

PD LAB 800
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SOMARC II

CONTRACEPTIVE SOCIAL MARKETING

PD-ABK-700

Submitted to:

AID/Office of Population
Family Planning Services Division
Rosslyn, Virginia

**SOMARC AND JHU/PCS ASSESSMENT
FOR A FAMILY PLANNING PROJECT**

IN PAPUA NEW GUINEA

July 9 to August 1, 1989

Prepared by:

John Stover
Don Levy
Rita Leavell
SOMARC/The Futures Group
1101 Fourteenth Street, NW
Washington, DC 20005

Edson Whitney
PCS
The Johns Hopkins University
Baltimore, MD

Under Contract No. AID/DPE-3051-Z-00-8043-00
and Contract No. AID/DPE-3004-A-00-6057-00

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
APO	Aid Post Orderly
CBD	Community Based Distribution
CDC	Centers for Disease Control
CIF	Cost, Insurance, Freight
CSM	Contraceptive Social Marketing
DOH	Department of Health
ESEAOR	East and Southeast Asia and Oceania Region
FOB	Freight on Board
FPA	Family Planning Association
GoPNG	Government of Papua New Guinea
IEC	Information, Education, Communication
IPPF	International Planned Parenthood Federation
JHU	John Hopkins University
K	Kina
KABP	Knowledge, Attitudes, Beliefs, Practice
KAP	Knowledge, Attitude Practice
MCHFP	Maternal Child Health Family Planning
MIS	Management Information System
NGO	Non-Government Organization
OTC	Over-the-Counter
PCS	Population Communication Services
PIPPA	Pacific Islands Planned Parenthood Affiliation
PNG	Papua New Guinea
PVO	Private Voluntary Organization
SOMARC	Social Marketing for Change
SPAFH	South Pacific Alliance for Family Health
STD	Sexually Transmitted Diseases
TFG	The Futures Group
TFR	Total Fertility Rate
USAID/RDO SP	United States Agency for International Development Regional Development Office, South Pacific
VFT	Vaginal Foaming Tablet
YO	Year Old

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I. EXECUTIVE SUMMARY

On request from USAID/RDO SP Suva and the Department of Health Government of Papua New Guinea, a team from SOMARC/The Futures Group and Johns Hopkins University/PCS visited Fiji and Papua New Guinea (PNG) to assess the possibilities for a social marketing project on family planning in PNG. The team was asked to provide the outline of a plan for such a project and to provide USAID and GoPNG with recommendations for follow-up action.

The visit was timed to overlap with the arrival of the AIDS/COM team to ensure that there was appropriate coordination in project development such as condom social marketing. After an initial briefing in Suva, Fiji, the team spent two weeks from July 14 to July 28 in Papua New Guinea, discussing GoPNG's plans for family planning intensification and assessing the needs and capabilities of the public and private sector to support a family planning project. The team met with government and health officials, private sector companies, and relevant NGOs in Port Moresby and several provinces to assess the status of family planning information, services and contraceptive supply, and the marketing capabilities in the country.

As the team met with various health officials and visited clinics and facilities in field trips to the provinces, it became apparent that there are several constraints to the delivery of family planning services in the government health system and in the potential social marketing project. These include:

- o The lack of training for the majority of health workers in family planning services and counseling;
- o The need for a responsive and consistent contraceptive supply system;
- o Guidelines that instruct health workers not to provide injectable contraceptives to women with fewer than four children, and
- o Guidelines that instruct health workers not to provide family planning services to unmarried women or men.

Because of the potential for increased demands on both the private and public delivery of family planning services that a social marketing campaign may generate, these constraints will need to be addressed and are discussed further in this report.

It is the team's assessment that the necessary infrastructure exists in both the private and public sectors to support a social marketing approach to family planning in Papua New Guinea. Of further significance is the commitment of the Department of Health and provincial health workers to addressing the concerns of family planning and their positive (sometimes enthusiastic) response to the potential of a social marketing intervention.

With contraceptive prevalence between 3 and 4 percent and a fertility rate of 5.4, there is a need and an opportunity to improve family planning awareness and increase usage.

The Johns Hopkins University/Population Communications Project could provide the technical assistance to develop a program to include general family planning concept demand generation, training in counseling and interpersonal skills for health workers, and informational and motivational materials for family planning providers and clients. This type of preparation of the public system and increased public awareness of family planning is a vital base for the further development of a social marketing program.

