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ENCOURAGING PRIVATE- SECTOR PROVISION OF LONG-ACTING AND PERMANENT FAMILY PLANNING METHODS IN BANGLADESH: AN IMPLEMENTATION EVALUATION

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States government.

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ACRONYMS

BDHS	Bangladesh Demographic and Health Survey
BEW	Business enabling workshop
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
FP	Family planning
FWA	Family welfare assistant
FWV	Family welfare visitor
IMC	International Medical College
IPC	Infection prevention and counseling
LARC	Long-acting and reversible contraceptive methods
IUD	Intrauterine device
HFWC	Health and family welfare centers
MoHFW	Ministry of Health and Family Welfare
MoLGRF	Ministry of Local Government, Rural Development and Cooperatives
MCH	Maternal and child health
MCMO	Marketing and community mobilization officer
NSV	No-scalpel vasectomy
NGO	Nongovernmental organization
NPT	Normalization Process Theory
OC	Oral contraceptives
OGSB	Obstetrician and Gynecologist Society of Bangladesh
PFPH	Private-for-profit hospital
PM	Permanent contraceptive methods
PMCH	Private medical college hospital
QA	Quality assurance
SHOPS	Strengthening Health Outcomes through the Private Sector
SMAMC	Shaheed Monsur Ali Medical College
SMC	Social Marketing Company
TFR	Total fertility rate
TOT	Training of trainers
USAID	United States Agency for International Development
WMC	Medical College for Women and Hospital

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EXECUTIVE SUMMARY

Bangladesh has made significant progress over the past 40 years in addressing population growth, by implementing policies and programs specifically focused on family planning (FP). Bangladesh has established a goal of achieving replacement-level fertility (2.1 births per woman) by 2016 (Ministry of Health and Family Welfare, 2010). Because they are the most effective types of modern contraception, Bangladesh's Directorate General of Family Planning (DGFP) of the Ministry of Health and Family Welfare (MoHFW) in Bangladesh has recognized that long-acting-reversible contraceptive methods (LARC) and permanent contraceptive methods (PM) should play a larger role in meeting consumer demand for contraceptives. In recent years, however, Bangladesh has not been successful in encouraging large numbers of FP users to shift to LARCs or PMs at appropriate points in their reproductive years. Currently, just 8 percent of married couples use either a LARC (including intrauterine devices (IUDs) and implants) or PM (female and male sterilization), which represents 13 percent of all modern and traditional contraceptive users in Bangladesh (NIPORT et al., 2013, henceforth referred to as BDHS, 2011).

Within the context of voluntary family planning programs focused on providing Bangladeshis with a full complement of FP options, one route to increasing LARC and PM access that is of particular interest to both United States Agency for International Development (USAID) and the government of Bangladesh is enhancing private sector involvement in LARC and PM provision (Alauddin et al., 2010; DGFP, 2011). Although some private sector facilities—especially commercial pharmacies and non-governmental organizations (NGOs)—are already important sources of short-acting methods for Bangladeshi women, there are few private facilities offering LARCs or PMs (BDHS, 2011).

Because antenatal care visits, delivery, and postnatal care visits present opportunities for introducing a full-range of FP options to women, a strategy for increasing access to LARCs and PMs is to integrate provision of these services into a facility's existing maternal and child health (MCH) offerings. In Bangladesh, the for-profit private sector is the leading source for antenatal care, serving 43 percent of women. The private sector is also the leading source for delivery—of the 29 percent of deliveries that are performed at health facilities, 15 percent are in for-profit private facilities, which comprises over half of all facility-based deliveries (2011, BDHS). This highlights the important role that the private sector plays in the maternal care continuum and their potential for providing access to FP, particularly in the postpartum period.

Given that relatively few private-for-profit health facilities have had experience in the provision of LARCs and PMs, introducing these services requires a multi-pronged approach that recognizes that this type of facility must function both as a service provider and as a profitable business. To address this need, the USAID-funded Strengthening Health Outcomes through the Private Sector (SHOPS) project has developed and implemented a program known as the SHOPS Integrated FP/MCH Service Delivery Model (hereafter, SHOPS Integrated Model). This model was implemented between 2012 and 2014 to introduce and facilitate LARC and PM service delivery in 38 private-for-profit facilities in Dhaka and Chittagong, the two largest cities in Bangladesh. Throughout the lifetime of the program, participating facilities received customized assistance for LARC and PM training and skill acquisition, as well as for marketing, demand generation, and commodity supply. The SHOPS Integrated Model was specifically designed to

help facilities simultaneously address these previously insurmountable barriers to LARC and PM provision.

Because the SHOPS Bangladesh program was scheduled to transition all activities to participating facilities in March 2014, an implementation evaluation was undertaken in the final months of the program to appraise the success of the SHOPS Integrated Model's implementation to date, and to explore factors that could support or impede LARC and PM provision in private facilities beyond the program's lifetime. This effort also sought to generate broader lessons learned for other stakeholders within Bangladesh who are trying to leverage the private sector to provide LARCs and PMs. Finally, the implementation evaluation findings are meant to augment the knowledge base on promising approaches for establishing service markets for LARC and PM, in the Bangladeshi private sector and beyond.

Considering these aims, the overarching research questions guiding this evaluation were:

1. What factors support ongoing LARC and PM service delivery in facilities targeted by SHOPS?
2. What factors detract from ongoing LARC and PM service delivery in the facilities targeted by SHOPS?
3. In what ways has the SHOPS Integrated Model influenced the viability of LARC and PM service delivery in targeted facilities?

Since this evaluation was principally interested in understanding model implementation from the perspective of participating facilities, it used a qualitative case study approach, undertaking a focused exploration of five Dhaka-based facilities whose experiences seemed to reflect a range of different implementation outcomes. The evaluation accordingly used service statistics and monitoring data for all participating facilities, to help identify a set of participating facilities that could not only yield an appropriate amount of detailed information, but also appropriately reflect the diversity of the overall facility group. This approach produced a small but meaningful sample that not only enabled in-depth exploration of the individual case facilities, but also yielded rich information about the implementation of the SHOPS model overall.

Within each case study facility, SHOPS captured staff and facility management perspectives on implementation of the SHOPS model using semi-structured, in-depth interviews. SHOPS staff analyzed these data using a two-stage thematic analysis approach that sought to synthesize both case-specific and cross-case concepts emerging from the data. To compare the performance of the sampled facilities to the performance of the program overall, the analysis also drew on program-monitoring data collected by SHOPS Bangladesh from all participating facilities. By triangulating primary and secondary data sources in this way, the analysis could test the validity of findings suggested by the case studies.

This evaluation produced several insights into what is required to introduce, deliver, and sustain LARCs and PMs in private facilities. The following insights have implications both for private facilities that might consider introducing LARCs and PMs in the future and for policymakers who seek to expand access to and use of modern family planning methods in Bangladesh.

- **Private facilities became willing and able to offer LARC and PM services because the SHOPS Integrated Model successfully eased market entry barriers.**

SHOPS dramatically lowered the hurdles that had prevented these facilities from offering LARC and PM services as an integrated part of their wider MCH service offerings. From the case study respondents' perspectives, introduction of LARC and PM services according to the

SHOPS Integrated Model required few (if any) capital investments and minimal diversion of staff time, thus reducing the risks entailed in participation. The flexible nature of the model seems to have also increased enthusiasm for the LARC and PM integration, because it allowed participating facilities to customize service delivery to fit their needs and capacity. Because these barriers were reduced, respondents across facilities had a generally positive assessment about LARC and PM provision to date and expressed a willingness to continue to offer LARCs and PMs in the future.

- **Although the rate of LARC and PM service delivery was low, delivery trends are similar to those observed in public facilities.**

Although SHOPS facilities succeeded in introducing LARCs and PMs, the number of LARC and PM services delivered each month was very low compared to the estimated totals for MCH services overall. LARC and PM provision trends for all SHOPS facilities were weaker than anticipated, at fewer than six LARC, PM, or injectable services per month on average. The modest service trends observed were not unique to the private sector, however, but were in line with the 2013 LARC and PM provision trends of comparable public facilities in Dhaka. For example, public facilities delivered an average of four IUDs, tubectomies, or implants per month, while private facilities were able to deliver an average of three of these services per month.

- **Private facilities are not in a position to market LARCs and PMs with the intensity needed to significantly increase demand for these methods.**

Although there was strong, uniform appreciation of the SHOPS marketing and demand-generation supports, at the end of the program none of the facilities was well-positioned to engage in intensive LARC and PM marketing and promotion without additional external support. Even with SHOPS-enhanced marketing and counseling support, however, demand overall was not perceived to be exceedingly strong. Increasing demand for LARCs and PMs on a broader scale will likely require additional efforts that are beyond the capability of any private facility acting alone.

- **Private facilities recognize and are motivated to offer LARCs and PMs by objectives that are not exclusively anchored to profit maximization or business expansion.**

A unique feature of the SHOPS Integrated Model was that it could be tailored to be compatible with the facilities' institutional missions and business motives. Judging from the statements of case study respondents, it seems that an expectation of growth in profits or revenue was not the main reason that some participating facilities chose to introduce LARCs and PMs. Their motivations seemed to be somewhat influenced by the institutional structure of the individual facility. When asked about the reasons why their facility had chosen to participate in the SHOPS program, private medical college hospital respondents were apt to stress non-economic incentives over traditional business motives, including expanding to their clients, meeting the nation's population and development goals, and offering their students the opportunity to learn how to provide LARCs and PMs. One explanation for these observations is that, since medical colleges are structured to derive revenue from tuition, the hospital division of such institutions focuses less on maximizing profits and more on maximizing patient flow to generate teaching opportunities.

- **Affordable and easily accessible commodity supply enables single providers to provide LARC services, whether or not their facilities offer LARCs and PMs.**

One of the most critical successes of the SHOPS Integrated Model was the establishment of reliable and flexible private sector access to LARC commodities. Prior to SHOPS, participating private facilities did not have commodity access, and many respondents cited this gap as one of the key reasons the facility had not been previously able to offer LARC and PM services. Illustrating the importance of predictable supply in the provision of most LARC and PM services, many respondents expressed confidence that as long as the facility's supply arrangement remained unchanged, the facility would continue to provide LARC and PM services. Further, since commodities could be ordered in small quantities and on short notice, individual providers across facilities were also able to order LARC commodities on their own, which gave them the freedom to supply and provide LARCs in their private practices or in other private facilities separately from the SHOPS Integrated Model. Importantly, this finding implies that in the event a SHOPS facility discontinues institutional promotion or support for LARC and PM services in the future, individual providers would still have the means to respond to client demand for LARCs.

- **In the likely event of provider turnover, skill retention could be a challenge for private-for-profit hospitals that participated in the SHOPS Integrated Model; however, other non-participating facilities could indirectly benefit from skill diffusion.**

Since it is common for doctors in Bangladesh to work across multiple public and private settings in order to maximize or supplement income, high rates of staff turnover are often the reality in private-for-profit facilities. In several SHOPS facilities, attrition of trained staff diminished capacity to provide LARC and PMs. Although this reality may impact the sustainability of LARC and PM provision at some of the SHOPS-targeted facilities, since medical personnel tend to "hop" from facility to facility, one facility's loss of trained providers is another facility's gain. During the lifetime of the SHOPS Integrated Model, there were several examples of LARC and PM diffusion to new and untargeted facilities after motivated and trained staff moved from one facility to another and urged SHOPS to provide support in their new facility.

I. INTRODUCTION

I.1 FAMILY PLANNING TRENDS AND BANGLADESH'S DEMOGRAPHIC FUTURE

Bangladesh has made significant progress over the past 40 years in addressing population growth by implementing policies and programs specifically focused on family planning (FP). The key indicator of this success is the substantial drop in the total fertility rate (TFR), from 6.3 births per woman in 1975 to 3.4 in 1994. Since 1994, however, the decrease in TFR has slowed significantly, and it has taken until 2010 for the TFR to reach its current rate of 2.3 (NIPORT et al., 2013, henceforth referred to as BDHS, 2011). The most recent Bangladesh Demographic and Health Survey (BDHS) indicates that the modern contraceptive prevalence rate nationally is 52 percent—a massive increase from just 5 percent in 1975. Nevertheless, 14 percent of the population still has an unmet need for FP (BDHS, 2011).

Most consumers meet their FP needs by using oral contraceptive pills, condoms, and traditional methods, all of which require behavioral consistency to be effective and are associated with high discontinuation rates. Because they are the most effective types of modern contraception, the Directorate General for Family Planning (DGFP) in the Ministry of Health and Family Welfare (MoHFW) has recognized that long-acting-reversible contraceptive methods (LARC) and permanent contraceptive methods (PM) should play a larger role in meeting consumer demand for contraceptives, to allow the country to reach its goal of achieving replacement-level fertility (2.1 births per woman) by 2016 (MoHFW, 2010). Recent analysis estimates that if Bangladesh is to reach its fertility targets by 2016, the number of users of short-acting methods needs to decline by about 2.9 million users while the number of those opting to adopt LARCs or PMs must increase by 8.6 million (Streatfield and Kamal, 2013). An increase of this magnitude will require a change in the status quo.

In recent years, Bangladesh has not been successful in ensuring that FP users have access to a full range of FP options at appropriate points in their reproductive years. Currently, just 8 percent of married couples use a LARC (intrauterine device (IUD) or implants) or PM (female or male sterilization),¹ a level that represents 13 percent of all contraceptive users in Bangladesh (BDHS 2011). In fact, LARC and PM use was higher in 1991 (with 12 percent of couples and 38 percent of modern contraceptive use), but prevalence declined thereafter, stabilizing in 2007 at just over 7 percent (BDHS, 2011). These low levels of LARC and PM adoption are perplexing because the data suggest there are many Bangladeshis who would benefit from choosing a LARC or PM: 79 percent of women either want no more children or would like to wait a while before having their next child (BDHS, 2011). Instead, the vast majority of these potential LARC and PM adopters continue to rely on short-acting or traditional methods to protect against unwanted pregnancy.

One suggested explanation for this disparity might be lack of knowledge or awareness of LARCs and PMs, but in fact, the 2007 BDHS showed that awareness of modern contraceptive

¹ Throughout the rest of this report, we refer to female sterilization is referred to as “tubectomy” and male sterilization as “vasectomy”—shorthand terms to describe the procedures performed when patients choose PMs as their FP method.

methods was widespread: over 80 percent of ever-married women were aware of at least one type of LARC or PM. This gap suggests that there are socio-cultural and structural factors that are discouraging Bangladeshis from choosing LARCs or PMs. In response, the government of Bangladesh, as well as stakeholders like the United States Agency for International Development (USAID), the World Health Organization (WHO) and the United Nations Population Fund (UNFPA), has been exploring ways to renew interest in and access to LARCs and PMs.

I.2 BOLSTERING LARC AND PM ACCESS THROUGH THE PRIVATE SECTOR

In recent years, Bangladesh's private health sector has grown substantially and has become a leading source of maternal and child health (MCH) services. Between 2001 and 2011, for example, childbirth deliveries in private-for-profit hospitals nearly tripled, from 2.7 percent to 11.3 percent, constituting 48 percent of all facility-based deliveries nationwide (BDHS, 2011). Among women seeking antenatal care, 43 percent obtain these services from private for-profit health facilities (BDHS, 2011). Further, out of the approximately 40,000 practicing doctors in Bangladesh, over half work full-time in for-profit health facilities. Many public sector doctors are also known to work part-time in private practice to supplement their incomes (Rahaim et al., 2011). Typically, doctors working in the private sector maintain private practices or work as part-time consultants in multiple facilities at once—including private hospitals, outpatient clinics, and even private pharmacies—rather than being attached to a single facility (World Bank, 2003).

Given the important role that the private sector plays in the maternal care continuum, one strategy for increasing access to a broad range of FP options that is supported by both USAID and WHO is to ensure that facilities where women seek MCH services—including antenatal care, post-natal care, and deliveries—are also equipped to provide post-partum counseling and offer a full range of contraceptive methods, including LARC and PM services (USAID, 2012; WHO and USAID, 2013). Although some private sector facilities—especially commercial pharmacies and non-governmental organizations (NGOs)—are important sources of short-acting methods for Bangladeshi women, few private facilities offer LARCs or PMs (BDHS, 2011). Considering the private sector's favorable positioning as the leading source of MCH care, the integration of LARC and PMs presents an important opportunity for the private sector offer a more comprehensive range of services to their clients, but also contribute to Bangladesh's national population and development goals.

Since many private health facilities are profit-generating businesses, integration of LARC and PM services into these entities' MCH offerings requires not only a compelling public health goal, but also the establishment of a private sector market for these services. Creating a viable market for LARC and PM in the private sector—that is, a market in which private providers are motivated and able to offer LARC and PM services without direct support from government or external stakeholders—will be imperative if the private sector is to play a larger role in LARC and PM provision.

To help the government of Bangladesh better understand how the private sector could be leveraged to meet the country's health and population goals, USAID/Bangladesh requested in 2011 that the Strengthening Health Outcomes Through the Private Sector (SHOPS) project undertake a series of activities to assess and address the Bangladeshi private health sector's ability to provide LARCs and PMs. SHOPS conducted two assessments of the private sector's readiness to provide LARCs and PMs early on in its involvement in Bangladesh (Rahaim et al.,

2011; Ugaz et al., 2013). These studies identified several factors that inhibit facilities' ability to reliably provide these services. Some of the most formidable obstacles identified include:

- Lack of reliable and consistent access to LARC commodities
- Undeveloped demand for private-sector-provided LARC and PM services
- Limited provider competency to counsel and deliver various LARC and PM services to clients
- Lack of an established quality-assurance system for private sector provision of LARCs and PMs

Drawing on these assessment findings and the support of USAID, the SHOPS Integrated FP/MCH Service Delivery Model (hereafter, SHOPS Integrated Model) was designed and implemented as a joint initiative by SHOPS Bangladesh, the USAID Mayer Hashi project, and the Social Marketing Company (SMC), in collaboration with AITAM Welfare Organization and the Obstetrician and Gynecologist Society of Bangladesh (OGSB), and with close coordination with the DGFP and the Directorate General for Health Services (DGHS). The initiative was intended to help establish a viable private sector market for LARCs and PMs by aiding the integration of LARCs and PMs into private sector hospitals' MCH service offerings. In this context, integration of LARC and PM includes three basic elements: the expansion of a facility's basic package of essential MCH services to include a variety of LARC and PM services; the modification of staff roles to accommodate for counseling on and provision of LARC and PM services; and implementation of strategies to help users of MCH services become aware of and link to LARC and PM services that are offered by the facility.

Given that relatively few facilities had experience in the provision of LARC and PM services, integrating these methods required a careful, multi-pronged approach that was responsive not only to the dual-purpose needs of private facilities—which must function both as service providers and as profitable businesses—but also to the clients who use these facilities. The SHOPS Integrated Model, launched beginning in March 2012 and implemented through March 2014, was specifically designed to weave these diverse needs into one comprehensive program.

I.3 RATIONALE FOR THE EVALUATION

The SHOPS Integrated Model represented a promising opportunity for enhancing the ability of private sector facilities to contribute to the expansion of LARC and PM access in Bangladesh. An implementation evaluation was launched in the final months of the program to appraise the success of the model and its implementation and to explore factors that could support or impede LARC and PM provision in private facilities in the future.

The implementation evaluation was designed to accompany three other primary data collection efforts that SHOPS executed over the past four years. SHOPS carried out two studies to identify the prospects and barriers for private sector provision of LARC and PM in Bangladesh: (1) a private sector assessment of LARC and PM service delivery capacity (Rahaim, 2011), and (2) a study of private providers' knowledge, attitudes, and practices (KAP) related to LARC and PM (Ugaz et al., 2013). In addition, a country profile report (SHOPS Project, 2012) documents the development of the SHOPS Integrated Model, its key components, and its main achievements. The implementation evaluation builds on these three works to evaluate program implementation *at the facility level* and to identify factors that might affect LARC and PM provision, as facilities transition into the post-program era. This effort also sought to generate broader lessons learned for other stakeholders within Bangladesh that are seeking to leverage the private sector to

provide LARCs and PMs. Finally, the implementation evaluation findings, in combination with the other SHOPS efforts, are meant to augment the knowledge base on promising approaches for establishing service markets for LARC and PM, both in the Bangladeshi private sector and beyond.

I.4 EVALUATION APPROACH AND RESEARCH QUESTIONS

Since this evaluation was principally interested in understanding model implementation from the perspective of the participating facilities attempting to integrate LARC and PM services into their MCH offerings, it used a qualitative case study approach to undertake a focused exploration of a select set of facilities whose experiences seemed to reflect a range of different implementation outcomes. Broadly speaking, a case study approach is a method for learning about a complex intervention within its natural context (Yin, 2009). Case studies reveal a lot about the processes and outcomes at certain intervention sites and the way these factors interrelate. Often, as was the case in this evaluation, multiple case studies are conducted to offset the lack of breath in a single case study and enable within- and cross-case analysis. Although multiple case study designs do not result in a statistical sample, use of a systematic and purposive selection techniques can produce a sample that is representative of the diversity of the entire set of intervention sites, which can yield information that can subsequently be used to assist in explanation building and enable transferability of findings related to the intervention in question (Yin, 2009; Government Accountability Office, 1990).

Within each selected facility, we captured staff and facility management perspectives on the facility-level implementation of the SHOPS Integrated Model using semi-structured in-depth interviews. To enhance our understanding of the performance of the sampled facilities in comparison to the performance of the program overall, we used program-monitoring data collected by SHOPS Bangladesh from all participating facilities and key program documents to interpret and contextualize case study findings. Triangulating primary and secondary sources in this way helps to bolster the validity of findings from each individual data source.

The overarching research questions guiding this evaluation were:

1. What factors support ongoing LARC and PM service delivery in facilities targeted by SHOPS?
2. What factors detract from ongoing LARC and PM service delivery in the facilities targeted by SHOPS?
3. In what ways has the SHOPS Integrated Model influenced the viability* of LARC and PM service delivery in targeted facilities?

* Within the context of this study, **viability** is defined as a provider's willingness to continue offering LARC and PM services without direct support from SHOPS or its partners. This definition implies that LARC and PM must be compatible with the facility's overarching business and staffing plans, which may (or may not) include dynamics related to increased revenue and profit.

I.5 DEFINING LARCS AND PMS IN CONTEXT

The SHOPS Integrated Model incorporated support for training and integration of injectable contraceptive services (hereafter referred to as “injectables”), although these are not typically thought of as LARCs or PMs. Since injectables are an increasingly popular contraceptive choice among Bangladeshi women, SHOPS included injectables in its program as a way of encouraging private facilities to participate in the SHOPS Integrated Model and ultimately to provide a wider variety of FP methods. This approach proved to be productive, as over 80 percent of participating facilities sought to integrate injectables into their MCH service offerings.

Conversely, although SHOPS offered training and support in integration of non-scalpel vasectomy (NSV) services, all but one of the participating facilities de-emphasized this service, preferring instead to focus on services they could market and provide directly to women. As a result, within the scope of this evaluation, the analysis of LARC and PM service integration and provision includes the following methods: IUDs, implants, tubectomy (female sterilization), and injectables.

