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**The Role of the
Provider in Family
Planning and
Reproductive Health
Services Marketing
Lessons Learned from
SOMARC III**

**SOMARC III
Special Study 5**

**The Futures Group
International**

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**THE ROLE OF THE PROVIDER IN
FAMILY PLANNING/REPRODUCTIVE HEALTH SERVICES MARKETING
Executive Summary and Lessons Learned**

SOMARC's approach to private sector family planning/reproductive health services marketing focuses on encouraging health providers to offer a wide range of family planning and reproductive health services in their private practices, thereby expanding their client base and increasing their service volume. Among commercial providers, SOMARC technical assistance focuses on promoting family planning services. In the NGO sector, SOMARC technical assistance focuses on encouraging family planning associations to promote other reproductive and/or child health services.

This paper describes lessons learned from independent commercial health care providers in Istanbul, Turkey, a health maintenance organization in Salvador, Brazil, and an NGO family planning association in Lima, Peru. Despite differences in country and services settings, the lessons learned are remarkably consistent with one another, and can be summarized in three main points.

Lesson Learned #1 Traditional advertising-based outreach promotion has little direct impact on client volume, referrals, or types of services provided

Lesson Learned #2 Increasing client interest in or awareness of the availability of family planning services, without changing provider behavior, does not necessarily translate into increasing family planning services delivery

Lesson Learned #3 Changing provider behavior by applying explicit, standardized screening tools or focused inreach promotion can increase service volume

Providers are typically seen as a target for technical training, mainly for the purpose of quality assurance. SOMARC experience shows that providers also need to be appreciated as a critical element in a marketing mix to attract and hold clients, and to increase those clients' utilization of available services. Services marketing is an effective and viable way to increase commercial and not-for-profit involvement in family planning and reproductive health. To reap the benefits of this approach, providers and their staffs need assistance in changing their own behavior to become more proactive with their clients.

INTRODUCTION

In recent years the mandate for contraceptive social marketing has expanded from supply methods (hormonal and barrier) to longer-lasting methods which require trained clinicians for their application. At the same time, family planning associations have taken steps to expand their service base beyond contraception, to meet the post-Cairo mandate for a broader reproductive health emphasis and to improve their prospects for financial sustainability. In response to these needs, SOMARC III has developed a “services marketing” initiative to work with commercial health providers in the area of family planning and with family planning non-governmental organizations (NGOs) in the area of financial sustainability.

SOMARC’s approach to private sector family planning/reproductive health services marketing focuses on encouraging health providers (physicians, nurses, midwives, etc.) to offer a wide range of family planning and reproductive health services in their private practices, thereby expanding their client base and increasing their service volume. Among commercial providers, services marketing usually focuses on promoting family planning services in obstetrics/gynecology, family medicine, and general practice. In the NGO sector, services marketing usually focuses on encouraging family planning associations to promote other reproductive and/or child health services.

Initial approaches to services marketing focused on quality assurance, training clinicians in advances in contraceptive technology for old methods (orals, injectables), in new methods (implants), and/or new techniques (minilaparotomy under local anesthesia, no-scalpel vasectomy, immediate postpartum and post-abortion IUD insertion). These efforts were needed to guarantee that clients could receive appropriate, high quality services from participating providers. However, while quality assurance is necessary to guarantee readiness to offer services that will protect clients’ health, it is not sufficient to ensure that services will actually be delivered. *Effective services marketing requires that we go beyond quality assurance.* Increasing services delivery requires *changing the behavior* of both clients and providers – clients so that they demand the services, and providers so that they proactively promote the services among their clientele. In addition to changing provider and client behaviors, greater emphasis on communication approaches other than mass media are required.

The purpose of promotion is to make clients *aware* that services are available, to make them *interested* in receiving the services, and to make them *seek out* and actually obtain the services they want. Services marketing targets both potential clients – people who are not yet using the facility for any services – as well as current clients who are using the facility for other reasons. When the purpose of client promotion is to bring new clients into the practice, we call it outreach. Services marketing has experimented with a number of outreach promotion techniques, including mass media advertising, posting posters and pamphlets, and distribution of discount coupons.

Marketing to clients through mass media advertising has proven successful in promoting family planning products, such as brands of oral contraceptives and condoms. Mass media has also been used effectively to promote selected family planning services, such as vasectomy (see Foreit et al., 1989). However, these methods can be considered “niche” services, attracting a very specific group of potential clients, and at the time the advertising campaigns were held, there were few if any competing providers in the market. Therefore, it remains to be seen if traditional outreach can attract new clients to services for which there are many competing outlets.

At the same time, the provider’s existing clientele is an excellent pool from which to draw demand for new services. “Inreach” techniques are designed to promote the new services to clients arriving for other reasons. Services marketing typically includes promotion aimed at these clients through passive

media such as posters and pamphlets inside the facility. Equally if not more important is training providers and their staff to proactively screen their clients for other FP/RH needs. Physicians often overestimate the extent to which they already provide preventive services. The literature on changing physicians' behavior shows that they are extremely resistant to change (see Cohen et al., 1994), and that continuing medical education programs to impart new theoretical information have been largely ineffective in generating significant and lasting behavior change.

Services marketing is substantially different than marketing family planning products. First, because the factors that lead a client to choose a particular clinical provider are different than the factors that lead her to choose a particular product, brand, or outlet for that product brand. Second, because the role of the provider is paramount – the provider of a clinical service essentially *produces* that good, whereas the provider of a product offers a good produced elsewhere. We have found that *changing the behavior of providers and other facility staff* is the key to expanding service delivery in a clinical setting. Our research shows that mass media and other traditional marketing outreach are relatively ineffective at bringing new clients into services. By and large, clients choose their clinical providers through word of mouth, primarily from friends and relatives and to a lesser degree from other clinicians. Expanding services requires that providers practice 'inreach' and proactively promote them among their existing clientele who have come in for other reasons. Providers and support staff can also promote by word of mouth within their professional and social networks. Within this context, inreach activities become a subset of a larger effort of 'integrated communications.'

