LA/PM Community of Practice
Technical Consultation

Expanding and Improving Access to LARCs and PMs through the Private Sector

Meeting Highlights

Washington, D.C.
March 4, 2014

USAID
FROM THE AMERICAN PEOPLE

SHOPS
Strengthening Health Outcomes *through* the Private Sector

CONTENTS

I. OVERVIEW AND MEETING OBJECTIVES

The private health sector is increasingly recognized as a vital part of the total market approach for family planning and other health areas. Interest in working with the private sector is on the rise. With this in mind, the Strengthening Health Outcomes through the Private Sector (SHOPS) project, the U.S. Agency for International Development (USAID)'s flagship initiative in private sector health, looked to bring together implementers and donors from the long-acting reversible contraceptive and permanent method (LARC and PM) community to focus on private sector provision of LARCs and PMs.

The SHOPS project hosted a full-day meeting on March 4, 2014 to explore the role of independent private providers in the provision of LARCs and PMs. Held in collaboration with Marie Stopes International, Population Services International, the RESPOND project, and USAID, and under the auspices of the Long-Acting and Permanent Methods Community of Practice, this technical consultation was designed to stimulate learning, foster an exchange of experience, and inform strategic thinking and programming within the family planning community. This meeting was the second in a series of knowledge-sharing events focused on approaches to improving and expanding access to LARCs and PMs. (The first meeting focused on mobile outreach, and the third meeting will focus on social franchising.) More than 45 global health practitioners shared experiences and insights about the barriers to provision of LARCs and PMs in the private sector, and identified promising approaches and research needs.

This report highlights key messages delivered by the presenters and provides a synthesis of the plenary and working group discussions. The agenda for the day can be seen in Annex 1. Presentation slides can be accessed by clicking on the titles on the Contents page and within the document.

The meeting opened with remarks from USAID and SHOPS leadership. There was then an overview presentation on current data related to use of the private sector for family planning, focused on giving the picture of the current and potential role of the private sector in LARC and PM provision.

The meeting moved into two panel sessions. The first focused on the enabling environment for private sector family planning provision. Four panelists each gave a short presentation on an aspect related to enhancing the enabling environment for LARC and PM provision in the private sector. After the panelists spoke, there was a short period for clarifying questions and then the audience moved into small groups to answer three questions posed. After small group discussion, the audience came back together and the moderator facilitated a discussion around the three questions. Ideas for the future programming and research agenda came out of these discussions.

The second panel followed the model of the first. This panel focused on improving access to commodities and demand for private provision of LARCs and PMs. Three panelists presented on these topics and gave time for clarifying questions. The audience similarly broke into small group discussions around the same three questions and came back into the large group to discuss ideas and to identify the future programming and research agenda.

The questions posed for each of the group discussions were:

- Which of the approaches you heard in the panel are promising and how should they be adapted or scaled?
- What additional approaches should be considered?
- Where is more information or research needed?

The remainder of this report will detail the presentations and the discussion that followed as well as the future directions that were identified.

2. OPENING REMARKS

Marguerite Farrell, private sector team leader, Service Delivery Improvement Division, USAID, opened the day by underlining the need for increased availability of modern contraceptive methods in the private health sector. She also discussed the support that USAID is currently providing for research and rollout of five new contraceptive methods. Farrell noted that globally, between 17 and 33 percent of women obtain family planning services through the private sector and there has been success in increasing access and choice for short-acting methods, but less success with LARCs and PMs in the private sector. “To ensure method choice, a wide range of methods needs to be available wherever clients choose to go.”

Susan Mitchell, director of the SHOPS project, went on to define private providers as including a broad range of practitioners and facilities. She outlined four barriers faced by private providers: a lack of access to training, an unsupportive policy environment, limited access to supplies, and weak demand for LARC and PM services. Noting that most private providers operate independently rather than as part of a network or franchise, she presented the following technical challenges:

- What approaches currently in use can be adopted and scaled up to address those barriers for independent private providers?
- What additional approaches should be considered?
- Where is further information and research needed on these issues?