I.6 ORGANIZATION OF THE REPORT

The report continues in Section 2 with a brief overview of the Bangladesh FP system and the role it plays in perpetuating Bangladesh's current method mix, as well as background on the SHOPS Integrated Model. Section 3 describes the design of the evaluation. Section 4 details findings, while Section 5 interprets these findings and provides recommendations. Section 6 presents conclusions from this evaluation.

2. BACKGROUND AND PROGRAM CONTEXT

Bangladesh's emphasis on FP is unique, as is the extensive system it has built to accommodate this emphasis. Although the country has achieved great success over the last four decades in lowering its TFR, it faces formidable challenges to sustain these achievements going forward. One way in which Bangladesh can preserve and build on these achievements is to encourage increased access to LARCs and PMs. The next section explains reasons why LARCs and PMs have come to constitute such a small proportion of Bangladesh's method mix, and how, in response to these challenges, the SHOPS Integrated Model set out to support LARC and PM provision in the private sector.

2.1 STRUCTURAL AND CULTURAL FACTORS INFLUENCING PREFERENCE FOR SHORT-ACTING CONTRACEPTIVES

2.1.1 BANGLADESH'S FAMILY PLANNING SERVICE DELIVERY SYSTEM

Since Bangladesh's founding as an independent country in 1971, the MOHFW (and specifically its DGFP) has been responsible for formulating and executing policies related to FP. Bangladesh has a unique administrative body (the DGFP) that is designated to specifically oversee family planning and sits at the same level as the administrative body responsible for overseeing general health policy and services, the Directorate General for Health Services (DGHS). Considering the fact that no other country in the world has elevated FP oversight and administration to this level, Bangladesh's population program is firmly established as a national priority, reflecting the widespread recognition of its role in national development (Rahaim et al., 2011; Khuda et al., 1997).

Over the past four decades, DGFP has placed emphasis on a FP service delivery structure that is specifically positioned to reach the poor, especially those in rural Bangladesh. One of the principal ways in which the government aimed to reach the poor was to shift provision of services to relatively low level cadres of workers, who could be trained more quickly and efficiently than higher level medical professionals to carry out promotion and delivery of most FP services. The DGFP's program eventually came to be anchored by an extensive network of over 20,000 community outreach workers, known as Family Welfare Assistants (FWA), and over 5,000 Family Welfare Visitors (FWV), working as paramedics in health and family welfare centers (HFWC) around the country (Streatfield and Kamal, 2013; Rahaim et al., 2011; Khuda et al., 1997). FWAs are responsible for door-to-door outreach as well as provision of short-acting methods. FWVs are the first-line providers of IUDs and injectable contraceptives, like DMPA. Women and men desiring tubectomies and vasectomies must seek services from a higher level medical facility, since PMs can only be performed by a trained medical officer. As a result, when patients request PMs, they are typically referred to an upazila (sub-district) health center or a district hospital, both of which operate under the purview of the DGHS.

Even though FP is heavily dependent on FWAs and FWVs, training for these critical positions has been inadequate, and little has been done over the past few decades to ensure that a well-trained, full-strength workforce is in place. FWA and FWV training materials have not been updated in over 20 years and do not incorporate best practices or updated WHO standards and guidelines; moreover, there have been only two major cohorts of FWA and FWV workers trained (Streatfield and Kamal, 2013; Khuda et al., 1997). This has implications not only for service quality, but also for access to services. With large numbers of FWAs and FWVs now reaching retirement age and not being replaced, there will be even less capacity to serve Bangladesh's ever-growing demand for FP services (Streatfield and Kamal, 2013; Rahaim et al., 2011; Khuda et al., 1997).

Bangladesh is relatively well-endowed with doctors,² who are potentially a suitable resource for FP service delivery, but there are capacity issues here as well. Because the system is structured so that the majority of FP services can be delivered without engaging such higher-level medical personnel, training on FP counseling and delivery of LARC and PM appears to have been deemphasized by Bangladesh's medical training institutions. Prior to the SHOPS intervention, none of the 18 public or 45 private medical colleges taught LARC and PM methods as a clinical skill or offered the opportunity to practice these methods in internship (Rahaim et al., 2011). Limited in-service training opportunities for doctors and nurses—especially those working in the private sector—have also limited the extent to which these providers could be positioned to contribute to Bangladesh's FP goals (Ugaz et al., 2013).

Compounding the already formidable challenges of Bangladesh's FP system is the fact that, in urban areas like Dhaka, the implementation of government FP policies and services is delegated to the Ministry of Local Government, Rural Development, and Cooperatives (MO-LGDRC).³ Because it has limited infrastructure and capacity, the MO-LGDRC approach to urban health and FP emphasizes the involvement of NGOs to fill capacity gaps. As a result, an eclectic mix of actors delivers FP services in Dhaka, including Dhaka City Corporation clinics and welfare centers, DGHS and private dispensaries, and two regional DGFP facilities, as well as many NGOs. Since the system is diverse and fragmented, it is hard to coordinate, and as a result there is often uneven coverage of FP service delivery in urban areas leading to service gaps and inefficiencies. One of these gaps is provision of LARC and PM. NGOs and public facilities alike have limited and uneven capacity to deliver these services, which seems to have contributed to underutilization of LARC and PM services in urban areas (MEASURE Evaluation, 2014; DGFP, 2011; Rob et al., 2010; Nasreen et al., 2007). In the 2011 BDHS for example, urban utilization of LARCs and PMs comprises just 12 percent of the modern method mix.

2.1.2 DEMAND-SIDE ISSUES

There are also demand-side issues hindering use of LARC and PM. The reluctance to adopt clinical methods like IUDs is widespread in Bangladesh (MEASURE Evaluation, 2014). Some have traced this reluctance to the conservative Muslim perception that women should not accept FP methods that increase bleeding or extend periods of impurity (Streatfield and Kamal, 2013). These conceptions may explain why a recent SHOPS study found that providers perceive that men not only prefer short-acting methods, but they also have a strong influence

² There are an estimated 3.05 physicians 1.07 nurses per 10,000 population (estimates based on a 2011 report produced by MoHFW's Human Resources Development Unit).

³ The MO-LGDRC's Dhaka District Family Planning Office is the specific administrative unit in charge of overseeing and coordinating FP policy and services in the city.

over a woman's choice of contraceptive method. In addition to IUDs, female sterilizations carry the stigma as the "poor woman's option," because they have historically been accompanied by reimbursement or other incentive schemes in the public sector (Ugaz et al., 2013). Negative attitudes about long-acting methods are likely reinforced by some of the structural issues discussed above. Personnel shortages, poor coordination, and insufficient training have deleterious influence on the quality of care provided in public facilities. Since LARC and PM have historically been in the domain of low level public sector facilities, perception of poor quality and service availability in these facilities is a further disincentive to consumers to consider choosing FP methods that must be delivered in a clinical setting (Nasreen et al., 2007). In addition, poor service quality can reinforce long-held public perceptions that LARC and PM carry more risks than short-acting methods (DGFP, 2011).

2.2 ROLE OF THE PRIVATE SECTOR IN FAMILY PLANNING AND THE SHOPS INTEGRATED MODEL

Despite the various barriers inhibiting LARC and PM adoption and delivery to date, the government of Bangladesh has acknowledged the importance of increasing access to and ultimately adoption of these services, and has taken steps to support the achievement of this goal. Recognizing that widespread access to high quality LARC and PM services is not likely to be achievable by relying solely on its public delivery system, the government has identified the need for increased involvement by private sector actors—including NGOs and private-for-profit facilities—in LARC and PM provision (DGFP, 2011). In response to this imperative, the government of Bangladesh enacted a number of policy changes between 2010 and 2012 that were designed to make it easier to deliver LARC and PM. These policy changes included: easing requirements to facilitate post-partum tubectomies; permitting staff nurses in public and private facilities to be able to insert IUDs; approval of a more affordable implant product (the Sino-Implant II); and streamlining registration requirements for private facilities wishing to receive FP commodities and funds (The RESPOND Project, 2012). Although these policy changes are not unwelcome, there are still a number of obstacles that may dissuade private providers from taking part in Bangladesh's FP delivery system. In many cases, even though it is now technically possible for private providers to participate in LARC and PM services provision, bureaucratic regulations and government-imposed limitations restricted private facilities' access to training and commodities, rendering participation functionally impossible (Rahaim et al., 2011). It is against this backdrop that SHOPS implemented its integrated model.

2.2.1 SHOPS INTEGRATED MODEL DESCRIPTION

From September 2011 through March 2014, SHOPS Bangladesh and its partners developed and implemented a program to create a viable market for LARC and PM provision in 50 private facilities in Dhaka and Chittagong, the two largest cities in Bangladesh. A third of the facilities are large private medical colleges, with teaching hospitals that are mandated to provide 30 percent of their services to the poor. The rest of the facilities are large private hospitals. Since all of the targeted facilities are for-profit institutions, the SHOPS Integrated Model was specifically designed to enable incorporation of high quality LARC and PM services in a way that was sensitive to facility stakeholders' business interests as well. The program aimed to remove or ameliorate the supply, demand, and capacity barriers in order to promote the establishment of a viable market for LARC and PM service delivery in private sector hospitals. The program—the first of its kind in Bangladesh—built on major lessons learned from the SHOPS private sector assessment (Rahaim et al., 2011) and the SHOPS KAP study (Ugaz et

al., 2013). Some of the particularly influential lessons that were derived from this research and that shaped key program components are described below.

- **Each private facility is unique in the way it runs its business, and it faces a unique set of business challenges and opportunities.** In the past, generic or pre-packaged approaches have attempted to enhance the provision of LARC and PM in the private sector in Bangladesh, but failed because they did not take into account the unique set of circumstances of each private facility. In contrast, the SHOPS Integrated Model was designed to be flexible in its approach and attentive to the unique needs, interests, and circumstances of each participating facility.
- **Private practitioners and private facilities have not always been able to take advantage of training opportunities in LARC and PM because the trainings do not take into account the structural and managerial differences between public and private facilities.** Prior to 2012, the national LARC and PM training curriculum required 21 days of didactic training, followed by clinical practicums for each method.⁴ Training structured in this way is not tenable for most private-for-profit facilities, since—as entities that operate both as businesses and health service providers—they need their staff to be continuously present to see patients and generate revenue. Although there have been efforts to break the curriculum into one- or two-week blocks, the modules were formatted as all-day sessions scheduled during business hours, and at times in inconvenient locations. These trainings were poorly attended by the private sector because they required providers to leave their practices for uncomfortably long periods of time. The SHOPS Integrated Model addressed this constraint by working with each program facility to set a training schedule and venue adapted to their specific needs. To implement private-sector-friendly adaptations to the established training regime, SHOPS and its partners worked with the DGFP to adapt the national training curriculum to focus more on clinical practice than classroom time, and, where necessary, to allow for the trainings to be held in individual facilities rather than centralized training centers.
- **Establishment of private sector LARC and PM market viability is constrained by multiple barriers, including limited capacity for service delivery, anemic demand for LARC and PM, and unreliable commodity supply.** The SHOPS Integrated Model was designed as an integrated approach to overcome barriers on all three fronts rather than focusing on one or two areas. SHOPS partner Mayer Hashi Project had previously implemented LARC and PM training for private sector providers, but the SHOPS effort was the first to focus on establishing the viability of LARC and PM provision in *private-for-profit* facilities. Similarly targeted, multi-pronged efforts incorporating capacity building and demand generation efforts to increase LARC and PM use have been successfully implemented in other countries (Blumenthal et al., 2013).

The SHOPS Integrated Model encompassed a range of activities grouped into four component clusters. Three facility-level components focused on assisting facilities with the introduction and integration of LARC and PM services into their existing MCH offerings; and one cross-cutting component focused on addressing the contextual and policy barriers that might hinder the private sector from delivering LARCs and PMs. These four components are described below.

⁴ ASA Masud, e-mail message to author, November 21, 2014.

Facility-Level Component 1. Increase the number of private providers and facilities trained to provide high quality LARC and PM services. Activities undertaken included the following.

- Assess 83 private sector facilities to determine if they met the selection criteria for participation;⁵ identify the LARC and PM methods each facility was most interested in providing; and identify the training needs for LARC and PM counseling, record keeping, and reporting at each facility. Fifty facilities were selected for participation, and each signed a memorandum of understanding with SHOPS.
- Develop and implement LARC and PM trainings to private providers from 32 private hospitals. Each training program was adapted to meet the specific needs and interests of each institution.
- Develop and implement a LARC and PM-focused “training of trainers” (TOT) for selected Ob-Gyn and nursing faculty at 15 private medical colleges. The TOT was modified from the national LARC and PM curriculum and was designed to not only increase skills and enable immediate LARC and PM service delivery in the medical college hospitals, but also to facilitate integration of LARC and PM practicums into the facilities’ standard medical training curricula.
- Out of the 47 facilities trained, 38 went on to initiate LARC and PM services. To facilitate delivery of services, SHOPS provided these facilities with a model LARC and PM quality assurance (QA) and reporting system that could be subsequently integrated into other facility monitoring systems.

Facility-Level Component 2. Increase demand for LARC and PM through private sector providers. Activities undertaken included the following.

- Deliver business-enabling workshops (BEWs) to facility stakeholders: SHOPS staff reviewed related policy and regulatory issues for integrating LARC and PM services into each facility’s existing array of MCH services, and introduced key considerations for developing a LARC- and PM-specific business plan.
- Support the development of facility-level marketing plans and branding strategies at all 38 facilities using the following process:
 - Consult with facility management and marketing staff to identify facilities’ marketing interests and facilitate the introduction of a customized marketing approach.
 - Design and distribute marketing materials (such as printed information pamphlets and signboards) at participating facilities.
 - Deploy a team of SHOPS marketing and community mobilization officers (MCMOs) to support implementation of each facility’s marketing strategy.

Facility-Level Component 3. Work with private providers and SMC to establish facility-level access to LARC commodities. Activities undertaken included the following.

- Ensure that all 38 facilities had the infrastructure and capacity to store supplies according to product requirements.
- Enhance stakeholders’ ability to plan for, order, and pay for commodities to be able to consistently meet patients’ demand for LARC and PM services.

⁵ To facilitate integration of LARCs and PMs with other MCH services, SHOPS required that program facilities have sufficiently high volumes of maternity or other reproductive health services (i.e. 50-100 deliveries per month, or in smaller facilities, no fewer than 20 reproductive health clients per day); documented support for LARC and PM provision from facility owners and administrators was also required.

Cross-Cutting Component. This component was directed at improving the enabling environment for the provision of LARC and PM in the private sector. As part of this effort, SHOPS and its partners formed a technical working group on LARC and PM in the private sector and met regularly with key stakeholders, such as the DGFP and USAID, to discuss progress to date and resolve issues as they emerged. Through these consultative efforts, SHOPS worked with USAID to arrange a donation of LARC commodities. SHOPS then led a lengthy effort to register these commodities as medical devices with the DGHS and to obtain MFDP authorization of the sale of these commodities to and through private sector entities like SMC. This cross-cutting component, though it was critical to setting up SMC as a reliable private-sector supplier of LARC Commodities, is not a focus of this evaluation, which rather focuses on the facility-level components of the SHOPS Integrated Model.

2.2.2 CONTEXTUAL FACTORS AFFECTING THE IMPLEMENTATION OF THE SHOPS INTEGRATED MODEL

The SHOPS Integrated Model was implemented during a long period of political unrest that began in 2011 and continued through the national election in January 2014. The unrest was rooted in the long-standing and bitter rivalry between Bangladesh's two most prominent political parties. Throughout the program period, supporters of the two major political organizations staged frequent protests, engaged in violent and retaliatory actions against rivals, and called for nationwide general strikes (commonly referred to in South Asia as *hartals*). The unrest was particularly bad during 2013. At least 322 people were killed in clashes, and the 85 days of *hartals* called by the two parties throughout the year frequently brought social and economic life for Bangladeshis to a standstill (Sohel, 2014). The unrest impacted the SHOPS Integrated Model in various ways. It caused delays in training and QA visit schedules, restricting movement of MCMOs and clients to facilities, and it limited the number of facilities that could be brought into the program, especially in Chittagong, since it was increasingly difficult for SHOPS staff to travel to and around that area.

3. METHODS

3.1 STUDY DESIGN

We adopted a multiple-case study design for this implementation evaluation, with case studies of four facilities. We purposively selected cases from the private facilities that implemented the SHOPS Integrated Model to be as broadly representative of the diverse experiences of participating facilities. By using service statistics and monitoring data for all participating facilities, we sought to identify a set of participating facilities that yielded an appropriate amount of detailed information and reflected the diversity of the overall facility group. This approach produced a small but meaningful sample that enabled in-depth exploration of the individual case facilities, while yielding rich information about the implementation of the SHOPS program.

To maximize the utility of these case studies in deriving implications regarding implementation of the SHOPS Integrated Model, we used multiple data sources to facilitate triangulation. That is, in addition to primary qualitative data, in the form of in-depth-interviews with staff and stakeholders from the case study facilities, we also used quantitative and qualitative secondary data were compiled by program staff.

To ensure that the case studies would provide the information needed to address the research questions, we defined a set of case study aims that we used to guide our sampling and data collection approaches. The specific aims of the case studies were:

- To examine how each of the facility-level components of the SHOPS Integrated Model were implemented in each of the facilities selected for the evaluation, and to identify any modifications or adjustments that were made to the model.
- To examine the degree to which LARCs and PMs were provided in the case study facilities.
- To use service statistics and program monitoring data to explore the degree to which the case study facilities' implementation experiences reflect the overall performance trends of the SHOPS-assisted facilities.
- To examine the outputs and progress toward full integration of LARCs and PMs that each of the case study facilities have garnered to date, and assess the extent to which these achievements were expected or consistent with the SHOPS Integrated Model.
- To examine how stakeholders from the case study facilities perceive their experience with LARC and PM service delivery to date, with a focus on the challenges and successes encountered along the way.
- To assess the extent to which stakeholders from case study facilities were planning to continue to provide LARC and PM, following the end of SHOPS support in March 2014.

3.1.1 CONCEPTUAL FRAMEWORK

As a three-pronged and multi-faceted effort, the SHOPS Integrated Model was a complex intervention, designed ultimately to be routinely embedded in participating facilities' MCH practice. Because of this complexity, this evaluation was guided by the Normalization Process Theory (NPT). NPT provides a framework to identify and describe factors that have been shown to be important for either promoting or inhibiting implementation of complex interventions, as well as to assess prospects for the intervention to be viably sustained (May et al., 2007). According to NPT, an intervention's full normalization is achieved when the adopting organizations have embedded and sustained the intervention to the point that it has become a routine part of service delivery.

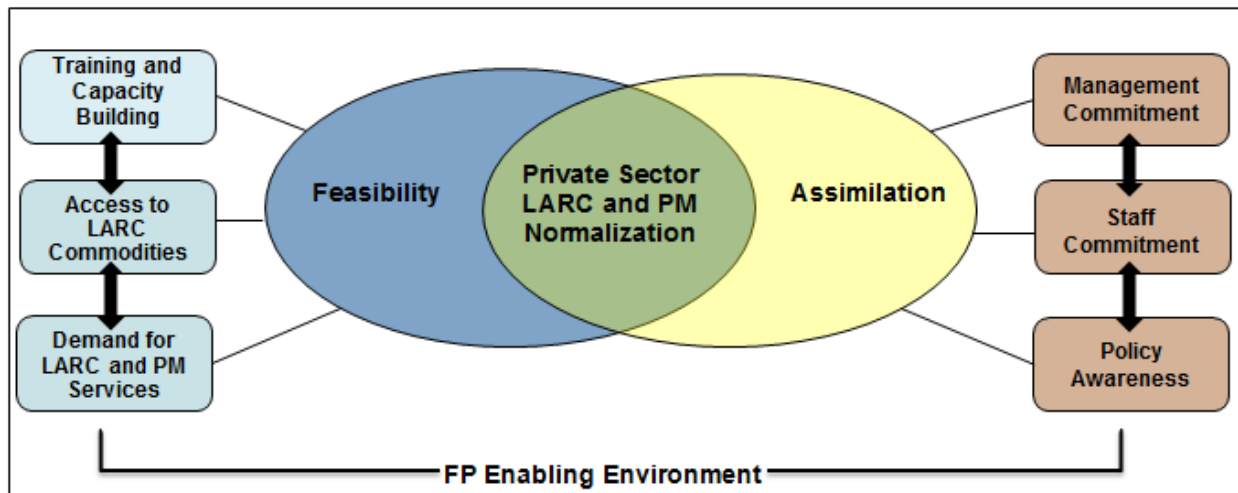
In the context of the SHOPS Integrated Model, the normalization of this approach would result from two interrelated processes: first, LARC and PM integration must become technically **feasible** at the facility level; and second, the intervention must be **assimilated** into the facility's existing business model and operating context. Intervention normalization is not just a matter of achieving full implementation, but also requires that a facility be able to sustain the intervention over time without external support. The SHOPS Integrated Model has been designed to address both routes of normalization, by providing training on service delivery as well as ongoing TA and marketing support.

Since SHOPS was ending at the same time that the evaluation was under way, the evaluation paid particular attention to how facilities were positioning themselves to move into a service delivery phase without SHOPS support. **In the absence of funding or scope to track the selected case study facilities over an extended period of time, the evaluation was not designed to determine whether or not a particular facility had achieved LARC and PM normalization, but rather to examine the progress that facilities had made toward normalization to date.**

To measure and understand that progress, the evaluation examined service statistics and program documents, supplemented by interviews with stakeholders to take stock of program implementation and identify the internal and external factors that could facilitate or hinder the facilities' ability to sustain LARC and PM service delivery into the future. These efforts were framed by a series of hypotheses about the factors thought to have the most bearing on private sector LARC and PM normalization.

The evaluation's working hypothesis was that the facilities that were the furthest along in developing internal capacity to provide and market LARC and PM services were in the best position to sustain LARC and PM services without external support. Figure 1 illustrates the process of normalization of LARC and PM service integration (represented by the **green** area in the center of the diagram). Several factors have direct bearing on the assimilation and feasibility processes that are required to introduce, deliver, and sustain LARC and PM at the facility level. The **light blue** boxes represent factors that the SHOPS Integrated Model was designed to be able to directly influence and shape. The **brown** boxes represent the factors affecting a facility's prospects for LARC and PM normalization that were not as easily (or directly) influenced by SHOPS' work *at the facility level*.

FIGURE 1: FACTORS INFLUENCING PRIVATE SECTOR LARC AND PM NORMALIZATION



According to our hypothesis, the factors represented in the boxes on the left side of the diagram would influence the extent to which a facility was able to integrate LARC and PM services into its existing MCH services (that is, “feasibility,” represented by the **dark blue** oval). (1) **Training and capacity building** is one of the first steps in the integration process. Although SHOPS provided the initial training and QA on LARC and PM service delivery techniques, facilities are ultimately responsible for maintaining their delivery capacity and quality over time. (2) Facilities cannot reasonably provide LARC services without being able to **access a flexible and cost-effective supply of LARC commodities**. Although SHOPS was successful in its efforts to establish a private sector commodity supply during the project’s lifespan, it will be up to SHOPS partners and implementing facilities to monitor and maintain commodity accessibility over the long term. (3) One of the most critical aspects of ongoing LARC and PM feasibility is the extent to which there is **extant or potential demand** for LARC and PM services at the facility. Demand can be directly influenced by a host of factors including: the existing and potential customer base; how and to whom LARC and PM services are marketed; how the facility differentiates itself from public sources of LARC and PM; and the price of LARC and PM services. SHOPS provided intensive TA to facilities to boost facility-level demand for LARCs and PMs during the lifetime of the project, expecting that facilities themselves would then take over these tasks.