This paper will present two case studies: one in Turkey and the other in Brazil. The Turkey case is the ongoing SOMARC project, which uses both outreach and inreach techniques. The Brazil case was a collaboration between the INOPAL-2 and OPTIONS-2 projects, which worked with a single health maintenance organization to promote postpartum and post-abortion IUD insertion, only inreach promotion was used. Following the case studies, findings from operations research conducted in Peru will be discussed, which worked to promote reproductive and child health services in family planning settings, using inreach techniques.

TURKEY

Recent growth in the country's private healthcare industry suggests a strong potential for providing family planning services in the private sector in Turkey. Early social marketing programs clearly demonstrated the ability and willingness of consumers to purchase family planning products through retail outlets. Since 1995, the SOMARC Project has been working with the Turkish Family Health and Planning Foundation and AVSC International to expand social marketing from family planning products to family planning services. SOMARC and its partners developed a network of private healthcare providers, the Women's Health and Family Planning Network (known as KAPS, its Turkish acronym), who were trained to provide high-quality family planning and reproductive health services to low-income clients. SOMARC launched KAPS in October 1995 in the Istanbul metropolitan area.

Based on findings from a baseline survey, SOMARC and its partners designed and implemented interventions to improve providers' clinical and counseling skills and to place IEC materials in participating facilities. Mandatory three-day training workshops for physicians and two-day training workshops for pharmacists were implemented to improve knowledge of contraceptive technology and to raise provider awareness of quality of care issues, including a client's right to choose a method of contraception and the importance of providing contraception to sexually active adolescents. KAPS encouraged facilities to post visible signs advertising family planning services, display easy-to-read written materials and posters about family planning, and encouraged physicians to talk with OB/GYN post-partum, prenatal and abortion clients about family planning options.

Outreach promotion included distributing brochures for clinical services at KAPS pharmacies, employing KAPS fieldworkers for interpersonal communication, and installation of a telephone information line. During a 3-month period, coupons good for a 20% discount on family planning and reproductive health services at participating KAPS facilities were distributed in three neighborhoods in Istanbul.¹ Limited mass media advertising was also used from time to time.

In September 1996, SOMARC and KAPS initiated a series of client intercept surveys to track client awareness of family planning and services received at KAPS facilities. In intercept surveys, clients are interviewed at the service sites, first when they arrive at the service and then again as they leave. Interviewers intercept all people entering the facility and identify female clients 18-45 years of age. These eligible respondents are asked a series of questions before entering the facility (intake interview) and again as they left (exit interview). By intercepting *all* entering clients (including men, women, and children) over a one-week period, client intercept surveys provide reliable measures of client volume by type of service provided and assessments of change (or lack thereof) in provider behavior. The methodology is also less expensive than attempting to install reliable management information/service statistics systems.

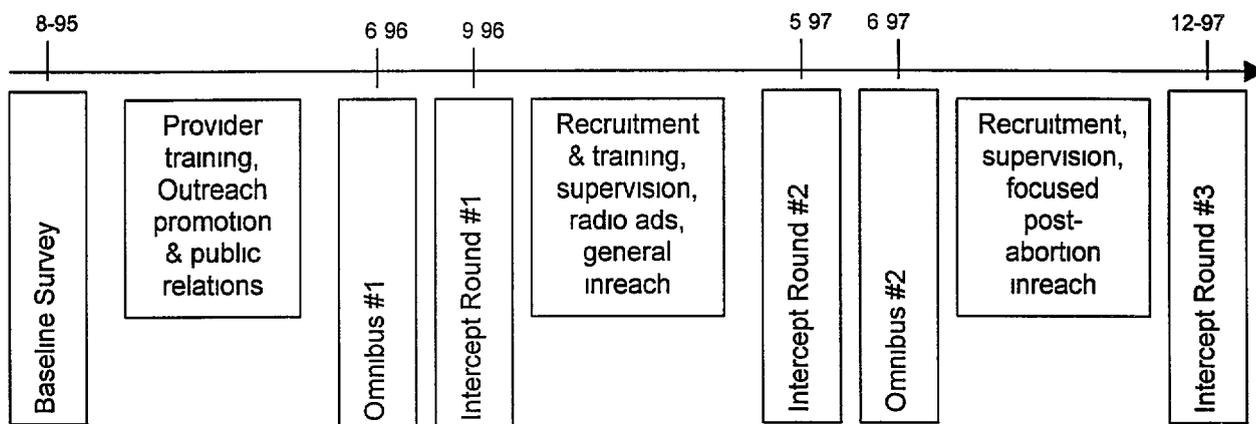
The first combined client intake/exit survey was conducted in September/ October 1996 and was intended to monitor network progress and to constitute the quantitative baseline against which the effects of new mass media promotion and additional in-service interventions would be assessed. The second client intercept survey was conducted in April, 1997, following a short radio advertising campaign. The third and final client intercept study was conducted in December, 1997, following implementation of a focused post-abortion intervention. These client intercept surveys were supplemented with two population-based "omnibus" surveys conducted by the same local market.

¹ A total of 4,000 coupons were distributed between July 1-September 30, 1996. Of these, 456 were redeemed, thus represents on average 1% of the caseload of reproductive-age women attended at participating facilities.

research firm which conducted the client intercepts. The omnibus surveys interviewed representative samples of women of reproductive age throughout the Istanbul metropolitan area.

Figure 1 presents the chronology of program and survey activities.