Mitchell emphasized the need for a longer-term (five-year) strategy that would address enabling factors (including training, task-sharing, and integrated approaches), access to supply, and demand variables.

2.1 “PROVISION OF LA/PMS THROUGH THE PRIVATE SECTOR: WHAT DO DHS DATA TELL US?” JORGE UGAZ, SHOPS PROJECT

Jorge Ugaz, research, monitoring, and evaluation specialist, SHOPS project, closed the session with “**Provision of LA/PMs through the Private Sector: What Do DHS Data Tell Us?**” This overview of the current role of the private health sector is based on an analysis of Demographic Health Survey data from 2006 to 2012, relating to 43 countries in three regions: South and Southeast Asia, Latin America and the Caribbean (LAC), and sub-Saharan Africa. The study found that the private sector plays a substantial role in the provision of modern contraception in all three regions—45 percent in South and Southeast Asia, 46 percent in Latin America and the Caribbean and 33 percent in sub-Saharan Africa. However, the role of the private sector is much smaller for provision of LARCs and PMs than for short-acting methods. Even among women from the upper two wealth quintiles, a substantial proportion of women in all three regions turn to the ***public*** health sector to obtain LARCs and PMs. This suggests that, despite the “strong presence” of the private sector in providing modern contraception in developing countries, there is limited access to LARC and PMs in the private sector. Improving such access may result in greater use and a more efficient use of resources.

3. ENHANCING THE ENABLING ENVIRONMENT FOR LARC AND PM PROVISION

Elaine Menotti, technical advisor and LARC/PM co-champion in the USAID Office of Population and Reproductive Health, facilitated the first panel, emphasizing the importance of the enabling environment to LARC and PM provision and ways in which it can be enhanced. Four panelists presented findings, based on research and field experience, relating to issues of training, task-shifting to increase capacity, and integrated service models for LARC/PM provision.

3.1 "CREATING A MORE CONDUCIVE ENVIRONMENT FOR LA/PM PROVISION: THE CASE OF TASK SHARING," ALEX LE MAY, INDEPENDENT CONSULTANT

Le May discussed the fact that private providers often face regulatory barriers affecting supply and demand. He summarized an analysis of national regulatory policies on task sharing, showing that many countries have regulations on the provision of specific contraceptive procedures that are more restrictive than WHO recommendations. The Marie Stopes International (MSI) Reproductive Health Policy Index on task sharing family planning maps how closely each country's LARC and PM guidelines follow the WHO guidelines: in general, Asia is more restrictive than sub-Saharan Africa, while East Africa is less restrictive on task sharing than West Africa.

Le May summarized various sources of opposition to increased task sharing, including professional associations, Ministry of Health officials, medical schools, and competing training initiatives. He presented a table outlining specific opposing arguments, with appropriate responses to them. Other selected key points include:

- National policies vary considerably in the degree to which they restrict task sharing.
- An innovative modeling approach currently under development by MSI, the "Taskalator," will allow advocates and policymakers to model the impact of task sharing in relation to patient access, doctors' time, and unmet need.
- Task sharing approaches need to find ways to include independent private providers in all aspects; task sharing poses both opportunities and threats to the livelihoods of independent providers. This may include finding ways to engage them in clinical quality assurance, sector-specific impact modeling to understand potential market dynamics caused by task sharing regulation, and helping independent providers adapt their livelihoods in the face of market responses to task sharing policy.
- Complication rates can actually be lower with task sharing, and task sharing provides services in areas that previously lacked them.

Le May concluded by outlining some inclusive approaches to quality assurance, adapting livelihoods, and impact modeling, relevant to independent private sector providers.

