COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

Country Profile

NEPAL

Using a franchise to improve the availability, quality, and use of reproductive health services

PROGRAM OBJECTIVE

In Nepal, the Commercial Market Strategies (CMS) project worked with local partners to test innovative ways to expand access to family planning services, strengthen local capacity to provide reproductive health products and services, and prevent the spread of HIV/AIDS.

October 2003

NEPAL AT A GLANCE

Population	**22.6 million**
Rural	89%
Below poverty line	42%
Per-capita income	$210
Health	
Fertility rate	4.1
CPR* (1997)	39%
CPR, modern (1997)	35%
Maternal mortality	150/100,000
Infant mortality	64/1,000
HIV prevalence	0.3%
Life expectancy	58
Access to mass media	
Radio	37%
TV	6%
Literacy rate	27%

**Contraceptive prevalence rate.*

The *Sewa* logo linked all providers in the network and figured prominently on clinic signboards, provider uniforms, and billboards. CMS's provider training in services marketing, which emphasized the importance of positive client–provider interaction, reinforced mass media promotion of the logo as a symbol of trustworthy, caring, and high-quality reproductive health services.

PROGRAM CONTEXT

Nepal is one of the poorest nations in the world, and many of its health and social indicators are among the lowest in South Asia. The majority of the population lives in rural areas without access to basic infrastructure or services. Access to mass media is limited, and literacy rates are low. Nepal's infant and maternal mortality rates are among the highest in the world. Average life expectancy is 58 years.

Nepal's population is growing at a rate of 2.1 percent per year, and women have an average of 4.1 children. The total contraceptive prevalence rate (CPR) is 39 percent, and the modern contraceptive prevalence rate is 35 percent. Sterilization is the most popular form of contraception, followed by injectables. However, the unmet need for family planning in Nepal is estimated at 31 percent: 14 percent for spacing methods and 17 percent for limiting births. There is, therefore, considerable potential for modern temporary methods.

HIV/AIDS prevention and awareness is a high priority for USAID/Nepal. Although the HIV prevalence rate in Nepal is less than 1 percent, recent studies indicate that HIV infection rates have increased dramatically, particularly among high-risk populations and "bridge groups" — groups that can potentially contract HIV from high-risk groups, such as sex workers, and then spread the disease to the general population. Bridge groups include truck drivers, migrant workers, and people who can afford to travel and pay for sex. For example, the infection rate among a key Nepali bridge group — migrant workers who live in western Nepal and travel to Bombay, India — was found to be 10 percent. And studies of female sex workers and IV drug users in Kathmandu showed infection rates of 17 percent and 40 percent, respectively (these studies, however, had small sample sizes).

PROGRAM COMPONENTS

CMS worked in Nepal from October 1998 until September 2002. During that time, overall program components included

- **Provider networks** — to expand private family planning and maternal–child health (MCH) services, especially in under-served rural areas
- **Strengthening local capacity** — to increase the effectiveness of a local NGO's social marketing programs and improve its management and financial systems
- **HIV/AIDS prevention and awareness** — to respond to alarming increases in sexually transmitted infection (STI) rates and thwart the spread of HIV/AIDS from high-risk groups to the general population

PROVIDER NETWORKS

CMS worked on two provider networks: (1) the already-established Parivar Swasthya *Sewa* Network (PSSN), a physician network in Kathmandu, and (2) the *Sewa* network, a new nurse and paramedic franchise designed to expand the provision of family planning and related services to under-served districts outside Kathmandu. *Sewa* means "service" in Nepali.

PSSN physician network. CMS took over the responsibility to promote PSSN, a network created to expand and improve the quality of private-sector family planning services, from its predecessor project, Social Marketing for Change (SOMARC). Using local advertising agencies, CMS implemented a marketing campaign to promote network doctors. Activities included radio and print advertising, a telephone hotline, open houses at PSSN providers' practices, community-level promoters, and discount coupons distributed in beauty parlors.

