Reviewer's report

Title: Assessing the effect of integrating a new method into family planning programs in India, Peru, and Rwanda

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Reviewer: Ricardo Vernon

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REVIEW OF ARTICLE ON SDM IN 3 COUNTRIES

This is an interesting article which adds evidence to the important question on whether adding a new method into health systems increases contraceptive prevalence besides increasing the convenience of clients. I think that the most important questions regard the methods used to assess the effects given the data the researchers apparently have. If they do have the data, they should stick to their pre-post, experimental-control design and conduct and present the data accordingly. Different editorial suggestions are made, but the writing is appropriate and the title reflects the contents of the article. All suggestions are minor essential or discretionary revisions).

Below are more specific comments on the contents:

1. I think it would be better not to use the word integration in the title. Integration is most often understood as linking one type of service with another, for example, HIV and FP, FP and immunizations, birth care and contraception. I think in English you use the word introduction when talking about adding a new method into the range of methods available, or refer to it as expanding the method mix. In this age of search engines I think it would be better to have consistency on these different uses, if you agree. (Discretionary suggestion)

2. I think you should add to your references Anrudh Jain’s (I think with Judith Bruce) work on the effects on contraceptive use prevalence of adding one method to the range of methods available. This piece of research adds to the evidence of his pioneering article. (Discretionary)

3. Page 4: “Most women ... found the method... without side effects.” I wonder if these side effects consider anxiety, both of the women and of the partner, from abstinence. Also, it would be good to provide data on use-continuity of the method here, if you have it. (discretionary)

4. Study sites: this section is somewhat confusing. As I understood it, in India the method was introduced in two blocks and not introduced in one block where it was not used before the project; In Peru, in three districts and compared to 3 other districts and in neither of these the method was introduced before the project; but in Rwanda, the province of Byumba was selected, in which two “sites” (whatever these are, and the number of “sites” in the province is not
identified) had already participated in a pilot study to introduce the method, and was compared with another province where the method had not been introduced, with a number of “sites” not specified. I think you should have a table explaining a) the number of SDP, sites, or whatever in addition to the number of blocks, districts or provinces in each condition; b) the dates when the introduction took place and the dates of follow up; c) explaining whether the method had been introduced or not before your intervention. One question is how the project ensured that the method had not been introduced by other agencies. Finally, another question is if they could simply eliminate from the analysis the two “sites” in Rwanda where the SDM had already been introduced. (minor essential revision)

5. The intervention: “… included advocacy to include CycleBeads …” Ok, but please specify if CycleBeads was actually provided in each site. This, the type of training and the type and number of providers that participated in each intervention group should be part of the table above. You are providing too few details about the intervention. Good science needs adequate documentation of the independent variable, not only of the variables you are trying to affect. (minor essential revision)

6. Service statistics: “service statistics were used to evaluate the effect … on contraceptive prevalence …”. This really needs a lot of explanations, because for practical purposes it is impossible do so. And why would you want to do this if you already have the surveys? You must mean the number of new users or the number of clients, or of contraceptive supplies provided, or something else than contraceptive prevalence. (minor essential revision) These other concepts are also much harder to estimate than commonly assumed. In any case, MIS figures are subject to many problems and would not be comparable across countries. I wonder if you could present the definitions used for new users in each site (discretionary revision)

7. RESULTS AND DISCUSSION

What proportion heard? Your Table 1 should compare baseline and endline, intervention and control. That is your experimental design and you should stick to it (except in Rwanda). The impact of the project on knowledge and use should be assessed by means of the double difference. That would also let us know how much of an introduction the interventions really were, especially if you also probed on knowledge of the use of the method, something you should present in the article if you did (I think if you have the data, this should be a compulsory revision, but since the lack of these data is not enough to invalidate the article, we should label it minor essential revision).

You probably don’t need the second table, if you need to free space: a description would suffice. (discretionary)

How many clients chose Standard Days? You are assuming here that no one was using SDM before your interventions when there is no need to make assumptions. Present the baseline data. (minor essential, if you have the data)
Text about Figure 1: “as expected, there were no new SDM users before the intervention started …”- I doubt that the MIS and data collection forms allowed for identifying SDM before the intervention, so you can’t state this. That should be assessed by the surveys, if the baseline inquired about the SDM. (discretionary)

Figures 2 and 3: to analyze the data on these figures you should subtract one line from the other and present the numbers or show as a percent of all users. In Figure 2, to the eye it looks as if the intervention had an impact in Peru (where the gap grows), but not in Rwanda (where the gap remains the same). If you did this, you could use statistical tests to assess if the differences are statistically significant or not. If you estimate the slope of the lines, you could see if there is a real change. You should estimate a simple linear regression.(discretionary)

Figure 3: this graph is not useful, because the number of potential clients and clinics and everything shifted substantially (or that is what I understood from the text)

If you have the data, I think that it would be better if you had a graph for each country showing the number of new family planning clients, total and SDM only, experimental and control (excluding in India all sterilization users in both and/or including them in both). That way you could assess the uptake of the new method and also the impact it might have on the total uptake of methods in clinics that introduce it. I think you would pretty much arrive to the same conclusion as in page 13 (not in the conclusions section) in terms of where do the interventions seem to have an effect. Even if the new method does not bring an increase in total new users, the fact that some choose it shows that services were apparently made more convenient to the clients. (discretionary)

Finally, there are a few typos; you should run a spelling check. (minor essential revision)

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests