Partnering with Private Providers to Promote Long-Acting Contraceptives in Urban Bangladesh: A Mixed-Methods Feasibility Study

CONTEXT: *Bangladesh's pluralistic health system has diversified opportunities for clients to obtain family planning, but public-private partnerships could improve access to services, particularly in urban areas.*

METHOD: *Sixteen providers, clients and program managers were interviewed to assess perspectives on a family planning orientation and demand-side financing referral program tested in Mirpur, Bangladesh. The 15-month program, conducted in 2015–2016, was designed to encourage private providers to identify non–family planning clients with unmet contraceptive needs, promote choice of a broader contraceptive mix and refer clients to one of three public or nonprofit clinics for provision of their preferred method. Use of the system was assessed by tracking referral slips.*

RESULTS: *Most stakeholders reported that it was acceptable and feasible to discuss fertility intentions with clients presenting for non-family planning matters. Providers were able to alleviate clients' misconceptions and fears concerning long-acting contraceptive methods, but were unable to address patriarchal and religious barriers. The majority of referrals were done by private providers who had a pre-existing relationship with one of the family planning clinics and referred clients to that clinic; overall, documented referrals accounted for 13% of provision of reversible and permanent methods at that clinic during the study period.*

CONCLUSIONS: *Providing private practitioners with appropriate training on contraceptives and referral could improve Bangladeshi women's access to long-acting and other contraceptive methods in urban areas, and may be useful for other types of health workers. Further study of suitable referral systems is warranted.*

International Perspectives on Sexual and Reproductive Health, 2019, 45:87–98, doi: https://doi.org/10.1363/45e8219

By Laura Bates, Rumana Huque, Prashanta Bhowmik, Rebecca King, Helen Elsey, James Newell and John Walley

Laura Bates is researcher, Rebecca King is lecturer, and James Newell and John Walley are professors–all at the Nuffield Centre for International Health and Development, Leeds Institute of Health Sciences, University of Leeds, UK. Helen Elsey is senior lecturer, Department of Health Sciences, University of York, UK. Rumana Huque is executive director, and Prashanta Bhowmik is research associate–both at the Association for Research and Knowledge Foundation, Dhaka, Bangladesh.

Bangladesh is the ninth most populous country in the world, and its population grows by two million people annually. Its national family planning program, set up in the mid-1970s, deploys a large cadre of field-based health outreach workers known as family welfare assistants, who stimulate interest in family planning, provide short-term contraceptives (the pill and condoms) directly to villagers and refer others to health centers for long-acting methods.

Although long-acting reversible contraceptives (LARCs) offer highly effective protection against unintended pregnancy for an extended period, they are not yet popular with married women in Bangladesh. The most preferred contraceptive method among married Bangladeshi women aged 10–49 has long been the pill, used by 27% of such women, followed by the injectable (12%), traditional methods (8%), tubal ligation (5%) and condoms (5%).[1] Use of the IUD and implant has been negligible (<1% each), even though these LARCs are safe, less reliant on user adherence and less dependent on supply chains.

More than 40 years ago, the Bangladeshi government began providing cash payments to women who initiated contraception, as well as to medical providers and to intermediaries who referred clients. Although the incentives were designed to reduce barriers to care, they generated much international debate, not the least because targeted women were poor and thus vulnerable to coercion. Nonetheless, most clients interviewed by the World Bank were reportedly satisfied with the incentive program.[2] Despite the controversy, the fertility rate in Bangladesh has fallen from 6.0 births per woman to 2.1,[3] largely because of direct provision of short-acting contraceptives to rural homesteads and the cash payment referral mechanism.[4] As of 2014, contraceptive prevalence was 62%,[5] and short-acting methods dominated the method mix as a result of outreach by family welfare assistants.

South Asian countries have a history of channeling government health subsidies directly to consumers or suppliers—an approach known as demand-side financing—to increase poor individuals' access to and use of maternal, reproductive and other health care services.[6] Financial incentives linked to service use are common components of Asian family planning programs, and are well understood by both public and private medical providers.[2,7,8] Voucher schemes, an alternative to cash incentives, similarly offer an exchange for subsidized goods or specific services. In Bangladesh, the 2004 Maternal Health Voucher Scheme increased women's use of antenatal and postnatal services, and as a result of their exposure to health services

indirectly led to increased contraceptive use.[9] One potential problem arising from an upsurge in demand for services is poor supply-side readiness, which can overwhelm the public health system.[10] To help resolve this issue in Bangladesh, the public and private sectors (including nongovernmental organizations, or NGOs) have established public-private partnerships, which offer private services in exchange for supply-side financial incentives.[11,12] The 2012 Bangladesh Population Policy, implemented and supervised by the Directorate General of Family Planning (DGFP), promotes these partnerships to expand family planning services and stabilize population size.[12,13]

Urban communities in Dhaka generally rely on a health system comprising a mix of private medical practitioners, NGOs, government clinics, tertiary hospitals and pharmacies, all of which offer family planning services. This pluralistic system provides clients with diverse opportunities to obtain contraceptives and is one reason for Bangladesh's success in improving national health indicators.[13] Yet Bangladesh continues efforts to stabilize its growing population, citing such reasons as regional disparities, resource constraints and socioeconomic welfare. The National Health Sector 2017–2021 program focuses on reducing disparities and reaching hard-to-reach populations, such as the poor. Gains in contraceptive prevalence are achieved by converting nonusers, and users of traditional methods, to modern methods;[8,12,14] however, contraceptive discontinuation, method switching and method failure associated with short-acting contraceptives could offset achievements in sexual and reproductive health outcomes.[15] Expanding the contraceptive mix to include LARCs (implant, IUD) and permanent methods (sterilization) increases consumer choice and the ability to space or limit pregnancies, reduces maternal and child mortality, and improves the health and well-being of families.[16]

This study examines a public-private partnership approach to improving delivery of family planning services. The use of family welfare assistants in rural areas has helped meet demand for family planning services, but this model has operated within patriarchal structures that keep women isolated at home.[17] In contrast, public-private partnerships could further integrate the pluralistic health system and increase exposure to family planning services, particularly in urban areas.