3.2 "TASK SHIFTING: ENABLING BROADER SERVICE PROVISION BY A WIDER RANGE OF PROVIDERS," DR. BIRHANU SENDEK, MARIE STOPES INTERNATIONAL ETHIOPIA

Dr. Sendek, MSI Ethiopia's director of quality and clinical services, discussed two countries—Uganda and Ethiopia—to illustrate the differences in national policies and implementation related to task sharing and opportunities for global learning. In Uganda, despite a supportive national policy allowing clinical officers to perform tubal ligations, task sharing has not yet been implemented. However, Uganda is experiencing a shortage of physicians (62 percent of positions are vacant) and a high demand for tubal ligation where it is accessible. A study of local evidence on task sharing of tubal ligations to clinical officers in Uganda, commissioned by the Ministry of Health, showed a high level of client satisfaction and a low level of complications for 518 women surveyed. On the basis of that study, as of September 2013 the Ministry of Health has authorized service delivery organizations to use clinical officers to perform tubal ligations and is planning a national scale-up.

Dr. Sendek spoke to experiences in Ethiopia where task sharing of tubal ligations had been permitted since 2011.

Other selected key points include:

- Ethiopia adopted task sharing for Implanon in 2009 and for tubal ligation in 2011. MSI Ethiopia consequently implemented this policy, with training, supervision, and quality audits of MSI Ethiopia clinical officers.
- Current research on task sharing through MSI Ethiopia will assess safety and client satisfaction, as well as document the shift toward progressive policies and examine existing barriers and supporting factors for further implementation of task sharing of tubal ligations.
- Further work remains to be done on private sector involvement in task sharing, including quality assurance, as well as integration of LARCs and PMs with other priority health services.

Dr. Sendek closed by stating that expanding access to LARCs and PMs through task sharing has the potential to significantly reduce maternal mortality and morbidity.

3.3 "ENABLING FACILITY INVESTMENT IN LA/PMS THROUGH AN INTEGRATED MODEL," STEPHEN RAHAIM, SHOPS PROJECT

Stephen Rahaim, Asia regional manager and behavior change communication (BCC) advisor, spoke about the unique challenges that private providers face in expanding their range of services, including a shortage of skilled providers, unavailability of commodities, and limited demand for services. They may also be wary of expanded interaction with government agencies, which sometimes apply regulations inconsistently. One approach to facilitating the addition of LARC/PM services is to offer a package that integrates these services into existing offerings. The package would include technical assistance, on-site training, micro-marketing,

and quality assurance. Several factors support the use of an integrated approach in Bangladesh:

- LARC/PM methods represent only 13 percent of total contraceptive prevalence, down from 30 percent in 1991
- Antenatal and postnatal care offer an opportunity for integrating contraceptive services
- The private sector provides more than half of all antenatal care visits
- An integrated service delivery model lowers the start-up investment required

As of September 2013, with SHOPS assistance, 37 private facilities in Bangladesh were providing IUDs, implants, and tubectomies through this integrated model. Technical support includes:

- On-site training
- Embedded marketing support
- Nongovernmental supply chain through a social marketing organization, supported by USAID
- Quality assurance integrated within existing processes
- Identification of a quality assurance focal person for feedback and communication within each facility

This approach requires tailoring to each facility, and therefore cannot quickly be scaled up.

3.4 "PERSPECTIVES ON IMPLEMENTING AN INTEGRATED MODEL FOR LA/PM SERVICES," PROFESSOR LATIFA SHAMSUDDIN, OBSTETRICAL AND GYNECOLOGICAL SOCIETY OF BANGLADESH

Professor Shamsuddin, president of the Obstetrical and Gynecological Society of Bangladesh (OGSB) and an ob/gyn, spoke about the success that her organization had in implementing an integrated service model. The OGSB is a national network of 1,300 providers. It operates two women's hospitals and one maternity hospital. OGSB partnered with SHOPS to implement the integrated model described above in its hospitals, focusing on increasing the availability of IUDs. The project was supported by a grant from USAID to provide on-site training for providers. OGSB found that the integrated model had several advantages, including:

- Incorporating family planning thinking into prenatal and postnatal treatment
- Leveraging the existing provider-client relationship
- Using existing facilities
- Greater flexibility in training providers
- Access to supply of commodities through social marketing agreements

3.5 PLENARY DISCUSSION

Participants broke into small groups to discuss three questions. Responses are summarized here.