After several years of promoting and working with PSSN, however, CMS program managers realized that its exclusive reliance on urban-based doctors — who tend to focus on the provision of gynecological services — was limiting the growth of the network

as well as its ability to serve lower-income clients. So CMS proposed developing and testing an alternate model that would build on the PSSN experience but utilize nurses and paramedics — formally trained clinician groups who serve mostly poor, rural clients.

Sewa *nurse and paramedic network.* In May 2001 CMS launched the *Sewa* pilot network in Nepal's Rupandehi district, an area with a lower socioeconomic profile and fewer doctors than Kathmandu. The main objective of the pilot was to test whether a nurse and paramedic (N&P) network could increase the use of family planning and reproductive health services. Intermediate goals were to improve service quality at *Sewa* clinics and to increase awareness of *Sewa* at the district level. The pilot program targeted the Rupandehi district's 142,176 married women of reproductive age.

CMS designed the *Sewa* network using a fractional franchise model, in which a package of services is added to an existing practice (or business) and offered in accordance with a specific set of guidelines established by the franchiser and outlined in a contract. The franchise model has several advantages: The contractual arrangement facilitates ongoing quality monitoring; there are considerable economies of scale in conducting training and promotion for a network, compared to individual providers; a network can be branded with a logo, which can be promoted as a symbol of high-quality services to attract new clients to network clinics; and N&Ps had expressed a desire to be affiliated with a larger provider community and linked with fellow providers. Key components of the *Sewa* network included

- **Provider recruitment** — *Sewa* recruited 64 of the 150 N&Ps with private clinics in the Rupandehi district to join the network. Selection criteria included the presence of a physical facility and a reasonable client volume, level of interest in joining the network, clinic location, existing service mix, and willingness to comply with the clinic monitoring protocols.

- **Membership contract** — The membership contract specifies the roles and responsibilities of the franchiser, Nepal Fertility Care Center (NFCC), and the franchisees, the individual N&P providers. The franchiser is responsible for providing training, quality monitoring, and marketing support, as well as establishing a referral system. In return, the franchisee agrees to pay membership fees, offer family planning and reproductive health services, follow quality protocols, adhere to an agreed-upon fee schedule, and maintain service statistics.

- **Training** — Network members received 7 days' reproductive health training and a 2-day session on services marketing. A subset of female nurses and midwives also received 21 days' training in intrauterine devices (IUDs). The reproductive health training, which included an overview of the service quality protocols outlined in the franchise contract, covered such topics as infection prevention, use of essential supplies, family planning, reproductive health (e.g., antenatal and postnatal care, gynecological problems), and STIs/HIV/AIDS. The services marketing session used role-playing, lectures, and group exercises to emphasize the importance of service quality and *interactive* marketing (the use of interpersonal techniques to build relationships and ensure a positive client–provider interaction) in retaining existing clients and attracting new ones. The session also outlined the network's external marketing activities (mass media; outreach; and information, education, and communication) and encouraged provider participation.

- **Marketing and promotion** — CMS supported network members with a broad range of marketing activities. The *Sewa* name and logo figured prominently on the clinic signboards and white coats given to each provider. Activities aimed at creating awareness for the network services ranged from mass media (e.g., radio and print advertisements, billboards, brochures, and leaflets) to interpersonal (e.g., a door-to-door campaign, clinic

WHY USE NURSES AND PARAMEDICS?

N&Ps reach lower-income clients. Numerous N&Ps work in rural, underserved districts and charge less than doctors. N&Ps in Nepal go through formal training, ranging from 10 months to three years. The *Sewa* network includes five types of N&Ps: Staff Nurse, Health Assistant, Auxiliary Nurse Midwife, Auxiliary Health Worker, and Community Medical Assistant.

Typically, N&Ps sell medicines and provide general medical consultation and treatment for minor illnesses. Family planning (except IUD and sterilization) and a limited set of reproductive health services are also provided at most N&P clinics.