In Dhaka, the private sector provides 80% of health services in urban slums. Most private providers are pharmacists (40%), nonformal traditional providers (35%) or private consultation providers (20%), and while they often provide services at convenient locations and hours, many operate without medical qualifications or provide services beyond their skill set.[18] A more integrated health system comprising medically trained public and private providers could help diversify the method mix and increase contraceptive uptake in urban areas, where unmet need among married women is double that in rural communities (25% vs. 12%).[19] Public-private partnerships, in Dhaka[20] and globally,[21] have facilitated referrals from private practitioners to medically qualified providers at NGO and government facilities for such conditions as tuberculosis, and hold promise for provision of family planning and maternal health services.[22] Our study explored an intervention that provided financial incentives for private practitioners to discuss family planning needs with all clients, promote a broader mix of contraceptive methods, and refer clients interested in using a LARC or permanent method to one of three local clinics offering services at little or no cost, thus reducing barriers to care and enabling clients to self-determine their health and fertility.[23]

METHODS

Study Setting and Overview

The study site was Mirpur—a heavily populated subdistrict in the northeast of Bangladesh's Dhaka Division—which UNICEF and others have identified as a priority area for interventions because of its considerable slum housing.[17] Our implementing partner, the Advancement Through Research and Knowledge (ARK) Foundation, has experience working in the area and delivered a one-day orientation program on family planning to private providers. Participating practitioners were eligible to receive financial payments if they referred clients to one of three clinics that provided long-acting contraceptives: a government clinic, an NGO-led primary health care clinic and an international NGO clinic (hereafter, we refer to these as the public clinic, the NGO clinic and the INGO clinic, respectively). The clinics, which were selected in partnership with DGFP and located within a two square-kilometer area, offered free short-acting, long-acting and permanent contraceptive methods, although the two NGO clinics charged a service fee; all three served urban and slum populations, and provided financial incentives to women who initiated use of a method (Table 1). In our mixed-method evaluation, we used quantitative methods to assess uptake of long-acting contraceptives resulting from private provider referrals, and qualitative methods to explore the acceptability and feasibility of the program among a sample of private providers, clients, clinic managers and policymakers. The study received ethical approval from the University of Leeds, the DGFP and the Bangladesh Medical Research Council.

Intervention Development

Despite being poor, residents of urban slums often seek health care from private providers perceived to offer quality services at convenient hours.[18] The DGFP designed a referral system whereby private practitioners refer clients to not-for-profit clinics. However, informal discussions with private providers in Mirpur revealed they had little formal training in family planning, had misconceptions about long-acting methods, discussed contraceptives only at clients' request and limited discussions to short-acting methods. Providers indicated their need for training on contraceptive methods, referral options and the referral process prior to testing a referral system.

DGFP, ARK and other NGO partners active in family planning met to develop the content of a training program. Because funding was limited, the resulting program consisted of an "orientation day" designed to broaden private practitioners' awareness of contraceptive methods (particularly long-acting ones) and provide training on the process of referring clients to fully trained providers of long-acting methods; the day was not designed to train participants to provide such methods directly.

Orientation Day

In December 2014, we identified 118 private medical practitioners working in Mirpur. ARK met with these providers to confirm their medical and contact information, and invited them to attend the orientation day program. Five orientation days, each attended by 10–15 participants, were held at a government health center between January and March 2015. Of the 55 providers (33 female and 22 male) who took part, 35 identified themselves as general practitioners; others described themselves as child consultants (6), gynecologists (4), orthopediatricians (2), consultants (1) or surgeons (1); the specialty of the remaining six is unknown. The attendance of specialists suggests that interest in family planning extends beyond general practitioners and gynecologists, perhaps because specialists receive some self-referring patients with general conditions.

Trainers used a variety of approaches, including presentations, videos, group discussions and role playing. Presentations were based on DGFP's existing training materials and covered basic information on contraceptives (and detailed information on long-acting methods), advantages and side effects of contraceptives, social stigma, clients' suitability and advantages of permanent methods. Videos were used to demonstrate the insertion of contraceptive implants. Role-plays focused on identification of clients who were appropriate for referral (i.e., males and females aged 18–49),* use of a paper-based referral system and information on the three referral clinics. In addition, interested participants—all of whom were female—were taken to a hospital in the same building as the training center to observe insertion of an IUD and implant. All participants received a DGFP-issued certificate. Completion of the orientation day was a prerequisite for participation in the referral evaluation study.

During the orientation day, private providers were informed of financial incentives that were available for referring certain clients. In line with DGFP's strategy to address unmet need by increasing use of long-acting methods among contraceptive users, private providers would receive a stipend when a client whom they had referred presented at one of the three clinics for a long-acting method; they would collect their stipend from the clinics every month. The clinics would also receive a payment for providing the method (Table 1).

*Although unmet need for contraceptives among young people is important to address, individuals younger than 18 are considered minors in Bangladesh and were not included in this study.

TABLE 1. Characteristics of family planning clinics participating in private-public referral program, Mirpur, Bangladesh, January 2015–March 2016

Characteristic	NGO	INGO	Public/government
Type	Urban primary health care center	International sexual and reproductive health clinic	Government primary health care clinic
Population served	Urban population, particularly poor and marginalized people	Urban population, including slum residents	Urban population, including slum residents
Contraceptives available	All	All except implant and permanent methods	All
Long-acting method provision	Organizes own camp once a month to administer long-acting and permanent methods	Transfers clients to the public clinic camp every month to obtain implant and permanent methods	Organizes own camp once a month to administer long-acting and permanent methods
Cost to use clinic	40 taka (US$0.50) service charge	25 taka (US$0.30) service charge, plus 15 taka (US$0.20) per year to cover subsequent visits	No service charge
Cost of contraceptives	Free except for condoms, which cost three taka (US$0.04) per dozen	Free	Free except for condoms, which cost 1.2 taka (US$0.01) per dozen
Incentive paid to client	150 taka (US$1.80) for IUD or implant	150 taka (US$1.80) for IUD	150 taka (US$1.80) for IUD or implant
Incentive paid to agent who referred client to clinic	50 taka (US$0.60) for IUD or implant referral	50 taka (US$0.60) for IUD referral	50 taka (US$0.60) for IUD or implant referral
Incentive paid to provider for service provision	60 taka (US$0.70) for inserting IUD or implant	None	60 taka (US$0.70) for inserting IUD or implant

Notes: NGO=nongovernmental organization. INGO=international nongovernmental organization.

DGFP leaflets and posters were distributed to participating providers during the orientation day to use in their chambers and trigger counseling on clients' family planning needs. Providers also received a referral booklet and three clinic address books, all of which had tear-off slips for clients and were designed by ARK and approved by DGFP. The address slips directed clients to the clinic, and the referral slips were to be presented to the clinic upon arrival. Each clinic had a folder to store clients' referral slips and record their selected contraceptive method.

