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Monitoring the Performance of a Reproductive Health Franchise in Nepal

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COMMERCIAL MARKET STRATEGIES
NEW DIRECTIONS IN REPRODUCTIVE HEALTH

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1 Abstract

1.1 Objective

To assess whether

- there were improvements in client perceptions of the quality of care received at clinics that were part of the Sewa (Nepali for "care") franchise network
- an increase in reproductive health visits occurred at the Sewa clinics

1.2 Program Description

The Commercial Market Strategies project implemented a pilot network of private-sector nurses and paramedics in Nepal. Network activities began in April 2001. Franchisees were given basic reproductive health training for seven days. In addition, a two-day training was given on services marketing, which included the use of interpersonal techniques to develop trust and loyalty among clients. Sewa clinics were supported by a referral mechanism and were supplied subsidized family planning products. External-marketing activities, such as mass media promotions, began only two weeks prior to the second-round survey, because of political unrest and associated delays in implementation.

1.3 Methods

Two rounds of surveys were conducted with clients who exited franchise clinics. The first-round exit survey was conducted in March 2001. The second round was conducted in February and March 2002. Logistic regression analysis was used to assess changes in clients' perceptions of the quality of care they received.

1.4 Results

Clients' perceptions of the quality of services improved after the intervention. The proportion of women who visited for reproductive health reasons was also higher in the second round. The latter suggests that a larger number of reproductive health clients visited clinics in round two. Better-educated women were more likely to make a reproductive health visit in round two as well. The greater likelihood of educated women making a reproductive health visit at round two was explained by an improvement in their perception of service quality. In round two, because of the delay in the implementation of external marketing activities, most clients were not aware that the provider was a member of the Sewa network. Those clients who were aware, however, were significantly more likely to make a reproductive health visit.

1.5 Conclusions

The Sewa franchise has made progress in increasing the availability, perceived quality, and use of reproductive health services. These improvements appear to be related to provider training on building relationships with clients. Clients' limited awareness of the Sewa franchise brand name, however, suggests that providers have not received the full benefits of belonging to a franchise. A stronger marketing effort that increases client volume is likely to lead to the strengthening of the Sewa franchise.

2 Introduction

The resources currently available to meet the reproductive health (RH) needs of women in developing countries are inadequate. This problem is in part due to a larger number of women of reproductive age, a greater demand for RH services, the need to provide a wider range of RH services to women, and stagnating donor funding (Indacochea and Vogel, 2001; Ross and Bulatao, 2001). To meet the greater need for RH services, various models of service provision through the private sector are being tested (Mills et al., 2002).

One model of service provision involves establishing a network of private-sector health providers who would deliver a package of services under an umbrella brand that signifies quality. Because of the abundance of small-scale, independent, private-sector providers in many developing countries, this model has the potential to substantially increase the provision of RH services in developing countries. A network of providers would be considered a health franchise if a controlling organization (franchiser) offered participating providers (franchisees) the right to provide a defined set of health services (Commercial Market Strategies, 2002).

Health franchises in developing countries are usually fractional franchises: a franchised set of services is added to an existing business. They primarily operate in four programmatic areas: they make services available, they assure the quality of available services, they increase the awareness, and use of services. The availability, quality, and use of services are interrelated: services have to be available to be used — quality services can lead to the continued or increased use of services, while the non-use of services can lead to services being discontinued (Montagu, 2002).

One of the challenges of a fractional health franchise is to control the quality of services provided by independent private practitioners. Client perceptions of the quality of care and client satisfaction are considered essential to maintaining client loyalty or to increase the number of new clients (Haddad et al., 1998). A recent multi-country study showed that client satisfaction was higher at franchised clinics and that franchises were successful at attracting RH clients (Stephenson et al., 2002). This study examines the experience of the Sewa nurse and paramedic franchise in Nepal and assesses whether there were changes in the perceived quality of services approximately one year after the formation of the network. This study also examines the extent to which there was an increase in the use of reproductive health services during this period.

3 The Franchise Network

3.1 Rationale

The Sewa nurse and paramedic franchise was launched on a pilot scale in the Rupandehi district in May 2001. Rupandehi district has relatively few trained physicians. An earlier assessment showed that clients tended to visit physicians mainly when they had fairly advanced medical problems. The objective of establishing the franchise was to increase the use of high-quality, basic, RH services among low-income populations. Nurses and paramedics would be trained to offer an integrated package of services including family planning, STI management, and antenatal care.