1) **What approaches currently in use can be adopted and scaled up to address the barriers for independent private providers?**

- On-demand training might be scalable without donor funding using a cascade model. Where personnel are lacking for on-demand training, as in sub-Saharan Africa, professional associations or other organizations might provide training. Continuing medical education can also be a revenue source for associations.
- Task sharing with the private sector should be specifically endorsed by the public sector—integrating the private sector into a total market approach.
- Some procedures, such as implant removal, call for improved training and supervision to enable task sharing.
- The integrated service model can incorporate improved supervision, to allow clinical officers to provide LARC/PMs (as in the public sector).
- Services can be bundled (offering discounts), as well as integrated to help make them more available in the private sector.

The discussion raised many additional questions:

- Are people choosing the private sector because it is better, or because it is the only option available in their area?
- Why are upper quintiles accessing the public sector?
- Many private providers work in the public sector; how do we deal with dual practice?
- What is the impact of incentives on referrals (for example, higher reimbursement rates in India for tubal ligation than for short-acting methods)?

2) **What additional approaches should be considered?**

- Public-private partnerships might leverage private provider expertise to build public sector capacity, particularly in cases like the dedicated provider model. Dialogue with government entities needs to be sustained, consistent, and predictable, in order to include strong private sector participation in a total market approach.
- Medical training should incorporate task sharing into the pre-service curriculum.
- There is a need for behavior change communication programs and materials targeted to providers, to be used at professional association meetings. This could include case studies on the value-added impact of adding various contraceptive services.
- The supply of commodities is a challenge for the private sector. Social marketing approaches may be effective.
- Design task-sharing arrangements that shift physicians into supervisory roles. Providers can share tasks rather than shift tasks completely to someone else.
- Train midwives in LARCs and PMs where allowable; integrate contraception with ante- and postnatal care as well as newborn care.

- Focus on continual skill building; provide continuing medical education for private providers through medical associations. Build capacity for monitoring and evaluation in professional associations.
- A care line mobile phone service can facilitate client follow-up and enhance provider-client communication.

3) Where is further information and research needed on these issues?

- Methodology (a roadmap) for assessing a national health system, looking at the policy environment as well as the market environment for private provision of LARCs and PMs
- Case studies of particular countries' experience (success factors and lessons learned) in implementing programming around LARCs and PMs
- Level of access and existing barriers to LARCs and PMs in the private sector
- Research on client preference regarding the type of provider, including the financial implications of those choices
- A repository or compendium on task shifting and task sharing
- Implications of task sharing for existing networks for referral or complications management

Discussion Highlights

A country's policy environment plays a critical role in the provision of LARCs and PMs through the private health sector, especially by regulating service provision. Specific services may be restricted differently in the private sector than the public sector. Private sector provision requires close attention to quality assurance measures as there are no inherent supervisory structures as in the public system. One idea is to identify a person in a facility to conduct monitoring and to report to a supervising agency.

Public-private partnerships, and public sector champions for private participation, can improve the policy environment and achieve sustainable provision of LARCs and PMs. Case studies on task sharing and task shifting in several countries would help in developing models and identifying best practices. These findings should be captured in the form of a methodology or toolkit, including attention to questions of client preferences and demand as well as the role of the total market approach (supporting the government to understand the role of the private sector and to look at the whole system of service delivery).

Expanded training in LARCs and PMs is essential, particularly on-site/on-demand trainings tailored to the needs of private providers. Networks, franchises, and professional associations can be mobilized to help fill this gap; a cascade model (i.e., training of trainers) can maximize the impact of donor funding. Systemic change will require improvement in pre-service training for private providers, as well as improved monitoring of implementation and quality of services.

4. IMPROVING ACCESS TO COMMODITIES AND DEMAND FOR PRIVATE PROVISION OF LARCS AND PMS

Patricia MacDonald, senior technical advisor and LARC/PM co-champion in the USAID Office of Population and Reproductive Health, facilitated the session on improving the supply of and demand for LARCs. Three presentations covered the impact of global access programs on supply, the effort to increase demand through social marketing to prospective clients, and the need to improve the communication skills and knowledge of providers.