Quantitative Data Collection and Analysis

From February 2015 to March 2016, two members of ARK's research field team made monthly visits to each provider to monitor referral system use. In April 2016, we counted the total number of referral slips used by each provider. Using the three family planning clinics' client register books, we calculated the number of short- and long-acting contraceptives provided to clients who had and had not been referred by a private provider during the 15 months. All referral data were entered into Excel for tabulation and analysis.

TABLE 2. Selected characteristics of interviewed participants

Participant	Gender	Provider worked for NGO clinic*	Referred clients to a public clinic
Private medical provider #02	Female	Yes	Yes
Private medical provider #04	Female	Yes	Yes
Private medical provider #08	Male	No	No
Private medical provider #09	Male	No	No
Private medical provider #11	Female	No	No
Private medical provider #29	Male	No	Yes
Private medical provider #39	Female	No	Yes
Referred client age 28	Female	Yes	na
Referred client age 23	Female	No	na
Nonreferred client age 35	Female	No	na
Nonreferred client age 35†	Female	No	na
Clinic manager (NGO)	Female	na	na
Clinic manager (government)	Female	na	na
Clinic manager (INGO)	Male	na	na
Policymaker (deputy program manager)	Male	na	na
Policymaker (program manager)	Male	na	na

*For clients, the measure refers to the practitioner whom the participant was consulting. †Although the client received a referral, the provider wrote the clinic and method details on the clients' prescription rather than on a referral slip. *Notes:* NGO=nongovernmental organization. na=not applicable. INGO=international nongovernmental organization.

To explore relationships between referrals and the locations of providers and family planning clinics, we collected global positioning system (GPS) coordinates for all participating providers and clinics (Appendix Figure 1). We used a smartphone GPS app (GPS Status & Toolbox) with an accuracy of approximately five meters. Coordinates were recorded and graphed using OpenStreetMap, a free online database-mapping program. Although Mirpur is predominantly a grid-based urban area, we calculated straight-line median distances between private providers and the three clinics as an indicator of minimum distance to travel. Distances were calculated using R, a free software environment for statistical computing and graphics.

Qualitative Data Collection and Analysis

Between September 2015 and February 2016, we interviewed a range of stakeholders who had been involved with the intervention. The design of the qualitative analysis was driven by pragmatism, and we sought to obtain maximum variation in the sample from the 16 interviews conducted (Table 2). We interviewed seven private providers selected at random from predefined categories, so that the sample included both providers who had referred clients and those who had not, as well as providers who had worked part time at a family planning clinic and others who had not. In addition, we conducted exit interviews with four female clients aged 18–49 who had just consulted a provider who had completed the orientation program. We interviewed the managers of the three participating clinics, as well as two sexual and reproductive health policymakers who had approved the study. The number of interviews conducted was limited by difficulties tracing providers who were lost to follow up, the busy schedules of providers and clients' willingness to participate. After participants provided consent, the interviews—which took about 20 minutes—were conducted in Bengali using an interview guide and were recorded, transcribed and translated into English. Interviews were anonymized during transcription.

The interview guide was designed to explore three subjects: private providers' contraceptive knowledge and their confidence in discussing an expanded mix of contraceptives with clients, the feasibility and acceptability of the paper-based referral system, and the functioning of the incentive system and its influence on private providers. Practitioners, clinic managers and policymakers were asked about all three topics, whereas clients were asked only about the referral system.

The transcribed interviews were uploaded into NVivo 10. Three researchers independently familiarized themselves with a sample of interviews and open-coded three interviews from the different stakeholder groups (private provider, client and clinic manager). The interview texts were then indexed into the agreed-upon codes, and then data were charted into framework matrices to facilitate comparison within and between groups. Discussion and analysis of the matrices revealed a number of key messages.

RESULTS

Use of the Referral System

Sixteen of the 55 providers (29%) used the referral slips to refer clients. All referrals were to the NGO clinic; there was no evidence in the provider referral booklets or the clinic client registers of any referrals to the public or INGO clinics. Eleven of the referring providers worked part time at the NGO clinic. In total, the 16 providers referred 242 clients using the paper-based referral system. Another 27 providers (49%) reported referring clients verbally (i.e., without a paper slip), although a search of the three clinics' registers provided no record of verbal referrals. The remaining 12 providers (22%) reported having not referred any clients; of those, eight had moved offices, left their job or left the area.

The NGO clinic register indicated that 138 of the referred clients (60%) had attended the clinic, identified the referring provider and obtained a long-acting contraceptive method. All of these successful referrals were made by eight providers, each of whom also worked for the NGO clinic. Collectively, these eight providers issued 201 (83%) of the 242 referral slips.

None of the 41 referrals made by the other eight referring providers—three who worked part time at the NGO clinic (28 referrals) and five who did not (13 referrals)—resulted in a client presenting at the NGO clinic for a contraceptive. The monthly monitoring visits revealed that the three providers who worked at the NGO clinic initially used the referral slips but then stopped, preferring to refer verbally; the other five providers felt that the referral system was inappropriate for them after trying it.

In summary, referrals were facilitated when private providers had a relationship with the clinic and used the paper referral mechanism.

During the 15-month study period, the NGO clinic provided 76 referred clients with an implant, 60 with an

IUD and two with a permanent method (Table 3); these referred clients accounted for 13% of the 1,230 insertion and sterilization procedures performed at the NGO clinic. Table 3 also shows background differences in the types of contraceptives administered at each clinic. Of note, oral contraceptives accounted for a greater proportion of the method mix at the NGO clinic that provided long-acting methods to referred clients than at the other clinics.

TABLE 3. Provision of short- and long-acting contraceptive methods at study clinics, by type of clinic and service

Method	NGO		INGO		Public	
	Normal	Referred	Normal	Referred	Normal	Referred
Pill*	12,050	0	1,124	0	1,646	0
Condom	4,590	0	1,097	0	726	0
Injectable	5,080	0	2,805	0	1,823	0
IUD	480	60	124	0	97	0
Implant	589	76	13	0	774	0
Sterilization	23	2	174	0	72	0

*Provision of three-month supply. *Notes:* NGO=nongovernmental organization. INGO=international nongovernmental organization.

Referral Distances

The distance between private providers and clinics may have influenced referrals. The manager of the public clinic suggested during his interview that the clinic's remoteness from the private providers explained the lack of referrals to the clinic. Geospatial data were consistent with this assertion; the median distance from referring providers to the NGO clinic, where many of the providers worked part time, was shorter (0.3 kilometers; range, 0.1–2.7) than the median distance to the public clinic (4.0 kilometers; range, 1.4–4.6) or to the INGO clinic (0.8 kilometers; range, 0.3–2.5). Nonreferring private providers tended to be 2–3 kilometers from all three clinics; the median distance from these providers was 3.1 kilometers for the public clinic (range, 1.3–4.5), 2.3 kilometers for the NGO clinic (range, 1.0–4.1) and 1.8 kilometers for the INGO clinic (range, 1.0–4.0). Although the NGO clinic was the closest facility to referring providers, several providers (#2, 4, 29, 39) reported that the distance they took into consideration when making referrals was the clinic's distance from the client's residence (rather than from their own office).