Beyond feasibility, several additional factors influence LARC and PM normalization in a private sector facility. These factors are related to the assimilation of LARC and PM services, (represented by the **yellow** oval) and are shown in boxes on the right side of the diagram. (1) The preservation of LARC and PM integration is more likely if the facility can retain **trained and committed clinical and relevant operational staff** that are willing to take responsibility for planning for and delivering LARC and PM services. (2) The extent of staff commitment to LARC and PM continuation is in turn heavily influenced by **facility management/leadership commitment**, since the individuals in these positions are primarily responsible for ensuring staff has the resources and support to maintain LARC and PM service delivery over the long run. SHOPS took into account prospects for facility and staff commitment when selecting facilities for model implementation; however, commitment levels are changeable and highly influenced by facilities’ dynamic operating contexts. (3) Staff must also maintain their **awareness of policies and regulations** that might affect LARC and PM service delivery. This includes awareness of which services they are allowed to provide, who is allowed to provide them, which clients can receive these services, and how they can receive these services. Although SHOPS provided

each facility with a policy orientation, it is up to the facility to ensure that all relevant staff follow applicable regulations and have means to keep abreast of changes to policies over time.

Lastly, LARC and PM service normalization is influenced by the extent to which the **external environment facilitates and enables private sector provision** of LARC and PM services. Through its cross-cutting program components, SHOPS worked successfully with stakeholders from the DGFP, DGHS, and professional associations like the OGSB, to ensure that policies, authorizations, and support for private sector LARC and PM provision was in place. Nevertheless, since environments are naturally dynamic, the environment in which facilities operate will continue to affect LARC and PM provision.

3.2 DATA SOURCES

This evaluation relied on two types of data: primary data and secondary data.

3.2.1 PRIMARY DATA

The primary data are qualitative in nature and take the form of form of semi-structured, in-depth interviews with staff and administrators from each of the case study facilities. SHOPS contracted a team of four local, independent consultants—two interviewers and two note takers—to conduct the interviews in February and March 2014. The interview respondents occupied key positions in their facilities with regard to LARC and PM provision, and they had engaged directly with SHOPS staff or trainers at one or more points during the lifetime of the program. In cases where there were multiple low level employees occupying key staff positions (such as nurses or marketing staff), one or two of these staff were invited to be interviewed, based on their availability. To reduce facility burden, the consultants scheduled interviews at a time of the respondent's choosing and, if necessary, interviewed respondents occupying similar positions in pairs to reduce the overall amount of time devoted to the interview. Selected interview respondents could choose to decline to be interviewed (although none did), and they could opt not to respond to specific interview questions if they wanted. Across the case study facilities, a total of 28 interviews were completed with 32 respondents. The consultants conducted all interviews in Bangla and used an audio recording device to capture the conversation. The consultants subsequently transcribed the interviews and translated them into English. The different types of primary data collected are summarized in Table 1.

The consultants used interview guides designed by SHOPS to reflect the key research questions and aims, tailored for specific respondent types (i.e., facility management/leadership, providers, nurses and pharmacists, marketing staff and MCMOs). Interviews cumulatively covered the following topic areas: how program components were implemented at the facility (i.e., training, QA, LARC and PM provision, perceptions of the SHOPS BEWs, reporting, and marketing strategies); facility-level modifications to the SHOPS Integrated Model; staff perceptions about the model's suitability for the facility; internal barriers and challenges for service delivery in the future; external barriers and challenges; key accomplishments to date; opportunities for expansion or continuation of LARC and PM service delivery; and plans to capitalize on these opportunities. The interview guides are provided in Appendix B.

TABLE 1: PRIMARY DATA COLLECTED

Primary Data	Respondents
In-depth facility stakeholder interviews (n=30)	<ul style="list-style-type: none"> • Facility management/leadership (i.e., administrative manager, owner, or managing director) • Ob-Gyn department head and or SHOPS focal point provider • Ob-Gyns trained by SHOPS partners • Nurses or other administrative staff (such as a pharmacist) trained by SHOPS partners • Marketing team staff (if applicable) • SHOPS MCMO assigned to case study facility

3.2.2 SECONDARY DATA

The primary data collected through in-depth interviews were supplemented by various forms of quantitative and qualitative secondary data. The secondary data allowed us to contextualize interview respondents' comments and to explore potential LARC and PM viability implications for the larger group of facilities that participated in the SHOPS Integrated Model. The secondary data include program monitoring data and service statistics (collected by SHOPS Bangladesh staff from all participating facilities throughout the lifetime of the program), consisting of: service statistics, QA reports, and program component tracking. To compare private sector facility performance with the public sector, we considered public and NGO facility service statistics obtained by SHOPS Bangladesh and provided by the Ministry of Local Government's North and South Dhaka district FP offices, and two regional service facilities overseen by the DGFP. Key facility-level documents were also reviewed, including the facility selection strategy and assessments and the memoranda of understanding, as well as each case study facility's LARC and PM business and marketing plans. The different types of secondary data collected are summarized in Table 2.

TABLE 2: SECONDARY DATA COLLECTED

Secondary Data	Data Sources
Performance measure and monitoring data	<ul style="list-style-type: none"> • LARC and PM service delivery statistics (all participating facilities, by type and month, November 2012–March 2014) • QA visit checklists (case study facilities only; most facilities had 3 QA visits) • Model component implementation status tracker (all participating facilities; includes tracking on training progress, marketing TA, QA status, and perceived staff commitment and overall performance) • Aggregated LARC and PM service delivery statistics from 201 public and NGO facilities in Dhaka (by type and month, January–December 2013)
SHOPS Documents	<ul style="list-style-type: none"> • Private Sector Facility Selection Strategy • Private Sector Selection Facility Assessment (case study facilities only) • MOU between the facility and SHOPS (case study facilities only) • Facility-level LARC and PM business and marketing plans (case study facilities only)

3.3 SAMPLE

We selected four individual facilities as case study subjects through a two-stage selection process. The first stage of the process used a theoretical sampling approach, on the basis of convergences or divergences in a number of key characteristics that we hypothesized could have bearing on LARC and PM normalization and viability. These characteristics include: facility type (e.g., private medical college hospital (PMCH) or private-for-profit hospital (PFPH)), the status of LARC and PM integration, length of implementation period, facility commitment to perform LARC and PM services, SHOPS staff perception of a facility's potential for success, and previous experience or exposure to LARC and PM service delivery. Only facilities with the following characteristics were considered eligible for case study subject selection:

- **Facilities that began service delivery before June 2013.** This date threshold ensured that facilities had been implementing LARC and PM services for three or more quarters by the time data were collected in February 2014. This criterion presumes that facilities needed ample time to work through initial model adoption in order to begin normalizing LARC and PM services at their facility.
- **Facilities in which SHOPS had been able to implement all aspects of the integrated model** including provider training, curriculum integration, BEWs, and deployment of a SHOPS-provided MCMO.
- **Facilities that were *not* run by SHOPS' partners** such as the OGSB, Marie Stopes Bangladesh, and AITAM Welfare Organization. Since partner-run facilities already had exposure to or a stake in LARC and PM promotion, these facilities were already well-positioned to be LARC and PM adopters prior to the implementation of the SHOPS Integrated Model.
- **Facilities located in the Dhaka vicinity.** Intensive, ongoing political strike activity in the Chittagong vicinity prevented the SHOPS team from being able to fully support and monitor implementing facilities in this area, and for the purposes of this study the Chittagong facilities cannot be considered to have implemented all aspects of the SHOPS Integrated Model.

Applying these criteria resulted in a subset of 15 facilities (5 medical colleges and 10 private hospitals). A second selection stage narrowed this subset to four suitable case study subjects by applying additional criteria

Since SHOPS implemented its program in two distinct kinds of facilities—private medical college hospitals (PMCHs) and private-for-profit hospitals (PFPHs)—the SHOPS team was interested in exploring implementation in both types of facilities with equal emphasis on each facility type. Accordingly, the sample included two facilities from the cluster of PMCHs and two from the cluster of PFPHs. Facilities from these clusters were purposively selected using a “range-representative” sampling approach, to permit a rich description and exploration of the ways in which implementation varied across participating facilities.

Using a range-representative sampling approach to select case study facilities enabled exploration of a broad range of implementation experiences across the full spectrum of facilities associated with the SHOPS program. To ensure that this variation was achieved, we used a field monitoring tool created by the SHOPS Bangladesh staff to track implementation and success of the SHOPS Integrated Model in 38 facilities. The tool is a scoring rubric that SHOPS Bangladesh staff used to score facilities for a set of key elements (11 for PMCHs, 10 for PFPHs). These elements reflected SHOPS Bangladesh's *subjective* assessment of the facility's progress toward LARC and PM integration, at different points throughout the lifetime of the program. Appendix A presents a detailed description of the tool and the way it was used to

select cases for this evaluation. Using this tool we were able to identify four facilities that, when considered together, represent the full range of implementation outcomes.

- **City Hospital** and **Medical College for Women and Hospital** (WMC Hospital) are facilities where most aspects of LARC and PM training, delivery and marketing were perceived to have gone smoothly.
- **Shaheed Monsur Ali Medical College Hospital** (SMAMC Hospital) seemed to have a somewhat more uneven experience, with some aspects of model implementation going well, and other aspects falling short of expectations.
- **Galaxy Hospital** was among those facilities that lagged behind other facilities and seemed to have experienced numerous implementation challenges.

Out of the remaining eight PFPH and three PMCHs, we also selected a one facility to pilot the data collection instruments (interview guides), giving the data collection consultants practice with the instruments during their training period. Taking into account facility willingness to participate, availability of providers for interview, and reduction of burden (i.e., no previous participation in SHOPS monitoring and evaluation activities), an additional PMCH, **International Medical College Hospital** (IMC Hospital) emerged as the most appropriate choice for piloting. Although SHOPS Bangladesh had perceived it as a “high potential” facility, International PMCH had been implementing services over a shorter period of time than the other four case studies, thus allowing some additional contrast. Since piloting efforts went well and the quality of the information collected from staff interviews was comparable to the data collected from the other four facilities, we incorporated International MCH data into the analysis and results discussion. Table 3 shows summary profiles for each of the case study facilities; narrative profiles of each of the case study facilities can be found in Appendix A.

TABLE 3: CASE STUDY FACILITY DETAIL

	Private-for-Profit Hospitals (PFPH)		Private Medical College Hospitals (PMCH)		
	City Hospital	Galaxy Hospital	WMC Hospital	SMAMC Hospital	IMC Hospital (Pilot)
Number of Beds	150	100	350	360	300
MCH Patients per Month	500 (including 60 deliveries)	2,000 (including 30 deliveries)	4,000 (including 200 deliveries)	5,000 (including 150 deliveries)	4,000 (including 180 deliveries)
Client Base	Upper class (\$1280 or more /month)	Middle class (\$250-390/month)	Lower-middle/middle class (\$77-390/month)	Poor/ lower-middle class (\$38-100/month)	Poor /lower-middle class (\$38-100/month)
SHOPS MOU Date	July 2012	February 2013	August 2012	August 2012	December 2012
Start of Service Delivery	November 2012	November 2012	February 2013	January 2013	June 2013
Number of Providers Trained	2 residents, 3 part-time consultants	2 part-time consultants	8 professors/doctors, 10 junior doctors	8 professors/doctors	8 professors/doctors
Number of Nurses Trained	4	2	16	17	9
BEW Participation	Trained providers (including focal point); administrators	N/A (Only focal-point provider received TA)	Over 20 staff (including trained providers, nurses and management)	N/A (Only facility administrator received TA)	Trained providers (including focal point) and nurses
Marketing Support	In-house marketing team; MCMO actively involved in reporting, face-to-face advising/promotion with clients, and community marketing	No marketing team; MCMO was responsible for reporting, face-to-face advising and promotion with clients, and community marketing tasks	No marketing team; MCMO responsible for development of marketing workplan, spreading the word among facility's existing referral network, distribution of leaflets; some face-to-face promotion with clients	No marketing team; MCMO responsible for development of a marketing workplan and distribution of leaflets in community; face-to-face advising and promotion with clients	In-house marketing team; MCMO provided monitoring, advising, TA services. (MCMO was male, limiting the extent of engagement with clients.)
Distinguishing Features/Reasons for Selection	High performance; examine transfer of MCMO capacity and know-how to staff for long-term maintenance of LARC and PM integration	Low performance; examine how support for LARCs and PMs could be cultivated in environments with low levels of managerial commitment	Successful implementation; examine success to date as well as ability to sustain after the end of the SHOPS program	"Middle of the pack" performer; examine experience of a facility that neither excelled nor floundered in implementing the SHOPS Integrated Model	High quality pilot data; provides opportunity to explore facilities in early implementation period; different role for MCMO

3.4 ANALYSIS APPROACH

3.4.1 QUALITATIVE DATA

We analyzed qualitative data from the in-depth interviews and document review using a two-stage thematic analysis approach, seeking both *within-case* analyses, to explore how concepts emerging at a single facility related to one another, and a *cross-case* analysis, to yield commonalities between case subjects (Eisenhardt, 1989). We subsequently assessed the impressions, overarching themes, and tentative relationships emerging from this process to examine their fit with the evaluation’s theoretical framework and ability to address the research questions.

In the first stage of analysis, interview transcripts and program documents were uploaded into the commercially available qualitative analysis software NVivo 10 (QSR International Pty Ltd., 2012) and were coded using a codebook of a priori codes, reflecting themes and concepts based on the factors identified in this study’s theoretical framework and research questions. In addition, the transcripts and documents were coded inductively for unanticipated patterns, themes, and categories that emerged from the data.

In our second stage of analysis, we used NVivo’s querying functions to investigate our coding and look for differences and similarities between respondent types and facilities. Examining coding within and across facilities allowed exploration of relationships across themes. Table 3 gives examples of the different themes explored. The insights from these queries are reflected in the study findings and conclusions.

TABLE 4: THEMES EXPLORED WITH NVIVO QUERIES

Examples of Themes Explored (within and across facilities/respondents)
<ul style="list-style-type: none">• Intersection of national and facility motivations to provide LARCs and PMs• Outlook on LARC and PM service delivery going forward• Strategies used to encourage LARC and PM uptake• Perceptions of SHOPS support• Barriers to LARC and PM provision• LARC and PM awareness and buy-in among staff (clinical and management staff)• Perceived trends in LARC and PM uptake and the extent to which these reflect/refute performance data

3.4.2 QUANTITATIVE DATA

We undertook a basic descriptive analysis of both the private and public sector service statistics in Microsoft Excel 2011 to assess average monthly and cumulative service delivery trends over the program lifetime and examine how the LARC and PM method mix varies among facilities and between sectors. We completed the descriptive analysis for all SHOPS facilities, not just those selected as case study subjects, so that that we could better place the case study facilities in context of the program at large and also assess service performance over time for the entire program.

3.5 ETHICAL CONSIDERATIONS

Prior to commencing data collection, the research team submitted the research protocol for ethical review by the Abt IRB. The Abt IRB deemed the study to be exempt from further review. The evaluation did not meet the threshold criteria that would trigger review by the Bangladesh DGHS IRB. Regardless of these exemptions, the evaluation team maintained ethical research

practices by implementing a verbal informed-consent process to secure voluntary respondent participation ahead of the interview. The research team scheduled interviews at the respondent's convenience and conducted them in a private location of the respondent's choosing. Although the case study facilities are identified by name in this report, the names of respondents are not included, to protect respondent privacy. Respondents were free to choose whether not to respond to any of the questions, and could designate any comment as "off the record" to exclude it from analysis or reporting.

SHOPS engaged an independent research team to complete the evaluation of the SHOPS Integrated Model implementation team. The lead researcher was not a part of the SHOPS Integrated Model's implementation team. Although the Bangladesh-based staff involved in implementing the SHOPS Integrated Model collected and compiled facility performance data, the lead independent researcher completed the analysis of this data. The lead researcher traveled to Bangladesh to hire and train a team of independent local consultants to conduct in-depth interviews with all of the case facility respondents. Like the lead researcher, these consultants were not involved in program implementation.

3.6 LIMITATIONS

This evaluation is primarily a case-study-based examination of the implementation of the SHOPS Integrated Model, and many of the insights that have emerged from this evaluation are based on data that is specific to the case study facilities selected for study. However, to maximize utility, we sought a "data driven" sample that reflected the range of implementation variation and employed data triangulation so that the evaluation could capture a more comprehensive picture of mediating factors that not only affected the sample facilities' operating contexts but also the wider LARC and PM Dhaka service environment. This approach created latitude for theoretical transferability to other facilities that participated in the SHOPS Integrated Model in Dhaka.

A further limitation is that financial and temporal limitations narrowed the scope of this evaluation, focusing on program implementation from a supply-side (i.e., facility) perspective. No conclusions can be drawn about the consumers who chose to engage (and not to engage) with private sector facilities to obtain services that fulfill their FP goals. An examination of private-sector LARC and PM consumer perspectives would be an excellent topic for further study.

4. FINDINGS

Findings from the implementation evaluation are presented in two parts. The first part of this section presents results from the analysis of performance monitoring data, collected from both private and public facilities in Dhaka that participated in the SHOPS Integrated Model, to highlight how the LARC and PM service delivery trends unfolded over the course of the program. The second part of this section presents qualitative case study data to put the monitoring data in context and to illuminate facility perspectives on introducing, providing, and sustaining LARC and PM services.

4.1 LARC AND PM SERVICE DELIVERY TRENDS

4.1.1 ALL SHOPS FACILITIES IN DHAKA (SERVICE TOTALS, AVERAGES, AND METHOD MIX)

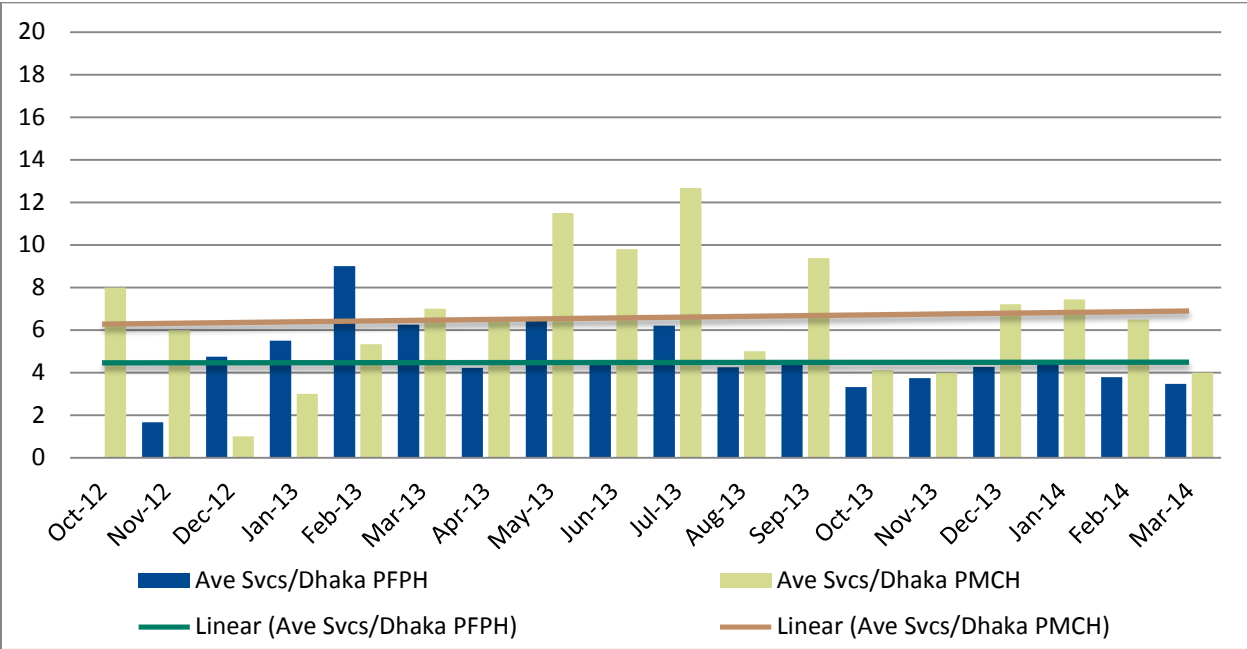
In the first year of the program, SHOPS identified 83 facilities to engage and assess for LARC and PM provision suitability. Fifty facilities were selected for participation and signed a memorandum of understanding with SHOPS. Of these, 47 facilities went on to participate in training, and 38 went on to obtain LARC commodities and to attempt to deliver and market LARC and PM services. One hospital in Dhaka “dropped out” shortly after they entered the service delivery phase because of attrition of trained providers; they are not included in this analysis. By the program’s end, 37 facilities were still engaged: 5 facilities (1 PMCH and 4 PFPHs) are located in Chittagong, and 32 facilities (10 PMCHs and 22 PFPHs) are located in Dhaka. This section examines only the performance outcomes for SHOPS facilities in Dhaka, because start-up in the five Chittagong facilities was severely delayed by political unrest in the area, and this case study sample is therefore entirely contained within Dhaka.

Over the entire period of service delivery (October 2012–March 2014), a total of 1836 LARCs, PMs, and injectables were delivered by 32 participating private hospitals and medical college hospitals in Dhaka. The monthly cumulative total of services increased steadily over time, as participating facilities came on line and began delivering services. Although the final Dhaka facility came online only in February 2014 (just one month before the end of the program), by September 2013 a full 90 percent of facilities were providing LARCs, PMs, and injectables.

SERVICE DELIVERY AVERAGES

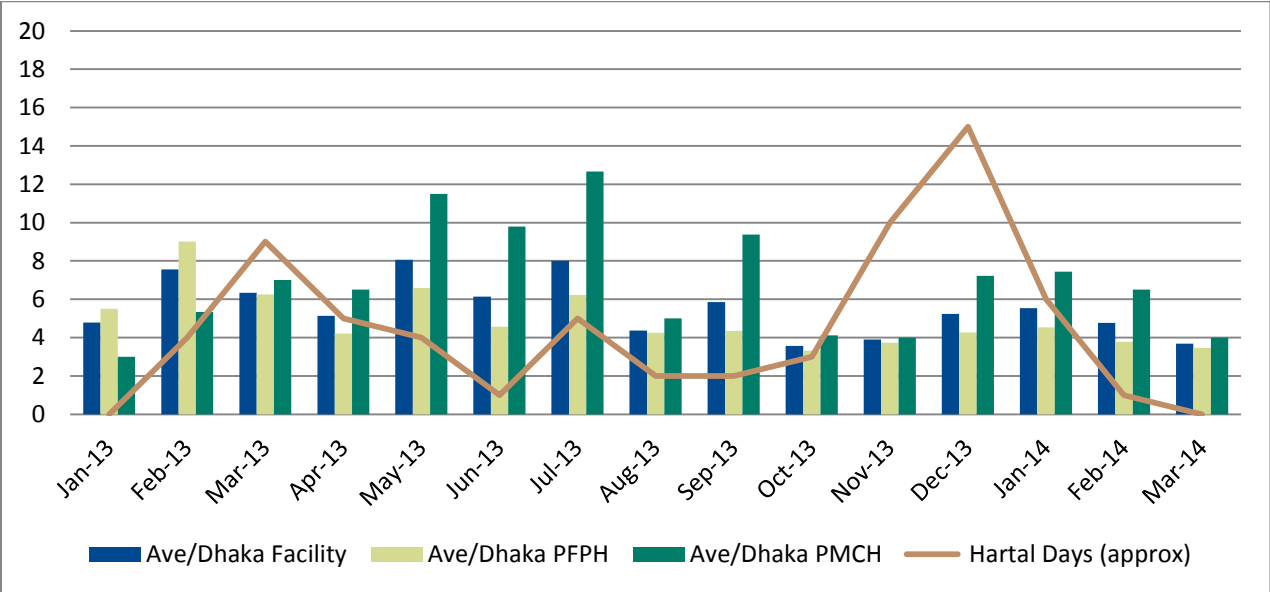
A relatively flat trend in service delivery can be observed in average monthly service totals. Figure 2 shows that the linear trends for both PMCH and PFPH facilities were generally flat over the 18 months that facilities participated in the SHOPS Integrated Model. On average, participating facilities provided about 5.5 LARC, PM *and* injectable services per month: PMCHs provided 6.6, and PFPHs provided only 4.3. Monthly delivery of LARC, PM, and injectables seems to “peak” in early 2013 for PFPHs and a few months later for PMCHs, indicating that most facilities did not accelerate the pace of service delivery over time.