Figure 1
Chronology of KAPS program development and monitoring activities



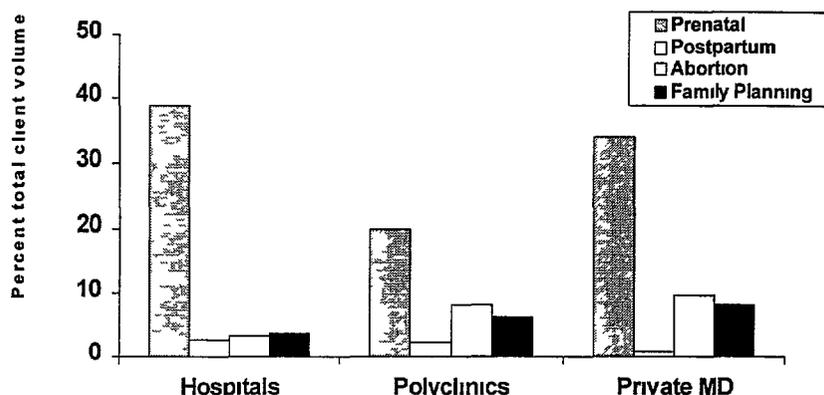
The KAPS network was officially launched on October 15, 1995. By August 1996, it included 6 hospitals, 11 polyclinics, 13 private physicians' offices, and 85 pharmacies. In April 1998, KAPS included 10 hospitals, 14 polyclinics, and 19 private physicians and 100 pharmacies. In order to include newly-enrolled facilities, each client intercept round covered a slightly different sample of KAPS members. The longitudinal analyses that follow are based on 16 facilities (6 hospitals, 3 polyclinics, 7 private physicians) which participated in all three survey rounds.

Lesson Learned #1 Outreach activities did raise women's awareness of the KAPS network. However, they had no significant impact on client volume, new client referral, or profile of services delivered.

KAPS activities focused on obstetrics/gynecology practices. Therefore, it is not surprising that the client profile among participating facilities was heavily dominated by pregnancy-related consultations, especially prenatal care. These profiles did not change over time, but did vary somewhat by type of facility: polyclinics had the lowest proportions of prenatal consultations, and private physicians saw the highest proportions of abortion-related visits and family planning consultations. Figure 2 presents client profiles (means of 3 rounds) by type of facility.

Figure 2

Overall client profiles remained constant over time, but varied by type of facility

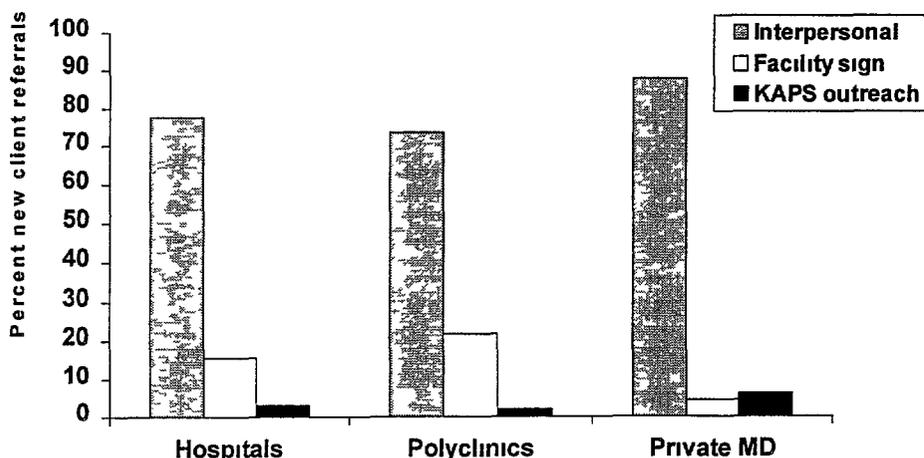


Within its first year, KAPS gained credible recognition among the population at large in Istanbul. Approximately one third of women interviewed in city-wide omnibus surveys in 1996 and in 1997 correctly identified the KAPS logo as standing for women's health and/or family planning. However, *this recognition did not translate into new business for the KAPS members*.

Total client volume at the participating facilities did not change over time, except for minor seasonal variation (more clients reported illness-related visits in December than in September or May). Similarly, there was no change in proportion of new vs. returning clients, more than 2/3 of clients intercepted had visited the facility previously for their own health. Overall, more than three out of every four new clients reported hearing about the facility from a relative or friend or from another physician. The facility sign was also an important referral mechanism for new clients at hospitals and polyclinics, but not at private physicians' offices. KAPS outreach (pamphlets, field workers, telephone information line, mass media advertising) failed to generate significant numbers of new clients, and fewer than one out of ten new clients reported even having been in contact with an outreach medium. Figure 3 presents principal referral sources for new clients, averaged over the 3 survey rounds.

Figure 3

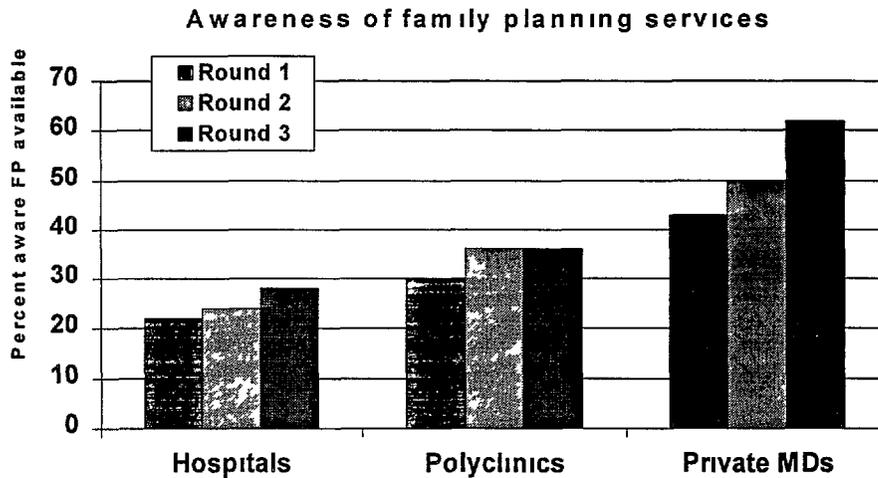
KAPS outreach promotion had little effect on new patient referrals



Lesson Learned #2 Increasing awareness of the availability of family planning services did not translate into increasing demand for family planning

Over time, greater proportions of clients visiting KAPS facilities were aware that family planning services were available on site, greatest awareness and greatest increase in awareness was registered at private physicians' offices. Fewer than one third of the clients visiting hospitals and polyclinics were aware that they could obtain family planning services at those sites.