Merits and Limitations of Orientation Day

• *Providers' need for information.* In interviews, all private providers attending the orientation day reported that they had no or little clinical knowledge regarding family planning, especially long-acting methods. One provider explained:

"There are a lot of things we do not know. Many of us are postgraduates, but we never learn these [contraceptive methods] precisely or see these [methods].... We learned the names of various contraceptive methods in our textbooks but never learn[ed] when and how to use [them] and at what age."—*Male provider, did not refer (#8)*

Another practitioner who did refer clients, (#29) indicated that prior to the orientation day, he had "been providing family planning services" to clients even though he had never received "training related to family planning."

• *Relevance to providers.* The orientation day was designed to introduce private providers to a broader method mix and to the process of referring clients to family planning clinics. As the following quotes illustrate, both referring and nonreferring providers reported improved motivation to counsel clients on their fertility needs, and felt the orientation day supported their intention to discuss their fertility needs:

"We had read the information about the different approaches of family planning methods in [the literature], but this training enhanced our practical knowledge about the applications of the family planning methods. For instance, the insertion of [the implant] and IUD, this had not been taught during our [medical] courses."—*Female provider, did not refer (#11)*

"The training itself was both enjoyable and effective. It covered all the issues related to family planning, specifically the advantages and disadvantages of short-term and long-term approaches. In addition to this, long-term contraceptive use and the precautions to minimize [STIs] were taught."—*Male provider, referred (#29)*

"The procedure of using [the] implant and IUD was shown by visual presentations. For a one-day session it was quite organized and motivating. I received some information from the training that was already familiar to me, but the approach [i.e., role plays] was different and so helped me to provide further family planning services to the clients. Besides, new information related to the long-term approach, such as insertion of an IUD during delivery and the duration of 10 years for the IUD, was also beneficial for me, as now I can advise clients about long-term methods instead of permanent methods."—*Female provider, referred (#2)*

• *Demand for additional training.* Practitioners and DGFP program managers reported that private providers have an unmet need for training in family planning. The orientation program enhanced participants' ability to discuss medically suitable long-acting methods. However, 64 providers declined the invitation to attend the orientation day, expressing their preference and need for comprehensive clinical training about family planning. Most attending providers echoed this sentiment; they suggested broadening the length and scope of the training, and requested practical, hands-on training and experience to support their provision of contraceptives to clients. As one participant said:

"The training was beneficial. But although the training was effective, I found it quite difficult to grasp everything at a one-day session. The reason could be due to the hurry to observe the practical sessions immediately after each theoretical session. I would ... suggest a few things regarding the training. Firstly, [the length] of the training should be more than one day—at least three days.... My second suggestion would be [that] along with the practical presentation, the training should incorporate some hands-on practice sessions."—*Female provider, referred (#4)*

DGFP policymakers shared these views and recommended longer training to support direct administration of long-acting methods:

"Many providers have no idea about long-acting reversible or permanent methods. Definitely, a six-day, hands-on training needs to be conducted.... If they were given skills through the training so that they can provide [the] implant and IUD at their chambers, instead of referring, then the use of long-acting methods will increase, and attachment with the government will also improve. Without this, we can't reach them since they are self-dependent ... [and] are not accountable to anyone."—*Male program manager*

Acceptability of the Referral Program

• *Counseling.* All four referring providers and two of the three nonreferring providers found it acceptable to identify unmet need for contraceptives by discussing fertility intentions with clients who were presenting for unrelated health matters. The remaining provider, a male surgeon who did not refer clients, believed that he was too specialized to screen clients for unmet need and that his gender was a barrier to counseling women. Both exit clients who had been referred also deemed the approach acceptable. Representative comments from providers and clients include the following:

"Among the clients with non–family planning issues, more than 60% accepted the different approaches of family planning."—*Female provider, referred (#4)*

"As a gynecologist, it is quite easy for me to provide family planning services to the clients. But I have patients who consult me for issues not related to family planning, so I ... make the topic more presentable to them too."—*Female provider, referred (#39)*

"It was acceptable to me, because the doctor's advice was for my welfare. There were no reasons to refuse it." —*Female client, was referred*

Several private providers believed that clients simply trusted their professional judgment and thus accepted their attempts to discuss fertility intentions, irrespective of the providers' gender—a view echoed by clients themselves. The following quotes illustrate clients' trust in their providers:

"The clients visiting me for reasons other than family planning have accepted being informed about ... different contraceptive methods. This may be due to their faith in me. Usually, according to the Bangladeshi people's perspective, female clients do not feel comfortable discussing family planning issues with male doctors. In [such cases], I had to deal with the clients through the indirect approach or through [prompting the client to reflect on her fertility intentions]."—*Male provider, referred (#29)*

"I did not find any difficulties while discussing family planning–related issues [with] clients who presented for non–family planning issues. They feel that, whatever the doctor is suggesting to them, it is for their own benefit. For instance, if a patient is suffering from fever and I am discussing issues related to family planning, they would simply accept it."—*Female provider, did not refer (#11)*

"People believe in doctors' words the most. If the doctors take the time to explain [contraceptives to] their patients, advise them to [use] long-term methods and refer them to the family planning providers, it will definitely work.... I will also suggest my friends and relatives ... come here to consult with the doctor."—*Female client, was referred*

• ***Providers helped clients overcome fears.*** Providers reported that a significant barrier to contraceptive uptake was the fear that many clients had concerning long-acting methods. After the orientation day, providers felt able to help clients overcome those fears and address misconceptions. Clients described how providers supported their consideration of switching methods:

"I used to take hormones through injections to prevent unwanted pregnancy and faced some physical complications, like feeling pain in the arm, [being] unable to move my arm, headache, sometimes vomiting. After consulting with the doctor, my perception toward reversible long-acting methods has changed.... I will take the implant because in the future if my husband demands another child, I can remove it easily, and I do not need to worry about having injections on a regular basis."—*Female client, was referred*

"I had some misconceptions about long-term methods.... I had a fear of using a long-term method [and worried] whether [my body would adjust to it] as I am using pills for so long. After consulting this doctor, my views toward long-term methods have changed and I will use the implant instead of pills to prevent pregnancy."—*Female client, was not referred (but received a handwritten referral on her prescription)*