FIGURE 2: AVERAGE MONTHLY LARC AND PM SERVICE DELIVERY, PARTICIPATING FACILITIES (PROJECT LIFETIME)



As noted previously in this report, all Dhaka facilities were operating in a context of mass unrest, especially during the latter half of 2013. While LARCs, PMs, and injectables were new service offerings that may have needed an extended period of time to catch on with clients, it is also true that the continuous—and at times violent—general strikes (*hartals*) often prevented facilities from being able to market their services and prevented clients from being able to travel to facilities to obtain services. When 2013 service delivery data are plotted against the approximate number of days per month in which a hartal (national or Dhaka-specific) was declared, there indeed appears to be an inverse relationship between the two variables (Figure 3).

FIGURE 3: "THE HARTAL HANGOVER" - 2013 UPHEAVAL AND SUPPRESSION OF SERVICES*

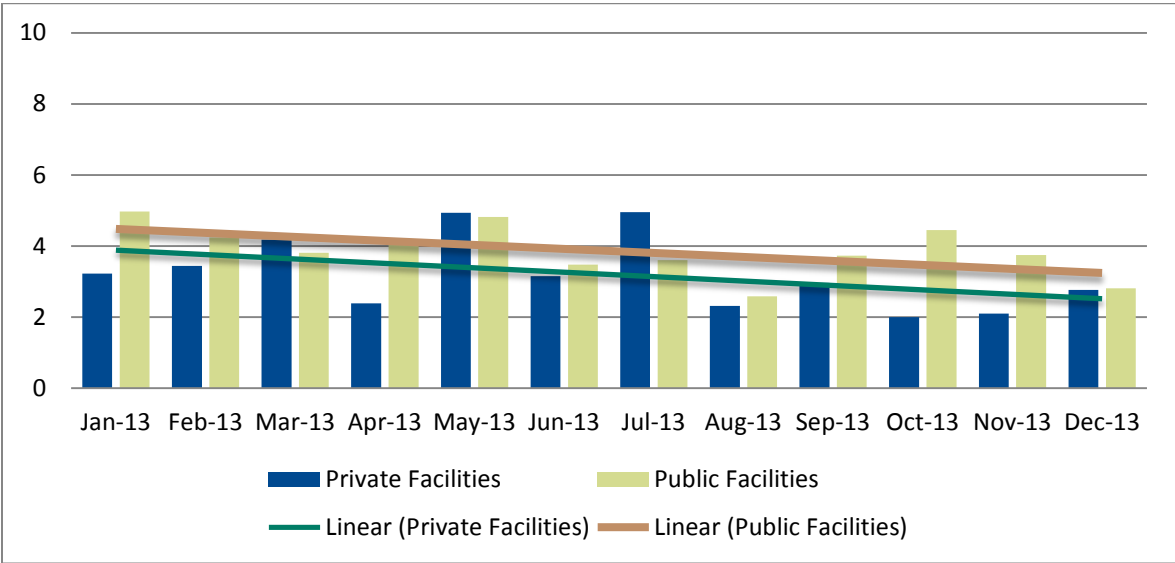


* Hartal days were estimated using news archives and archive announcements from the US Embassy in Dhaka.

COMPARING PRIVATE FACILITIES TO PUBLIC FACILITIES

One could look at these trends and conclude that the fledgling private sector service market for LARCs and PMs is underperforming. However, a broader comparison with the 2013 service delivery statistics for comparable sample of 201 public and NGO facilities in Dhaka shows a similar pattern (Figure 4).⁶ In 2013, public and NGO facilities provided 3.9 IUD, tubectomy or implant services per month on average, while private facilities provided 3.2 IUD, tubectomy, or implant services per month on average, with both types of facilities reflecting a negative linear trend as the year wore on. This performance indicates that within a relatively short period of time, private sector facilities participating in the SHOPS Integrated Model were able to “catch up” to the public sector’s delivery rate for IUDs, tubectomies, and implants. It also implies that the low rates of LARC and PM provision observed may be a reflection of a broader lack of demand for these specific methods, and is not unique to the private sector.⁷

FIGURE 4: MONTHLY LARCS AND PMS –PUBLIC VS. PRIVATE FACILITIES IN DHAKA (IUD, TUBECTOMY, AND IMPLANT)



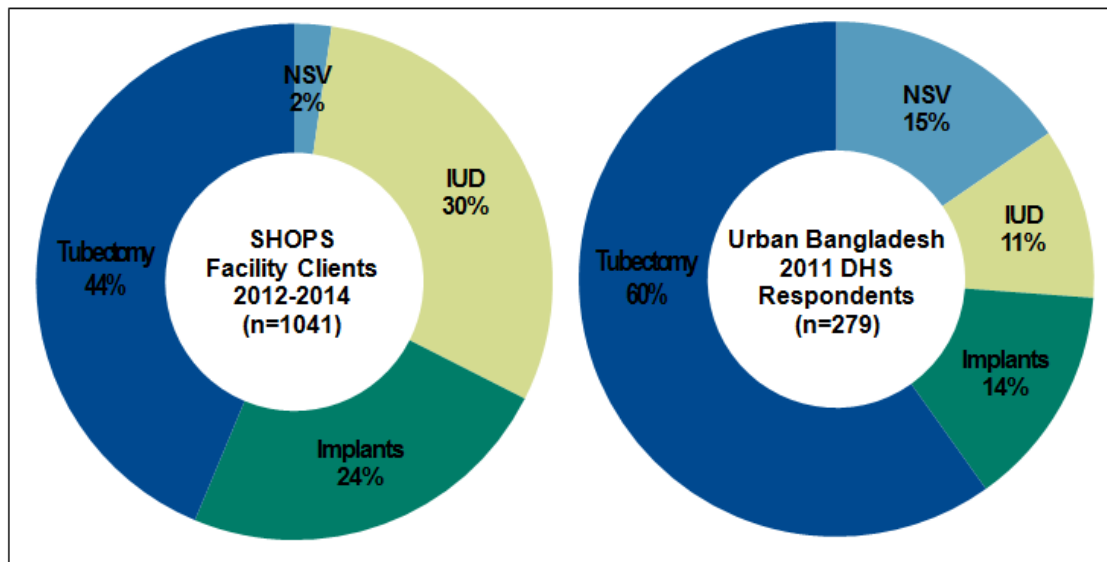
LARC AND PM METHOD MIX

Out of the total number of LARCs, PMs, or injectables SHOPS facilities provided during the project lifetime, 57 percent were LARCs or PMs. An examination of the different types of LARC and PM services that patients sought from SHOPS facilities shows that tubectomies (44 percent) were the most popular type service provided. IUDs and implants respectively comprised 30 and 24 percent of overall services rendered, while NSV was the least-provided service at just 2 percent.⁸ Comparing this pattern to the nationwide method mix for LARCs and PMs, Figure 5 shows a greater proportion facility clients opted for LARC methods than would be otherwise expected, based on the 2011 DHS results for urban LARC and PM users. A chi-square test (X^2) found a statistically significant difference between the DHS and SHOPS method mixes.⁹ This analysis indicates that private facilities may be having greater than expected

⁶ Since public sector data on injectable services delivered was not available and most private sector facilities participating in the SHOPS Integrated Model opted not to provide NSV, only service statistics for IUDs, implants, and tubectomies are compared.
⁷ This is especially evident when comparing the monthly NSV delivery rate (4.4) for 2013 with the combined rate for IUDs, implants, and tubectomies (3.9). This suggests that NSV is by far the most popular LARC and PM method in public and NGO facilities.
⁸ Only three SHOPS facilities elected to launch NSV services, which explains why few NSV clients were served. Most facilities chose to focus first on services that they could market and provide to women.
⁹ The chi-square value is 580.32 with 3 degrees of freedom and $P < .0001$.

success in attracting users to implants and IUDs, which have historically been the least-used modern FP methods in Bangladesh.

FIGURE 5: LARC AND PM METHOD MIX – SHOPS FACILITY CLIENTS VS. URBAN DWELLERS



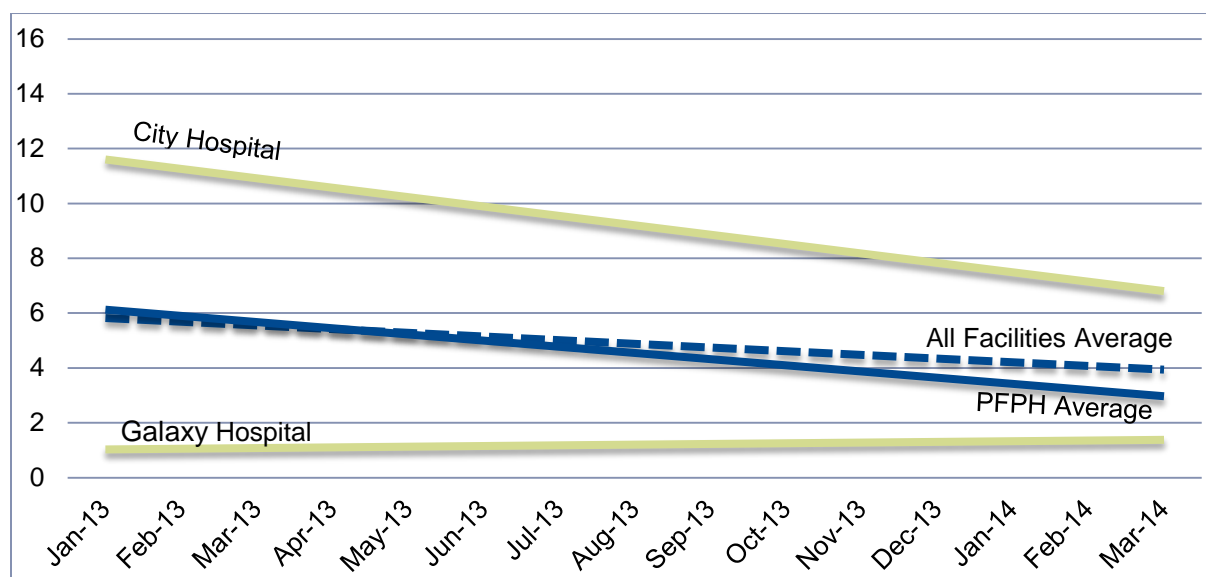
4.1.2 CASE STUDY FACILITIES

Analyzing overall service statistics by facility type reveals some differences in trends between PFPH and PMCH facilities. The next section presents some of these differences, along with detail about the case study facilities.

PRIVATE-FOR-PROFIT HOSPITALS

PFPH facilities provided 4.3 services per month on average, and as Figure 6 shows, the rate of service delivery at these facilities trended negatively over the course of the program. Figure 6 also compares the two PFPH facilities selected for case study to the larger group of participating PFPH facilities in Dhaka. Galaxy and City hospitals provide an opportunity to explore the extremes of the implementation experience and detail on these facilities' performance is provided below. There is not a case representing the mid-point.

FIGURE 6: LARC AND PM SERVICE DELIVERY – PRIVATE-FOR-PROFIT HOSPITALS



City Hospital delivered a total of 147 services between November 2012 and March 2014, making it one of the highest performing of the PFPH facilities over the lifetime of the project. City Hospital delivered an average of 8.6 services per month, although (as shown in the trend line in Figure 6) the rate of delivery declined over the course of the 17 months the facility was actively delivering services. During this period, City Hospital provided four types of services: injectables, IUDs, tubectomies, and implants. Nearly half (48 percent) of all of City Hospital Services were injectables, a proportion similar to the other PFPHs. In seven of these facilities, injectables made up well over half of services provided (ranging from 57 to 100 percent). Overall, injectables, IUDs, implants, and tubectomy services constitute a very small proportion of this facility's MCH services. According to City Hospital's original program suitability assessment, SHOPS and facility staff estimated that about 500 MCH patients are served monthly. Based on this estimate and City Hospital's monthly service statistics, only about 2 percent of MCH patients per month are opting to receive a LARC or PM service.¹⁰ Although this figure indicates a low rate of LARC or PM uptake, it does not reflect the proportion of women opting for a short-term contraceptive method, nor does it indicate the proportion of women that would be interested in using a LARC or PM method in the future.

Galaxy Hospital delivered a total of 20 services between December 2012 and March 2014. At just 1.3 services per month, Galaxy Hospital was among the lowest performing facilities, although its delivery rate remained relatively stable over the course of the program. Unlike most other PFPH facilities, Galaxy Hospital's service delivery was IUD-driven (60 percent of services), with implant services constituting the next largest proportion of services (20 percent). Like City Hospital, the IUDs, implants, and injectables provided constitute a negligible proportion of this facility's MCH services. According to Galaxy Hospital's original program suitability assessment, SHOPS and facility staff estimated that about 2,000 MCH patients are served monthly. Based on this estimate and on City Hospital's monthly service statistics, only about 0.05 percent of MCH patients per month are opting to receive a LARC or PM service.

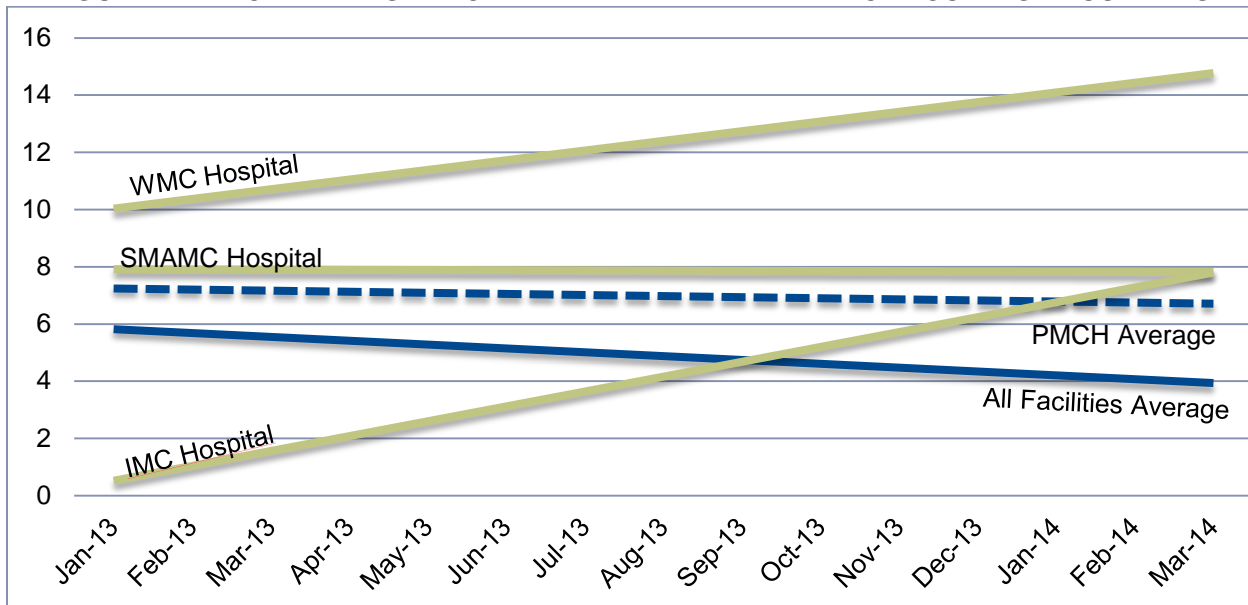
PRIVATE MEDICAL COLLEGE HOSPITALS

PMCH facilities provided about two more services per month on average than their PFPH counterparts (6.6 services). In addition to providing more services, the delivery rate at all PMCH facilities taken together was stable over the course of the program, suggesting that PMCH facilities in Dhaka were in a better position to sustain LARC and PM provision in the post-SHOPS era. Factors contributing to this stability are explored in section 4.2.

As Figure 7 shows, both WMC Hospital and SMAMC Hospital performed better than the average PMCH, although SMAMC Hospital was clearly closer to being an "average" performer. Even though International MCH started relatively late into the program, its delivery trend was positive; by 2014, IMC Hospital was performing at a level at or above the PMCH average.

¹⁰ In calculating this percentage for this and other facilities, we presume that only one LARC and PM service can be provided to a client at a time, and that given the design of LARC and PM products, clients are not seeking multiple services per month. We acknowledge that there are likely exceptions to this assumption (i.e., a client has an IUD removed and subsequently has an implant placed), but as less than 3 percent of services provided by all facilities were removals, this scenario was not common. An additional caveat to this statistic is that it is based on SHOPS Bangladesh and facility staffs' estimates of monthly MCH clients patronizing each facility; we were not able to obtain data from facilities to verify these estimates.

FIGURE 7: LARC AND PM SERVICE DELIVERY – PRIVATE MEDICAL COLLEGE HOSPITALS



WMC Hospital, with a total of 176 services delivered between February 2013 and March 2014, delivered more services than any other participating facility. WMC Hospital delivered an average of 12.6 services per month, and although the rate of delivery dipped at the end of 2013, the overall trend service delivery rate for this facility was positive. WMC Hospital provided a wide variety of services—including injectables, LARCs, and PMs (including one NSV). However, over half of the services provided (52 percent) were injectables; no other participating PMCH had such a high proportion of injectables in its method mix. Out of the LARC and PM services provided, IUDs made up the smallest proportion of services (6 percent). Since this facility is specifically oriented to serve women, it is estimated to have a high monthly flow of MCH clients (4,000). Although the service statistics suggest that provision of LARCs, PMs, and injectables has been successful, WMC Hospital provided these services to a tiny proportion of its monthly clientele (0.3 percent on average).

SMAMC Hospital, with a total of 118 services delivered between January 2013 and March 2014, was neither a particularly strong nor weak performer. SMAMC Hospital delivered an average of 7.9 services per month, and although the total number of services varied monthly, SMAMC Hospital’s overall linear service delivery trend was flat throughout the program. SMAMC Hospital provided a more balanced mix of services than many other facilities, providing roughly equal proportions of injectable and implants (38 and 32 percent, respectively). Tubectomies, IUDs, and implant removals constituted the balance of services provided. Still, like other facilities, LARC and PM services barely register among the estimated 5,000 MCH patients seen each month (0.2 percent of clientele on average).

IMC Hospital delivered a total of 56 services between June 2013 and March 2014, with an average of 5.6 per month. Although there was *harta* activity throughout much of the time that the facility was delivering services, by the end of the SHOPS Integrated Model, the rate of service delivery at IMC Hospital seemed to be on an upward trajectory. The mix of LARC and PM services provided at IMC Hospital is similar to that of WMC Hospital: injectables comprised about half of services (48 percent), while tubectomies and implants each made up 22 percent of services. As with all PMCH facilities, IUDs were the least popular of the LARC and PM services provided. With an estimated 4000 MCH patients per month, injectable, LARC, and PM services again represent a small proportion of services provided to these clients (0.2 percent of clientele on average).

4.1.3 IMPLICATIONS OF PERFORMANCE MONITORING DATA

The delivery rate for injectables, LARCs, and PMs was low compared to participating facilities' estimated overall MCH service totals. Service delivery rates ranged from 4.3 (PFPH) to 6.6 (PMCH) per month on average. This trend has both positive and negative implications for LARC and PM provision in the current private-for-profit context. At this low level, provision of these services probably does not strongly register (positively or negatively) with facility management. Although LARC and PM services are not likely to be an important revenue-generating venture for facilities, it is important to remember that the SHOPS Integrated Model was set up to minimize the risk in introducing LARC and PM services and to give facilities space to explore how LARC and PM services could best be integrated as a “value-add” to existing MCH service offerings.

The low delivery rates for injectables, LARCs, and PMs at private facilities were generally comparable to rates in the public sector. This suggests that *current* demand, at least, is anemic, tamped down by contextual factors, including political unrest and consumer biases against LARCs and PMs. With the wind-down of the SHOPS Integrated Model in March 2014, anemic overall demand will mean that some facilities will face a relatively difficult operating context going forward.

The prospects for SHOPS facilities are explored in the next section, using the case studies as illustrative examples that are also relevant and applicable to the other facilities SHOPS targeted.

4.2 LARC AND PM PROVISION AT THE FACILITY LEVEL

This section explores implementation of the SHOPS Integrated Model and provision of LARC and PM services from the perspective of some of the participating facilities. An analysis of case study interview data yields some key themes that highlight how participating facilities functioned, in **introducing, delivering,** and potentially **sustaining** LARC and PM services.

4.2.1 INTRODUCING LARC AND PM SERVICES

The LARC and PM implementation experience starts with the process facilities followed to introduce LARCs and PMs, which in turn involved motivation (or commitment) of management, training of staff, and supply of commodities.

4.2.1.1 MOTIVATIONS

As discussed in Section 2, FP is a front-and-center national priority in Bangladesh and there is widespread recognition of the links between the impacts of Bangladesh's population dynamics and the country's overall well-being. It is not surprising, therefore, that a key motivation to participate in the SHOPS Integrated Model was to afford facilities the opportunity to contribute to the “national population program.” So strong was this motivation that, in every case study facility, being able to contribute to the fulfillment of the national cause was unanimously cited as the *principal* reason to introduce LARC and PM services at the facility. Even though the PMCH and PFPH facilities share this primary motive, respondents also acknowledged ancillary motives, although they were described differently by respondents from PMCH and PFPH facilities. This difference may be influenced by the contrasting ways in which these two types of facilities derive revenue.

It is a national program. In our country, population is increasing day by day. Government services cannot cover such a huge population. The private sector also has the responsibility to combat the national problem.

– WMC Hospital Respondent

PRIVATE MEDICAL COLLEGE HOSPITALS

When talking about the reasons why their facility had decided to introduce LARC and PM services, PMCH respondents emphasized the need for the facility to offer a comprehensive range of MCH services, since PMCHs have a responsibility as teaching facilities to provide

This is a medical college, so we want to provide all types of services to our clients at the same time we are teaching FP to our students. As we are providing [LARC and PM] services to our clients, it has also created opportunity to demonstrate to our students. Overall it is a national program and we are contributing to it.