In conjunction with the above steps, SOMARC The Futures Group would assist in the development of a contraceptive social marketing program to provide widespread availability of nonclinical contraceptive products using the capabilities of the commercial sector. Three products--a condom, a low dose oral contraceptive and a vaginal foaming tablet--would be provided by USAID or another donor, packaged and branded in ways appropriate to the consumers of Papua New Guinea, and distributed throughout the project areas to pharmacies and trade stores using commercial distributors. Condoms and vaginal foaming tablets would be distributed as widely as possible, given the needs of the STD and AIDS programs, but only selected trained trade store personnel would offer the oral contraceptive.

A review of the anthropological literature as well as market research including baseline KAP and qualitative research would be used in the development of appropriate messages and materials for both general family planning motivation and brand method promotion. Traditional and non-

traditional media such as TV, radio, theater and music groups, as well as point-of-sale materials, would be used by both PCS and SOMARC in coordination. Community health workers or sales promoters might be used on a trial basis to promote and motivate in some project areas and to reach the more rural populations.

Projections of the potential impact of social marketing on contraceptive prevalence range from a low of 0.3 percent to a high of 0.6 percent in the first year, and rising to between 2 and 3.2 percent at the end of the fifth year. That equates to the social marketing program generating between 2,800 and 5,600 new users in the first year through the private sector only, and rising to between 20,600 and 32,900 new users at the end of the fifth year. The program is also expected to increase usage of family planning services in the public sector.

The total cost of the CSM program would amount to approximately \$2.8 million (excluding commodities) over three years. These costs include a resident advisor and PCS services, together representing more than one-half (52 percent) of the implementation costs. Both of these costs, though not usually included in a social marketing activity, are considered necessary for the success of the intervention in Papua New Guinea. The resulting cost per user at the end of three years would range from \$82 (low prevalence projection) down to \$38 (high prevalence projection).

Given the relatively high investment cost to implement a full-scale national social marketing program, and the uncertainty about the potential impact, it is recommended that a test market project be undertaken in the first instance.

The test market would be conducted in the provinces of Morobe, Simbu, Eastern Highlands and Western Highlands over a period of 26 months at a cost of \$813,000 (excluding commodities). Of this amount, approximately \$350,000 could be financed from SOMARC II central funds. The remainder, representing PCS implementation costs, would be required from USAID/RDO/SP through a buy-in to PCS. The objectives of the test market would be to:

- o Evaluate the impact of a social marketing program so as to be able to more accurately project the effect on a national scale;

- o Test the systems and mechanisms for program implementation and get a more accurate fix on costs;
- o Achieve a better understanding of the prevailing and countervailing attitudes to contraceptive usage, and how such attitudes would affect potential prevalence; and
- o Design and test IEC messages, service provider and client materials, as well as refining training of trainers and service providers' curricula in interpersonal communication and counseling skills.

A full evaluation of the test market exercise should then lead to a recommendation as to whether a national social marketing program should be implemented.

The SOMARC team was requested to review ways in which the social marketing program may "dovetail" with AIDS prevention and control efforts. Both programs would benefit from coordination in research, IEC, condom marketing, and to some extent service provider training and the possible sharing of some administrative facilities and cost. Beyond these discrete areas, the peculiarities of both interventions mandate individually tailored activities. Further, until both programs are designed, it would not be possible to quantify the cost benefit of any coordinated efforts.

Next Steps

- o GoPNG and USAID/RDO SP/SUVA to consider the findings of the assessment and provide concurrence for the implementation of the test market activity.
- o USAID/RDO/SP to provide additional funding for JHU/PCS activities in test market as well as the required contraceptives for the test market effort.
- o GoPNG to continue to work toward the promulgation of a National Policy and addressing those constraints that may have a negative impact on growth in contraceptive prevalence.

SOMARC The Futures Group and JHU PCS are prepared to respond in the immediate future to a request from USAID and GoPNG for technical assistance in the further development of a family planning communication and social marketing project.

II. BACKGROUND

At the request of USAID RDO SP Suva, and the Department of Health, Government of Papua New Guinea (reference cables: Suva 1500, April '89 and Suva 2142, May '89), a team comprised of John Stover, Don Levy and Rita Leavell from TFG SOMARC II; and Edson Whitney from JHU/PCS visited PNG from July 14 to July 28, 1989. The team's visit coincided with an AIDSCOM and CDC team in order to facilitate any feasible and appropriate coordination in program planning. The scope of work for the SOMARC team encompassed the following:

- o To determine acceptability and support for the use of social marketing techniques in the delivery of health education, population family planning and AIDS prevention programming;
- o To assess mass media potential and capabilities in Papua New Guinea to support social marketing efforts;
- o To identify and formulate ways in which social marketing can be incorporated into PNG components of USAID regional population family planning and or AIDS prevention and control projects.