3.2 Memberships

Sixty-four providers (including staff nurses, health assistant, auxiliary nurse midwives, auxiliary health workers, and community medical assistants) out of the 120 trained providers in the Rupendehi district were recruited to be part of the Sewa franchise. A contractual agreement was developed that clearly defined the roles and responsibilities of the franchisee and franchiser (the Nepal Fertility Care Center). Franchisees were expected to pay a one-time registration fee of $1.40 and an annual membership fee of $9 (paid in monthly installments). The fee was introduced to add value to the membership and to help select providers who were committed to franchise membership.

The franchiser also helped establish a relationship between the local social marketing company and Sewa providers. Although no special discounts are given to franchise members, this relationship enabled providers to have a steady supply of subsidized family planning products.

3.3 Clinical Training

To be selected as a franchise member, providers needed to have completed formal training from a registered training institution, own or rent a certified private facility, provide services regularly from that private facility, and have been previously trained to provide injectable contraception. In addition, franchisees had to be willing to comply with the clinic monitoring protocols. All franchisees were provided intensive RH training consisting of a seven-day basic orientation. A subset of eligible female providers was given additional training for IUD insertion. The basic RH training included

- Family planning: supply of non-clinical contraceptive methods, provision of information about clinical contraceptive methods, referrals for clinical methods, screening, management of side-effects, family planning counseling, and infection prevention
- Reproductive health: antenatal care training, included identification of high risk pregnancy (related to blood pressure, urine sugar/albumin, weight or anemia); referral for high risk pregnancy; provision of tetanus toxoid immunization; nutritional counseling; and referral for safe delivery
- STI/HIV/AIDS: identification of STI symptoms, syndromic management of STIs, and individual and couple counseling for the prevention of STIs/HIV/AIDS

3.4 Service-Marketing Training

A separate two-day session was conducted on services marketing. Training was organized around how promotional activities such as mass media, outreach, and IEC are used to generate demand for services (external marketing); how the trust development, bonding, empathy, and reciprocity builds loyalty with a client (relationship marketing); how quality of services is important in increasing clients' perceptions of the value of the services offered; and how word-of-mouth is important in increasing client flows. The sessions used a combination of lecture, role-play, and group exercises. At the end of the training session on service marketing, all franchisees were asked to develop marketing plans using what was learned during the training.

3.5 Marketing and Promotion

The franchisees were supported by an external marketing campaign revolving around a brand name and logo. These were developed after a series of focus groups with the client population and providers. Planned marketing activities included creating awareness and demand for the franchise services through radio advertisements, brochures, leaflets, a door-to-door campaign, billboards, clinic open house, promotional booths in local farmers' markets, and advertisements in print media. Political and civil unrest in Nepal, however, caused major delays in the implementation of the external marketing campaign and most marketing activities (including mass media advertising and outreach activities) began just before the implementation of the round two exit survey in February 2002. A monthly newsletter is circulated to all franchise members to keep them informed of activities and reinforce their affiliation to the network.

3.6 Referral System

Referral linkages were established to strengthen the franchise. The internal referral system allows providers to refer clients to trained female providers for IUD insertion or removal. For the referral of more complicated health problems, the external linkage is established with private physicians and government health facilities in the district. This system ensures that clients have access to an integrated package of services.

3.7 Quality Monitoring

A field coordinator makes monthly quality-monitoring visits to the franchisees. The main purpose of these visits is to ensure that service-quality protocols, based on the elements of quality defined by Judith Bruce (Bruce, 1990), are being followed. The field coordinator observes service delivery at the clinic and administers a detailed checklist to assess the provider's compliance with quality protocols. The results of the assessment are shared with the service provider and corrective actions to improve areas of weakness are suggested. The field coordinator assesses how the provider is performing with respect to specific aspects of provider-client interaction that are covered in the service-marketing training. Various aspects of relationship marketing, such as positive client-provider interaction and informing clients about services offered at the clinic, are emphasized.

4 Data and Methods

4.1 Study Design

This analysis is based on pre-test and post-test measurements taken at health facilities staffed by nurses and paramedics who were trained to provide RH counseling and deliver services. For the pre-test measurement in round one, 24 of the 70 providers[1] identified as potential franchise members were selected through stratified random sampling. Providers were stratified by belonging to one of five categories: staff nurse, health assistant, auxiliary nurse midwife, auxiliary health worker, and community medicine assistant. In round two, for the post-test measurement, 24 out of the 42 providers who had received training by round two were randomly selected. Providers at two of the selected pharmacies/clinics at round two were away, however, and could not be contacted upon repeat visits. Thus, the actual number of outlets where interviews were conducted in round two was 22.