—SMAMC Hospital Respondent

diverse learning opportunities for their students. When probed specifically about the potential “business case” for offering these kinds of services in their facilities, PMCH respondents simply reemphasized the linkage between service to national goals and provision of LARCs and PMs and deemphasized or ignored motives related to business development, profit, or client cultivation. Although this stance may seem specious for a private commercial entity, it

is important to note that, unlike private-for-profit hospitals, all the SHOPS PMCHs are part of large educational organizations that are structured to bring in revenue mainly via student tuition rather than hospital fees. Further, since private medical college hospitals are nationally mandated by the government of Bangladesh to serve low income clients, in return for their initial land grants, they must price their services accordingly. Although this approach does not maximize revenue, it *does* bring clients in the door, which in turn is critical to ensuring that the organization can fulfill its duty as an educational institution, thus maintaining a robust tuition-paying student body. In other words, although LARCs and PMs are not necessarily seen as a means to directly enhance the business, they are not solely fulfilling a charitable purpose at these facilities.

We are providing this service not for making profit. We wanted to contribute something for our nation. Sometimes we even give free [LARC and PM] services to our clients. We never thought in that way [sic].

—IMC Hospital Respondent

PRIVATE FOR-PROFIT HOSPITALS

PFPH respondents as well spoke a lot about the national population program and the importance of “service to the nation.” Nevertheless, we might expect PFPHs to be motivated by more overt business motives, since these facilities’ revenues depend on the fees they charge for the medical services they render. City Hospital respondents were more explicit about the business-related motives for offering LARC and PM services. One respondent noted that LARCs and PMs provided another way in which the facility could distinguish itself from its competitors.

We have ICU, NCU, burns unit, and some other services which you will not get in most of the private hospitals. We are providing quality services to our clients and doing business. Introducing FP services has opened another window of services for us.

—City Hospital respondent

Several other respondents from City Hospital recognized that, in service to the national population program, the facility can subsequently fashion itself as a “one-stop” for women’s health services, which can help to attract more clients.

The owners and administration were very much interested; that’s why they gave permission to introduce LARC and PM services in this hospital. They look at this service as participating in the national population program at the same time they are doing business out of it. They know that day by day demand for LARC and PM services is increasing in this hospital. When anyone is taking LARC and PM services, they also know other services of this hospital. In this way the number of our client is increasing, and clients mean business.

—City Hospital respondent

Galaxy Hospital respondents reported different motives. Like the rest of the sample, they cited contribution to Bangladesh’s population program as motivating their participation, and the potential of LARC and PM services to contribute to business objectives was not explicitly recognized. The reasons for this stance may be linked to the way that LARC and PM services were delivered at Galaxy. Galaxy Hospital only became part of the SHOPS Integrated Model at the behest of a single provider, wanting to expand FP service options for her consultative practice at this facility. Although she had

Yes, we have an overall business plan for our hospital, but we don’t have any plan for [LARC and PM] services. [Ob-Gyn] doctors are responsible for providing [LARC and PM] services and doing its plan [sic]. We have just given them permission to continue this service.

—Galaxy Hospital respondent

administrator support to provide these services in concept, this support was always passive and unengaged, without administrator-level buy-in to the business case for LARCs and PMs. This reality may explain why, despite the presence of a strong champion for FP services on staff, the facility did not have any plan to leverage these services. The case of Galaxy demonstrates the need for strong administrator motivation, in addition to strong staff motivation.

4.2.1.2 TRAINING

Once SHOPS was able to confirm that a facility was sufficiently motivated to integrate LARC and PM services into its existing MCH offerings, SHOPS staff worked with facilities to sequence skills training in a way that was not overly burdensome (in terms of lost time and resources). Together with its training partners, Mayer Hashi and AITAM, SHOPS planned flexible, customized trainings that allowed facilities to opt in or out of training for certain LARC or PM methods, and designate specific staff to be trained. Customizing training in this way ensured that no facility would have to sacrifice valuable staff time for training on irrelevant topics. Facilities were consulted about the best times and places to schedule the training. In PMCH facilities, training was provided on-site by AITAM; trainings for PFPH facilities were facilitated by Engender Health in off-site locations and often included trainees from multiple facilities. Across all SHOPS facilities, on-site training drew relatively large cadres from PMCH facilities (4–10 doctors and 6–17 nurses) and lower numbers from PFPH facilities (1–8 doctors and 0–15 nurses). The flexibility and control afforded to facilities was universally appreciated among respondents from all case study facilities. Trained staff were aware that the trainings had been set up to be “private sector friendly.” Staff were particularly grateful that the set-up of the trainings permitted them to focus during the sessions, but still be able to perform their everyday work. This flexibility was universally appreciated.

As this training was conducted in our hospital it created [more] opportunity for the participants. Otherwise such a big number of staff could not have received training. It is impossible to send so many staff at a time for training. Moreover, all staff received training from one source and that helped to maintain uniformity in our skill and knowledge.

—International MCH Respondent

In addition to designing trainings that were flexible and sensitive to the needs of private sector facilities, SHOPS training placed emphasis on balancing the didactic and practical elements of training, since training on LARCs and PMs in Bangladesh has traditionally been almost entirely didactic. Respondents from all facilities were universally in favor of training that prioritized practical experience.

All doctors theoretically know about LARCs and PMs. Many of the doctors do not have practical experience on LARCs and PMs, especially on implants. This training created an opportunity to learn practically how to provide IUD, injection, implants, tubectomy, and NSV.

—SMAMC Hospital Respondent

Although practicums were a widely appreciated component of the SHOPS training, respondents from four of five facilities noted that they would have preferred to have *more* opportunities for practical training. This preference was especially true for trainees from PMCHs. Respondents from all three facilities noted that, because the trainer (AITAM) could not gather enough volunteers ahead of time, not all trainees were able to practice on live patients. In addition, respondents particularly from PMCH facilities thought there should be more opportunities for nurses to learn some of the practical elements of LARC and PM service delivery (especially administration of injections), rather than training that focused just on infection prevention and counseling, since they are often helping doctors deliver services. Many respondents (especially those in the medical colleges) expressed a need for refresher training for some trainees, especially those who do not provide LARCs and PMs regularly (e.g., graduate doctors or nurses).

Training was good, but right now all the doctors we feel that we need refresher training. During the training session everybody did not [get a] chance to learn it by doing it. At that time we did not have enough clients. Now we feel we need more hands-on experience. I think we need more training for our improvement, especially for the nurses because they have received only the introductory part of the training, some nurses received training on infection and prevention, counseling. But for the nurses they need more hands-on training for improving their skills on LARCs and PMs.

—IMC Hospital Respondent



LARC and PM provider training included lecture and practical components.

4.2.1.3 SUPPLY

Another key component was the facility’s ability to access the inputs and materials needed to deliver IUDs, implants, and injections. As explained in Section 2, prior to the SHOPS Integrated Model, there was no practical way for private facilities to purchase LARC commodities for service delivery. SHOPS was able for the first time to facilitate a linkage between participating facilities and its supply partner SMC, and inaccessible LARC commodities became a distant memory. All facilities described relatively straightforward procurement processes for LARC commodities. Products were affordable and easy to order, and they arrived within a day of calling SMC. Although hospital pharmacies were responsible for maintaining a stable supply of products (in all but one of the facilities at the time of data collection), respondents explained that ordering products from SMC was so simple that a pharmacy was not necessary to facilitate this procurement. Galaxy Hospital’s lone provider purchased all of her commodities directly from SMC, and direct purchase was also reported by providers in other facilities. In most cases these providers were purchasing a supply of LARC products to facilitate their work in other facilities or in their private practices.

We have very good relations with SMC. Whenever we call them they take immediate action and they are easy to work [with]. Sometimes we purchase commodities individually for our other [practices] from SMC. Whenever we call them they just supply it immediately.

—WMC Hospital respondent

The simplicity and effectiveness of this commodity supply has positive implications for the future provision of LARCs and PMs in the Dhaka private sector. If providers are able to access supply both in and outside of facilities, they will have the ability to meet demand whether or not they are working in a facility that was part of the SHOPS Integrated Model.

4.2.2 DELIVERING LARC AND PM SERVICES

This section examines how facilities went about operationalizing LARC and PM services, once the building blocks of motivation, training, and supply were in place. Specifically, how were services supported and coordinated within the facilities; and how did facilities go about generating demand for services through marketing, counseling, and pricing?

4.2.2.1 FACILITY SUPPORT AND COORDINATION

Though critically important to the introduction of LARC and PM services, overt support is also critical for ensuring successful service delivery, at various institutional levels—facility ownership and administration, providers, and support staff. Although demonstration of LARC and PM support was an important criterion for selection and participation in the SHOPS Integrated Model, support is dynamic, and in large, busy institutions like hospitals, it can be easily diverted.

HIGH LEVEL SUPPORT AND COORDINATION

Interviews with facility staff indicate that hospital management (i.e., owners and administrators) was generally supportive of LARCs and PMs, although this support could manifest in different ways. In facilities like City Hospital, Galaxy Hospital, and SMAMC Hospital, support from management was mostly passive: management gave permission for the activities, but delegated responsibility for LARCs and PMs to the Ob-Gyn department. High level staff at these facilities were generally disengaged and seemed to have low levels of knowledge about how LARC and PM services were delivered, tracked, or marketed. In general, descriptions by lower level staff of the monitoring and oversight structures at Galaxy, City, and SMAMC hospitals indicate that it was in fact not typical for these owners and administrators to be closely attentive to the workings of any specific health service.

I have given all authority to our [Ob-Gyn] consultant to continue FP services in my hospital. It is her department let her face that. If she needs any support I will extend my hand.

—Galaxy Hospital respondent

In contrast, at WMC Hospital and IMC Hospital, support for LARC and PM services was actively manifested, and this may be a factor in the increasingly strong performance of these facilities as shown above in Figure 7. Interviews revealed that management was more knowledgeable about the program (demonstrating engagement) and had taken steps to facilitate implementation of the SHOPS Integrated Model, whether by setting aside an “FP corner” (i.e., a designated space for FP counseling) or negotiating with the pharmacy to ensure that they did not mark up the prices of LARC commodities. The WMC Hospital administration and ownership were the most engaged of any of the case study facilities. For example, it was the only facility where management actively tracked service delivery, by requesting the Ob-Gyn department to prepare a LARC and PM-specific progress report. This feedback seems to have helped to bolster high level awareness and support for LARCs and PMs among WMC Hospital management. This support seems to have helped propel WMC Hospital to strong performance, and also may help to sustain and expand the program at the facility in the future.

Our facility owners always supported us to initiate this program in this facility. We are going to open another branch in Uttarakhan area, [and] our owners told us to initiate this program in our new branch. They always supported us to take necessary measures to initiate this program.

—WMC Hospital respondent

All higher level staff interviewed remarked that bringing in LARC and PM services under the aegis of the SHOPS Integrated Model required little or no investment on their part. From many respondents' perspectives, SHOPS and its partners did most of the legwork to introduce LARCs and PMs at the facility.

To me the investment is nothing because as a medical college hospital [providing LARCs and PMs]...is essential. SHOPS has taken on all the trouble for getting government permission and ensuring supply from [the supplier]. We are just enjoying the [benefits].

—SMAMC Hospital respondent

I don't think we have made any extra investment here. We have just utilized our existing resources to fulfill the demand of our clients as well as of the nation.

—City Hospital respondent

As described earlier in this report, the SHOPS Integrated Model was designed to ease some of the investment and start-up barriers to LARC and PM provision (i.e., training, QA and reporting, marketing and counseling). What SHOPS requested from facilities to participate in the program was generally perceived to be minimal: releasing staff for training; allowing staff to counsel and provide services in their regular practice; allocating a FP corner; and encouraging staff to work with the MCMO to market and monitor LARC and PM services. However, not all facilities actually made the full investment SHOPS envisioned. Some opted not to establish FP corners, while others tried to minimize the extent to which nurses were released to engage in counseling duties, relying on the MCMO instead. Such minimal levels of investment did not go unnoticed by lower level staff.

In this hospital FP services were not provided to its clients [before]—now they have [made] the decision [to offer LARCs and PMs]. But still they have not allocated one room for FP counseling. To me investment was not enough in that sense.

—SMAMC Hospital respondent

INTER- AND INTRADEPARTMENTAL SUPPORT AND COORDINATION

In each of the case study facilities, LARC and PM provision was anchored by the Ob-Gyn department. The degree to which other departments within the facilities were coordinated and involved in these efforts varied, and seemed to be influenced by the overall organizational structure of the facility. Respondents from the case study facilities indicated that, in general, departments tended to operate autonomously from one another, so extensive coordination was not perceived as necessary to deliver LARC and PM services.

Respondents from the PMCHs reported that they had received a few referrals from other departments in the facility, indicating that other departments were aware of the availability of LARCs and PMs. The large cadres of professors, graduate doctors, nurses, and students at the PMCHs who received LARC and PM-related training may have fostered greater overall facility awareness and helped to “deepen the bench” of staff contributing to LARC and PM promotion and provision.

In the two PFPs, by contrast, the Ob-Gyn departments function as loosely coordinated networks of part-time consulting physicians who operate individualized practices. This structure seems to have limited the awareness of those who were not directly involved in SHOPS activities, regarding the effort to make LARCs and PMs available.

I think in this hospital other than the [Ob-Gyn] doctor nobody is interested in providing LARC and PM services.

—Galaxy Hospital respondent

Since all case study facilities had at least some degree of departmental fragmentation, it is not surprising that reporting and QA functions were decentralized and relatively informal (for LARCs and PMs, and also for other services). All departments are responsible for keeping their own registers—which means that some LARC and PM acceptors end up being tracked on the surgery register (i.e., for tubectomies) rather than the Ob-Gyn register. The PFPH facilities seemed to have more decentralized recordkeeping than the PMCHs, since each individual consultant kept their own register. (At the two PMCHs, in contrast, there was a single department-level register.) Nurses at City Hospital commented that it was difficult to keep track of multiple registers, and, indeed, SHOPS QA visits found that LARC and PM record keeping lacked the appropriate amount of detail (such as recording patient consent). In response to questions about these findings, SHOPS was informed that consultants as well as nurses did not have time to maintain thorough records.

QA as well as recordkeeping seems have been fairly informal in the case study facilities. Respondents reported that, in most cases, the department head is responsible for “looking over” services and maintaining quality. Department heads mentioned using the DGFP’s “quality checklist” to help them ensure that everything was in order. However, only the SMAMC Hospital respondents specifically cited that they used the SHOPS tools and checklists to aid QA monitoring. Although case study facilities did not appear to have systematic QA systems in place, facility respondents repeatedly emphasized that maintenance of quality was of utmost importance, as it is a primary means to compete against other private (and even public) facilities. As a result, the attitude toward QA seemed to be that, because it should be part of everyday practice, there was not much need to do anything special to maintain LARC and PM service quality.

We will continue QA on our own. We don't want to lose our valuable clients. At the same time we want to teach our students best practices. If we don't maintain quality in that case what our student will learn from us?

—SMAMC Hospital respondent

4.2.2.2 DEMAND GENERATION

Ongoing provision of LARC and PM services presumes that procedures are in place to generate demand for these services. In SHOPS facilities, program and facility staff catalyzed client flow through inwardly and outwardly directed marketing activities, pricing, and counseling, both inside and outside of exam rooms.

LEVERAGING EXISTING CLIENTELE

Across all of the case study facilities, facility staff seemed to be the most focused on leveraging existing patients to generate demand, especially MCH clientele. Respondents noted that it made sense to target current clients first because they perceived there to be existing, unsatisfied demand for LARC and PM services among these clients.

This is the question of clients' confidence, if they are confident in your service they will come back to you again and again. So maintaining quality is the best strategy.

—WMC Hospital respondent

[The] hospital authority knows that they have a huge community [already] and they prefer to take services from private facilities; clients prefer to take one-stop services. Hospital management will utilize that demand.

—City Hospital respondent

An additional reason that facilities like City Hospital chose to leverage current clients to generate LARC and PM demand was that they recognized that their middle- and upper-class client base would be willing to pay for services they could otherwise get for free from government or NGO facilities. To serve this

client base, City Hospital is striving to be what they described as a “one-stop” for MCH services. Respondents from all of the case study facilities noted that providing comprehensive and high quality services also increases the likelihood of attracting new clients through word-of-mouth referrals.

Of course, in order to leverage the existing client base, facilities must also have the means to encourage awareness and adoption of LARC and PM services. All the study facilities distributed and displayed SHOPS marketing materials in doctors’ examination rooms and, in most cases, in facility waiting areas as well.



SHOPS-provided marketing materials were available in examination rooms and displayed in waiting areas.

All facilities engaged in some form of FP counseling: all the doctors interviewed reported counseling their clients about LARC and PM in their examination rooms. Outside counseling was also employed—i.e., counseling clients outside of the medical examination room context, in waiting rooms, in line at the immunization clinic, or (if it existed) in the facility’s FP corner. However, support staff lack the time to engage in outside counseling consistently. In each case study facility, the SHOPS-provided MCMO alleviated this gap by leading counseling and follow-up efforts.



Facility staff provide FP counseling in examination rooms as well as in facility waiting areas.

ENGAGING NEW CLIENTS

Outside of the purview of the MCMOs, additional community-level marketing, to inform and engage new clients, seems to have been actively undertaken only by those facilities that had stand-alone marketing teams (i.e., City Hospital and IMC Hospital). Facility marketing teams from City Hospital and IMC Hospital raised awareness by distributing SHOPS-provided leaflets

and by advertising LARCs and PMs as one of the available facility services, at periodic community health fairs and through general outreach to referral centers. Specific, targeted marketing of LARC and PM services was carried out entirely by the case study facilities' MCMOs; while the SHOPS Integrated Model was active, MCMOs went deeper into the community to do one-on-one counseling, marketing, and leaflet distribution on a regular basis.

DOCTORS AS A COMPARATIVE ADVANTAGE

Whether targeting existing or new clients, all case study facilities seemed to be keen on generating demand by emphasizing what most respondents saw as the private facilities' comparative advantage in LARC and PM service delivery: the fact that trained *doctors* were providing the services. As explained in Section 2, the unique structure of Bangladesh's public FP delivery system has emphasized training of lower level workers to deliver most FP services. This arrangement seems to have stoked prevalent bias and mistrust about the quality and safety of LARC and PM services provided in the public sector. As a result, respondents from all case study facilities recognized that this sentiment could be exploited to generate demand for their services, as provided by a trained doctor.

At initial discussion most of the clients want to know who will insert IUD and implant or even give the injection. When I assure them that the service will be given by the senior doctor they feel happy. Clients think if other than a reputed doctor provides the services there may be chances of [a] misplace or any trouble may happen. That's why during counseling we ensured them that this will be provided by the doctors.

—Galaxy Hospital respondent

To me the most successful outcome of this program is establishing the private sector in providing LARC and PM services to a huge population [of people] who were hesitant to go [to] government facilities for taking LARC and PM services.

—City Hospital respondent

PRICING

Even though all of the case study facilities are for-profit entities, it does not seem that profit maximization was the main consideration when pricing LARC and PM services. This is especially true of the PMCH facilities, particularly IMC Hospital and SMAMC Hospital. Respondents from all of the PMCH facilities noted that they were motivated to keep costs low (or even free) in order to attract the lower income clients that the government of Bangladesh requires them to serve.

In case of poor people we always try to give services-- even free of cost...[to attract new customers] we are emphasizing [neighborhood] publicity as well as quality services, and also keeping the cost low for each service.

—IMC Hospital respondent

Our existing clients are our main sources of demand. As we are providing this service at a reasonable price and the service is being provided by the doctors that has also created demand in the community.

—City Hospital respondent

Both City and Galaxy Hospital respondents spoke about pricing their services to be reasonable to clients, but they did not place emphasis on ensuring that prices were low enough to attract poor clients. Based on the prices respondents reported their facilities were charging for LARC and PM services, City and Galaxy Hospitals' aggregate average service price is about twice the average price of LARCs or PMs reported by PMCHs. As noted above (section 4.1.1.1), PMCHs are structured

differently than PFPs and are not as pressured to derive profits from service fees. This difference, as well as the remarks of the respondents from these facilities, helps explain the differences in prices seen in Table 5.

TABLE 5: CASE STUDY FACILITY SERVICE PRICES (AS REPORTED IN INTERVIEWS)

Service Prices (USD)	City Hospital	Galaxy Hospital	WMC Hospital	SMAMC Hospital	IMC Hospital
Injection	1.29	1.29	0.64	0.45	0.64
Implant	6.45	12.90	6.46	0.64	2.58
IUD	19.36	12.90	6.46	0.64	5.16
Tubectomy	32.26	32.26	19.36	25.81	19.38

Whether or not facilities were seeking to maximize profits from LARC and PM provision, the available data suggest that the profits generated over the lifetime of the SHOPS program were not substantial. Still, given that estimated profit margins for services were high, LARC and PM services have potential to boost the overall value of MCH services at facilities. Since the private sector maintains high confidentiality about detailed information on cost and income, it was not possible to collect this type of data from case study facilities for analysis. Instead, proxy data sources were used to calculate maximum potential profits based on the services provided, examining the service costs projected in each facility’s SHOPS business plan, facility service totals, and price information culled from interview data. Estimated profits and profit margins correspond to the volume of services delivered at each case study facility and are presented in Table 6.¹¹

TABLE 6: ESTIMATED PROFIT DERIVED FROM LARC AND PM SERVICES

Facility	Total Profit	Profit Margin
City Hospital	\$1060	88%
Galaxy Hospital	\$185	86%
WMC Hospital	\$1525	85%
SMAMC Hospital	\$476	70%
IMC Hospital	\$208	72%

4.2.3 SUSTAINING LARC AND PM SERVICES

Full normalization of LARC and PM services in the case study facilities presumes that facilities are not only able to successfully introduce and then deliver a new service but are also able to sustain it over time. This section explores two concepts that seem to have significant bearing on the extent to which LARC and PM services in the private sector can be maintained at present levels (or even increased): skill transfer and skill retention. The section closes with an examination of respondents’ outlooks about the future of LARC and PM services in the absence of direct support from SHOPS.

4.2.3.1 SKILL TRANSFER

SHOPS envisioned that participating facilities, especially PMCHs, could play a significant role in facilitating the spread of LARC and PM services to other providers and facilities. The primary mechanism for this transfer would be twofold: from provider to provider, and from MCMO to facility staff.

DIFFUSING AND TRANSFERRING SKILLS FOR PROVIDERS

In addition to skills training, SHOPS provided opportunities for medical college professors to learn how to incorporate and deliver a unit on LARCs and PMs with practical components for

¹¹ These figures presume that the cost information captured from facility business plans was accurate and that facilities charged the prices reported for all services rendered. Since neither of these factors can be confirmed, the profit figures presented should be considered only as general estimates.

medical and nursing students. In exchange for participation in the TOT, SHOPS expected PMCHs to begin to deliver practical skills training to students. As of March 2014, 8 of the 11 PMCH facilities in Dhaka and Chittagong (including all three of the case study facilities) had incorporated a LARC and PM practicum into their basic teaching curriculum and had successfully implemented a practicum for MBBS students, interns, and junior doctors, for one or more terms. Although all respondents from the PMCHs were in agreement that the practicums were going well, some respondents noted that their facilities lacked some of the equipment needed for a high quality practicum. Fortunately, SHOPS had already registered this need, and by the end of the program, all 11 PMCH facilities in Dhaka and Chittagong had been stocked with all the equipment necessary to incorporate comprehensive practicums, including IUD inserting tools, pelvic models, and mini-auto clips. The initiation of practicums in PMCH facilities is an important development that has implications for the long-term ability of Bangladeshi medical professionals to respond to demand and to provide LARC and PM services. As discussed previously, prior to the SHOPS Integrated Model, training of doctors in LARCs and PMs was de-emphasized in facilities across the country, public and private. The SHOPS PMCH that are now regularly incorporating a LARC and PM practicum are ensuring that future generations of doctors and nurses will have more than just theoretical knowledge about the full range of FP services.