4.1 "GLOBAL ACCESS PROGRAMS AND LOCAL SUPPLY CHAINS FOR LARC COMMODITIES: IS EVERYONE BEING SERVED?" FRANCOISE ARMAND, ABT ASSOCIATES

In her presentation, Francoise Armand, principal associate and senior private sector advisor at Abt Associates, examined recent changes in the availability of LARC commodities at the global and local (country) levels. She concludes that Copper-T IUDs are widely available at the global level and highly affordable to institutional programs, with unit prices as low as 74 cents. Global market shaping initiatives have also succeeded in reducing the price of implants to public sector and NGO programs in sub-Saharan Africa from an average of $22 in 2007 to just under $10 in 2012, resulting in considerable increases in shipments of these commodities to the region. At the local level, however, supply gaps can occur that affect independent private facilities because LARC commodities are typically distributed through public sector and NGO channels. In addition, there is a need to increase access to training for these methods among unaffiliated private providers.

4.2 "IUD SOCIAL MARKETING CAMPAIGN IN JORDAN," HOUDA KHAYAME, SHOPS JORDAN

Houda Khayame, social marketing manager for the SHOPS project in Jordan, presented a campaign that used mass media and targeted communications. In Jordan, the private sector accounts for more than half of contraceptive provision: 62 percent of IUD services, and 56 percent of other modern methods. However, discontinuation rates are high. The BCC strategy was designed to position the IUD as a long-term method.

The campaign strategy began with segmenting the market in terms of preferred method—distinguishing between customers who favored the pill and those amenable to the IUD. Key

messages emphasized the safety, effectiveness, and reversibility of the IUD. The communication plan included:

- Using selected private sector doctors as spokespeople
- "Edutainment" lectures involving community health workers for counseling and referrals
- Service referrals, with vouchers for private providers
- Merchandising (for all providers)
- Quizzes, including prizes
- Social media
- Follow-up phone calls to new adopters

A survey three months later showed significant difference in knowledge between respondents who were exposed and unexposed to the campaign. Many people remembered key campaign messages, and 10 percent had begun using IUDs. Social media results included a six-fold increase in Facebook "likes" over the first eight months of the campaign (from 1,838 to 11,224). Public providers also showed an increase in IUD provision. Success factors included:

- Involving country stakeholders from the beginning of the campaign
- Fully integrated campaign components
- Service providers' participation, to strengthen message credibility
- Private providers' participation increases contraceptive use through the private sector
- Showcasing contraceptive methods on mass media, showing their actual size and shape, to allay fears
- Effective community outreach

4.3 "ADDRESSING PROVIDER BIAS TO INCREASE DEMAND THROUGH PROVIDER BEHAVIOR CHANGE COMMUNICATION," MAXINE EBER, SIFPO PROJECT, PSI

Maxine Eber, deputy director of the USAID Support for International Family Planning Organizations project, pointed to factors that deter private providers from offering LARC services:

- Labor- and time-intensive methods (opportunity costs that impact the bottom line for small, privately owned clinics)
- Lack of confidence in the skills and ability to manage side effects
- Outdated or inaccurate information about LARCs
- Perceived safety risks that could impact the provider's or clinic's reputation
- Perceived lack of client demand

Providers can be supported through communication training, to promote two-way communication with clients. PSI has developed a series of resources to help build capacity

among staff to conduct personalized communications to address common provider objections to providing LARCs.

4.4 PLENARY DISCUSSION

The discussion then focused on two broad challenges:

1) **How do we improve access to commodities and demand for private provision of LARCs and PMs?**

On the supply side, a number of approaches were suggested:

- Identify the gaps in global access programs, and design complementary programs to serve those women and providers, who are left out.
- Provider associations (or other agents) could make volume purchases of commodities.
- Partner with suppliers for commercial introduction of commodities. Address import restrictions.
- Provider segmentation represents a scalable approach for targeting particular services and trainings to appropriate providers.
- A peer-to-peer model of provider networking could be facilitated through a mobile phone system with free communication.
- Address financial barriers using a comprehensive approach, combining global access with vouchers and other tools.
- Find ways to incentivize private providers to participate in trainings.