In essence, the team was required to assess the feasibility of a contraceptive social marketing program, explore any possible linkages with an AIDS prevention program, and provide the DOH and USAID with recommendations for future implementation. In executing the scope of work, the team was briefed by USAID in Suva, spent two weeks in Papua New Guinea meeting with officials from the government, private sector companies, officials from international organizations and NGOs in the National Capital District, Morobe, Madang and Eastern Highlands provinces. (See List of Persons Contacted.) At the end of the visit, the team debriefed USAID both in Sydney and in Suva.

The team wishes to take this opportunity to express its appreciation for the hospitality, goodwill and cooperation of officials of the Department of Health. Special thanks to Drs. Quinten Reilly, Timothy Pyakalia, Tomkins Tabua and Sister Dawa Masere. Our thanks also to Barry Karlin and Andy Piller for their guidance and assistance during our visit to Papua New Guinea.

III. THE COUNTRY SITUATION

A. Introduction

Papua New Guinea consists of the eastern half of the island of New Guinea (the mainland) and about 600 islands in the Bismarck and Solomon Seas to the north and east of the mainland. The largest islands after the mainland are New Britain, New Ireland and Bougainville. The center of the mainland is a densely populated, fertile mountain region. The lowland savannah and swampy areas are less fertile and sparsely populated. The rough terrain has isolated many population groups, resulting in over 700 distinct languages. Most of the population have some knowledge of Pidgin, Motu or English.

B. Demographic Situation

The first complete census in PNG was conducted in 1980. It reported a population of 3 million people. The only previous censuses (1966 and 1971) covered only 10 percent samples in rural areas. Thus, it is difficult to determine the growth rate precisely, but it is estimated at about 2.3 percent. A new census is planned for 1990.

The Highlands Regions contain 37 percent of the population while 19 percent are in the Papuan (southern) Region, 28 percent in the New Guinean (northern) Coastal Region and 15 percent in the Islands Region. Only 16 percent of the population live in urban areas and 43 percent of the population are under age 15.

The current population is estimated to be about 3.8 million. The crude birth rate is probably about 46 and the crude death rate is about 13. The total fertility rate is about 5.4. It is unclear whether fertility has declined in recent years. Several factors act to limit fertility in traditional PNG cultures: long periods of breastfeeding (an average of 2-3 years in some areas), a strong tradition of postpartum abstinence and pathological sterility (due to venereal disease). The use of contraception may be no more than 2 percent of married women of reproductive age, although 1984 health records reported 1 percent prevalence among women of childbearing age. The 1988 summary of provincial reports listed 3.6 percent national average use either by new acceptors or continuing acceptors (distinction not made) based on a total estimated population of 767,600

women aged 15-44 years. Recent information does not exist on knowledge, attitudes and practices of family planning. A KAP survey was recently conducted in three provinces (Enga, Morobe and Central) as part of a UNFPA pilot project, but the results from that survey are not yet available.

C. Economics

Since 1985 the economy of PNG has experienced real annual growth rates of 4.8 percent with an inflation rate of under 5 percent. Exports in 1988 valued (kina) K1.23 billion, foreign reserves stand at K400 million covering four months of imports, with very manageable budget deficits of K230 million and overall external debt of U.S. \$2.2 billion. The country has extraordinary reserves of gold, copper and silver; is rich in forests and fisheries; and has a potential for export production of oil palm, coffee, cocoa, tea and coconuts. However only one-eighth of the labor force is formally employed, one-third of which is in the public sector. The rest are engaged in small holdings of cash crops or subsistence farming, which, however, does provide disposable income. The economy has been affected by the closure of the largest copper mine (Bougainville) which contributes close to 20 percent of government revenues, resulting in severely restricted government expenditures, particularly in the social services. The country continues to be supported by Australian aid currently running at around \$250 million a year.

PNG has an open economy and society, good telecommunications, satellite television, and dependable air transport (both private and government owned). On the other hand, ground transport is difficult, electricity is concentrated in 25 small urban centers in addition to the mining sector, and there is a high cost to doing business (salaries and overheads). (See Appendix 1.)

The GNP per capita of PNG is over \$600. A recent report on PNG prepared by Peat, Marwick for the U.S. Embassy states that 72 percent of the population are engaged solely in subsistence activities; thus, only 28 percent of the population participate in the cash economy. However, others challenged this assessment saying that small trading stores carrying beer, soft drinks and cigarettes reach into the remotest villages.