Female interviewers were given four days of training on how to administer the questionnaire. Two female interviewers were stationed at each clinic from 8 a.m. to 7 p.m. for two full days. Except for a few clients who came to purchase drugs in an emergency, interviewers were trained to interview all male and female clients who exited the outlets. Round one interviews were conducted during April 2001. A total of 205 male and 286 female clients were interviewed during that round. Round two interviews were conducted after about nine months, during February/March 2002. A total of 323 male and 294 female clients were interviewed during that round.

4.2 The Questionnaire and Measures

The questionnaire collected data on socio-demographic variables (such as age, gender, marital status, and education), service utilization (reproductive health or general health reasons for visit, first or return visit to the outlet), and perceived quality of services. The questionnaire was designed to measure clients' overall perceptions of the quality of services offered. An alternative approach would have been to measure client perceptions of the quality of specific franchised services. In this study, we measure overall perceptions of quality for two reasons: clients tend to generalize their perceptions of the quality of a particular provider's services without differentiating categories of services offered and it is difficult to separate franchised services from other provider-offered services (as the same space is shared for examination and equipment) (Montagu, 2002).

A methodological difficulty related to measuring perceived quality is that clients usually are unwilling to express negative opinions about providers (Williams, 2000; Bernhart, 1999). This type of problem arises from courtesy bias. Several approaches have been used to reduce or eliminate the effect of the courtesy bias in client responses. One approach has relied on assessing changes in perceived quality by relying solely on clients' negative opinions of service quality (Williams, 2000). As only a small percentage of clients tend to evaluate the quality of services negatively, this approach is most useful when the number of respondents to this question is large. A second approach measures perceived quality relative to events or behaviors. For example, to determine privacy, patients would be asked whether anyone who did not participate in providing care was present during counseling and treatment, rather than being asked if privacy was

[1] A total of 64 of these providers actually became members of the SEWA franchise.

observed during counseling and treatment (Bernhart, 1999). We used the latter approach. We measured those attributes of services that are of value to the clients and, therefore, are likely to influence clients' utilization of these services in the future. A similar approach was useful in measuring changes in the perceived quality of services offered by midwives in Uganda (Agha et al., 2002).

We relied on unprompted responses to the question, "Why did you choose to visit this facility?" Response options included convenient location, proximity, knowing the provider personally, popularity of the provider, provider's caring manner, and provider's expertise or reliability. Pre-testing of the questionnaire in Kathmandu, as well as a previous study in Nepal, showed that these were the most commonly cited reasons for choosing an outlet.

The outcome measures of perceived quality used in this study include the following reasons for clients' choice of a clinic: convenient location, proximity, personal knowledge of the provider, popularity of the provider, provider's caring manner, and provider's expertise/reliability. Other outcome measures of interest included whether the client visited the clinic for RH reasons and whether the client made a return visit to the clinic.

4.3 Data Analysis

At the bivariate level, Table 2 shows clients' reasons for choosing a clinic and the proportion of clients coming to clinics for RH reasons at round one and round two. Chi-squared tests of independence examine whether round one and round two measurements on these variables were significantly different from each other.

At the multivariate level, because of differences in the socio-demographic composition of the samples from round one and round two surveys, logistic regression analysis is used in Table 3 to determine whether round one and round two measurements on outcome variables are significantly different from each other, after adjusting for socio-demographic variables. In addition, in Table 3 we test whether trends on outcome variables were stronger for males or females.

At the bivariate level, in Figure 2 we examine if a higher proportion of clients reported coming for a return visit in round two than in round one. At the multivariate level, in Table 4 we examine whether the higher proportion of clients who come for a return visit is associated with higher clients' perceptions of the quality of care received from providers.

Multivariate logistic regression analysis also was employed to determine whether knowledge of the provider being a Sewa member was associated with a greater likelihood of a RH visit in round two (Table 5). Because of small sample sizes, we report on differences at $p<0.10$.

5 Results

Table 1 shows socio-demographic characteristics of the male and female samples at round one and round two. Males interviewed during round two were on average about three years younger than males interviewed during round one (33 years versus 36 years, $p<0.05$). Consistent with their younger ages, a smaller proportion of males in round two were married (77 percent versus 86 percent, $p<0.01$). There was no significant difference between the two surveys in the educational levels of the male samples, with about 60 percent of males having received any secondary or higher education.