Two of the *Sewa* pilot clinics.

open houses, and promotional booths in local farmers' markets). In addition, CMS developed a monthly newsletter which reinforced the value of *Sewa* membership and kept providers informed of network activities.

- **Referrals** — CMS established internal and external referral systems to ensure that the clients had access to an integrated package of services. The internal system allowed network N&Ps to refer a client to a trained female provider for IUD services. For more complicated health problems, the external system provided a link to private physicians and government health facilities.

- **Quality monitoring** — Each month, the franchiser sent a field coordinator to all network clinics to monitor quality of care and ensure that service protocols were followed. The field coordinator checked clinic service statistics, observed service delivery, and administered a detailed checklist to assess technical quality. Checklist categories included infection prevention, availability of essential supplies and equipment, and client–provider interaction. The field coordinator reinforced services marketing techniques, emphasizing once more the importance of good client–provider interaction. To fully assess provider compliance with service protocols, the coordinator also spoke with clients. Upon completing the monitoring visit, the coordinator shared the monitoring results with the service provider and, if necessary, suggested ways to improve weak areas.

The *Sewa* franchise, now managed by Population Services International, has been consolidated into a new, expanded network, Sun Quality Health, which operates in rural and peri-urban areas, including the Kathmandu, Bhaktapur, and Lalitpur districts in the Kathmandu Valley. Although the Sun Quality Health network includes doctors, it is a paramedic-focused franchise, drawing heavily on the *Sewa* fractional franchise model. This new network will offer a full range of family planning products and services, including long-term and permanent methods, as well as MCH services, STI diagnosis and treatment, and HIV/AIDS prevention.

STRENGTHENING LOCAL CAPACITY

Established as a non-governmental organization (NGO) in 1978, the Contraceptive Retail Sales Company (CRS) increases awareness and use of family planning and health products using modern social marketing techniques. CRS markets a range of products, including birth-spacing methods (such as pills and condoms), home delivery kits, bleaching powder for decontamination, and oral rehydration salts.

As requested by USAID/Nepal, CMS's assistance to CRS focused on assessing and improving organizational development, strategic and business plans, and sales and distribution systems; designing qualitative and quantitative studies to develop a behavior-change communications strategy; and improving the positioning of its existing brands. CMS also assessed and advised on CRS's capacity to contribute to national social marketing endeavors.

With CMS's help, CRS overhauled its management systems and recruited senior staff to manage marketing and sales and improve cost-recovery rates. CMS also brought in consultants to develop a social marketing business plan, establish new administrative and accounting systems, set up financial management software, and train staff to use the new systems and software.

HIV/AIDS PREVENTION AND AWARENESS

To respond to the dramatic increase in HIV infection rates among high-risk and bridge groups and slow the spread of the epidemic to the general population, CMS launched a new condom brand, *Number One*, and developed an integrated HIV/AIDS mass media advocacy campaign.

The HIV/AIDS campaign complemented existing government awareness campaigns and had two main target audiences and objectives:

- **Young males** — to encourage young males to adopt behavior that reduces their risk of HIV exposure

- **Policymakers and opinion leaders** — to encourage greater dialogue about HIV in order to advance HIV/AIDS prevention policies and programs

Launched during the World Cup Soccer tournament in May 2002, the campaign leveraged the dramatic rise in TV and radio audiences and ran until the end of December 2002 (USAID's AIDSMARK project took over the management of the campaign and the condom in October 2002).

Visually striking, memorable black-and-white images of 10 well-known Nepali celebrities accompanied the campaign slogan: "Let's start talking about HIV/AIDS today." Messages focused on destigmatization and the promotion of healthy behaviors and were disseminated through TV public service announcements, radio spots, billboards, and public relations activities — including press conferences, media placements, and special events. CMS also developed a partnership with the Nepal Film Artists National Association and co-sponsored its annual awards ceremony, presided over by Nepal's queen. At the ceremony, which was broadcast nationally, the queen highlighted and praised the celebrities' HIV awareness and prevention efforts.