Other suggested approaches addressed gaps in demand:

- A total market approach can analyze the profile of each quintile in a market.
- Vouchers can be used to stimulate the market. Public vouchers can enhance the private sector by raising awareness and credibility (“halo effect”).
- Can vouchers be applied to marketing permanent methods (procedure rather than product)?
- Engage private providers in broader BCC initiatives through public-private partnerships.
- Continuing medical education should incorporate communication skills as well as technical skills.
- Empower clients to be more assertive through social marketing, to counteract provider bias.
- Tailor communications to cultural context, using available channels (e.g., edutainment events at shopping malls); link promotion events to service points, using community outreach.
- Utilize the International Planned Parenthood Federation model as a structured organization of providers.
- Certify private providers through professional associations; incentivize referrals to certified providers.

- If social franchises become sustainable, they can provide marketing services for their members.

2) What are the research needs on these topics?

Participants identified research gaps in marketing, consumer preference, impact assessment, and other areas. With regard to supply, several research topics emerged:

- Supply channels at the country level should be tracked to identify bottlenecks.
- Would the ART model or models from other health areas be appropriate to try with family planning commodities, that is, designating contraceptive services as a public good to be provided free of charge?
- Identify where people access a particular method to design programs that increase access.
- What are the longer-term implications of global access programs for private sector provision?
- Is the goal sustainability or creating a market? How do we incorporate sustainability into project design?
- What are the opportunities and channels to connect with independent private providers? How can quality be assured?

Suggested research related to demand included:

- What are women willing to pay for various services, and why? Do some prefer the role of paying customer, or feel disempowered in the role of beneficiary?
- Can vouchers stimulate demand for services? Can they increase knowledge and awareness more broadly?
- What is the impact of mass media, and who does it reach? Does it create new users? How do we assess the impact of BCC initiatives? Impact studies will require increased funding.
- How do we engage young people and men?
- Can the lessons gleaned from BCC around same-sex marriage (in the U.S.) be adapted to increasing demand for LARCs and PMs, as normalization of new attitudes to contraception and family size?
- Case studies on fragile states can examine the role of the private sector in a context where the public sector is largely absent.

Discussion Highlights

Building the market for LARCs in the private sector may require substantial investment from pharmaceutical companies to ensure supplies; however, they need to have confidence in the level of provider training and quality assurance. Professional associations could make volume purchases as well as provide specialized (fee-based) provider training and monitoring services.

Building demand is just as important as ensuring supplies of commodities. Lack of demand means that the opportunity cost of attending trainings may outweigh the benefit to private

providers. Social franchises, once well-established, may be able to conduct demand generation activities such as social media messaging, vouchers, and “edutainment” events.

A comprehensive approach would include: analysis of import restrictions and other barriers to accessing supply; market analysis (by location, quintile, age group, gender); provider segmentation; partnerships with public sector agencies, professional associations, and/or commercial suppliers; specialized, on-demand training approaches; an integrated system for referrals; and use of mass marketing best practices.

5. FUTURE DIRECTION

More effective involvement of the private health sector in providing LARCs and PMs will require overcoming limitations in both supply and demand, including promoting a more receptive policy environment. Improvements in access to contraceptive services have the potential to reduce maternal mortality and to raise the levels of health, nutrition, and education of children globally.

To enhance the *supply of services*, it is critical is to ensure the training of private providers in LARCs and PMs and to monitor the implementation of these new skills. Interventions need to be sustainable (without ongoing donor funding) and must provide incentives for providers to attend trainings. Potentially sustainable solutions include: modularized trainings at convenient locations; implementing cascade models, with training of trainers and on-demand training; identifying local organizations as potential partners in offering training; supporting associations in adding CME work as a source of revenue; and incorporating task sharing into pre-service education.

Other approaches relevant to enhancing the supply of services include the following:

- A methodology needs to be developed to assess a given country's policy and market environments with regard to LARCs and PMs.
- Quality assurance measures are essential to ensure optimal service delivery through the private sector, especially where task shifting and sharing is involved.
- Public-private partnerships and other models of cross-sector integration need to be developed, for example, in commodity supply, training, referral, and quality assurance.
- A total market approach to analyze existing gaps, duplication, and inefficiencies in service delivery.