• ***Religious and other barriers.*** Private providers reported that some clients were unwilling to consider long-acting methods because of strong conservative religious beliefs. They also indicated that husbands and other family members restricted women's method choice. The following quotes illustrate these barriers:

"It has been quite difficult for me to explain family planning to the people who are religious fundamentalists." —*Female provider, referred (#39)*

"Some husbands and family members do not allow female clients to use long-acting methods. This could be due to the fear of problems during intercourse and religious constraints. One patient told me that from the religious point of view, if she uses long-acting methods, she cannot go to heaven after her death. Clients also fear [IUD or implant insertion] even after counseling.... They do not accept the fact of discontinuing menstruation for a long time. "—*Female provider, referred (#29)*

"I would accept being counselled on long-acting methods because the doctor would provide advice for my betterment. But I do not need any contraceptive. Besides, my husband does not support any contraceptive method because these are against the law of the religion."—*Female client, was not referred*

One male provider felt that male clients discussed prevention of unplanned pregnancies with him more readily than female clients did, but he discussed only the condom. Another provider reported that joint husband and wife consultation enhanced discussions about method choice. However, three of the interviewed clients indicated that a husband did not need to sanction a decision concerning long-acting methods:

"If my husband does not support [my contraceptive use], I will convince him to support it."—*Female client, was referred*

"My husband is very supportive. If I tell him that I want to use this method for my betterment and [that] the doctor also advised this method, he will support me."—*Female client, was referred*

"No, [the provider] did not speak to my husband. Besides, I don't think it is necessary to discuss family planning with my husband."—*Female client, was not referred*

• *Use of referral slips.* Although many clients presented their referral slips to the NGO clinic, two interviewed clients expressed reservations about using them. The manager of the INGO clinic explained that such reluctance may stem from the country's history of rewarding field agents who coerced clients into having tubectomies or clinical tests:

"The clients may have thought that the doctor[s] would [benefit] if they had mentioned their names. The doctors have some connections with the diagnostic clinics, and thus when they refer clients for some tests to those clinics, they receive financial benefits from them. Everyone is now aware [of] this. I think the clients may have the same perception ... and for this reason, they are not willing or do not want to mention if they were referred by a doctor."

The clinic manager added that he sometimes sees a similar phenomenon among clients who he knows have been referred verbally by a local pharmacist but do not mention the referral.

In light of public attitudes toward financial incentives, it is possible some clients presented without a referral slip and withheld details about who referred them. However, most family planning clients at the public clinic were brought by family welfare assistants, and the clinic manager reported receiving no unaccompanied clients during the study. In contrast, clients presenting to the INGO clinic did so alone and were explicitly asked who had referred them. Despite this proactive effort to identify referrals, no private provider–referred clients were identified at the INGO facility.

Feasibility of the Referral Program

• *Impact of provider-clinic relationships.* Successful referrals were based primarily on private providers' knowledge of and trust in the NGO clinic's staff and services but may have been supported by proximity to the clinic. A female provider (#2) explained that she had an association with the NGO clinic and referred clients there because of her confidence in the facility's services.

"I always refer clients to the NGO clinic ... because it is well-equipped and provides all sorts of services related to family planning. Besides, the clinic is close to [clients'] residence. In the absence of a referral slip, I refer them verbally and mention the details about the clinic in the prescription."

Five private providers referred clients to the NGO clinic despite not working there. Two of these providers were interviewed and reported that to maintain their support for the referral incentive scheme, they would need additional information about the clinics to which they referred clients, as well as a follow-up mechanism to communicate with clinics about their clients. Clinic managers echoed the need for such communication. The manager of the NGO clinic reported that after the orientation, he had no communication with private providers other than those who also worked at the clinic. Similarly, the managers of the other clinics had no relationship with any of the private providers. As the manager of the INGO clinic noted, the providers might have referred clients more often if they had had better relationships with the family planning clinics:

"It would have been better if I [had known] the names of the doctors who received the training. I would have communicated with the doctors and would have asked them to refer clients to this clinic. I think this lack [of] communication could be another reason for [providers'] not referring clients to this clinic."—*INGO clinic manager*

• *Obstacles to use of referral slips.* Practitioners indicated that several aspects of the referral system were problematic, including the burden of remembering to carry referral booklets between consulting rooms and the time required to populate the many sections of the referral slip. Because providers met with patients in multiple chambers, the referral booklet, and the leaflets and posters that served as prompts for discussion of long-acting methods, were not always in the same room as the provider and client. Consequently, some providers referred clients verbally in lieu of using the paper slip or wrote details about the recommended method and clinic on clients' prescriptions. One client confirmed that her private provider had modified the referral process:

"I have to show my prescription to the family planning service provider at the NGO clinic, and then the provider will guide me accordingly.... No, I did not receive any referral slip from the doctor. Instead, she wrote the name of the method and the address of the family planning clinic in the prescription."—*Female client, was referred*

As noted earlier, we were not able to find evidence of long-acting method uptake arising from verbal referrals. However, uptake of long-acting methods may have been underreported. One provider said that he, and possibly others, referred clients to a large public clinic that was not part of the study. Moreover, some women may have obtained their contraceptives from other sources; one client, who had received a referral, reported that she and other women preferred the implant to the IUD "because it is available at the pharmacy."

• *Concerns regarding relevance and incentives.* Although providers who attended the orientation day presumably had

professional interest in family planning, specialist providers (e.g., surgeons) reported that their specialty limited their opportunity to discuss fertility, and that they did not refer any clients. Moreover, the orientation day did not sufficiently prepare or persuade them to systematically discuss fertility needs with clients. As one male provider (#9) explained:

"This training does not match with my profession, and therefore it has not been possible for me to provide family planning services to the clients. Regardless, however, I had attended this training to acquire knowledge regarding family planning services."

Some private providers indicated that the referral system was inconvenient for certain clients, and that the design of the incentive system made counseling patients and collecting payment too time consuming for providers, particularly those who had no relationship with the referral clinic. As the manager of the INGO clinic explained:

"Doctors do not want to spend time explaining any procedure to the clients, [more specifically] spending time [patiently] counseling clients about the use of long-term methods of contraception.... Rather, they are in a hurry [to receive] more patients in a day, so that they can earn more."

