate partner violence prevention among social networks of young men in Dar es Salaam | Tanzania | √ | | √ | | IMAGE study | IPV and/or other violence prevention and/or support |

| | | | | | | | | |
|---|---|-------------------------|---|---|---|--|--|---|
| Jones, Peltzer, Weiss, et al. | Implementing comprehensive prevention of mother-to-child transmission and HIV prevention for South African couples: study protocol for a randomized controlled trial | South Africa | √ | | | | cognitive behavior theory | HIV prevention |
| Jewkes, Nduna, Levin, et al. Jewkes, Nduna, Levin et al. | Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial A cluster randomized-controlled trial to determine the effectiveness of Stepping Stones in preventing HIV infections and promoting safer sexual behaviour amongst youth in the rural Eastern Cape, South Africa: trial design, methods and baseline findings | South Africa | √ | | √ | | existing public health evidence base | HIV prevention |
| Jemmott, O'Leary, Jemmott, et al. | Effect of a Behavioral Intervention on Perpetrating and Experiencing Forced Sex Among South African Adolescents A Secondary Analysis of a Cluster Randomized Trial | South Africa | √ | | | | Social Cognitive Theory and the Theory of Planned Behavior | IPV and/or other violence prevention and/or support |
| Hossain, Zimmerman, Kiss et al. | Working with men to prevent intimate partner violence in a conflict-affected setting: a pilot cluster randomized controlled trial in rural Côte d'Ivoire | Cote d'Ivoire | √ | | | | Social norm theory | IPV and/or other violence prevention and/or support |
| Harvey, Lees, and Mshana et al. | A cluster randomized controlled trial to assess the impact on intimate partner violence of a 10-session participatory gender training curriculum delivered to women taking part in a group-based microfinance loan scheme in Tanzania (MAISHA CRT01): study protocol | Tanzania | √ | | | | IMAGE | IPV and/or other violence prevention and/or support |
| Hargreaves, Stangl, Bond, et al. | HIV-related stigma and universal testing and treatment for HIV prevention and care: design of an implementation science evaluation nested in the HPTN 071 (PopART) cluster-randomized trial in Zambia and South Africa | Zambia and South Africa | | √ | √ | | Link and Phelan's theories of the social determinants of health building on Goffman's theory of stigma | HIV prevention |
| Gupta, Falb, and Lehmann, et al. | Gender norms and economic empowerment intervention to reduce intimate partner violence against women in rural Côte d'Ivoire: a randomized controlled pilot study | Cote d'Ivoire | √ | | | | Existing public health evidence base | IPV and/or other violence prevention |

| | | | | | | | | |
|-------------------------------------|---|---------------|---|---|---|---|---|---|
| | | | | | | | | and/or support |
| Green, Blattman, Jamison, and Annan | Women's entrepreneurship and intimate partner violence: A cluster randomized trial of microenterprise assistance and partner participation in post-conflict Uganda | Uganda | √ | | | | existing public health evidence base | IPV and/or other violence prevention and/or support |
| Govender and Edwards | Appreciative inquiry into lifeskills-based HIV/AIDS education in South African schools | South Africa | √ | | | | Nothing mentioned | HIV prevention |
| Gooptu and Bandyopadhyay | "Rights to Stop the Wrong": Cultural Change and Collective Mobilization—The Case of Kolkata Sex Workers | India | √ | | √ | √ | driven by local NGOs, iterative approach | SRHR |
| Gibbs, Corboz, Shafiq, et al. | An individually randomized controlled trial to determine the effectiveness of the Women for Women International Programme in reducing intimate partner violence and strengthening livelihoods amongst women in Afghanistan: trial design, methods and baseline findings | Afghanistan | √ | | √ | | Developed by NGOs, developed over several learning cycles and several implementation contexts | IPV and/or other violence prevention and/or support |
| Falb, Tanner, Ward, et al. | Creating opportunities through mentorship, parental involvement, and safe spaces (COMPASS) program: multi-country study protocol to protect girls from violence in humanitarian settings | DRC, Ethiopia | √ | √ | √ | | Existing public health evidence base | IPV and/or other violence prevention and/or support |
| Fabbri, Dutt, Shukla, et al. | The effect of report cards on the coverage of maternal and neonatal health care: a factorial, cluster-randomised controlled trial in Uttar Pradesh, India | India | | √ | √ | | existing public health evidence base | MCH |
| Doyle, Levto, Barker, et al. | Gender-transformative Bandebereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial | Rwanda | √ | | | | sociological theories of gender and masculinities | IPV and/or other violence prevention and/or support |