The level of *demand for services* is important as well, as a key factor in providers' incentive to add new service offerings, undergo additional training, and maintain skills. Therefore, marketing tools need to be integrated into training programs. BCC campaigns are needed, targeting providers as well as clients. Programs need to be integrated with other health services, especially prenatal and postnatal care and delivery, to enhance access. Other targeted approaches are also needed, to enable young women to delay their first birth.

5.1 AREAS FOR FURTHER RESEARCH

At the broadest level, a focused research effort is required to develop (1) a clearinghouse of relevant data and field experience; (2) case studies on various approaches to task sharing; and (3) ultimately, one or more toolkits or roadmaps for program implementation.

Detailed research topics include the following items. In relation to the supply of services:

- Task sharing — how to handle implant removal; implications for referral systems and complications management
- Existing access to LARCs and PMs in the private sector

- Other health delivery models that may have relevant lessons, e.g., ART delivery or the IPPF model
- Private sector effectiveness in fragile states
- Added value to providers of LARC and PM services, in revenue or building client base
- Minimum personnel requirements for training of trainers and task sharing initiatives

In relation to demand for services:

- Client preferences regarding choice of provider
- Client willingness to pay (especially in relation to task sharing scenarios)
- The impact of mass media campaigns: who is being reached?

Fulfilling this research agenda, and improving access to the most effective contraceptive services, will require sustained collaboration and cooperation among donors, governments, and nongovernmental organizations on the ground.

ANNEX. MEETING AGENDA

LA/PM Community of Practice Technical Consultation

Expanding and Improving Access to LA/PMs Through the Private Sector

March 4, 2014

Meeting Objectives:

- Discuss/explore the role of the private sector in LA/PM provision
- Outline barriers encountered by the private sector
- Discuss strategies/solutions based on participant experience

Time	Session	Speaker
10:00–10:30	Registration and breakfast	
10:30–10:45	Introductory Remarks	Marguerite Farrell, Private Sector Team Leader in the Service Delivery Improvement Division, USAID
	Setting the Stage	Susan Mitchell, Project Director, SHOPS Project
10:45–11:15	Provision of LA/PMs through the private sector: What do DHS tell us?	Jorge Ugaz, Research, Monitoring and Evaluation Specialist, SHOPS Project
11:15–1:15	How do we enhance the enabling environment for private provision of LA/PMs?	Elaine Menotti, MPH, Technical Advisor, USAID (facilitator)
	Creating a more conducive environment for LA/PM provision	Alex le May, Independent Consultant
	Task Shifting: Enabling broader service provision by a wider range of providers	Dr. Birhanu Sendek, Director of Quality and Clinical Services MSI Ethiopia
	Enabling Facility Investment in LA/PM through an Integrated Model	Stephen Rahaim, Asia Regional Manager, BCC Advisor, SHOPS Project
	Perspectives on implementing an integrated model for LA/PM services	Professor Latifa Shamsuddin, Ob/Gyn, President Obstetrical and Gynecological Society of Bangladesh
1:15–2:15	Lunch	
2:15–4:00	How do we improve access to commodities and demand for private provision of LA/PMs?	Patricia MacDonald, RN, MPH, Senior Technical Advisor, USAID (facilitator)
	Global Access Programs and Local Supply Chains for LARC commodities: Is everyone being served?	Francoise Armand, Principal Associate and Senior Private Sector Advisor, Abt Associates
	IUD social marketing campaign in Jordan	Houda Khayame, Social Marketing Manager, SHOPS Jordan
	Addressing Provider Bias to Increase Demand through Provider Behavior Change Communication	Maxine Eber, Deputy Director, SIFPO Project, PSI
4:00–4:30	Pulling it all together: Priorities for future research and programming	Susan Mitchell, Project Director, SHOPS Project Minki Chatterji, Director of Research, SHOPS Project

For more information about the SHOPS project, visit www.shopsproject.org.

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