Since the PFPs are not teaching facilities, there is not a built-in means to formally transfer skills to other providers. Instead, trained providers from PFPs (and also PMCHs) seem to be more likely to *diffuse* their skills to other facilities, given that it is very common for private sector

Before I used to avoid providing FP services to my clients, but after I received training from SHOPS I started providing counseling to my clients on LARC and PM at this facility and in other facilities where I work.

-SMAMC Hospital respondent

physicians in Bangladesh to practice in multiple facilities (World Bank, 2003). Reflecting this trend, the majority of the senior doctors from the case study facilities work across multiple facilities and/or maintain private practices. Having the skills as well as individual access to LARC commodities, most of these providers mentioned that they were actively providing LARCs and PMs to clients patronizing their practices in other facilities. By diffusing their skills in this way, SHOPS-trained providers are helping

to broaden private sector provision of LARCs and PMs beyond the facilities initially targeted by the program. **This expansion in turn has the potential to further increase consumer access to LARC and PM services, by increasing the cumulative number of private sector service points available.**

MARKETING CAPACITY

The MCMO was primarily envisioned as program-provided support that would help facilities kick-start demand generation by galvanizing internal capacity to market LARC and PM services. Yet even in the case study facilities with stand-alone marketing teams, the MCMO seemed to take on much of the burden for intensive advising, promotion, and marketing of LARCs and PMs. Instead of the MCMOs complementing the internal capacity of facilities, it seems instead that MCMOs often provided this capacity. Marketing teams (where they existed) supplemented the MCMOs' efforts to distribute SHOPS-produced LARC and PM promotional materials, by making these available in the facility as well as at regularly scheduled health fairs and community events, but they did not do much more than this. MCMOs also took the lead on advising clients on LARC and PM services outside of examination rooms in the facility and in the broader community. Although nurses were sometimes engaged to help with this task, there seems to be limited scope for them to take over completely for the MCMO. Facilities were highly appreciative of the work that their SHOPS-furnished MCMOs were providing, and their failure to ensure task-sharing with the MCMO does not seem to be a repudiation of the importance of the MCMOs' tasks.

All [Ob-Gyn] doctors highly appreciated the MCMO in this hospital. Her marketing drive [and work] advising clients in the hospital, helping nurses and pharmacy staff with LARC and PM record keeping, and communication [with everyone] was excellent.

—WMC Hospital Respondent



SHOPS MCMOs publicize availability of LARCs and PMs in the communities surrounding participating facilities.

Instead, facility respondents suggest that permanent facility staff lacked the time to be able to engage regularly in outside advising and intensive community marketing. The only case study facility that seemed to depend less on the MCMO for vital tasks was IMC Hospital. As in other facilities, this MCMO did community marketing and advising. However, because he is male (all of the other MCMOs were female), and advising requires discussion of sensitive topics, it was appropriate for him to be less intensively involved in direct counseling for women in waiting rooms, in the facility's FP corner, or in the community. This reality positioned the MCMO to provide technical assistance and advising to IMC Hospital staff rather than provide direct counseling service to facility clients, creating a counseling vacuum into which graduate doctors and nurses were drawn, early in the implementation. As a result, this facility was able to benefit not only from the MCMO's TA but also from the increased internal capacity to conduct outside counseling.

4.2.3.2 SKILL RETENTION

None of the respondents interviewed expressed significant concerns about retaining the skills necessary to continue to deliver high quality LARCs and PMs. At the time of data collection, all respondents perceived that demand for LARC and PM services would continue to build over time, albeit slowly, which would provide practice opportunities to keep skills fresh. However, considering the trends discussed above, the relatively low rates of service delivery experienced by most SHOPS facilities could affect skill retention at the facility level over the medium-to-long term. USAID generally cautions against providers persisting in low-patient-flow environments, because it makes it more difficult to maintain skill competence and confidence to deliver LARCs and PMs (Rivera et al., 2009). Without knowing how service trends will develop in the future, one can say that these providers do not appear to have much leeway to slow their pace of delivery and still maintain competence and confidence to deliver LARC and PM services at a high standard. If demand does slow inside the facilities, providers will have to gain more practice elsewhere—in other facilities where they work or in their private practices.

Staff attrition, too, poses a risk to the smooth continuation of LARC and PM service delivery in PFPH facilities. Since they are continuously training new providers, PMCH facility respondents were unfazed by the prospects of trained-staff attrition. In PFPH facilities, by contrast, respondents were unable to say with confidence how they would shore up skill retention when

staff members depart, even though attrition is not uncommon. Although SHOPS provided Galaxy Hospital with training for two providers and City Hospital with training for three providers, by March 2014 just one trained provider remained in place at each facility; neither facility was prepared to replace staff lost to attrition. According to respondents from these facilities, the main reason for this shortfall was not for lack of staff who could feasibly be trained to fill the gap, but rather that the facilities were not willing to invest the time or resources on their own to connect untrained staff to new training opportunities.

It is a problem. I don't know how they are going to fill up the gaps, because senior doctors have no time to train new doctors. According to me [we] need formal training to transfer skill, otherwise no one gives value to it.

—City Hospital respondent

It is true that owners will not spend money to provide training to their staff-- it is government or other donors [that] have to do it.

—City Hospital respondent

The implications of having just one trained provider are not positive. In the case of Galaxy Hospital, where there has just been one provider trained from the start of implementation, the pace of service delivery has always been slow. The situation at City Hospital is particularly unfortunate, since they had been a high performing facility through much of the lifetime of the program. But with just a fraction of trained providers on hand to deliver LARC and PM services, and no MCMO marketing and counseling support to generate demand, City Hospital may struggle to maintain the same level of LARC and PM performance going forward. Nor are Galaxy and City Hospitals unique in experiencing attrition. Other participating facilities are also poised to face skill retention issues, especially where relatively few providers were trained in the first place. According to monitoring data, two-thirds (n=16) of the participating PFPH facilities opted to train just one or two providers from the start. This implies that all of these facilities could be vulnerable to skill-retention challenges, in the event of staff turnover.

In relation to the problem of skill transfer and retention within the facility, respondents emphasized the importance of *external* training, facilitated by an outside entity not formally connected to the facility. This was a theme that emerged across case study facilities, PMCH and PFPH alike. As implied above, for PFPH hospitals, the only option to retain skills in the face of staff attrition seems to be through external training. But even for PMCH facilities, periodic external training was preferred. Respondents indicated that, although they were able to transfer skills to students, interns, and junior doctors through their normal training mechanisms, this training did not have the same ability to inspire doctors and nurses to be enthusiastic about LARCs and PMs. **In other words, while internal training can maintain skill capacity, it does not have the same power to galvanize enthusiasm for and buy-in to LARC and PM provision.**

We believe that external training helps a lot to motivate doctors as well as inspire them to promote and continue these services.

—IMC Hospital respondent

4.2.3.3 LOOKING AHEAD AND PLANNING FOR THE FUTURE

As they looked back over their period of participation in the SHOPS Integrated Model, respondents were universally positive about their experiences overall. Most case study facilities indicated that they perceived LARC and PM service delivery as effectively integrated into their broader MCH and reproductive health service offerings.

To me our reproductive health service to our clients has got full shape. Now we are providing all reproductive-health related services, which includes [LARC and PM] services to our clients.
—City Hospital respondent

Indeed, in terms of service delivery, LARC and PM provision seems to have proceeded much like any of the other services that the case study facilities provided. The exception is Galaxy Hospital, where delivery of LARCs and PMs remains integrated into only one consultant's practice and was not widely recognized as an available service by other providers in the facility.

Even though service delivery trends for almost all of the case study facilities demonstrate otherwise, the perception of respondents across facilities was that there had been a gradual increase in LARC and PM clients over the course of the SHOPS Integrated Model. This optimism seems to be a reflection of respondents' experiences and explains why none of the respondents anticipated that their facility would not try to continue to offer LARC and PM services. To do otherwise was perceived as a disservice to facility clients.

We will continue it. We have started it not for SHOPS; rather for our own interest, to satisfy our clients. We wanted to provide one-stop services on MCH/reproductive health to our clients from this hospital. As a private organization we got that opportunity through this program. We will capitalize it 100 percent.

—City Hospital respondent

Facility respondents also reported that the barriers that had kept them from providing LARC and PM services previously—specifically, lack of access to commodity supply and service delivery skills—had been sufficiently resolved. Since SHOPS was able to address many of the barriers to entry for LARCs and PMs and make the introduction of these services in facilities a low risk endeavor, respondents across facilities were positive about prospects for continuation, provided that these barriers remain mitigated.

I personally don't think there will be problem after SHOPS support [ends]. Now we have skill and we have access to supply of the products. So I don't see any problem.

—WMC Hospital respondent

With the end of the SHOPS Integrated Model and with normal staff attrition, however, things will surely change. Facilities to date have proven that, although they were willing to follow SHOPS's lead and accept support for LARC and PM service provision, they have been less willing to fulfill unfamiliar responsibilities, such as skills training (in the case of PFPHs) and some key LARC and PM marketing tasks. Respondents expressed a decidedly more mixed outlook on the prospects for marketing and overall client growth at the facility. Even though all case study respondents agreed that the MCMO had played a vital role in marketing LARCs and PMs at their facilities, none of the facilities had concrete plans to retain the MCMO or to transfer the full complement of MCMO tasks to others within the facility. **As a result, some respondents anticipated not only a dip in client flow and demand, but also lower enthusiasm on the part of staff.**

Given the relatively low service rates to date, it is understandable that facilities are not willing to invest their own resources to facilitate additional training or marketing. Although the SHOPS Integrated Model seems to have successfully enabled participating facilities to serve as a critical access point for LARC and PM services, some respondents' comments indicate that, without ongoing external support for training, TA, promotion, and marketing, many SHOPS-supported facilities could struggle to maintain a vibrant LARC and PM practice into the future.

When SHOPS assistance [ends] there may be reluctance among us. Now whenever the MCMO visits us we feel encouraged, they always ...follow up [with us]. That thing will be missing. We need at least 5-10 years support in training, marketing, promotion, and community level promotion for sustainability of LARC and PM program in our country.

—WMC Hospital respondent

Intensive support would be required to recalibrate Bangladesh's FP method mix to help the country achieve its population goals, in the absence of stronger internal capacity and willingness to independently continue critical activities like the SHOPS-supported training and promotion efforts. Additional external assistance will continue to be needed to ensure that the private sector can continue to play an integral role in this important process. Given the challenges that have emerged from this evaluation, it is recommended that future programs should include consideration of ways to (1) address skill retention in private facilities and (2) stimulate consumer demand for LARCs and PMs at a systemic level.

5. DISCUSSION AND LESSONS LEARNED

This report presents the results from a qualitative study evaluating the implementation of the SHOPS Integrated FP/MCH Service Delivery Model in private facilities in Bangladesh. The selection of case studies was carefully based on monitoring data, to ensure a sample that would be appropriately representative of the diverse experiences of the facilities targeted by SHOPS program. Accordingly, this study's findings suggest broader insights into what will be needed to introduce, deliver, and sustain LARCs and PMs as integrated FP services in private facilities. These findings have implications for policymakers not only in Bangladesh but in other countries as well.

- **Private facilities became willing and able to offer LARC and PM services because the SHOPS Integrated Model successfully eased barriers to market entry.**

Building on lessons drawn from the SHOPS private sector assessment and its subsequent KAP study, SHOPS sought to introduce an integrated model of LARC and PM provision that was designed to make provision of LARCs and PMs appealing to private sector facilities, while reducing or eliminating some of the identified barriers to entry. Interview respondents (from case study facilities included in this evaluation) generally agreed that SHOPS had indeed dramatically lowered the hurdles that had prevented these facilities from incorporating LARC and PM services into their wider MCH offerings. From the respondents' perspectives, introduction of LARC and PM services required few (if any) capital investments and minimal diversion of staff time, since the SHOPS Integrated Model provided flexible assistance for training and skill acquisition, marketing and demand generation, and supply. This targeted support effectively suppressed the risks the facilities would have faced to participate. The flexible nature of the model increased enthusiasm for introduction of LARCs and PMs by allowing participating facilities to customize the service delivery to fit their needs and capacity. Because these barriers and risks were reduced, respondents across facilities had a generally positive assessment about LARC and PM provision to date, expressing a willingness to continue to offer LARCs and PMs into the future. These sentiments imply that the SHOPS Integrated Model served as an effective pathway for galvanizing private sector interest in LARCs and PMs, and the model can be used to stimulate an increase in access points for LARC and PM services.

- **The rate of LARC and PM service delivery was low—not only at the participating private facilities, but also in comparable public facilities.**

Although the targeted facilities successfully introduced LARCs and PMs, the number of these services delivered at facilities was small in comparison to the estimated monthly totals for MCH services provided overall. At fewer than six services per month on average, provision of LARCs, PMs, and injectables did not provide substantial sources of revenue. Although participating facilities believe there is great potential for LARCs and PMs among their client bases, actual demand fell short of their original expectations. Respondents emphasized that it will take more

time than the lifespan of the SHOPS Integrated Model for interest in LARC and PM services to take root.

These modest service trends were not unique to the private sector. SHOPS facilities seem to closely match the LARC and PM provision trends of comparable public facilities located in Dhaka, based on an analysis of service delivery totals reported for 2013. For example, public facilities delivered an average of four IUDs, tubectomies, or implants per month, while private facilities delivered an average of three of these services per month. It seems that, regardless of sector, demand for these services was generally weak. These data suggest that increasing access to services alone will not be enough to improve Bangladesh's contraceptive method mix.

Nevertheless, a closer inspection of program monitoring data suggests that private facilities may have had some success in convincing clients to adopt certain types of LARCs and PMs. Although injections were the most popular of the medium-to-long term methods chosen by private sector clients, SHOPS facilities also attracted a larger proportion of their clients to IUDs, implants, and tubectomies than might be seen in the Bangladeshi population at large. Throughout the lifetime of the SHOPS Integrated Model, 57 percent of private facility clients selected an IUD, implant, or tubectomy. This compares favorably to the proportion of current users of medium-to-long term methods users who reported using an IUD, implant, or tubectomy in the 2011 DHS, at 42 percent.

- **Private facilities are not in a position to market LARCs and PMs with the intensity needed to significantly increase demand for these methods.**

Marketing and demand generation activities featured prominently in SHOPS outreach to private sector facilities. SHOPS support took many forms: TA to develop tailored business and marketing plans; marketing materials; and intensive marketing and counseling outreach by a SHOPS-employed MCMO. These inputs were designed to help facilities learn how to promote and market LARCs and PMs and ultimately integrated them into its broader business and marketing strategies. Although there was strong and unanimous appreciation of the SHOPS marketing and demand generation support (particularly the MCMO), none of the facilities was well-positioned at the end of the program to engage in intensive LARC and PM marketing and promotion without external support. In the case of the MCMOs, for example, though facilities strongly believed in their usefulness, especially for outside counseling and intensive community outreach, they all lacked the existing staff capacity to continue to fulfill these duties, and they were not willing to invest in extra staff capacity for these activities. As a result, facilities were anticipating a drop in LARC and PM client flow, since marketing and counseling activities would have to be curtailed in the absence of SHOPS.

However, even with SHOPS-enhanced marketing and counseling support, demand overall was not strong. MCMOs and doctors noted that patient apprehension is still common about LARCs and PMs, particularly IUDs. This may be one reason why facilities preferred to market LARCs and PMs first to existing clients, to build on the trust they had already established with the client. Increasing the demand for LARCs and PMs on a broader scale will require additional efforts, beyond the scope of any single private facility (and beyond the scope of this evaluation and report).

- **Private facilities are motivated to offer LARCs and PMs by considerations that go beyond profit maximization or business expansion.**

The SHOPS Integrated Model was designed to be tailored in accordance with each facility's institutional missions and business motives. Case study respondents indicated that an expectation of growth in profits or revenue was not always their main reason for introducing LARCs and PMs. Instead, Bangladesh's unique treatment of FP and population policy as an issue of prominent national concern was strongly reflected in the stated motives of respondents. Again and again, respondents cited their facility's desire to participate in the "national population program" as a main force motivating LARC and PM provision.

In addition, the institutional structure of individual facilities influenced their motivation. In particular, respondents across the PMCHs de-emphasized traditional business motives and spoke instead of service to their clients and their nation, and of affording students the opportunity to learn how to provide LARCs and PMs. (Since medical colleges are structured to derive revenue from tuition, there is little pressure on the hospital division of these institutions to maximize profits; instead, they maximize patient flow to generate teaching opportunities.) Respondents from PFPHs, though they also emphasized contributing to Bangladesh's national population program, did acknowledge the connection between LARC and PM provision and business; in one case, offering LARCs and PMs was cited as a means for the facility to distinguish itself from its competitors.

- **Affordable and easily accessible commodity supply enables LARC service provision, even in challenging or limited operating contexts.**

One of the most critical successes of the SHOPS Integrated Model was the establishment of reliable and easy private sector access to LARC Commodities. Prior to SHOPS, participating private facilities did not have commodity access. Given the important role that supply plays in an individual facility's ability to provide most LARC and PM services, many respondents cited this gap as one of the key reasons the facility had not been previously able to offer LARC and PM services. After SHOPS helped to connect facilities to commodity supply via its partner SMC, facilities reported that they were able to quickly and easily order commodities needed to provide LARC and PM services. Many respondents expressed confidence that, as long as the facility's supply arrangement remained unchanged, the facility would continue to be willing and able to provide LARC and PM services.

The supply arrangement established by SHOPS also has the potential to facilitate spread of LARC and PM services to other private-sector settings. Since commodities could be ordered in small quantities and on short notice, individual providers across facilities were able to order LARC commodities on their own, enabling them to provide LARCs and PMs in their private practices or in other private facilities that were not part of the SHOPS Integrated Model. Importantly, this finding suggests that, in the event a SHOPS facility discontinues its active institutional support for LARC and PM services, individual providers will still have the means to respond to client demand for LARCs and PMs.

- **In the likely event of provider turnover, skill retention could be a challenge for PFPs that participated in the SHOPS Integrated Model—though other, non-participating facilities could indirectly benefit from skill diffusion.**

It is common for doctors in Bangladesh to work across multiple public and private settings to supplement their income, and high rates of staff turnover are often the reality at the facility level. PFPs seem to be particularly susceptible to LARC and PM skill retention challenges, especially because they do not have the same internal training and skill-renewal capacity as private medical college hospitals.

Both of the PFPs examined in this study suffered from attrition, even though SHOPS had trained more than one doctor to provide LARC and PM services at each facility. By the end of the program, just one provider remained in place at each facility; neither facility was in position to rebuild lost LARC and PM capacity. While the facilities had other staff that could potentially be trained to fill the skills gap, the facilities were unwilling to seek the additional training, or to hire additional staff specifically trained in LARCs and PMs. This outcome suggests that LARCs and PMs have not yet demonstrated sufficient return to allow facilities to make additional investments in training on their own. More generally, this finding raises doubts about the long-term capacity for LARC and PM service delivery in some facilities.

However, in a context where medical personnel readily move from one facility to another, one facility's loss of LARC and PM service delivery capacity may be another facility's gain. During the lifetime of the SHOPS Integrated Model, there were several examples of LARC and PM diffusion to new and untargeted facilities, as motivated and trained staff members moved to a new service location and urged SHOPS to provide support in their new facility. Considering that the providers interviewed for this study expressed near universal enthusiasm for LARCs and PMs, it is likely that there are prospects for continued diffusion for LARCs and PMs to other facilities, as staff move on to practice in additional facilities.

Continued tracking, follow-up, and support of these providers would be advisable going forward, in case they encounter unexpected barriers (for example, in accessing supplies) in their new places of work.

6. CONCLUSIONS

The SHOPS Integrated Model made it possible for private sector health facilities to systematically integrate LARCs and PMs into their MCH service offerings. Incorporation of these services results in a substantial increase in the access points for consumers wishing to adopt LARCs and PMs in urban Dhaka. The outstanding problem is that, across facilities, the number of LARC and PM services delivered monthly was small and stagnant overall. Although the SHOPS Integrated Model incorporated several facility-level components to spur local demand, performance trends suggest that these activities—though important—are not likely to be sufficient for increasing adoption of LARC and PM services in the long term.

Because SHOPS was able to reduce the overall investment that facilities had to make to offer LARCs and PMs, these low service delivery rates were tolerable. But they indicate that LARC and PM services do not yet present an opportunity for significant added revenue for facilities. Nevertheless, evidence from the case studies suggests that facilities may not be motivated solely by the prospect of revenue generation. Instead, participating private facilities expressed strong interest in delivering LARC and PM services as a way to contribute to Bangladesh's national population program. In addition, some facilities noted that offering high quality LARCs and PMs provides a way to differentiate themselves from competitors and allows them to function as a “one stop” for women's health services.

Case study facilities were generally positive about their experiences delivering LARCs and PMs to date and most of them fully expect to continue delivering LARCs and PMs into the future. They recognize that it will take more time to build up a substantial LARC and PM client base. Still, two potential barriers may hamper private sector LARC and PM provision in the future: staff attrition, and limited capacity to generate demand. Many facilities, particularly private-for-profit facilities that lack capacity for internal training, are not willing or able to seek out refresher training on their own to regenerate skills lost to attrition or through infrequent service delivery. Facility staff will likely continue to generate low levels of LARC and PM demand by counseling current clients, but they are not set up to pursue intensive, opportunistic marketing, advising, and promotion—services performed by the SHOPS-provided MCMO. More efforts will be needed to generate widespread LARC and PM demand than facilities can manage on their own.

What are the implications for the viability of LARC and PM service markets in private sector facilities? Importantly, within the context of voluntary family planning programs focused on providing Bangladeshis with a full complement of FP options the SHOPS Integrated Model demonstrates that, with reduced barriers to entry, private facilities are in fact willing to introduce and integrate LARCs and PMs into their MCH service offerings. These private facilities delivered IUDs, tubectomies and implants at rates that are comparable to public and NGO facilities—providing a strong indication of the contribution the private sector can make. This finding indeed validates the GOB and donor investment in policies and TA to increase private facilities' participation in LARC and PM delivery.

LARCs and PMs are likely to remain viable at many of the facilities that implemented the SHOPS Integrated Model. However, the potential for continued staff attrition or moribund demand means that some facilities will struggle to sustain LARC and PM provision. Ongoing outside support— particularly in the form of additional skills training and marketing activities— will help to maintain the viability of LARC and PM services in private-for-profit facilities going forward.