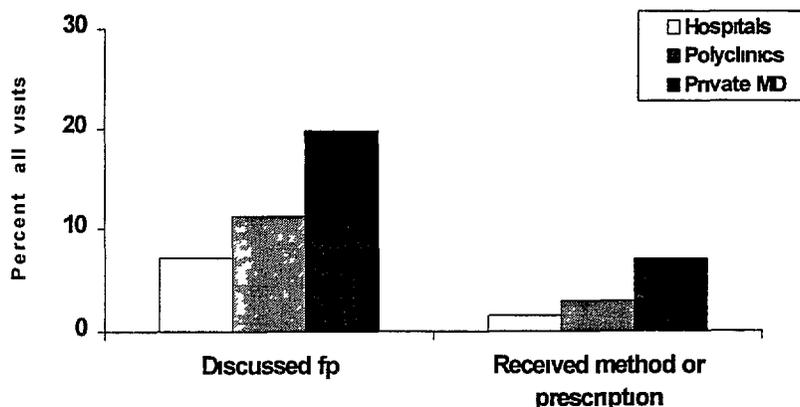
Figure 4



However, this growing awareness of family planning services availability also did not translate into a greater volume of family planning services delivered, in large part because client volume continued to be dominated by pre-natal consultations. One in five clients at private physicians' offices reported that the provider discussed family planning during the course of the consultation, this proportion was only one in ten at hospitals and even less at polyclinics. Figure 5 presents means from the 3 survey rounds.

Figure 5

Clients of private physicians most likely to discuss family planning or receive a method



Lesson Learned #3 Focused inreach promotion increased family planning counseling and service delivery during abortion-related visits

Following the first client intercept survey, KAPS implemented inreach promotion to stress three priority client groups: abortion, prenatal, and postpartum. After the second round, SOMARC and AVSC developed a focused post-abortion approach with two objectives:

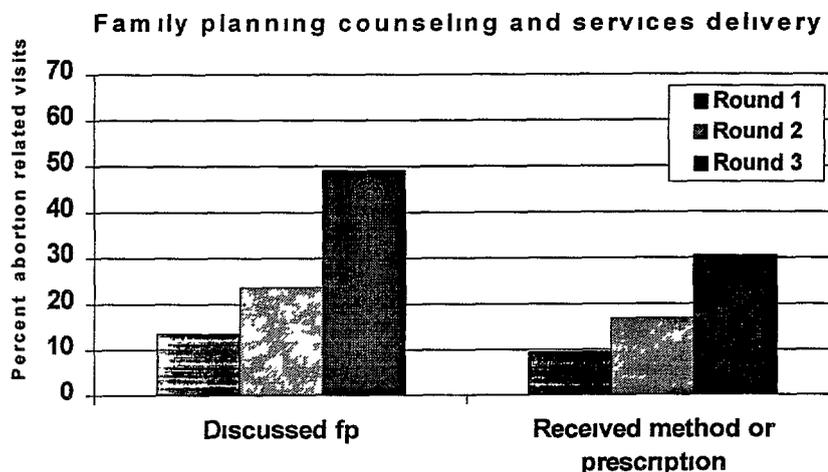
1. Ensure that all women receiving an abortion at KAPS facilities or returning for a post-abortion check-up receive family planning counseling. If the client does not spontaneously ask about contraception, the provider should initiate the discussion.
2. Recommend that all post-abortion women who do not want to get pregnant right away leave the KAPS facility with contraceptive protection. Abortion clients who do not receive an injection or IUD should be given a pill prescription or orientation in the correct use of a barrier method.

One-on-one training and follow-up was provided to KAPS members to drive home the need for family planning promotion at all stages of the abortion process – at the initial visit to confirm the pregnancy and schedule the abortion procedure, at the time of the procedure itself, and at the post-abortion checkup. Clinicians and their staffs were encouraged to emphasize three key messages:

1. That the woman could get pregnant again very soon after having the abortion, perhaps in only two weeks post-abortion,
2. That if she did not want to get pregnant again, she should begin contracepting immediately,
3. That the physician was prepared to offer her family planning counseling and a method of her choice.

Round 2 of the client intercept surveys showed modest gains in family planning counseling and services delivery provided during abortion-related consultations. By round 3, nearly half of all abortion-related visits reported having discussed family planning, and almost one third accepted a family planning method or prescription during the course of the visit. Figure 6 presents proportions of abortion-related visits receiving family planning counseling and methods, across facilities.

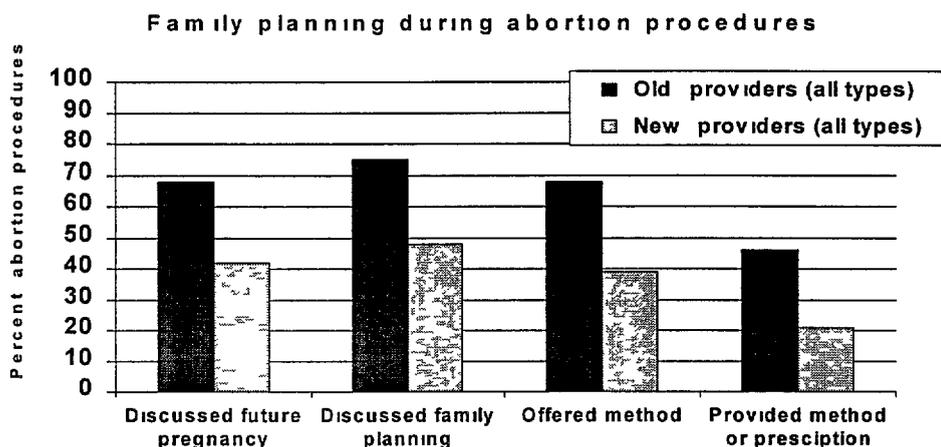
Figure 6
Abortion-related visits (all facilities)



The major determinant of post-abortion counseling was whether the abortion procedure was actually performed during the visit. Providers were less likely to discuss family planning during an initial visit to schedule the abortion procedure or during the post-abortion check-up. Longevity in KAPS was also significantly related to family planning promotion. “Old” providers – that is, those who had joined KAPS prior to September 1996 – were significantly more likely to discuss pregnancy and family planning immediately following an abortion procedure than “new” providers, those who had joined more recently. Figure 7 presents proportions of round-3 clients who reported receiving family planning counseling and methods immediately following an abortion procedure, by facility’s longevity in KAPS.