The CMS campaign broke new ground in HIV/AIDS programming in Nepal. It was the first time that national celebrities — famous movie, television, radio, music, and sports stars — used their influence to bring attention HIV/AIDS issues. It was the first campaign to integrate a consistent creative style and key messages throughout a range of media — national television, radio, and newspaper advertising; day-and-night

billboards; and a host of special advocacy activities. The first condom was shown on national television, the first harm-reduction messages were communicated, and comedy was used to dispel misconceptions and promote compassion for those affected by HIV/AIDS. In addition, an HIV-positive Nepali bravely agreed to appear in national media for the campaign.

PROGRAM CHALLENGES

Several factors, including a Maoist uprising, combined to delay the launch and implementation of the Sewa *network.* A violent Maoist uprising throughout Nepal caused considerable civic unrest and resulted in a number of delays. At various points during the project, the uprising disrupted training sessions and public-sector providers were advised by the government to remain in their communities, which meant that they could not travel for training. Similarly, it was not safe for subcontractors from Kathmandu to travel to the pilot district.

The need to adhere to government-approved training modules and to wait for available space in government facilities (where network clinicians could go for training) also delayed project implementation. It was important, however, to partner with the government to coordinate the implementation of the *Sewa* network because clinicians valued the government-sanctioned training certificates provided by these facilities.

Finally, implementation of the franchise suffered from the absence of a Nepal-based CMS representative, who could have helped to expedite and manage the launch. The limited size and funding of the pilot project did not justify the expense of hiring and maintaining a full-time staff person in Nepal. As a result, CMS relied on three local subcontractors — all of whom had numerous other projects competing for their time and attention.

PROJECT RESULTS

The following results are from a nine-month period, February to October 2002.

Increased reproductive health service utilization at Sewa *clinics.* Service statistics showed an increase in average monthly family planning and reproductive health visits from 28 to 50 clients per month. There was also an increase in total number of clients at *Sewa* clinics — average daily client visits increased from 12.7 to 14.2 (see Figure 1). An opposite trend was observed in the control group clinics.

Improved technical quality at Sewa *clinics.* Observed technical quality improved on 23 out of 24 indicators. All network clinics improved their average scores for infection prevention, availability of essential supplies, record keeping, and the provision of family planning services. Routine quality monitoring also allowed CMS to identify and target areas for improvement, such as the use of sterilized gloves, decontamination, proper hand-washing, family planning counseling, and client privacy (see Figure 2).

Improved perceived service quality at Sewa *clinics.* Client satisfaction with *Sewa* clinic services improved by 58 to 75 percent. At control group clinics, however, client satisfaction remained unchanged (see Figure 3).

Sewa clinics also improved on "caring provider" and "reliable provider" — indicators of perceived quality that CMS baseline research identified as important determinants of provider choice (and subsequently incorporated into the services marketing training module). The proportion of clients citing caring provider as a reason for choosing the clinic increased from 34 to 41 percent at *Sewa* clinics. Similarly, the proportion of clients citing reliable provider as a reason for choosing the clinic increased from 35 to 52 percent. An opposite trend was observed in the control group clinics (see Figures 4 and 5).

NUMBER ONE FOR SEXUALLY ACTIVE YOUNG MEN

CMS, through its consortium member Population Services International, introduced and positioned a new condom brand, *Number One*, specifically for preventing STIs/HIV/AIDS in sexually active young men. As part of the brand's development, CMS conducted market research on condom availability and distribution, and pre-tested potential names and package designs with its target audience. *Number One* condoms were a key element in the HIV/AIDS advocacy campaign events.

Launch event for CMS's *Number One* condom.