The socio-demographic characteristics of the female samples at round one and round two were not significantly different from each other. Females had an average age of about 31 years, about 86 percent of them were married at the time of the surveys, and over 35 percent had any secondary or higher education.

Table 1: Characteristics of the samples

	Males		Females	
	Round 1 (n=205)	Round 2 (n=323)	Round 1 (n=286)	Round 2 (n=294)
Mean Age	36.1	33.0	30.5	31.3
Marital Status				
Never married	12.7	22.9	9.4	10.5
Married	86.3	76.8	86.0	86.1
Other	1.0	0.3	4.6	3.4
Education				
Never been to school	17.1	19.5	42.3	43.2
Any primary	23.9	20.1	16.8	20.4
Any secondary or higher	59.0	60.4	40.9	36.4

Figure 1 shows the percentage of respondents who had heard of the Sewa franchise in round two and the percentage who were aware that the provider they were visiting is part of the Sewa franchise. Only 21 percent of males and 24 percent of females had heard of the Sewa franchise, and only 7 percent of males and 14 percent of females were aware that the provider they were visiting was a member of Sewa.

Figure 1: Percent of clients who had heard of Sewa at round two and knew that provider is a Sewa member

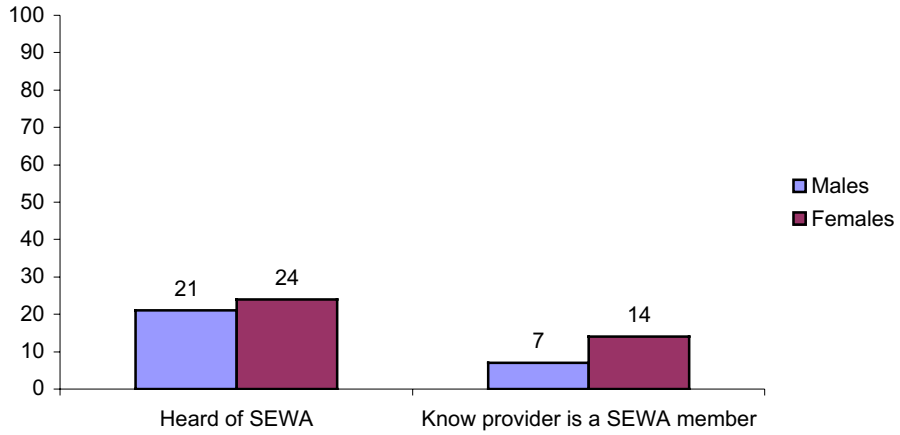

Table 2 shows respondents' reasons for choosing the clinic at which they were interviewed. Males reported significant increases in their perception of the convenient location of the outlets (8 percent to 47 percent), personal knowledge of the provider (39 percent to 46 percent), popularity of the provider (2 percent to 8 percent), provider's caring manner (30 percent to 58 percent), and provider's expertise/reliability (60 percent to 68 percent) as the reasons for their choice of outlet. Females reported significant increases in convenient location of the outlet (11 percent to 23 percent), proximity of the outlet to the household (47 percent to 68 percent), personal knowledge of the provider (26 percent to 38 percent), provider's caring manner (37 percent to 82 percent), and the provider's expertise/reliability (65 percent to 79 percent) as reasons for their visit.

Table 2 also shows whether respondents visited the clinic for RH reasons. Only 5 percent of males visited the outlets for RH reasons and there was no change in this proportion between rounds one and two. In contrast, about 19 percent of women reported visiting the outlets for RH services in round one; this percentage increased to 26 percent by round two.

Table 2: Reasons for choosing the clinic

	Males Round 1 (n=205)	Round 2 (n=323)	Sig. level	Females Round 1 (n=286)	Round 2 (n=294)	Sig. level
Reasons for choice of outlet						
Convenient location	8.3	47.1	****	11.2	22.5	****
Proximity	46.3	52.9	-	46.9	68.4	****
Personal knowledge of provider	38.5	46.4	*	25.5	38.1	***
Popularity of provider	2.4	8.1	***	3.5	6.1	-
Provider's caring manner	30.2	57.6	****	37.4	81.6	****
Provider's expertise/reliability	60.0	68.4	**	65.4	78.6	****
Reason for visit is RH	5.4	4.6	-	19.2	25.5	*

*p<0.10 **p<0.05 ***p<0.01 ****p<0.001

Table 3 shows adjusted odds ratios indicating changes in clients' reasons for choosing the clinic at which they were interviewed. An odds ratio of greater than one shows an increase in that indicator between rounds one and two, while an odds ratio of less than one shows a decrease in that indicator between rounds one and two. The second column in Table 3 shows the odds of a male being more or less likely to report reasons for his choice of outlet at round two compared to round one. The third column of Table 3 shows the odds of a female being more or less likely to report reasons for her choice of outlet at round two compared to round one). The fourth column of Table 3 shows whether the trends reported by males and females were significantly different from each other.