The DGFP program manager and deputy program manager suggested that larger incentives and direct payment to private providers would motivate them and increase referrals:

"If [DGFP] could arrange paying the doctors [directly] for referring patients, that would have encouraged them. The time [the provider] spends seeing a patient, if he [can] get that equal [financial] amount of honorarium, he will feel the dignity. If we could arrange paying the doctors directly, they would feel that they are working with the government." *—Male deputy policy manager*

However, discussions with private providers about the value and role of financial incentives yielded mixed responses. Of the three nonreferring private providers who were interviewed, one felt that incentives should not be necessary, another reported being unaware of any incentives and the third felt that the nominal amounts of the payments reduced his motivation to refer. Moreover, of the four private providers who referred clients, two said that they were unaware of any incentive scheme and a third did not wish to discuss the subject; only the fourth reported being aware of the incentives and confirmed having received payment for each client referred to the clinic. It is unclear what, if any, role the incentive system had on private providers' referrals. All providers had received information on the incentive system, and their reticence to discuss the topic suggests some sensitivity concerning the appropriateness of financial incentives:

"If such an incentive scheme does exist, I do not support it, as this should be a voluntary activity for the benefit of our nation. One should not be given any incentive for this activity."*—Male provider, did not refer clients (#9)*

"Doctors are not thinking about this little amount.... They don't have to consider it, and they are busy as well." *—Male provider, did not refer clients (#8)*

• *Potential for wider support.* Private providers believed that pharmacists were not supporting clients' consideration of long-acting contraceptives and thus were not championing a broad method mix. Pharmacists were thought to favor short-acting methods because they believed such methods met customers' needs and because the methods provided them with repeat customers. Moreover, one provider indicated that some clients might prefer obtaining short-acting methods from a pharmacist rather than acting on a referral. Together, these comments suggest that engaging pharmacists and other health workers may present an untapped opportunity to broaden support for long-acting methods, as the following quotes illustrate:

"I feel it would be a good idea if the referral slips could also be provided to the pharmacist. Private practitioners usually practice in a particular period of time, whereas pharmacists receive different clients seeking solutions for health-related problems throughout the day."*—Female provider, did not refer (#11)*

"I think the model should involve field health workers and clients in the training, so that the clients could be involved directly within the program."*—Female provider, referred (#2)*

The DGFP managers supported expansion of some aspects of the referral system, namely the breadth of coverage (number of clinics and areas of focus) and the scope of training. The aim would be to improve provider knowledge and reduce reliance on the referral system by enabling providers to offer on-site family planning services. Moreover, the DGFP was seeking to explore the efficacy of direct payments to providers (as a means of developing public-private partnership) and increased governance of private practitioners (who are currently unregulated):

"This study was conducted in Mirpur only. Now, we want it to be conducted in densely populated areas of Dhaka city with [all private providers]. [This study did not] invest that much time in the training because it was uncertain whether the private practitioners can spend enough time for this.... I think it would be fruitful if they were convinced to receive training for a week, or on-the-job training, so that they could learn through hands-on practices." *—Male deputy program manager*

"We do not have health workers to provide door-to-door services in urban areas.... Here services are provided by NGOs and private providers, [and] they are unregulated. Ensuring quality is difficult." *—Male program manager*

DISCUSSION

Our findings highlight that family planning is an area in which private providers have limited knowledge. Other studies have found that when providers do not have adequate knowledge of long-acting methods, their ability to advise clients and refer them to other trained providers,[18] or to provide such services themselves, is diminished.[21]

Our results are consistent with studies conducted in Bangladesh[15] and elsewhere[22,23] that found that clients' fear of side effects undermined use of long-acting methods. Private providers and other specialists are unable to counter such concerns when they lack even basic training on such methods. This clearly affects availability of services and reduces women's access to long-acting contraceptives.

As other investigators have pointed out, the importance of the informal private sector in providing services to the urban poor means that ways must be found to work with the sector to increase coverage of quality services.[10] Our study highlights the challenges of facilitating linkages between private and other providers within the health system. Although the incentive payments may have been set too low, our results suggest that payments alone may not trigger referrals because relationships between providers and clinics are key. The intervention prompted providers who worked both privately and in the NGO clinic to discuss clients' fertility intentions, identify clients with unmet need for contraception and refer those clients to the NGO clinic. Thus, when relationships already existed, referrals happened smoothly. Further study is warranted to explore whether improving communication and understanding between private practitioners and providers at clinics (whether public, NGO or INGO) would extend the success of a client referral system.

Religious beliefs are sometimes considered incompatible with reproductive choice. However, evidence from other Muslim countries, including Pakistan, demonstrates that religion—including Islam—is not inconsistent with family planning and the use of modern (including long-acting and permanent) contraceptive methods.[24] Women's acceptance of and support for inequality in the social and health system may also influence family planning decisions.[25] Educated wives with greater knowledge of contraception are more likely than their peers to seek male participation in family planning.[26] In this study, private providers demonstrated an ability to contribute to that knowledge and raise awareness of long-acting methods. However, family planning programs that focus on husbands' participation in and permission for reproductive services may unintentionally reinforce patriarchal cultures that oppress women's right to sexual and reproductive health. Wider engagement and possible partnership with religious[24,27] and nonreligious leaders may support efforts to empower all Bangla women to safeguard themselves and their families from unplanned pregnancies.

Clients' fear of long-acting contraceptives, and the ready supply of short-acting methods at Dhaka's pharmacies, impede efforts to increase societal acceptance of long-acting methods. Pharmacists are an important group in Bangladesh's pluralistic health system; more than 40% of urban slum residents using the pill or condoms report having obtained their current supply from a pharmacy.[28] However, although pharmacists serve an informal advisory role in matters concerning contraception, pregnancy and referral for STI symptoms, most have only basic training.[28] Increasing their participation in the referral system and their understanding of long-acting methods could result in greater advocacy for and provision of a broader method mix. Subsidies at pharmacies and private chambers would be needed to support fertility rights across socioeconomic groups. While efforts to improve connection and quality within the informal sector are important, improvements in the formal sector are needed as well; Adams et al. note that "features of informal private sector service provision that have facilitated market penetration," such as evening service hours, "may be relevant in designing formal services that better meet the needs of the urban poor."[18(p.i32)]

Scaling-up use of the referral system will require continued efforts to recruit private providers, pharmacists and others (e.g., family welfare assistants) for family planning training; identify additional family planning referral clinics; and facilitate relationships between providers and family planning clinics. Family welfare assistants currently operate only in rural areas, but adapting this community-based service model to urban slums could improve slum dwellers' awareness of and access to family planning services through referrals to private, nonprofit and public clinics. Extending the orientation program to family welfare assistants could further increase effective linkages to and use of formal quality family planning services.