| | | | | | | | | |
|---|---|--------------|---|---|---|---|--|---|
| Devries, Knigh, Allen et al. | Does the Good Schools Toolkit Reduce Physical, Sexual and Emotional Violence, and Injuries, in Girls and Boys equally? A Cluster-Randomised Controlled Trial | Uganda | √ | √ | | | transtheoretical model | IPV and/or other violence prevention and/or support |
| Decker, Wood, Ndinda, et al. | Sexual violence among adolescent girls and young women in Malawi: a cluster-randomized controlled implementation trial of empowerment self-defense training | Malawi | √ | | | | Empowerment self defense | IPV and/or other violence prevention and/or support |
| Creel, Rimal, Mkandawire, et al. | Effects of a mass media intervention on HIV-related stigma: 'Radio Diaries' program in Malawi | Malawi | | | √ | | Existing public health evidence base | HIV prevention |
| Clark, Spencer, Shrestha et al. McGhee, Shrestha, Ferguson, et al. | Evaluating a multicomponent social behaviour change communication strategy to reduce intimate partner violence among married couples: study protocol for a cluster randomized trial in Nepal "Change Really Does Need to Start From Home": Impact of an Intimate Partner Violence Prevention Strategy Among Married Couples in Nepal | Nepal | √ | | √ | | The Socio-Ecological Model, the Steps to Behaviour Change Framework, and the Integrative Model of Behaviour Prediction | IPV and/or other violence prevention and/or support |
| Christofides, Hatcher, Pino, et al. | A cluster randomised controlled trial to determine the effect of community mobilisation and advocacy on men's use of violence in periurban South Africa: study protocol | South Africa | √ | | √ | √ | existing public health evidence base | IPV and/or other violence prevention and/or support |
| Chatterji, Stern, Dunkle, and Heise | Community activism as a strategy to reduce intimate partner violence (IPV) in rural Rwanda: Results of a community randomised trial | Rwanda | | | √ | | based on SASA | IPV and/or other violence prevention and/or support |

| | | | | | | | | |
|---|--|----------------------------------|---|---|---|---|---|---|
| -Beattie, Isac, Bhattacharjee, et al. -Javalkar, Platt, Prakas et al. | -Reducing violence and increasing condom use in the intimate partnerships of female sex workers: study protocol for Samvedana Plus, a cluster randomised controlled trial in Karnataka state, south India -Effectiveness of a multilevel intervention to reduce violence and increase condom use in intimate partnerships among female sex workers: cluster randomised controlled trial in Karnataka, India | India | √ | √ | √ | | based on Stepping Stones | HIV prevention and IPV and/or other violence prevention and support |
| -Beattie, Bhattacharjee, Isac et al. -Prakash, Beattie, Javalkar, et al. | -Supporting adolescent girls to stay in school, reduce child marriage and reduce entry into sex work as HIV risk prevention in north Karnataka, India: protocol for a cluster randomised controlled trial -The Samata intervention to increase secondary school completion and reduce child marriage among adolescent girls: results from a cluster-randomised control trial in India | India | √ | √ | √ | √ | existing public health evidence base | HIV prevention and child marriage |
| Bapolisi, Ferrari, Blampain et al. | Impact of a complex gender-transformative intervention on maternal and child health outcomes in the eastern Democratic Republic of Congo: protocol of a longitudinal parallel mixed-methods study | DRC, Ethiopia | √ | | √ | | Existing public health evidence base | MCH |
| Baiocchi, Omondi, Langat et al. | A Behavior-Based Intervention That Prevents Sexual Assault: The Results of a Matched-Pairs, Cluster-Randomized Study in Nairobi, Kenya | Kenya | √ | | | | Social Learning Theory, and Health Belief Model, existing public health evidence base | IPV and/or other violence prevention and/or support |
| Andersson, Cockcroft, Thabane, et al. | HIV prevention in favour of the choice-disabled in southern Africa: study protocol for a randomised controlled trial | Botswana, Namibia, and Swaziland | | | √ | √ | existing public health evidence base | HIV prevention |
| Alhassan, Nketiah-Amponsah, Ayanore, et al. | Impact of a bottom-up community engagement intervention on maternal and child health services utilization in Ghana: a cluster randomised trial | Ghana | | | √ | √ | Not specified | MCH |
| Mamun, Parvin, Yu, et al. | The HER respect intervention to address violence against female garment workers in Bangladesh: study protocol for a quasi-experimental trial | Bangladesh | √ | √ | √ | | Freirian conscientization; Stepping Stones | IPV and/or other violence prevention and/or |