It would be worthwhile to explore the reasons for the differences between old and new KAPS facilities. On the one hand, the old facilities had had more exposure to KAPS training and assistance. However, we cannot rule out other differences between providers – the first providers to join may have been more motivated and interested in providing family planning to begin with, even if they were not proactively promoting it in their practices. This answer to this question would have potentially important managerial implications for selection and/or qualification criteria, orientation, training, etc.

Figure 7
Abortion procedures Old vs New facilities



SUMMARY OF LESSONS LEARNED

Neither mass media and other outreach promotion nor increasing client awareness of service availability were sufficient to promote family planning service delivery in private practices whose main business is not family planning. Behavior change interventions directed at providers and focused on a specific client need and easily identifiable scenario, in this case, visits made for induced abortion, were successful in stimulating family planning counseling and service delivery.

BRAZIL

Brazil is characterized by a strong private health sector. Health maintenance organizations (HMO) are a major player in the health market, covering 13.5 million beneficiaries in 1991, almost all paid by employer benefits (World Bank, 1994). Most HMO plans exclude specialized diagnostic and therapeutic procedures, chronic infectious diseases, and prescriptions for outpatient consultations. Although most HMOs cover preventive and prenatal care, few offer family planning.

Promedica is the largest HMO in the northeast state of Bahia, with about 150,000 beneficiaries covered by employer-paid plans. Promedica maintains its own hospitals, emergency services, and laboratories. Out-patient consultations are provided by affiliated physicians who attend clients in their own private practices and receive fees for services directly from Promedica according to a pre-established scale. Affiliated obstetricians have hospital privileges at the Promedica hospital to attend deliveries among their prenatal clients. The hospital also maintains salaried physicians to attend births, abortion complications, and other surgical procedures.

Promedica began offering family planning services to its beneficiaries in 1983². In a departure from the usual practice of not providing prescription drugs or devices for outpatients, all contraceptives dispensed from Promedica are purchased by the organization and provided without charge. Attending physicians are paid for family planning consultations and services at a level commensurate with simple office visits. All contraceptive methods except implants, including minilaparotomy and vasectomy, are offered as interval (non pregnancy-related) procedures. Promedica is the single largest provider of IUD insertion services in Brazil.

Prior to 1991, the only immediate postpartum method available in the Promedica hospital was tubal ligation. In 1991, Promedica undertook an operations research study of the acceptability and cost-benefit of postpartum and post-abortion IUD insertion, together with The Population Council/INOPAL II Project and The Futures Group International/OPTIONS II Project. Promedica physicians were trained in postpartum/post-abortion IUD insertion procedures and counseling in December 1991. Beginning March 1, 1992, all women admitted to the Promedica hospital for delivery or treatment of abortion complications were offered the choice of IUD insertion prior to hospital discharge. Availability of the new service was promoted by posters, announcements in client newsletters, prenatal classes for expectant mothers, and by physicians themselves. Physicians who inserted IUDs in hospital were paid an extra fee, equal to the fee they would have received by performing the insertion in their private practice. Follow-up of hospital admissions was conducted through February 28, 1994, or until the woman left Promedica whichever came first, for women admitted between June 1 – December 31, 1991 (control group) and between March 1, 1992 – February 28, 1994 (experimental group). Promedica's accounting system provided information on number, type, and costs of all subsequent outpatient visits, laboratory tests and procedures, family planning services, and hospitalizations.

² Promedica's director is known for innovations in preventive health care. Promedica was the first HMO to provide infant vaccinations and oral rehydration. For many years it offered an annual prize in prevention of hospital infections and in 1991-92 worked closely with the Bahia State Secretariat of Health to combat the cholera epidemic.

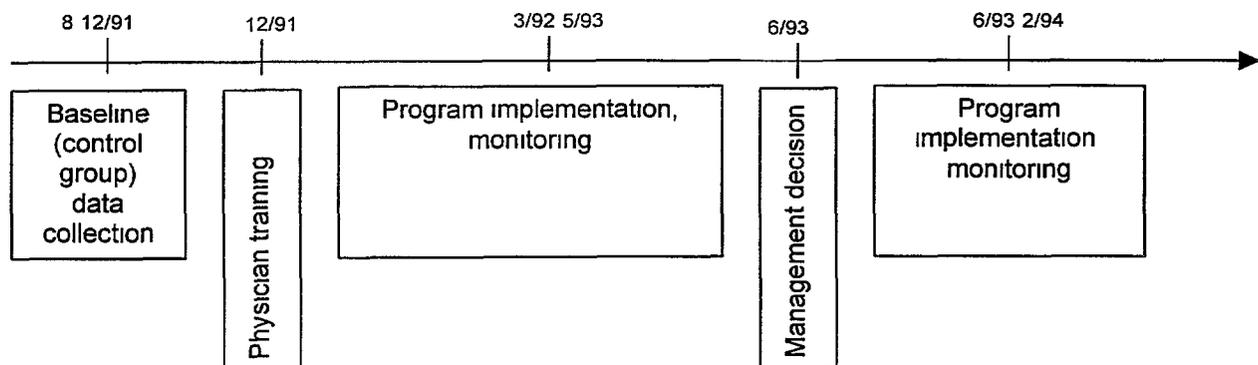
Results

Postpartum and post-abortion IUD services showed immediate acceptance among Promedica clients, quickly surpassing postpartum tubal ligation – itself a very popular method. Within 6 months after inauguration of the new service, postpartum acceptance rates reached a plateau of 18 percent of all deliveries and remained unchanged for the next nine months. Sixty percent of attending physicians were providing IUDs to at least some of their clients.