Improving reproductive health services for urban slum populations will require close collaboration between local and national government departments to ensure adequate supply and distribution of commodities among public and private providers. Publicity campaigns can increase awareness of options available to help women and men achieve their fertility goals.[29] Medical graduate and postgraduate training will likely enhance providers' knowledge and provision of short- and long-acting methods. Training nonspecialized private providers to offer long-acting methods directly to clients may improve clients' ability to exercise their fertility rights discretely. However, mechanisms to ensure quality and accountability are needed: Private-sector providers are unregulated and largely underqualified, and would require equipment and sterile working conditions. The lack of a regulatory system poses challenges to ensuring quality and to the development of an integrated family planning service. DGFP's use of incentives may be an opportunity to gain leverage on an unregulated sector and establish accountability. However, if the current incentive system is to encourage providers to offer family planning services or refer clients, it may need some modification, and DGFP's suggestion to give direct and larger payments to referrers warrants careful study to avoid risk of coercion.

Limitations

The design of the incentive system was convoluted, and our qualitative work on this topic was limited. More interviews with a greater variety of clients and private providers would have offered greater understanding of the frequency of the documented perspectives. Our quantitative outcome

relied heavily on a human paper trail to track referral slips, and our reliance on the slips meant that we could not track verbal referrals, clients who presented without their slip, or referrals made to non-study clinics. However, our quantitative data demonstrated that the referral mechanism was feasible and appeared to increase uptake of long-acting methods, perhaps to an even greater extent than reported here.

Conclusions

Our study highlights several recommendations for policy and practice. In particular, private providers need to be aware of the family planning clinics within their catchment area, as knowledge and trust in such clinics supports referral and uptake of long-acting contraceptives. We also recommend orientation training for private providers serving the urban poor. Furthermore, while the referral system shows merit, it requires the client to visit an additional clinic before obtaining contraceptives, and we should not rely on this system alone. We recommend that DGFP encourage partnerships between national and international health-training institutions to offer competency training to undergraduate and postgraduate medical providers in contraceptive provision (including provision of long-acting methods) and care, and also develop systems of quality assurance and governance.

Strong relationships between private providers and clinics are needed to increase uptake of long-acting contraceptives within a pluralistic health system. Private providers in Bangladesh are keen to extend their skills and provide family planning advice and services. To do this, health care providers require theoretical and practical training on long-acting methods to increase supply-side readiness within urban areas.

REFERENCES

1. National Institute of Population Research and Training (NIPORT) et al., *Bangladesh Demographic and Health Survey 2014*, Dhaka, Bangladesh, and Rockville, MD, USA: NIPORT, Mitra and Associates, and ICF International, 2016.

2. Cleland J and Mauldin WP, The promotion of family planning by financial payments: the case of Bangladesh, *Studies in Family Planning*, 1991, 22(1):1–18, http://dx.doi.org/10.2307/1966515.

3. World Bank, Fertility rate, total (births per woman), no date, https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=BD.

4. Bongaarts J, How exceptional is the pattern of fertility decline in Sub-Saharan Africa?, *Expert Paper*, New York: United Nations Department of Economic and Social Affairs, 2013, https://www.un.org/en/development/desa/population/publications/pdf/expert/2013-4_Bongaarts_Expert-Paper.pdf.

5. World Bank, Contraceptive prevalence, any methods (% of women ages 15–49), no date, https://data.worldbank.org/indicator/SP.DYN.CONU.ZS?locations=BD.

6. Ross JA and Isaacs SL, Costs, payments, and incentives in family planning programs: a review for developing countries, *Studies in Family Planning*, 1988, 19(5):270–283, http://dx.doi.org/10.2307/1966792.

7. Rob U and Alam MM, Performance-based incentive for improving quality of maternal health services in Bangladesh, *International Quarterly of Community Health Education*, 2014, 34(4):303–312, http://dx.doi.org/10.2190/IQ.34.4.b.

8. Streatfield PK and Kamal N, Population and family planning in Bangladesh, *Journal of the Pakistan Medical Association*, 2013, 63(4 Suppl. 3):S73–S81.

9. Hatt L et al., *Economic Evaluation of Demand-Side Financing (DSF) Program for Maternal Health in Bangladesh*, Dhaka, Bangladesh: Abt Associates, 2010.

10. Murray SF et al., Effects of demand-side financing on utilisation, experiences and outcomes of maternity care in low- and middle-income countries: a systematic review, *BMC Pregnancy and Childbirth*, 2014, 14:30, http://dx.doi.org/10.1186/1471-2393-14-30.

11. Asian Development Bank, *Public-Private Partnership Monitor*, Manila, Philippines: Asian Development Bank, 2017.

12. Bangladesh Ministry of Health and Family Welfare, *Bangladesh Population Policy*, Dhaka, Bangladesh: Ministry of Health and Family Welfare, 2012, http://www.bangladesh.gov.bd/sites/default/files/files/bangladesh.gov.bd/policy/98896a22_df81_4a82_b70c_24125dec56d7/Bangladesh-Population-Policy-2012.pdf.

13. NIPORT et al., *Bangladesh Demographic and Health Survey 2011: Policy Briefs*, Dhaka, Bangladesh: Ministry of Health and Family Welfare, 2011.

14. Streatfield PK and Karar ZA, Population challenges for Bangladesh in the coming decades, *Journal of Health, Population and Nutrition*, 2008, 26(3):261–272, http://www.jhpn.net/index.php/jhpn/article/view/574/564.

15. Huda FA et al., Contraceptive practices among married women of reproductive age in Bangladesh: a review of the evidence, *Reproductive Health*, 2017, 14:69, http://dx.doi.org/10.1186/s12978-017-0333-2.

16. Save the Children Fund, *Every Woman's Right: How Family Planning Saves Children's Lives*, London: Save the Children, 2012.

17. Schuler SR et al., Bangladesh's family planning success story: a gender perspective, *International Family Planning Perspectives*, 1995, 21(4):132–137 & 166.

18. Adams AM, Islam R and Ahmed T, Who serves the urban poor? A geospatial and descriptive analysis of health services in slum settlements in Dhaka, Bangladesh, *Health Policy and Planning*, 2015, 30(Suppl. 1):i32–i45, http://dx.doi.org/10.1093/heapol/czu094.

19. Kabir A et al., Unmet need for family planning among married women: experience from rural and urban communities, *Faridpur Medical College Journal*, 2013, 8(1):26–30, https://pdfs.semanticscholar.org/cfd4/6748d72982d28e82058dfa84849995eeef2e.pdf.

20. Zafar Ullah AN et al., Effectiveness of involving the private medical sector in the National TB Control Programme in Bangladesh: evidence from mixed methods, *BMJ Open*, 2012, 2(6):e001534, http://dx.doi.org/10.1136/bmjopen-2012-001534.