| | | | | | | | | |
|---|---|----------|---|---|---|---|---|--|
| | | | | | | | | support |
| <p>·Abramsky, Devries, Kiss, et al.</p> <p>·Abramsky, Devries, Kiss et al.</p> <p>·Abramsky, Devries, Michau et al.</p> <p>Kyegombe, Abramsky, and Devries et al.</p> | <p>·A community mobilisation intervention to prevent violence against women and reduce HIV/AIDS risk in Kampala, Uganda (the SASA! Study): study protocol for a cluster randomised controlled trial</p> <p>·Findings from the SASA! Study: a cluster randomized controlled trial to assess the impact of a community mobilization intervention to prevent violence against women and reduce HIV risk in Kampala, Uganda</p> <p>·Ecological pathways to prevention: How does the SASA! community mobilisation model work to prevent physical intimate partner violence against women?</p> <p>·The impact of SASA!, a community mobilization intervention, on reported HIV-related risk behaviours and relationship dynamics in Kampala, Uganda</p> | Uganda | √ | √ | √ | | Informed by IMAGE, Stepping Stones, Promundo, Stages of Change Theory | HIV prevention and prevention and/or support for IPV and/or other violence |
| Hoang, Quach, Tran et al. | 'Because I am a man, I should be gentle to my wife and my children': positive masculinity to stop gender-based violence in a coastal district in Vietnam | Vietnam | √ | | | | Theories of masculinity | IPV and other violence prevention and/or support |
| Das, Verma, Ghosh, et al. | Community mentors as coaches: transforming gender norms through cricket among adolescent males in urban India | India | √ | | √ | | existing public health evidence base | gender norms |
| Chatterjee | ActionAid's Young Urban Women programme in urban India: taking an intersectional approach to decent work, unpaid care, and sexual and reproductive health and rights | India | √ | | √ | √ | existing public health evidence base, Power Cube | MCH |
| Halim, Mzilangwe, Reich, et al. | Together to end violence against women in Tanzania: Results of a pilot cluster randomized controlled trial to evaluate preliminary effectiveness of interpersonal and community level interventions to address intimate partner violence | Tanzania | √ | | √ | | Socio-Ecological Model, Social-Cognitive Theory | IPV and/or other violence prevention and/or support |
| Boydell, Nulu, Hardee & Gay | Implementing social accountability for contraceptive services: lessons from Uganda | Uganda | | | √ | | Existing public health evidence base | contraception |