At the end of the first year, the operations research team took stock of project accomplishments. It was noted that not only were there physicians who had never inserted an IUD postpartum, but nurses' records were showing cases of women who had requested an IUD at admission but who had not received the method prior to discharge. Promedica administration incorporated postpartum/post-abortion IUD insertion as a routine service and took the following steps, which were communicated by letter and in meetings with their affiliated physicians:

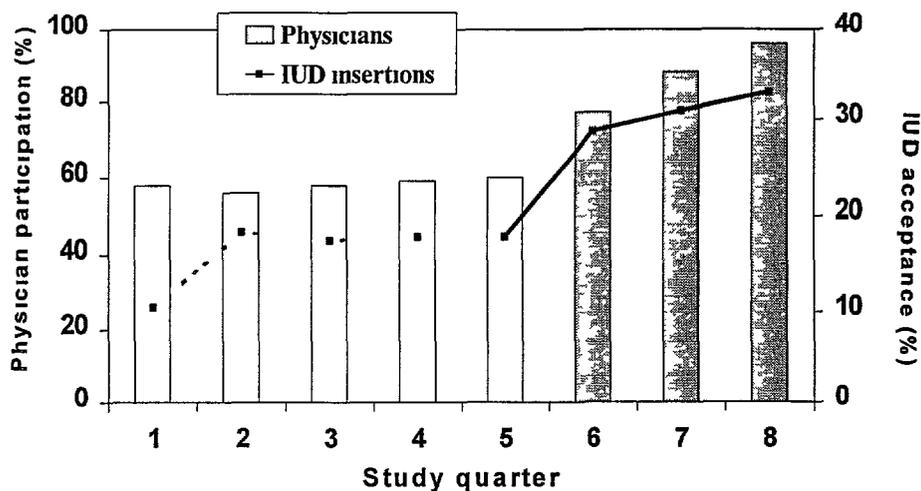
1. For all women admitted for delivery or treatment of abortion complications, the admission nurse asked the client if she would like an IUD prior to discharge. This information was registered on the client's intake form.
2. The attending physician was required to note IUD insertions on the client's intake form. If the client had requested an IUD and the physician did not insert one, he/she was required to write the reason for non-insertion (e.g., medical complications, client change of mind, etc.) on the intake form.
3. Physician compliance was monitored by inspection of client intake forms. Management issued quarterly reports to all attending obstetricians, informing them of their individual performance and Promedica as a group.

Figure 8
Chronology of Promedica program development and monitoring activities



The impact of the management decision on provider behavior is clearly seen in the following graph. The percentage of physicians inserting IUDs is shown in the bars, which are shaded to highlight performance following the management decision. The line shows the percentage of deliveries with a postpartum IUD insertion. The solid portion shows performance after the management decision.

Figure 9
Evolution of Postpartum IUD Provision

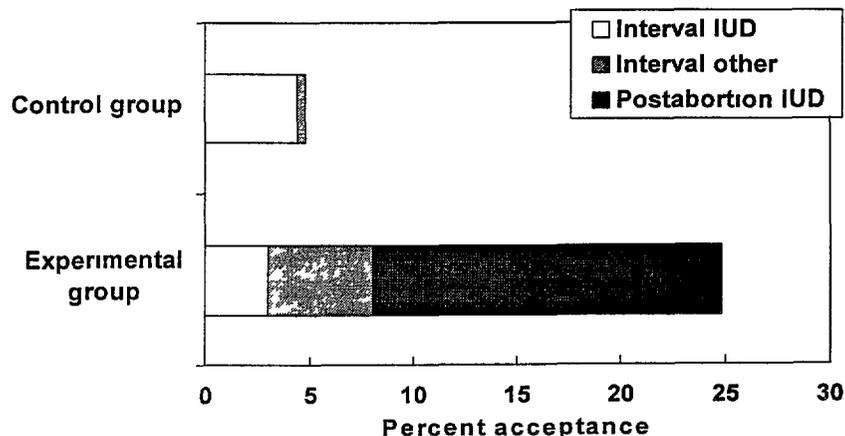


Within 3 months, the proportion of physicians providing postpartum IUD insertions jumped by 28 percent and by the end of the observation period, all but one obstetrician were routinely providing in hospital insertion. The proportion of maternity cases which received IUDs increased in a similar manner.

For the most part, women who accepted an IUD immediately following treatment for abortion complications were not likely to have accepted a method post-discharge. Comparison of contraceptive acceptance rates within six months post-discharge showed that women who were offered an IUD in hospital were more likely to have accepted a contraceptive method from Promedica than women in the control group who were not offered an IUD in hospital. Virtually all of the difference is due to immediate post-treatment acceptance.

Figure 10
Effect of offering post-abortion IUD

Contraceptive acceptance in first 6 months post-abortion



Even when family planning services were freely available to all who wanted them, the most effective manner of increasing acceptance among abortion clients was immediately following treatment for the abortion complication

LESSON LEARNED

Client interest in receiving a new clinical procedure (postpartum IUD insertion) may be insufficient to assure provider compliance, external support for provider behavior change may be needed. In the case of Promedica, this took the form of an institutional commitment to service that was reflected in administrative procedures and management supervision of individual provider performance

PERU

Non-governmental organizations in Peru cover only a small portion of the family planning market. USAID began to cut back NGO subsidies in the early 1990s, with the result that a few of the smaller organizations have already disappeared. The largest Peruvian family planning NGO is INPPARES, the IPPF affiliate, which maintains a central clinic in Lima and smaller outlying clinics and community programs. Following the Cairo meetings, INPPARES expanded its service capacity to include a larger array of reproductive health services. However, many clients were unaware that the new services were available (when asked what *new* services they would like to see added, fully 34% of clients mentioned STD treatment, prenatal care, cancer screening, and other services *already* offered), and clinic capacity was significantly under-utilized.