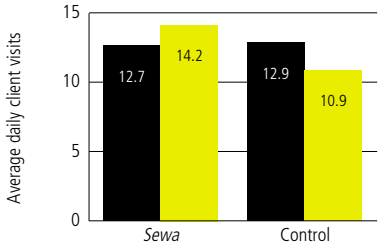
This billboard in downtown Kathmandu promotes CMS's HIV/AIDS advocacy campaign. The woman on the billboard is a Nepali celebrity. This campaign marks the first time that national celebrities used their popularity to bring attention HIV/AIDS issues.

There is a positive association between client satisfaction and repeat visits — with a higher proportion of satisfied clients making repeat visits. Similarly, clients reporting caring and reliable provider as reasons for choosing the clinic are more likely to make repeat visits.

Providers perceived direct benefits from key Sewa *components.* Provider survey data showed that the top three perceived benefits from the network were linkage with other providers (59%), technical training (50%), and increase in client flow (50%). These positive perceptions of *Sewa* providers parallel improvements in client flow and quality as measured by survey instruments and monitoring visits.

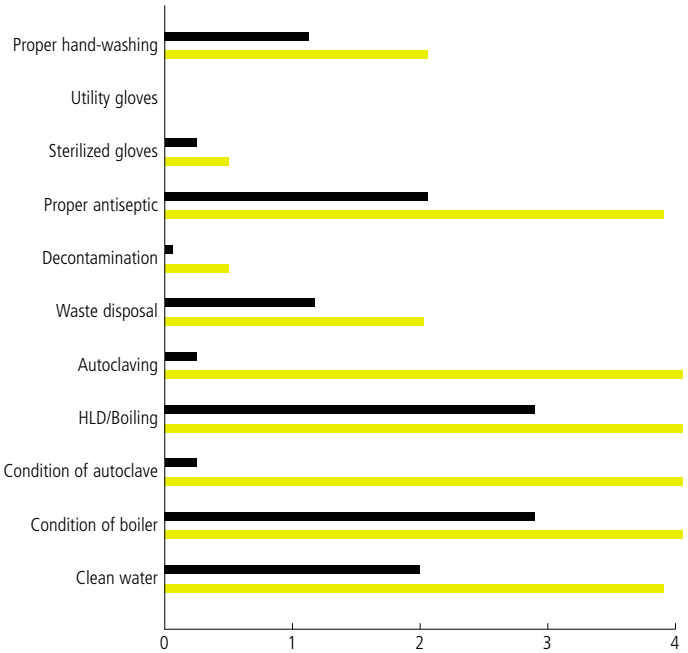
Sewa *brand awareness is low.* CMS's marketing efforts did not build sufficient recognition for the *Sewa* brand. Evaluation data show that awareness of the *Sewa* network was very low: 24 percent of respondents at *Sewa* clinics and only 15 percent of married women of reproductive age in the pilot district had ever heard of the franchise. Although baseline research findings were used to develop mass media messages, the limited marketing budget did not allow for extensive formative research or for monitoring the effectiveness of media activities. Radio messages included quality cues (such as friendly, caring providers of reproductive health services), but perhaps fell short of reinforcing the overall *Sewa* brand. Short-term technical assistance to improve the design and implementation of the mass media campaign might have helped, but CMS did not have sufficient funds to send qualified marketing experts. Political unrest and the associated implementation delays might have hampered CMS's efforts: Network promotion — including mass media and outreach — began only two weeks prior to the second-round survey.

Figure 1 ■ Average daily client flow



Source: CMS Client Exit Survey.

Figure 2 ■ Technical quality: Average score for infection prevention at 64 *Sewa* clinics



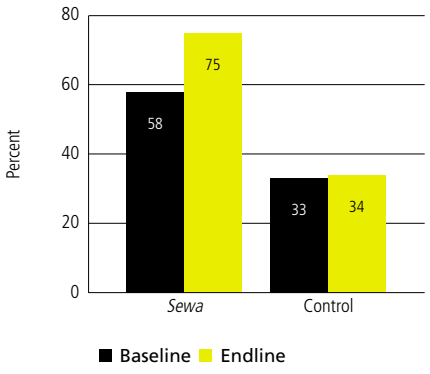
Source: CMS Quality Monitoring Checklist.