| | | | | | | | | |
|---|---|--------------------|--|---|---|---|--|---------------------------|
| Butler, Johnson, Chiweza, et al. | A strategic approach to social accountability: Bwalo forums within the reproductive maternal and child health accountability ecosystem in Malawi | Malawi | | √ | √ | √ | existing public health evidence base | MCH |
| Gullo, Galavotti, Kuhlmann et al. | Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: A cluster-randomized controlled evaluation | Malawi | | √ | √ | | existing public health evidence base | MCH |
| Steyn, Boydell, Cordero et al. | Rationale and design of a complex intervention measuring the impact and processes of social accountability applied to contraceptive programming: CaPSAI Project | Ghana and Tanzania | | √ | √ | | existing public health evidence base | contraception |
| Dasgupta, Y. K. Sandhya, Lobis et al. | Using Technology to Claim Rights to Free Maternal Health Care: Lessons about Impact from the My Health, My Voice Pilot Project in India | India | | | √ | √ | Existing public health evidence base | Respectful maternity care |
| Mafuta, Dieleman, Essink, et al. | Participatory approach to design social accountability interventions to improve maternal health services: a case study from the Democratic Republic of the Congo | DRC | | √ | √ | | Dialogue Model, existing public health evidence base | MCH |
| George, Mohan, Gupta et al. | Can community action improve equity for maternal health and how does it do so? Research findings from Gujarat, India | India | | √ | √ | | program designed by local NGO based on experience | MCH |
| Balestra, Dasgupta, Y.K. Sandhya et al. | Developing political capabilities with Community-Based Monitoring for health accountability: The case of the Mahila Swasthya Adhikar Manch | India | | √ | √ | √ | program designed by local NGO based on experience | MCH |
| Warren, Ndwiga, Sripad, et al. | Sowing the seeds of transformative practice to actualize women's rights to respectful maternity care: reflections from Kenya using the consolidated framework for implementation research | Kenya | | √ | √ | √ | Legal obligations in country, existing public health evidence base | Respectful maternity care |
| Austad, Chary, Martinez et al. | Obstetric care navigation: a new approach to promote respectful maternity care and overcome barriers to safe motherhood | Guatemala | | √ | | | Existing public health evidence base | Respectful maternity care |
| Saggurti, Atmavilas, Porwal, et al. | Effect of health intervention integration within women's self-help groups on collectivization and healthy practices around reproductive, maternal, neonatal and child health in rural India | India | | √ | √ | √ | Existing public health evidence base | MCH |

| | | | | | | | | |
|---|---|-----------|---|---|---|---|--|---|
| Schuler, Nanda, Ramirez and Chen | Interactive workshops to promote gender equity and family planning in rural communities of Guatemala: results of a community randomized study | Guatemala | √ | | | | Social ecological model, health behavior theories, existing public health evidence base | contraception |
| Shattuck, Kerner, Gilles et al. | Encouraging Contraceptive Uptake by Motivating Men to Communicate About Family Planning: The Malawi Male Motivator Project | Malawi | √ | | | | Existing public health evidence base | contraception |
| de Souza | Creating “Communicative Spaces”: A Case of NGO Community Organizing for HIV/AIDS Prevention | India | √ | | √ | √ | Not specified | HIV prevention |
| Mecwan, Sheth & Khanna | Enhancing social accountability through adolescent and youth leadership: a case study on sexual and reproductive health from Gujarat, India | India | | √ | √ | | program designed by local NGO based on experience | SRHR |
| Iyer, Sen and Sreevathsa | Deciphering Rashomon: An approach to verbal autopsies of maternal deaths | India | √ | | √ | | Existing public health evidence base | MCH |
| Diniz, Rattner, Lucas d'Oliveira et al. | Disrespect and abuse in childbirth in Brazil: social activism, public policies and providers' training | Brazil | √ | √ | √ | √ | Nothing mentioned | Respectful maternity care |
| Odallo, Opondo, Onyango | Litigating to ensure access to quality maternal health care for women and girls in Kenya | Kenya | | | | √ | Human rights-based approach, legal obligations | MCH |
| Shaikh, Mburu, Arumugam et al. | Empowering communities and strengthening systems to improve transgender health: outcomes from the Pehchan programme in India | India | √ | √ | | | self-efficacy framework; community mobilization, collectivization and empowerment strategies | HIV prevention and IPV and/or other violence prevention and support |