ANNEX A: CASE STUDY SELECTION DETAILS

Final case study selection was aided by a monitoring tool developed by the SHOPS Bangladesh staff. For each implementation element, facilities were assigned scores to reflect the SHOPS staff assessment of the facility's progress in that category (as of November, 2013). The tool's scoring elements are presented in Table 7. A score of "0" reflects poor progress, a score of "1" reflects average progress, and a score of "2" reflects excellent progress.

TABLE 7: SHOPS BANGLADESH FACILITY SCORING ELEMENTS

Element	Scoring Questions	Score Values	
LARC and PM delivery rate	What is the average number of LARCs and PMs performed each month?	10+ LARCs and PMs/month	2
		5-10 LARCs and PMs/month	1
		0-5 LARCs and PMs/month	0
LARC and PM reporting	Is regular record-keeping/reporting taking place? Who at the facility is tasked with record-keeping? How involved is the MCMO in this process?	Staff are keeping appropriate records and reporting regularly	2
		Staff keep records and give to MCMO for regular reporting	1
		Record keeping is irregular; fully dependent on MCMO	0
Skill transfer (MCs only)	Are LARC and PM practicum sessions regularly conducted for interns, doctors, and students?	Regularly scheduled practicums	2
		Irregularly scheduled practicums	1
		No practicums scheduled to date	0
QA	Has the facility maintained all of the QA standards to satisfaction of SHOPS?	All QA standards maintained	2
		Some or most QA standards maintained	1
		QA not yet conducted	0
Number of trained Providers	How many providers currently working in the facility have been trained in LARC and PM service delivery?	3+ providers	2
		2 providers	1
		1 provider	0
Focal person	Is the key focal person trained by SHOPS active and engaged in building up LARC and PM delivery at the facility?	Focal person is highly active	2
		Focal person is moderately active	1
		Focal person is not active	0
Commitment	How committed is management/ownership to integrating LARC and PM with MCH services? How committed are providers to integrating LARC and PM services in the facility?	Management, ownership, providers, and staff are highly committed to LARC and PM integration.	2
		Management/ownership are moderately committed while providers/staff are highly committed to LARC and PM integration.	1
		Management, ownership, providers, and staff are at best moderately committed to LARC and PM integration.	0
Marketing	Has the facility identified and activated a marketing team/staff to promote LARC and PM services?	Facility marketing team exists and has active ownership over promoting LARCs and PMs.	2
		No self-contained marketing team, but other	1

Element	Scoring Questions	Score Values	
	What is the MCMO role in marketing?	staff are involved in LARC and PM promotion.	
		LARC and PM promotion is entirely dependent on MCMO.	0
Business Enabling Workshop (BEW)	Which facility stakeholders have attended a BEW? How far along is the facility in the development of their business plan?	Key staff from all units of facility participated in BEW; facility business plan was available for review in BEW.	2
		Key staff from all units of facility participated in BEW; facility business plan was not available for review in BEW.	1
		Only management/owner attended BEW; facility business plan was not available for review in BEW.	0
Counseling	What kind of space and staff resources have been dedicated to counseling for LARC and PM? How involved is the MCMO in counseling?	Facility has a dedicated room and engaged staff to provide LARC and PM counseling.	2
		Facility has set aside space for counseling; staff are moderately involved in LARC and PM counseling.	1
		Facility depends on MCMO for LARC and PM counseling.	0
Compliance	Has the facility done what it needs to do to maintain regular compliance with government policies on LARC and PM provision?	Facility implemented steps to get into compliance and regularly checks for updates.	2
		Facility implemented steps to get into compliance.	1
		Facility has not implemented steps to get into compliance.	0

To gain a snapshot of overall progress, the scores for each element were added and then divided by the maximum score (22 for PMCHs, 20 for PFPHs) to obtain a percentage score indicating each facility's overall LARC and PM integration progress. The 15 facilities on the short list had overall percentage scores ranging from 15 to 95. The four case study facilities were then selected in consultation with SHOPS on the basis of the following considerations:

- Would the facility be accessible to and cooperative with data collectors?
- Would the facilities present opportunities to examine issues of interest as defined in the conceptual framework?
- When taken as a whole, would the four facilities represent a range of integration experiences?
- Did the selected facilities have an MCMO in common? (Since MCMOs served multiple facilities, the selected facilities should be represented by different MCMOs in order to give a broader perspective on the integral role that the MCMO played in LARC and PM integration.)

Based on these considerations, four facilities (listed on in Table 8) emerged as the best case study subject candidates.

TABLE 8: CASE STUDY SUBJECTS

Facility Name	SHOPS LARC and PM Integration Score
Medical College for Women and Hospital	95 (21/22)
City Hospital	80 (16/20)
Shaheed Monsur Ali Medical College Hospital	63 (14/22)
Galaxy Hospital	45 (9/20)

The four selected facilities had integration scores ranging from 45 to 95, and all had one year or more of LARC and PM service delivery experience by the time facility interviews were conducted in February 2014. The selection excluded the very weakest performers (with scores of 5 or under) because it is presumed that these facilities had limited prospects for LARC and PM normalization. A higher scoring but comparatively weak performer (Galaxy Hospital) was selected instead, to provide lessons about LARC and PM integration in more challenging contexts.

CASE STUDY PROFILES

CITY HOSPITAL

The facility has 150 beds and, at the time the facility first engaged with the program, it was estimated to serve approximately 500 MCH patients per month (including 60 deliveries). The facility is located in a more affluent area of Dhaka and considers its client base to be mostly middle- to upper-class (incomes over \$1280 per month).¹² City Hospital signed its memorandum of understanding with the SHOPS Integrated Model in July 2012 and began service delivery in November 2012. Facility staff including providers and administrators attended a SHOPS BEW in January 2013. In interviews, SHOPS Bangladesh staff described this facility as a “typical” private hospital; they noted that they perceived the facility’s staff, management, and providers to be solidly committed to making LARCs and PMs work within the facility. Although SHOPS monitoring data tells a largely positive story about this facility, QA reports and the MCMO interview also reveal that there were initial concerns at the facility about devoting a lot of time and resources to participate in the program. Over the course of implementation, the facility struggled to keep up with recordkeeping and sought assistance from their SHOPS-assigned MCMO for this task. A total of two resident Ob-Gyns and three part-time Ob-Gyn consultants with private practices received SHOPS training, although only three were actively engaged in FP service delivery. Four nurses were trained to support the doctors in infection prevention and FP counseling. Near the end of the program, the facility MCMO still remained actively involved in reporting, counseling, and marketing activities, but the facility’s marketing team was aware of the LARC and PM services and purported to be marketing them along with other facility services. Outside of its overall performance, an additional motivation for selecting this case was that it provided the opportunity to examine the planning process to transfer the MCMO’s capacity and know-how to staff, for long-term maintenance of LARC and PM integration.

GALAXY HOSPITAL

Galaxy Hospital is a 100-bed facility. At the time the facility first engaged with the program, it was estimated to serve approximately 2,000 MCH patients per month (including 30 deliveries). The facility caters to mostly a middle-class client base (people making about \$250–390 per month). Galaxy Hospital signed its MOU with the SHOPS Integrated Model in February 2013, although its lone participating provider had begun delivering services in November 2012.

¹² All dollar figures are USD.

SHOPS provided individual TA to the provider to develop a LARC and PM business plan for the facility, but management did not make other staff available to attend a BEW. In interviews, SHOPS Bangladesh staff noted that they had originally avoided this facility, reasoning that, since its owners and administrators are associated with Jamaat-e-Islami (the conservative Islamist party in Bangladesh), they would not support provision of LARCs and PMs. Programming was eventually initiated at the behest of one Ob-Gyn who had become familiar with the SHOPS Integrated Model when engaged as a consulting provider at East West Medical College (another SHOPS facility). She maintained a part-time consulting practice at Galaxy Hospital and felt that her clients would benefit from LARC and PM access there as well, so she urged SHOPS to initiate the program there. With her support, SHOPS eventually secured the relatively passive support of the administration there, training two nurses as well as another doctor (although this doctor and one of the nurses left the facility shortly after training). Even with this champion, however, SHOPS performance monitoring indicates that Galaxy was a low-performing facility. We chose to include it as a case study subject because it offers a chance to examine if and how support for LARCs and PMs could be cultivated in environments with low levels of managerial commitment.

MEDICAL COLLEGE FOR WOMEN AND HOSPITAL (WMC HOSPITAL)

WMC Hospital has a large, 350-bed facility that is affiliated with a women's medical college. At the time of initial engagement it was estimated that WMC Hospital served 4,000 MCH clients per month (including 200 deliveries). WMC Hospital primarily caters to lower-middle to middle-class clientele (\$77-390 per month), although it is also mandated by the government to provide services to the poor. According to SHOPS Bangladesh staff, WMC Hospital's owner is a former president of Bangladesh and is "very public service oriented," so there may be some extra motivation at this facility to serve a lower income client base. In addition, interviews with facility staff indicated that prior to SHOPS they already had a strong interest in delivering LARCs and PMs. For example, the facility has an arrangement with the DGFP so that a Family Welfare Visitor (paramedic) is available in the facility on a part-time basis to counsel, refer, and provide services to women as needed. WMC Hospital signed their MOU with SHOPS in August, 2012, and began delivering services in February, 2013. The facility participated extensively in SHOPS training: 8 doctors trained in IUD, implants, and tubectomy; 10 junior doctors on injections; and 16 nurses in infection prevention and FP counseling. Although the facility does not have a marketing department, a large number of staff (over 20) attended a BEW. Based on interviews with SHOPS Bangladesh staff as well as monitoring data, WMC Hospital appeared to have excelled in implementation, engaging its staff in supportive tasks like recordkeeping, reporting, and counseling. As recommended by SHOPS, the facility set aside space to establish a "family planning corner" to serve as a designated space for FP counseling and marketing. Given the positive perceptions about WMC Hospital's commitment and performance, this facility was selected as a case study subject to examine the factors in successful implementation as well as the potential to continue its success after the end of the SHOPS Integrated Model.

SHAHEED MONSUR ALI MEDICAL COLLEGE HOSPITAL (SMAMC HOSPITAL)

Like WMC Hospital, SMAMC Hospital is a large, 360-bed facility affiliated with a medical college. At the time of initial engagement it was estimated that SMAMC Hospital served 5,000 MCH clients per month (including 150 deliveries). SMAMC Hospital primarily caters to lower middle and poor clientele (\$38-100 per month); it has been contracts with a few local corporations and garment factories to provide general and preventive health care services to these clients' employees. According to SHOPS Bangladesh staff, the owner of SMAMC Hospital (and the head of the Bangladesh Private Medical Practitioners Association) supported bringing

LARC and PM services to his facility but was initially concerned the time investment required to establish these services. SMAMC Hospital signed a memorandum of understanding with SHOPS in August 2012, and began delivering services in January 2013, after training about 8 doctors/professors to provide and teach various LARC and PM methods and 17 nurses on infection prevention and counseling. Only the facility administrator received business planning TA from SHOPS staff, reflecting concerns about staff time, given that the facility does not have a marketing team. The facility's assigned MCMO assisted with a variety of tasks, including reporting, counseling, and marketing. SHOPS monitoring data indicates that the facility was perceived to be a "middle of the pack" performer. Among the case study subjects, SMAMC Hospital was selected to represent the experience of facilities that neither excelled nor floundered as program participants.

PILOT FACILITY: INTERNATIONAL MEDICAL COLLEGE HOSPITAL (IMC HOSPITAL)

IMC Hospital is a large, 300-bed facility located on the outskirts of Dhaka in an area that is home to many garment factory workers—a lower middle to low income community (\$38–100 per month). At the time of initial engagement it was estimated that IMC Hospital served 4,000 MCH clients per month (including 180 deliveries). IMC Hospital signed an MOU with SHOPS in December 2012, and began delivering services in June 2013. Eight doctors were trained to provide and teach a variety of LARC and PM methods, and nine nurses were trained on infection prevention and counseling. This facility has a full-time marketing team that took responsibility for marketing LARC and PM services, with many members attending a BEW in June 2013. IMC Hospital established a family planning room to facilitate counseling, as an FP "center" in the facility. At the time of piloting data collection (late January 2014), the facility had been implementing services for less than one year. Since the quality of the data collected was high and the facility provided an opportunity to explore issues that emerge early in the implementation phase, this facility's data were included in the analysis. The MCMO was one of very few males serving in that role, and accordingly was less directly involved in counseling and community marketing (in certain aspects) than was the case at other facilities, instead providing monitoring, advising, and TA services.

ANNEX B: IN-DEPTH INTERVIEW DISCUSSION GUIDES

DISCUSSION GUIDE FOR FACILITY ADMINISTRATORS

Facility and Respondent Background

1. How long has your facility been operating?
2. Generally, what kinds of services are offered to patients/clients at your facility?
3. How would you characterize your facility's clientele? (*i.e.*, rich, poor, from the immediate vicinity, from across Dhaka and other areas, mostly women, mostly men, garment workers etc.)
4. What are your primary responsibilities in your current position at this facility?
5. How long have you been working in your current position?
6. How long have you been working at this facility?

Incorporating the Integrated Model

7. Prior to engaging with SHOPS, what was your facility's experience with or exposure to family planning (FP) services in general?
 - a. [If some previous experience with FP] What was this facility's previous experience with or exposure to LARC and PM services?
8. Had your facility previously worked with external partners like SHOPS to introduce or change the services offered here at this facility?
 - a. [If answer is yes] Please describe this partnership (*i.e.*, with whom, for how long, terms of partnership, etc.)
 - b. [If answer is yes] Do you think these partnerships influenced the terms of your facility's partnership with SHOPS? If so, how?
9. What originally motivated your facility to sign an MOU with SHOPS to introduce and implement LARC and PM services at this facility?
10. Was staff interested in LARCs and PMs prior to working with SHOPS?
 - a. [If answer is yes] What do you think most interested them in LARCs and PMs?
 - b. [If answer is no] What were the reasons that staff was not interested in LARCs and PMs?
11. Were there any specific issues or concerns that you brought up during the MOU negotiation process? If so, please describe what these were.
 - a. [If there were issues/concerns] Did SHOPS address these concerns to your satisfaction?
 - i. If so, how did they do this?
 - ii. If not, what outcome would you have preferred instead?

Management of LARCs and PM Introduction and Implementation

12. Which departments were involved in the introduction and implementation of LARCs and PM services at this facility?
13. How do you coordinate each of these departments' roles? (*i.e.*, through written memoranda, e-mail correspondence, regular meetings, phone calls, observations, etc.)
 - a. Did SHOPS assist this coordination? If so how?
14. Based on your experience so far, do you feel that the other departments/staff you have had to collaborate with to introduce LARCs and PM services have cooperated to the degree you expected? Why or why not?
15. Do you feel that you were empowered by facility ownership to make the decisions needed to implement LARCs and PM services here? Why or why not?
16. Was the facility owner involved in the introduction and implementation of LARCs and PM services here?
 - a. [If answer is yes] What role did the owner play in negotiation or decision making needed to introduce LARCs and PM here?
17. Now that this facility has begun delivering LARCs and PM services, do you feel that the level of ownership support has changed in any way? If so, please explain how you think it has changed.

Training and Skill Transfer

Training Needs

18. [Monsur Ali and Women's Medical College Only] Through SHOPS your facility received training on providing IUD, injections, implants, tubectomy, and NSV. What were the reasons your facility chose to train staff in these skills?
19. [Monsur Ali and Women's Medical College Only] Did you incorporate a LARC and PM practicum for into the existing medical training curricula for your students?
 - a. [If the answer is yes] Do you think this facility will continue to incorporate LARC and PM practicums into its training curriculum? Why or why not?
20. [City and Galaxy Hospitals Only] Through SHOPS your facility received training on providing IUD, injections, implants and tubectomy; what were the reasons your facility chose to train staff in these skills?

Perspectives on Training

21. How well do you think the training for staff on LARC and PM methods went overall?
 - a. What worked well?
 - b. What could have been improved?
22. SHOPS intended to structure the training in a way that was not overly disruptive to your facility's normal business. Do you think the training succeeded in this way?
 - a. [If answer is yes] What about the way this training was structured was most helpful for this facility?
 - b. [If answer is no] What could have been done to make the training even more compatible with your facility?
23. Now that SHOPS assistance is winding down, how will this facility meet its LARC and PM training needs going forward?

- a. Will your facility want to seek out a training model that is similar to the model SHOPS used? Why or why not?
24. [If not interested in using SHOPS model] What kind of training approach is this facility considering using instead?
- a. [If ongoing training will not be offered] How will your facility ensure that staff has the skills needed to continue to deliver LARC and PM services in the future?

Delivering LARC and PM Services

Pricing LARC and PM Services

- 25. What is the service fee for each type of LARC and PM service you offer here?
- 26. What factors were taken into account when the prices for these services were set?
- 27. To what extent do you think the service fee makes a difference in your patients' decisions about whether or not to select a certain type of LARC and PM?

Building and Maintaining Quality

- 28. Does this facility have a system in place to monitor LARC and PM quality?
 - a. [If answer is yes] To what extent is LARC and PM quality assurance integrated with this facility's other quality assurance systems, such as those for MCH or other reproductive health services?
- 29. What tools and systems do you use to help track service quality?
 - a. Does this facility use the family planning compliance checklist? Why or why not?
- 30. How well do you think the facility's quality assurance system for LARCs and PMs is working?
 - a. What, if anything, about this system could be improved?
- 31. Will your facility continue to use this quality assurance system after the SHOPS Family Planning Program assistance to this facility has ended? Why or why not?

LARC and PM Reporting

- 32. Does this facility have a system in place for reporting on LARC and PM services delivered?
- 33. How well do you think the reporting system this facility has in place is working?
 - a. What, if anything, would you want to improve about it?
- 34. Will this facility continue to use this reporting system after the SHOPS Family Planning Program assistance to your facility has ended? Why or why not?

LARC Supply

- 35. What process does this facility use to procure LARC supplies (*i.e., IUDs, implants, and injectables*)?
 - a. What information is needed to be able to order the right amount of LARC supplies?
 - b. How has this facility been financing its LARC supply?
- 36. How does LARC procurement differ from processes to supply other services offered at this facility, such as those for MCH or other reproductive health services?

Facility-Level Marketing and Demand Generation

Business Enabling Workshop (BEW) [City Hospital and Women's MC Only]

- 37. Was this meeting helpful for you and/or others from this facility? Why or why not?

38. [If attended meeting] Was there anything that you think was missing from the meeting? If so, please describe.
39. [If attended meeting] Was there anything that you think was unnecessary in the meeting? If so, please describe.

Facility-Level Business and Marketing Plan

40. Is a LARC and PM business and marketing plan in place to guide demand generation for these services at your facility? If not, why?
41. In what ways did the SHOPS assist the development of this facility's LARC and PM business and marketing plan?
 - a. [If knowledgeable about SHOPS assistance] Do you feel that this assistance was helpful? Why or why not?
42. Is your facility's LARC and PM marketing plan integrated with broader facility marketing efforts, such as those for MCH or other reproductive health services? If not, why?

Facility-Level Marketing Activities

43. What staff members have been involved in assisting LARC and PM marketing at this facility?
44. How has this facility used its SHOPS-assigned marketing and community mobilization officer (MCMO)?
45. The SHOPS community mobilization officer services to this facility will be ending in March. How do you think this will impact your marketing activities for LARC and PM?
 - a. Will permanent facility staff be able to take over the community mobilization officer's duties? If so, which staff?

Marketing Outcomes

46. How successful do you think LARC and PM marketing activities have been to date?
 - a. What have been the main challenges related to LARC and PM marketing?
47. Is this facility interested in continuing to use the current LARC and PM business and marketing plan after the SHOPS assistance to this facility has ended?
 - a. [If answer is yes] Do you anticipate any changes will be necessary to continue to implement the plan successfully?
 - b. [If answer is no] Do you anticipate that the facility will continue to specifically market LARC and PM services? Why or why not?
 - c. [If answer is no] What other strategies will this facility use to bring in LARC and PM business?

Overall Assessment and Going Forward

48. Overall, how well do you think LARC and PM service delivery and integration with MCH or other reproductive health services here at this facility has gone?
 - a. What has been successful?
 - b. What do you wish was going better?
 - c. Do you think staff and providers are enthusiastic about providing LARC and PM? Why or why not?
49. How would you characterize the level of investment it took on the part of this facility overall to introduce LARC and PM services here? When I say investment I am talking about the financial, time, and physical space commitments you had to make to introduce LARC and PMs here.

50. Do you anticipate that this facility will continue to offer LARC and PM services after SHOPS assistance to this facility has ended? Why or why not?
51. Is there anything that you anticipate can or will affect the ways in which this facility delivers LARC and PM services after SHOPS assistance to this facility has ended?

DISCUSSION GUIDE FOR DEPARTMENT LEADERSHIP/FOCAL POINT

Facility and Respondent Background

1. Generally, what kinds of services are offered to patients/clients at this facility?
2. How would you characterize this facility's clientele? (I.e., rich, poor, from the immediate vicinity, from across Dhaka and other areas, mostly women, mostly men, etc.)
3. What are your primary responsibilities in your current role at this facility?
4. How long have you been working in your current position?
5. How long have you been working at this facility?
6. **[Doctors Only]** Do you also work in other facilities or in private practice? If so where?

Introducing the LARC and PM Services

7. Prior receiving assistance from SHOPS, what was this facility's experience with or exposure to family planning services in general?
 - b. **[If some previous experience with family planning]** What was this facility's experience with or exposure to LARC and PM services?
8. Were there any specific issues or concerns that you brought up during the MOU negotiation process? If so, please describe what these were.
 - a. **[If there were issues/concerns]** Did SHOPS address these concerns to your satisfaction?
 - i. If so, how did they do this?
 - ii. If not, what outcome would you have preferred instead?

Management of LARC and PM Introduction and Implementation

9. Which departments have been involved in the introduction and implementation of LARC and PM here?
10. Based on your experience so far, do you feel that the other departments/staff you have had to collaborate with to introduce LARC and PM services have cooperated to the degree you expected? Why or why not?
11. Do you feel that you have an appropriate level of support from this facility's administrator/owner for LARC and PM service delivery?
 - a. **[If answer is yes]** How does your administrator demonstrate support?
 - b. **[If answer is no]** What would you like your facility administrator/owner to be doing differently?

Training and Skill Transfer

Training Needs

12. [Monsur Ali and Women's Medical College Only] Through SHOPS this facility received training on providing IUD, injections, implants, tubectomy, and NSV. What were the reasons this facility chose to train staff in these skills?
13. [City and Galaxy Hospitals Only] Through SHOPS this facility received training on providing IUD, injections, implants and tubectomy; what were the reasons this facility chose to train staff in these skills?

Skill Transfer and Retention

14. What was the total number of staff that was originally trained on LARC and PM procedures at this facility?
 - a. Was this the right number of staff to train? (*i.e., too few? Too many?*)
 - b. Since the SHOPS training have you identified any additional staff that should receive LARC and PM training?
 - i. [If answer is yes] What steps have been taken to ensure skill transfer to these staff?
15. Since the original SHOPS training, do you feel that you have opportunities to keep your skills up to date? Why or why not?
16. What happens when a trained staff member leaves?
 - a. Are there procedures in place to facilitate skill transfer from departing staff to incoming or remaining staff? If so please describe them.
17. [Monsur Ali and Women's Medical College only] Describe how AITAM's Training of Trainers (TOT) was implemented at this facility.
 - a. Was the way in which the TOT was delivered helpful to you? Why or why not?
 - b. How has it influenced the way you teach your classes on LARC and PM techniques?
18. [Monsur Ali and Women's Medical College only] Did you incorporate an LARC and PM practicum for LARC and PM into the existing medical training curricula for your students?
 - a. [If the answer is yes] If so, how did your students respond to the practicums?
 - b. [If the answer is yes] Do you think this facility will continue to incorporate LARC and PM practicums into its training curriculum? Why or why not?