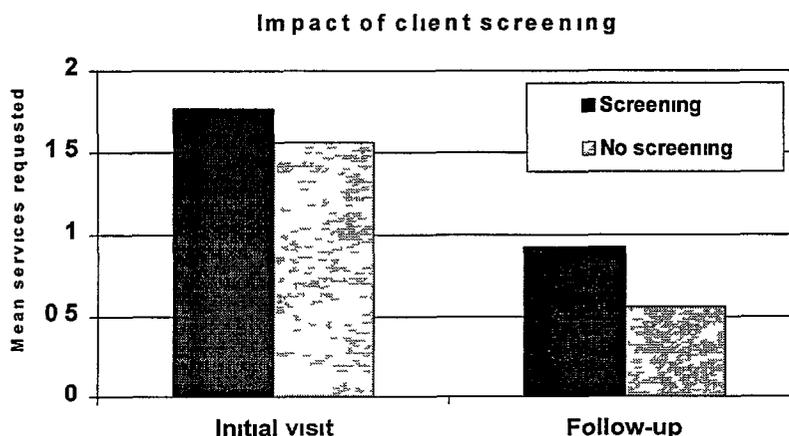
INPPARES designed a client screening device to identify clients in need of other reproductive services. It consists of a pamphlet describing the following potential health problems:

- breast and cervical cancer
- reproductive tract infections
- general complaints, including headache, fatigue, indigestion, shortness of breath, etc
- signs of psychological stress, including insomnia, lethargy, etc
- child health problems, including low weight, hyperactivity, motor development, etc

In collaboration with The Population Council/INOPAL III Project, INPPARES tested the impact of proactive client screening on services requested and return visits. Over a 4-week period on randomly-selected days, the clinic receptionist gave each new client a screening pamphlet and explained its use with a flip chart. On the other days, standard clinic practices were followed and new clients did not receive the screening pamphlet or orientation. Attending physicians were given no special instructions on client care.

Information on services requested during the initial visit and the 30 days following, was taken from the clinic accounting system. Leon et al (1998) described the results of the screening process. As a group, clients who received the screening orientation requested significantly more services both during their initial visit and during the 30-day follow-up period than clients who did not receive the special orientation.

Figure 11
Mean number of services requested by new clients



Clinic revenues showed similar significant gains with client screening

LESSON LEARNED

Client inreach can take many forms and does not necessarily need to involve primary service providers
Client screening by non-medical staff can significantly increase client demand for services independent of supporting behavior by physicians

DISCUSSION

The text above describes lessons learned from independent commercial health care providers in Istanbul, Turkey, a health maintenance organization in Salvador, Brazil, and an NGO family planning association in Lima, Peru. Despite differences in country and services settings, the lessons learned are remarkably consistent with one another, and can be summarized in three main points.

Lesson Learned #1 Traditional advertising-based outreach promotion has little direct impact on client volume, referrals, or types of services provided (Turkey)

Lesson Learned #2 Increasing client interest in or awareness of the availability of family planning services, without changing provider behavior, does not necessarily translate into increasing family planning services delivery (Brazil, Turkey)

Lesson Learned #3 Changing provider behavior by applying explicit, standardized screening tools or focused inreach promotion can increase service volume (Peru, Turkey)

These lessons learned are amply supported by the marketing and health care literature. Gelb and Johnson (1995) flatly state that "word of mouth is more effective than advertising" in promoting health care facilities. They buttress their argument with Mangold's (1987) literature review which concluded that word of mouth communication is more effective than advertising in motivating purchase of services and Murray's (1991) report that consumers find word of mouth communications from family and friends to be more trustworthy even than referrals from other physicians. SOMARC work with the Mexican NGO, MEXFAM, further demonstrates the efficacy of interpersonal communication motivating all clinic staff to "talk up" clinic services both within the facility and outside among their friends and acquaintances increased clinic service volume by 9-10 percent within a few months.

While word of mouth from family and friends effectively motivates clients to choose one provider over another, it is up to the provider to broaden the services delivered once the client has arrived at the facility. Several researchers have pointed out the difficulties in overcoming provider inertia. Stanaland and Gelb (1995) suggest that because most physicians do not derive significant earnings from prevention, there is little incentive for them to perform preventive procedures. Nevertheless, training in specific provider behaviors and implementing patient-specific provider prompts can effectively change providers' behavior (see Wender (1993) and Cohen et al (1994)).

The challenge to family planning services marketing is to effectively scale up these findings throughout the private sector. This will require dealing with the following issues:

1. What are the most promising targets of opportunity for services marketing?
2. What keeps providers from proactively offering wider services?
3. What can providers expect from services marketing?
4. How to monitor progress in services marketing?

Issue #1 What are the most promising targets of opportunity for family planning/reproductive health services marketing?

Not all providers or consultations are compatible with proactive service delivery. Any practice that sees large numbers of women of reproductive age, either as clients or as caretakers (e.g., pediatrics), is a potential candidate. Within these practices, providers may need guidance to identify the most appropriate opportunities for inreach. Postpartum and abortion-related visits are a definite indication for

family planning counseling, illness-related consultations probably less so. Prenatal family planning counseling is important for motivating postpartum acceptance, especially in the immediate postpartum period, but providers may find it better to wait until the third trimester to introduce the topic.

Another issue in provider selection is the setting – whether to concentrate efforts on multiple-provider settings such as hospitals and polyclinics, which have larger case loads? This depends on several factors. First, larger settings also have multiple levels of bureaucracy, getting to the attending physicians may mean going through directors and managers. Second, salaried physicians in group settings may be less motivated to change their behavior than physicians in their own practices, unless there is an external “enforcement” system in place. Finally, in some countries, stand-alone practitioners as a group may see more high-priority cases, such as induced abortion, than multiple-provider practices, failure to involve the smaller practices will limit the impact of the initiative.