After adjusting for socio-demographic characteristics of the samples, males were 9.5 times more likely at round two than at round one to report convenient location of outlet as a reason for their choice of that outlet (females were 2.3 times as likely). These trends were significantly different from each other: the convenient location of the outlet became even more important for males than it did for females. While there was no significant change in male reports of proximity as a reason for the choice of outlet, females became 2.6 times as likely as before to report that proximity was a reason for their visit. Moreover, the trend for females was significantly stronger than the non-significant trend for males. In round two, both males and females were more likely to report that personal knowledge of the provider was a reason for their visit, but the trend for males was not significantly different from the trend for females.

Males were 3.4 times as likely to report the popularity of the provider as a reason for their visit at round two compared to round one, while there was no significant change in female reports of provider popularity as a reason for the visit. Both males (3.3 times) and females (7.6 times) became significantly more likely to report a provider's caring manner as a reason for their choice of the outlet, although the trend in this indicator was significantly stronger for females. Both males (1.5 times) and females (2 times) were more likely to report provider's expertise/reliability as a reason for their visit at round two, but the trend for males was not significantly different from the trend for females.

Finally, while females in round two were 1.5 times as likely than they were at round one to report that they came for a RH visit, there was no significant trend in this indicator for males.

Table 3: Adjusted odds ratios[1] for reported reasons to choose clinic at round two versus round one

	Odds Ratios		Difference in Trends
	Males (n=528)	Females (n=580)	Sig. level
Reasons for choice of outlet			
Convenient location	9.47****	2.30****	****
Proximity	1.31	2.55****	**
Personal knowledge of provider	1.49**	1.84***	-
Popularity of provider	3.41**	1.87	-
Provider's caring manner	3.30****	7.60****	***
Provider's expertise/reliability	1.51**	1.97****	-
Reason for visit is RH	0.85	1.51**	-

*p<0.10 **p<0.05 ***p<0.01 ****p<0.001 [1]For each of the seven outcome variables shown, the odds ratio shown is associated with the survey round and is adjusted for age, gender, marital status, and education.

Figure 2 shows the percentages of all females and males who made a return visit to the clinic. There was no difference between round one and round two in the percentage of all males or all females who returned. The percentage of women with secondary or higher education who made a return visit, however, was higher at Round 2 than at Round 1 (95 percent versus 85 percent, p<0.05).

Figure 2: Percent of males and females who made a return visit to the Sewa clinic at round one and round two

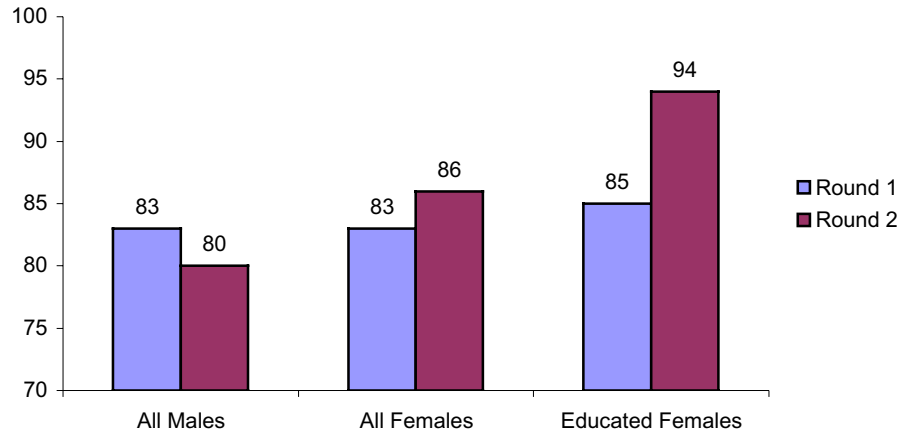

Table 4 shows factors associated with a return visit to the clinic among females with secondary or higher education. Model one shows that females with secondary or higher education in 2002 were 2.6 times as likely to make a return visit to the pharmacy than females with similar education in 2001 _ even after adjusting for age and marital status. After adjusting for reasons for the visit in model two, females with secondary or higher education in 2002 were no longer more likely to make a return visit to the clinic. This result suggests that the reason that females with secondary

or higher education were more likely to make a return visit at round two was because of improvements in perceived quality of services between rounds one and two.