Perspectives on Training

19. How was training delivered here? (*i.e., hands-on or lecture-based, on site or off-site, with just doctors and nurses from this facility vs. others, etc.*)
 - a. Were all participants able to complete practical (hands-on) training? If not, what was the reason for this?
20. How well do you think the training went overall?
 - a. What worked well?
 - b. What could have been improved?
21. What are your impressions of the training content?
 - a. Was there anything that you think was missing from the training? If so, please describe.

- b. Was there anything that you think was unnecessary in the training? If so, please describe.
22. SHOPS intended to structure the training in a way that was not overly disruptive to this facility's normal business. Do you think the training succeeded in this way?
- a. [If answer is yes] What about the way this training was structured was most helpful for this facility?
 - b. [If answer is no] What could have been done to make the training even more compatible with your facility?
23. How will this facility ensure that staff has the skills needed to continue to deliver LARC and PM services in the future?

Delivering LARC and PM Services

Pricing LARC and PM Services

24. What is the service fee for each type of LARC and PM service you offer here?
25. What factors were taken into account when the prices for these services were set?
26. To what extent do you think the service fee makes a difference in your patients' decision about whether or not to select a certain type of LARC and PM?

Building and Maintaining Quality

27. Does this facility have a system in place to monitor LARC and PM quality?
- a. [If answer is yes] To what extent is LARC and PM quality assurance integrated with this facility's other quality assurance systems?
 - b. What kind of assistance did SHOPS provide in developing this system?
28. What tools and systems do you use to help track service quality?
- a. Does this facility use the family planning compliance checklist? Why or why not?
29. How well do you think the facility's quality assurance system for LARCs and PMs is working?
- a. What, if anything, about this system could be improved?
30. Will this facility continue to use this quality assurance system after the SHOPS Family Planning Program assistance to this facility has wound down? Why or why not?

LARC and PM Reporting

31. Please describe the system that this facility uses to report and track LARC and PM services that are delivered here.
- a. To what extent is LARC and PM reporting integrated with this facility's other reporting systems?
32. Who is responsible for LARC and PM-related reporting?
- a. Are those who are responsible for reporting using the system that has been introduced by SHOPS? Why or why not?
33. Has the LARC and PM reporting system been adjusted or modified since it was first introduced? If so, how and why?
34. How well do you think the LARC and PM reporting system this facility has in place is working?
- a. What, if anything, would you want to improve about it?

35. Will this facility continue to use this reporting system after the SHOPS Family Planning Program assistance to this facility has ended? Why or why not?

LARC Supply

36. What process does this facility use to procure LARC supplies (*i.e.*, IUDs, implants, and injectables)?
- What information is needed to be able to order the right amount of LARC and PM inputs?
 - How has this facility been financing its LARC and PM input supply?
37. How does LARC commodity procurement differ from processes to supply other services offered at this facility?
38. Has this facility been able to maintain a sufficient stock of products and equipment to meet current demand for LARC? Why or why not?
39. How would you characterize this facility's relationship with Social Marketing Company?
- Are they easy to work with? Why or why not?
40. Are there any plans to change this facility's system for LARC supply procurement after the SHOPS project support to this facility has ended?
- [If answer is yes] What will be done differently and why?

Facility-Level Marketing and Demand Generation

Business Enabling Workshop (BEW)

41. Was the business enabling meeting helpful for you and/or others from this facility? Why or why not?
42. [If attended meeting] Was there anything that you think was missing from the meeting? If so, please describe.
43. [If attended meeting] Was there anything that you think was unnecessary in the meeting? If so, please describe.

Facility-Level Business and Marketing Plan for LARCs and PMs

44. Is a LARC and PM business and marketing plan in place to generate demand for these services at this facility? If not, why?
45. In what ways did the SHOPS assist the development of this facility's LARC and PM business and marketing plan?
- [If knowledgeable about SHOPS assistance] Do you feel that this assistance was helpful? Why or why not?
 - [If knowledgeable about SHOPS assistance] Did the SHOPS business enabling meeting prompt this facility to make any changes to the business and marketing plan for LARCs and PMs? If so, please describe what changed.
46. What strategies are being used to engage existing patients?
47. What strategies are being used to engage new patients?
48. Is this facility's LARC and PM business and marketing plan integrated with broader facility marketing efforts, such as those for MCH or other reproductive health services? If not, why?

Facility-Level Marketing Activities

49. What staff members have been involved in assisting LARC and PM marketing at this facility?
 - a. What is each of their roles?
50. How are the SHOPS Family Planning Program communication materials used to carry out the facility's marketing plan? (I.e., leaflets, brochures, outdoor and indoor signage)
 - a. Were these marketing materials distributed to the facility? If not, why?
 - b. Have these marketing materials been distributed to the community? Why or why not?
51. Where are clients counseled about their family planning options at this facility?
 - a. How has this changed since the facility began receiving assistance from SHOPS?
52. [Doctors Working in Other Facilities or in Private Practice] How has the way in which you counsel your private chamber patients on family planning options changed since you were trained on LARC and PM?
53. [Doctors Working in Other Facilities or in Private Practice] What kind of advice do you give to your private chamber patients who are interested in or suitable for a long-acting or permanent family planning method?
54. [Doctors Working in Other Facilities or in Private Practice] Do you think it would be difficult for you to provide LARC and PM services to your patients outside of this facility? Why or why not?
55. How has this facility used its SHOPS-assigned marketing and community mobilization officer (MCMO)?
 - a. What marketing activities did the SHOPS community mobilization officer assist?
 - b. Did the SHOPS community mobilization officer assist other LARC and PM-related activities? If so, please describe them.
56. The SHOPS community mobilization officer services to this facility will be ending in March. How do you think this will impact your marketing activities for LARC and PM?
 - a. Will permanent facility staff be able to take over the community mobilization officer's duties? If so, which staff?

Marketing Outcomes

57. How successful do you think marketing activities for IUDs and implants have been to date?
 - a. What have been the main challenges related to LARC and PM marketing?
58. What have been the main sources of this facility's demand for LARCs and PMs?
 - a. Do these demand patterns correspond to your target audiences? If not, why do you think this is the case?
59. Has any aspect of the marketing plan been adjusted or modified over time? If so, how and why?
60. Is this facility interested in continuing to use the current business and marketing plan after the SHOPS Family Planning Program assistance to this facility has ended?
 - a. [If answer is yes] Do you anticipate any changes will be necessary to continue to implement the plan successfully?

- b. [If answer is no] Do you anticipate that the facility will continue to specifically market LARC and PM services? Why or why not?
- c. [If answer is no] What other strategies will this facility use to bring in LARC and PM business?

Overall Assessment and Going Forward

- 61. Overall, how well do you think LARC and PM service delivery and integration with MCH or other reproductive health services has gone, here at this facility?
 - a. What has been successful?
 - b. What do you wish was going better?
 - c. Do you think staff and providers are enthusiastic about providing LARC and PM? Why or why not?
- 62. How would you characterize the level of investment that it took on the part of this facility overall to introduce LARC and PM services here? When I say investment I am talking about the financial, time, and physical space commitments you had to make to introduce LARCs and PMs here.
- 63. Do you anticipate that this facility will continue to offer LARC and PM services after the SHOPS assistance to this facility has ended? Why or why not?
- 64. Is there anything that you anticipate can or will affect the ways in which this facility delivers LARC and PM services after the SHOPS assistance to this facility has ended?
 - a. [If answer is yes] Please describe the factors that you think could impact LARC and PM services.
 - b. [If answer is yes] What do you think that the facility would have to change or do in response to these factors to continue delivering LARCs and PMs?

DISCUSSION GUIDE FOR DOCTORS, NURSES, PHARMACISTS

Facility and Respondent Background

1. How would you characterize this facility's clientele? (*I.e., rich, poor, from the immediate vicinity, from across Dhaka and other areas, mostly women, mostly men, garment workers, etc.*)
2. What are your primary responsibilities in your current role at this facility?
3. How long have you been working at this facility?
4. [Doctors Only] Do you also work in other facilities or in private Practice? If so where?

Incorporating the Integrated Model

5. Prior to engaging with SHOPS, what was your experience with or exposure to family planning services at this facility?
 - a. [If some previous experience with family planning] What was your experience with or exposure to LARC and PM services at this facility?
6. Prior to the involvement of SHOPS here at this facility, what concerns did you have about providing LARC and PM services here in this facility?
 - a. [If there were concerns] Were these concerns resolved? If so, how?

Management of LARC and PM Introduction and Implementation - Doctors and Nurses Only

7. Where do you get referrals for new LARC and PM patients? (*i.e. from marketing staff, from the immunization department, from the pharmacy, from senior Ob/Gyns, etc.*)
8. Do you feel like you have an appropriate level of support from the facility ownership, administration, and medical department leadership for LARC and PM service delivery here at this facility? Why or why not?

Training and Skill Transfer- Doctors and Nurses Only

9. How was training delivered here? (*I.e., hands-on or lecture-based, on site or off-site, with just doctors and nurses from this facility vs. others, etc.*)
 - a. Were you able to complete practical (hands-on) training? If not, what was the reason for this?
10. How well do you think the training went for you overall?
 - a. What worked well?
 - b. What could have been improved?
11. What are your impressions of the training content?
 - a. Was there anything that you think was missing from the training? If so, please describe.
 - b. Was there anything that you think was unnecessary in the training? If so, please describe.
12. SHOPS intended to structure the training in a way that was not overly disruptive to your schedule. Do you think the training succeeded in this way? Why or why not?
 - a. [If answer is no] What could have been done to make the training even more compatible with your schedule?
13. Do you think you need any additional training in LARC and PM approaches?

- a. [If answer is yes] What kind of training do you think would be helpful?
- b. [If answer is yes] Where do you think you will pursue additional training or skill development assistance in LARC and PM approaches?

Delivering LARC and PM Services

14. [Graduate Doctors and Nurses Only] What has it been like to integrate LARC and PM provision into your work?
 - a. Have you been able to apply the skills you gained through your training? Why or why not?
15. [Graduate Doctors and Nurses Only] What, if any, challenges have you encountered when delivering LARC and PM services?
16. [Graduate Doctors and Nurses Only] What kind of LARC and PM quality assurance and monitoring requirements do you have at this facility?
 - a. Do you think that the quality assurance system the facility has in place is appropriate? Why or why not?
 - b. What, if anything, would you do differently to monitor and maintain LARC and PM quality assurance?
17. Is the facility's LARC and PM record keeping and reporting system easy to use? Why or why not?
18. Is the LARC and PM record keeping/reporting system compatible with other reporting systems you have to use here at this facility? Why or why not?

LARC Supply

19. Did you have any role in the procurement or planning for LARC supplies (i.e., IUDs, injectables, and implants)?
 - a. [If answer is yes] How do you keep track of LARC supplies?
 - b. [If answer is yes] Did you have the support you needed to perform that role (*i.e., from your facility management, from SHOPS, from Social Marketing Company*)?
 - c. [If answer is no] How does this facility determine supply needs as they relate to LARC and PM?
20. Since you have been delivering LARCs here, have you ever run out of the supplies you needed?
 - d. [If answer is yes] What is the process for reordering supplies?
 - e. [If answer is yes] How long does it take to get new supplies once you've ordered them?

Facility-Level Marketing and Demand Generation - Graduate Doctors and Nurses Only

21. Where are clients counseled about their family planning options at this facility?
 - a. How has this changed since the facility began working with SHOPS?
22. When are patients counseled about family planning options? (*i.e., only when clients are already coming for family planning-related services, or when they are here for other services, such as immunizations for their children or deliveries*)
23. How receptive do clients seem to family planning counseling?

24. [Doctors Working in Other Facilities or in Private Practice] How has the way in which you counsel your private chamber patients on family planning options changed since you were trained on LARC and PM?
25. [Doctors Working in Other Facilities or in Private Practice] What kind of advice do you give to your private chamber patients who are interested in or suitable for a long-acting or permanent family planning method?
26. [Doctors Working in Other Facilities or in Private Practice] Do you think it would be difficult for you to provide LARC and PM services to your patients outside of this facility? Why or why not?

Overall Assessment and Going Forward

27. How well do you think LARC and PM integration with MCH and other reproductive health services offered here has gone overall?
 - a. What has been successful?
 - b. What do you wish was going better?
28. Do you think facility leadership/administration is enthusiastic about providing LARC and PM? Why or why not?
29. Do you anticipate that this facility will continue to offer LARC and PM services after the assistance to this facility has ended? Why or why not?
30. What, if anything, do you anticipate will change about the ways in which this facility will deliver LARCs and PMs, once SHOPS assistance winds down?

DISCUSSION GUIDE FOR MCMO AND MARKETING STAFF

Facility and Respondent Background

1. Generally, what kinds of services are offered at this facility?
2. How would you characterize this facility's clientele? (*I.e., rich, poor, from the immediate vicinity, from across Dhaka and other areas, mostly women, mostly men, garment workers, etc.*)
3. Who are the key actors who were involved in introducing LARCs and PMs here at this facility?
4. What are your primary responsibilities in your role at this facility this role?
5. How long have you been working at this facility?

Incorporating the Integrated Model

6. [Marketing Staff Only] Prior to engaging with SHOPS, what was your experience with or exposure to family planning (FP) services at this facility?
 - a. [If some previous experience with FP] What was your experience with or exposure to LARC and PM services at this facility?

Management of LARC and PM Introduction and Implementation

7. Do you feel that you have an appropriate level of support from the facility ownership, administration, and medical department leadership for LARC and PM service delivery here at this facility? Why or why not?

Delivering LARC and PM Services

8. What role (if any) have you played in reporting or quality assurance (QA) tasks?
 - a. Has the facility made any efforts to transfer these tasks to permanent staff? Why or why not?

Facility-Level Marketing and Demand Generation

Business Enabling Workshop (BEW)

9. Did you attend a business enabling meeting led by SHOPS staff?
 - a. [If answer is yes] Was this meeting helpful for you and/or others from this facility? Why or why not?
10. [If attended] Was there anything that you think was missing from the meeting? If so, please describe.
11. [If attended] Was there anything that you think was unnecessary in the meeting? If so, please describe.

Facility-Level Marketing Plans

12. What strategies are being used to engage existing patients?
13. What strategies are being used to engage new patients?
14. Do you consider the LARC and PM marketing plan to be integrated with this facility's broader marketing plan for MCH or other reproductive health services? Why or why not?

- a. [If not integrated] How is the way in which LARCs and PMs are marketed different from other services at this facility?
15. In what ways did SHOPS assist the integration of this facility's marketing plan for IUDs, implants, injectables, and tubectomy into this facility's broader marketing approach for reproductive health services?
- a. [If knowledgeable about SHOPS assistance] Do you feel like this assistance was helpful? Why or why not?

Facility-Level Marketing Activities

16. [MCMO Only] What role did you have in assisting this facility's marketing tasks?
- a. Did you share any of your tasks with other staff at this facility?
17. How is this facility planning to transition from receiving direct assistance from the MCMO?
- a. Will permanent facility staff be able to take over the MCMO duties? If so, which staff?
 - b. Are there any tasks that you think will be discontinued without MCMO assistance? If so, which tasks are these?
18. How are the SHOPS Family Planning Program communication materials used to carry out the facility's marketing plan? (I.e., leaflets, brochures, outdoor and indoor signage)
- a. Were these marketing materials distributed to the facility? If not, why?
 - b. Have these marketing materials been distributed to the community? Why or why not?
19. Where are clients counseled about their family planning options at this facility?
- a. How has this changed since the facility began working with SHOPS?
20. When are patients counseled about family planning options? (I.e., only when clients are already coming for FP-related services, or when they are here for other services, such as immunizations for their children or deliveries)
21. How receptive do clients seem to family planning counseling?

Marketing Outcomes

22. How successful do you think LARC and PM marketing activities have been to date?
- a. What have been the main challenges related to LARC and PM marketing?
23. Has this facility been getting any client referrals from other places in the community? If so, where?
24. What have been the main sources of this facility's demand for LARCs and PMs?
- a. Do these demand patterns correspond to your target audiences? If not, why do you think this is the case?
25. Do you think this facility will be interested in continuing to use the LARC and PM marketing plan after SHOPS assistance to this facility has ended?
- a. [If answer is yes] Do you anticipate any changes will be necessary to continue to implement the plan successfully?
 - b. [If answer is no] Do you anticipate that the facility will continue to specifically market LARC and PM services? Why or why not?

Overall Assessment and Going Forward

26. How well do you think LARC and PM integration into MCH and other reproductive health services here has gone overall?
- a. What has been successful?
 - b. What do you wish was going better?

27. Do you think facility leadership/administration is enthusiastic about providing LARC and PM?
Why or why not?
28. Do you anticipate that this facility will continue to offer LARC and PM services after SHOPS assistance to this facility has ended? Why or why not?
29. What, if anything, do you anticipate will change about the ways in which this facility will deliver LARCs and PMs, once SHOPS assistance to this facility has ended?

7. REFERENCES

- Alauddin, M., G. Bowers, G. Lewis, and B. Ravenholt. 2010. *USAID/Bangladesh: Population and Family Planning Program Assessment*. Washington, DC: USAID Global Health Technical Assistance Project.
- Blumenthal, P., N. Shah, K. Jain, A. Saunders, C. Clemente, B. Lucas, K. Jafa, and M. Eber. 2013. "Unmet Need: A Multicountry Experience Matching Demand Creation and Service Delivery." *Contraception* 87: 170–175.
- Directorate General of Family Planning. 2011. *Improving the Uptake of Long-Acting and Permanent Methods in the Family Planning Program: Bangladesh National Strategy 2011-2016*. Dhaka, Bangladesh: Engender Health Mayer Hashi Project.
- Eisenhardt, K. 1989. Building Theories from Case Study Research. *Academy of Management Review* 14: 4.
- Faculty of Sexual and Reproductive Healthcare. 2013. Training Requirements for Doctors Wishing to Obtain the Letter of Competence in Intrauterine Techniques and to Obtain the Letter of Competence in Subdermal Contraceptive Implants. London: Royal College of Obstetricians and Gynaecologists. http://www.fsrh.org/pages/DFSRH_and_LoC_recertification.asp
- GAO Program Evaluation and Methodology Division. 1990. *Case Study Evaluations*. Washington, D.C.: Government Accountability Office (GAO).
- Khuda, B., J. Stoeckel, and N. Piet-Pelon. 1997. *Bangladesh Family Planning Programme: Lessons Learned and Lessons for the Future*. Dhaka, Bangladesh: International Centre for Diarrhoeal Disease Research.
- May, C., T. Finch, F. Mair, I. Ballini, C. Dowrick, M. Eccles, L. Gask, A. MacFarlane, E. Murray, T. Rapley, A. Rogers, S. Treweek, P. Wallace, G. Anderson, J. Burns, and B. Haven. 2007. "Understanding the implementation of Complex interventions in health care: The normalization process model." *BMC Health Services Research* 7: 148.
- MEASURE Evaluation. The Future of Long-acting and Permanent Methods of Contraception in Bangladesh. Chapel Hill, NC: MEASURE Evaluation; 2014.
- Ministry of Health and Family Welfare. 2010. *Health, Population, and Nutrition Sector Strategic Plan 2011-2016*. Dhaka, Bangladesh: Government of the People's Republic of Bangladesh.
- . 2011. *Human Resources Development Unit Annual Report*. Dhaka, Bangladesh: Government of the People's Republic of Bangladesh.
- Nasreen, H., S. Masud Ahmed, H. A. Begum, and K. Afsana. 2007. *Maternal, Neonatal, and Child Health Programmes in Bangladesh*. Dhaka: BRAC.
- National Institute of Population Research and Training (NIPORT); Mitra and Associates; and ICF International. 2009. *Bangladesh Demographic and Health Survey 2007*. Dhaka, Bangladesh and Calverton, MD, USA.
- National Institute of Population Research and Training (NIPORT); Mitra and Associates; and ICF International. 2013. *Bangladesh Demographic and Health Survey 2011*. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.
- National Institute of Population Research and Training (NIPORT); MEASURE Evaluation; and ICCDR, B. 2012. *Bangladesh Maternal Mortality and Health Care Survey 2010*. Dhaka, Bangladesh.
- QSR International Pty Ltd. 2012. "NVivo Version 10, Qualitative Data Analysis Software."
- Rahaim, S., J. Ahmed, M. Smith, and H. Li. 2011. *Bangladesh Private Sector Assessment of Long Acting and Permanent Family Planning Methods and Injectable Contraceptives*. Bethesda, MD: Abt Associates Inc. Strengthening Health Outcomes through the Private Sector.

- The RESPOND Project. 2012. Achieving Positive Policy Changes for Family Planning in Bangladesh. *RESPOND Project Brief No. 8*. New York, NY: RESPOND Project/EngenderHealth.
- Rivera, R., R. Jacobstein, E. McGinn, J. Shelton, R. Salem, and D. Hubacher. 2009. *IUD Toolkit: Essential Knowledge about the Copper T-380A IUD*. Washington, D.C.: USAID.
- Rob, U., M. N. Talukder, U. Khan, and A. K. M. Zafar. 2010. "Urban Family Planning Program of Bangladesh: Issues and Challenges" (Workshop Report). Dhaka: Population Council.
- SHOPS Project. 2015. *Bangladesh Program Profile*. Bethesda, MD: Abt Associates Inc. Strengthening Health Outcomes through the Private Sector Project.
- Sohel, K. 2014. "Political Turmoil Eats Up 1% of GDP." *The Dhaka Tribune*, April 10, accessed July 18, 2014. <http://www.dhakatribune.com/economy/2014/apr/10/political-turmoil-eats-1-gdp>
- Streatfield, P. K., and N. Kamal. 2013. "Population and Family Planning in Bangladesh." *Journal of the Pakistani Medical Association* 63(4).
- Ugaz, J., S. Rahaim, K. Banke, J. Williams, and W. Chowdhury. 2013. *Assessment of Private Providers' Knowledge, Attitudes, and Practices Related to Long-Acting and Permanent Methods of Contraception in Bangladesh*. Bethesda, MD: Abt Associates Inc. Strengthening Health Outcomes through the Private Sector Project.
- USAID Maternal Child Health Integrated Program (MCHIP). 2012. *Program Learning for Postpartum Intrauterine Contraceptive Device Integration with Maternal Health Services*. Washington, D.C.: USAID.
- World Bank. 2003. *Private Sector Assessment for Health Nutrition and Population in Bangladesh*. Washington, D.C.: World Bank.
- World Health Organization (WHO); U.S. Agency for International Development (USAID); and Maternal and Child Health Integrated Program (MCHIP). 2013. *Programming Strategies for Postpartum Family Planning*. Geneva: WHO.
- Yin, R. 2009. *Case Study Research: Designs and Methods*. Thousand Oaks, CA: Sage Inc.