Issue #2 What keeps providers from proactively offering wider services

We have discussed the problem of general inertia and physicians’ perception that they are already proactively offering services. In Turkey, clients’ reports notwithstanding, many physicians reported that they routinely counseled all their abortion clients in family planning.

Some observers believe that physicians have the false impression that proactively expanding services will interfere with or reduce current service volume. For example, in Turkey it is felt that some abortion providers believe that abortion is a repeat business and that offering family planning would cut down this business. Is the premise true, and if so, would providing accurate information to providers help overcome their resistance to the new behavior?

At the level of KAPS facilities in Turkey, approximately half of the abortion clients (57% of abortions scheduled, 54% of abortions performed) were new to the facility and 10 percent appeared to be repeat abortion clients. At the population level, examination of total abortions to women ages 40-49 suggests that half of urban women in Turkey receiving an abortion will *not* go on to have another abortion in their lifetime (1996 DHS, ever-married urban women), and only one in four urban women receiving an abortion will go on to have 2 or more abortions in her lifetime.

Therefore, in Turkey – with high induced abortion rates – only one in four abortion clients can be expected to return to the same facility for another abortion at any time in the future. Only one in eight can be expected to return to the same facility for more than one abortion in the future. These proportions will be lower in countries with lower overall induced abortion rates. *Offering family planning to abortion clients is a good way to convert a one-time client to a long-time client.*

Issue #3 What can providers expect from marketing

The impact of marketing on any provider’s service volume will depend on the profile of existing service-seeking. Providers should be aware that client needs differ. If most visits are compatible with proactive expanded service delivery (e.g., family planning associations expanding into other reproductive health), inreach marketing can increase the total services offered/sold (Peru example). If most visits are not compatible with proactive expanded service delivery (e.g., practice dominated by

illness and prenatal), inreach marketing may not increase total services offered/sold during any one client visit. Nevertheless, providers may benefit from an improved image of their practice, especially if their existing clientele return for additional services or refer their friends and relatives. The traditional components of the marketing mix – word of mouth communication vs mass media, inreach vs outreach promotion, etc – must be adjusted to accommodate the special needs of services (as opposed to products) marketing.

Issue #4 How to monitor progress in services marketing

Service statistics in the public and subsidized sectors are weak at best, in the private commercial sector, provider service statistics are non-existent and self-reports unreliable. Even if programs invest in office accounting systems and technical assistance, prevailing economic and legal conditions may discourage commercial providers from keeping and reporting the kinds of data that services marketing interventions need for monitoring. Our experience suggests that it is preferable to use some kind of client intercept survey (case review) for facility-based monitoring and population-based survey (like DHS) to measure impact at population level. Programs should also consider conducting and updating censuses of the universe of service providers to measure expansion of coverage.

CONCLUSIONS

Family planning/reproductive health services marketing has much in common with other efforts to increase physician involvement in preventive care. Putting theory into practice requires going beyond technical competence. Wender's (1993) review of the cancer literature cites four provider-specific obstacles to prevention: *lack of time, lack of expertise, lack of positive feedback, and distraction by other health problems*.

1 Lack of time

Providers need help in using their time more effectively because it is neither realistic nor practical to increase the amount of time allotted per client visit. In Turkey, the majority of KAPS clients spent less than half an hour – start to finish – in the facility. The post-abortion initiative focused on short client messages that could be delivered “on the margin”, in the space of two minutes.

2 Lack of expertise

Lack of knowledge in counseling techniques may be a greater barrier than specific technical knowledge. The early KAPS training in Turkey focused on clinical issues. Post-abortion family planning service delivery did not increase greatly until KAPS focused orientation on the abortion-related consultation. Similarly, the Peru case instituted structured client screening on specified potential areas of need. It is important to note that both of these focused interventions required less time and fewer resources than the traditional group training.

3 Lack of positive feedback

Providers may not believe that their advice is either needed or that it makes a difference. Day-to-day practice does not always give direct feedback on adequacy or effectiveness of provider behavior. Promedica in Brazil instituted explicit feedback on provider performance as part of their management system. The SOMARC client intercept surveys in Turkey gave KAPS providers quantitative information on their performance.

4 Distraction by other health problems

Many client visits are motivated by a chronic or acute health problem. Providers need assistance in assessing which client visits are appropriate for introducing advice about prevention without shortchanging the patient's need for curative care or exacerbating the time barrier. In Turkey, KAPS modified the inreach approach from the generic "make every client contact count" to a focused emphasis on high-need situations such as post-abortion care.

Services marketing is an effective and viable way to increase commercial and not-for-profit involvement in family planning and reproductive health. To reap the benefits of this approach, providers and their staffs need assistance in changing their own behavior to become more proactive with their clients.

Bibliography

- Cohen, SJ, Halvorson, HW, and Gosselink, CA, 1994 Changing physician behavior to improve disease prevention *Preventive Medicine*, **23**, 284-291
- Foreit, KG, de Castro, MPP, and Franco, EFD, 1989 The impact of mass media advertising on a voluntary sterilization program in Brazil *Studies in Family Planning*, **20**, 107-116
- Gelb, B and Johnson, M, 1995 Word of mouth communication causes and consequences *Journal of Health Care Marketing*, **15**, 54-60
- Leon, FR, Velasquez, A, Jimenez, L, and Calderon, A, 1998 Increasing demand for reproductive health services in a Peruvian clinic Unpublished paper, The Population Council
- Mangold, WG, 1987 Use of commercial sources of information in the purchase of professional services what the literature tells us *Journal of Professional Services Marketing*, **3**, 5-17
- Murray, KB, 1991 A test of services marketing theory consumer information acquisition activities *Journal of Marketing*, **55**, 10-25
- Stanaland, AJS and Gelb, BD, 1995 Can prevention be marketed profitably? *Journal of Health Care Marketing*, **15**, 59-63
- Wender, RC, 1993 Cancer screening and prevention in primary care *Cancer*, **72**, 1093-1099
- World Bank, 1994 The organization, delivery, and financing of health care in Brazil agenda for the 90s Report No 12655-BR

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