Table 4: Odds ratios explaining the greater likelihood of return visit to the clinic in round two versus round one (among females with secondary or higher education)

	Odds Ratios	
	Model 1 (n=224)	**Model 2 (n=212)**
Survey Round		
Round 1	1.00	1.00
Round 2	2.62**	1.15
Age	0.98	0.97
Marital Status		
Other	1.00	1.00
Married	1.60	0.92
Reason for Visit[1]		
Convenient location		1.52
Proximity		3.42**
Personal knowledge of provider		6.02***
Provider's caring manner		2.80*
Provider's expertise/reliability		9.45****
Chi-square (degrees of freedom)	6.00 (3)	36.65(8)
Pseudo R^2	0.04	0.24

*p<0.10 **p<0.05 ***p<0.01 ****p<0.001 [1]Popularity of the provider dropped from the model because it predicted success perfectly and 12 observations were not used in model two.

Table 5 shows factors associated with a RH visit in round one and round two. In Round 1, age was significantly associated with the likelihood of a RH visit: with every year of age, a female becomes less likely (or 0.96 times as likely) to make a RH visit. In round two, in addition to the association with age, married females were four times as likely as other females to make a RH visit. Finally, knowing that the provider is a Sewa member makes a female about twice as likely to make a RH visit.

Table 5: Odds ratios of factors associated with a RH visit at rounds one and two

	Odds Ratios	
	Round 1	**Round 2**
	Females (n=286)	**Females (n=294)**
Age	0.96**	0.95****
Marital Status		
Other	1.00	1.00
Married	1.67	3.96**
Education		
Less than secondary	1.00	1.00
Any secondary	0.58	0.69
Knows Provider is Sewa Member		
No	-	1.00
Yes	-	1.93*
Chi-square (degrees of freedom)	8.93(3)	22.88(4)
Pseudo R^2	0.03	0.07

*p<0.10 **p<0.05 ***p<0.01 ****p<0.001

6 Discussion

Males and females were more likely to report convenient location of the outlet as a reason for their choice of the clinic in round two, suggesting that there was greater awareness of the clinics in that round. Females were also more likely to report proximity of the outlet as a reason for choosing it at round two. In that round, both males and females were more likely to report that knowing the provider personally, the provider's caring manner, and the provider's expertise/reliability were reasons for choosing the clinic. Higher male and female reports of personally knowing the provider and the provider's caring manner at round two are consistent with the employment of personalized marketing techniques by providers to increase their client base or increase their clients' loyalty. These findings suggest that the relationship-marketing component of provider training had a positive impact on clients' perceptions of the accessibility and quality of services provided by members of the Sewa RH franchise.

There was an increase in the proportion of women who visited the clinics for RH reasons, from 19 percent to 26 percent. Thus, in three of the four programmatic areas in which franchises operate _ availability, quality, and use of services _ the Sewa franchise has made progress. The franchise, however, appears to be weak in a fourth area _ awareness among clients that providers belong to the franchise network.

The vast majority (90 percent) of Sewa clients were not aware that the provider they had just visited is a member of Sewa. A franchise's success usually is based on its reputation (Montagu, 2002). Thus, our findings indicate that Sewa providers have not experienced the full benefits of belonging to a franchise. A stronger marketing and awareness-raising effort may strengthen the Sewa network by increasing the client flow. A surge in client volume may, in turn, lead to greater interest among franchise members in providing RH services. As Sewa members gain experience with providing RH services, the quality of services may improve further and lead to greater utilization of Sewa clinics for RH purposes.

Overall, male and females respondents did not become more likely to revisit a Sewa clinic. This finding may, in part, be a reflection of the short duration of the study period (nine months). Stronger effects may be observed over a longer period of time; especially after the strengthening of the external-marketing component. In spite of the short duration of the study period, however, one sub-group of clients _ females with secondary or higher education become significantly more likely to revisit a Sewa clinic. Moreover, the increased likelihood of revisits by relatively educated women is explained by improvements in their perceptions of quality of services. These findings are consistent with the hypothesis that educated females are more likely to be quality conscious (the perception of the provider's expertise/reliability was the indicator most strongly associated with return visits of educated women) and more likely to respond to changes in perceived quality by changing their pattern of utilization of health services.

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