21. Lei X et al., Public-private mix for tuberculosis care and control: a systematic review, *International Journal of Infectious Diseases*, 2015, 34:20–32, http://dx.doi.org/10.1016/j.ijid.2015.02.015.

22. Pandit-Rajani T, Sharma S and Muramutsa F, *Fostering Public-Private Partnership to Improve Access to Family Planning in Rwanda*, Washington, DC: Futures Group, 2010.

23. Kumar J, *How Does Quality of Care Relate to a Rights-Based Approach to Family Planning Programs?* New York: Population Council, 2015.

24. Mir AM and Shaikh GR, Islam and family planning: changing perceptions of health care providers and medical faculty in Pakistan, *Global Health: Science and Practice*, 2013, 1(2):228–236, http://dx.doi.org/10.9745/GHSP-D-13-00019.

25. Nanda G et al., The influence of gender attitudes on contraceptive use in Tanzania: new evidence using husbands' and wives' survey data, *Journal of Biosocial Science*, 2013, 45(3):331–344.

26. Kamal MM et al., Determinants of male involvement in family planning and reproductive health in Bangladesh, *American Journal of Human Ecology*, 2013, 2(2):83–93.

27. Boonstra H, Islam, women and family planning: a primer, *Guttmacher Report on Public Policy*, 2001, 4(6):4–7.

28. Mookherji S et al., The role of pharmacies in providing family planning and health services to the residents of Dhaka, Bangladesh, *MCH-FP Extension Project (Urban) Working Paper*, Dhaka, Bangladesh: International Centre for Diarrhoeal Disease Research, Bangladesh, 1996, No. 21.

29. Shelton JD and Burke AE, Effective LARC providers: moving beyond training, *Global Health: Science and Practice*, 2016, 4(Suppl. 2):S2–S4, http://dx.doi.org/10.9745/GHSP-D-16-00234.

RESUMEN

Contexto: *El sistema de salud pluralista de Bangladesh diversificó las oportunidades para que las clientas obtuvieran servicios de planificación familiar, pero las alianzas público-privadas podrían mejorar el acceso a los servicios de planificación familiar, particularmente en las zonas urbanas.*

Método: *Dieciséis proveedores de servicios, clientes y gerentes de programas fueron entrevistados para evaluar las perspectivas sobre un programa de orientación de planificación familiar y de referencia financiado por el lado de la demanda, que fue probado en Mirpur, Bangladesh. El programa de 15 meses, realizado en 2015–2016, fue diseñado para alentar a los proveedores privados a identificar clientas de servicios distintos a la planificación familiar con necesidades anticonceptivas insatisfechas, promover la elección de una mezcla de anticonceptivos más amplia y referir a las clientas a una de las tres clínicas públicas o sin fines de lucro para la obtención de su método preferido. El uso del sistema se evaluó mediante el seguimiento de los recibos de referencia.*

Resultados: *La mayoría de las partes interesadas informó que era aceptable y factible discutir las intenciones de fecundidad con las clientas que se presentan para asuntos distintos a la planificación familiar. Los proveedores pudieron atenuar las ideas falsas y los temores de las clientas sobre los métodos anticonceptivos de acción prolongada, pero no pudieron abordar las barreras patriarcales y religiosas. La mayoría de las referencias fueron realizadas por proveedores privados que tenían una relación preexistente con una de las clínicas de planificación familiar y refirieron a las clientas a esa clínica; en general, las referencias documentadas representaron el 13% de la provisión de métodos reversibles y permanentes en esa clínica durante el período de estudio.*

Conclusiones: *Brindar a los profesionales privados capacitación adecuada sobre anticonceptivos y referencias podría mejorar el acceso de las mujeres de Bangladesh a métodos anticonceptivos de larga duración y de otro tipo en áreas urbanas; y puede ser útil para otros tipos de trabajadores de la salud. Se justifica el estudio adicional de sistemas de referencia adecuados.*

RÉSUMÉ

Contexte: *Au Bangladesh, le système de santé pluraliste a diversifié, pour les clientes, les possibilités d'obtention de la planification familiale, mais les partenariats public-privé pourraient améliorer l'accès aux services, en particulier dans les milieux urbains.*

Méthode: *Des entretiens ont été organisés avec 16 prestataires, clientes et gestionnaires de programme afin d'évaluer les points de vue concernant un programme d'orientation sur la planification familiale et d'aiguillage à financement du côté de la demande testé à Mirpur (Bangladesh). Mené en 2015–2016 sur une période de 15 mois, ce programme était conçu pour encourager les prestataires privés à identifier les clientes hors planification familiale qui présentaient un besoin de contraception non satisfait, à promouvoir le choix d'un éventail de contraception plus large et à orientation les clientes vers l'une de trois cliniques publiques ou à but non lucratif pour l'obtention de leur méthode préférée. L'utilisation du système a été évaluée par suivi des fiches de recommandation.*

Résultats: *La plupart des intervenants ont déclaré qu'il était acceptable et faisable de parler des intentions de fécondité avec les clientes se présentant pour des raisons autres que la planification familiale. Les prestataires ont réussi à dissiper les idées fausses et les craintes des clientes concernant les méthodes contraceptives de longue durée, mais ils n'ont pas pu résoudre les obstacles de nature patriarcale et religieuse. Dans la majorité des cas, les orientations provenaient de prestataires privés qui avaient une relation préexistante avec l'une des cliniques de planification familiale et aiguillaient leurs clientes vers cette clinique. Globalement, les recommandations documentées ont représenté 13% de la prestation de méthodes réversibles et permanentes dans cette clinique pendant la période de l'étude.*

Conclusions: *L'offre aux praticiens privés d'une formation appropriée sur la contraception et l'aiguillage pourrait améliorer l'accès des Bangladaises aux méthodes contraceptives longue durée ou autres dans les milieux urbains. Elle pourrait être utile aussi à d'autres types d'agents de santé. Il y a lieu de procéder à une étude approfondie des systèmes d'aiguillage appropriés.*

Acknowledgments

The study was implemented in Dhaka by the Association for Research and Knowledge Foundation as part of the COMDIS-HSD research consortium (http://comdis-hsd.leeds.ac.uk/) funded by the UK Department for International Development. The views expressed in this article do not necessarily reflect the official policies of the UK government.

Author contact: *lauraannbates@outlook.com*

APPENDIX FIGURE 1. Relative locations of participating providers and study clinics

Note: Pinned circles indicate family planning clinics; dots indicate chambers of private medical providers.