LESSONS LEARNED

A fractional franchise model can improve service quality at independent, private-provider clinics. The contractual relationship, which forms the basis of the fractional franchise model, permits the franchiser to monitor the service quality of participating clinics regularly and establishes a framework within which to provide corrective feedback. As demonstrated by the *Sewa* pilot, quality coordinators should use a detailed checklist to assess performance on a range of indicators — particularly those related to client–provider interaction — and should reinforce the topics covered in technical and services marketing training. *Sewa* clinic improvements in technical and perceived quality most likely were due to CMS's comprehensive approach, which stressed the combination of training and regular quality monitoring. Without a binding agreement (franchise contract) with individual providers it would have been difficult to assess the service quality at private clinics routinely — and even more difficult to suggest corrective actions.

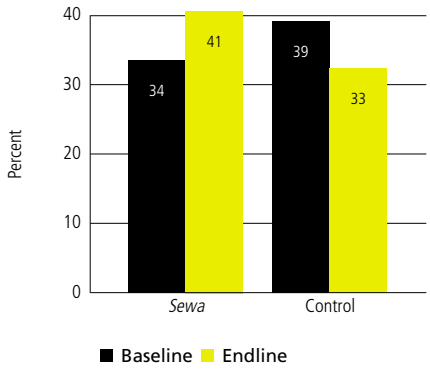
Brand awareness is essential to achieve the full benefits of the franchise model. CMS's evaluation data show that the *Sewa* pilot improved the availability, perceived quality, and use of reproductive health services. Improvements appear to be related to provider training on services marketing, particularly the use of interpersonal techniques to build relationships and ensure positive client–provider interaction. Clients' limited awareness of the *Sewa* brand, however, suggests that providers did not receive the full benefits of belonging to the franchise. A stronger external marketing effort (including mass media, outreach, and IEC) to increase brand awareness likely would have addressed this issue and strengthened the franchise.

Figure 3 Percent of clients who report that they are satisfied with the service requested



Source: CMS Client Exit Survey.

Figure 4 Percent of clients who report caring provider as a reason for clinic choice



Source: CMS Client Exit Survey.

ADDITIONAL RESOURCES

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Agha, S; A Karim; A Balal; and S Sossler. 2003. *A Quasi-Experimental Study to Assess the Performance of a Reproductive Health Franchise in Nepal*. Washington, DC: USAID/ Commercial Market Strategies Project.

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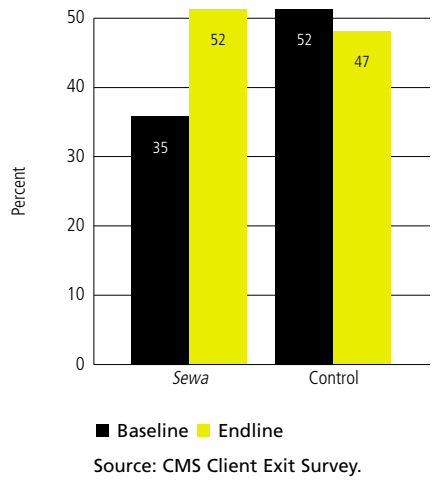
McBride, J and R Ahmed. 2001. *Social Franchising as a Strategy for Expanding Access to Reproductive Health Services*. Washington, DC: USAID/Commercial Market Strategies Project.

Montagu, D. 2002. "Franchising of Health Services in Low-Income Countries," *Health Policy and Planning,* Vol. 17, No. 2, 121–130.

Cover photo: Curt Carnemark / World Bank.

Figure 5 Percent of clients who report reliable provider as a reason for clinic choice



Source: CMS Client Exit Survey.

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Commercial Market Strategies (CMS) is a USAID-funded project that aims to increase access to and demand for reproductive health and family planning products and services in developing countries through the private sector.