D. Family Planning

PNG currently has no formal population policy. Efforts to develop a policy began in 1975. A draft policy was submitted to the National Executive Council in 1978 but it was rejected. A new attempt was made in 1982, but the policy was rejected by Parliament. At that time Parliament also abolished the Family Planning Division within the Department of Health and gave all responsibility for family planning activities to the provincial governments. In 1987 a new effort began to draft a policy, and a workshop in 1988 drafted policy guidelines. These guidelines have not yet been discussed by the National Executive Council or promulgated by Parliament. The new guidelines call for "the basic rights of individuals and couples, especially the right to decide freely and responsibly on the number and spacing of their children and the right to information on and access to the means to do so." The National Health Plan 1986-1990 gives a stated objective of reducing the crude birth rate to 30/1000 by 1990, but gives no other targets for implementation on a national or provincial basis.

E. Public Sector Family Planning Services

Family planning services in the public sector are integrated with maternal child health and are provided through 19 hospitals, 468 health centers and health subcenters, and 2,331 aid posts. The current knowledge base and skills of the service providers are limited through a lack of appropriate training or re-training counterproductive guidelines, and cultural idiosyncracies. Specifically the training of doctors, nurses, health extension officers, community health workers and aid post orderlies devotes very little time and substance to family planning. Further, guidelines directing service delivery require the presence of a husband to provide approval for his wife to use a contraceptive, restrict contraceptive use to married women, and restrict use of the injectable to women who have had at least four children.

Contraceptive prevalence through the public sector only is currently estimated at 3.6 percent of women of reproductive age (WRA). (See Table XV, pg. 53.)

Prior to the current economic problem, GoPNG purchased most of the contraceptives for public sector use; for example 84,000 units of Depo-Provera were purchased for the current fiscal year at a cost of \$.95 per unit.

Recently, a greater quantity of contraceptives is being donated by UNFPA and USAID. Two types of pills are available--Microlut for breastfeeding mothers and Eugynon for other women. Eugynon is now being replaced by a low dose pill. All contraceptives are distributed free of cost.

The family planning program is largely implemented through the provincial governments. The Department of Health coordinates training and planning activities. Family planning activities in the Department of Health are located under the Coordinator for Family Health. Family Health is one of seven divisions under Primary Health Services and uses an integrated concept of delivery with MCH activities. The delivery of family planning services depends on the commitment of the provincial government to family planning. There has been no family health education for health workers for several years in PNG. The Division has, however, produced some print material (see Appendix 2), radio programs and spots (Appendices 3 and 4) and covers family planning issues in a publication called Health News--a newspaper with a general audience circulation of approximately 50,000 monthly. Occasionally the Division coordinates with EM TV, a discussion program on health issues including family planning.

E. Family Planning Outside the Public Sector

Outside the public sector, family planning services are provided by the Family Planning Association (an IPPF affiliate), private clinics, and commercial sales primarily through pharmacies.

1. FPA

The FPA operates through four clinics and provides contraceptives (pills, injectables, condoms and Lippes Loop), counseling, training and IEC services. Little usable data are available on the acceptor rate in clinics. Clients pay a clinic fee and are provided contraceptives at no extra cost. Condoms are also marketed through the mail at K6 (\$7.08) per box of 100. Preferred methods in the clinics are the injectable and the pill. Condoms are seldom requested (stock seen was badly outdated) and use of the Lippes Loop is inhibited by the lack of trained personnel. Family planning is promoted through a once-weekly radio program, occasional television and press advertising and some print material. Additionally, outreach activities are targeted at in- and out-of-school youth and women's groups in villages. A limited CBD program is being implemented but

success and growth are being hindered by a lack of supervisory personnel. The organization receives assistance from IPPF through the ESEAOR field office in Papua New Guinea as well as being under the IPPF umbrella subgrouping PIPPA.

2. Private Clinics

There are approximately 200 private clinics throughout PNG operated by private physicians which include family planning as part of the service mix. These clinics purchase contraceptive supplies from pharmaceutical wholesalers and retail to clinic clients. Clientele is primarily expatriate residents and upper-income locals.

3. Private Sector Contraceptive Marketing

A wide variety of contraceptive methods is available in pharmacies located in urban areas throughout PNG. Products are mostly imported by wholesale distributors from Australia and in a few instances imported directly by individual retailers.

a. Condoms

There are more than a dozen different brands of condoms mostly in two presentations--3 pack and 12 pack. A house brand of Johnston's Pharmaceuticals is marketed in a 10 count. The majority share of market appears to be held by Durex brands followed by Ansell and a variety of other Asian brands. Prices for a 3 pack range from K0.95 to 2.50 (\$1.12-\$2.95), and for the 12 pack from K3.10 to K6.90 (\$3.66-\$8.14). In the areas outside Port Moresby prices are a little higher reflecting the cost of transportation. It is estimated that sales through pharmacies are approximately 250,000 condoms per year. Condoms are openly and sometimes prominently displayed on top of counters in pharmacies. There is however no point of sale, promotional or advertising support for any brand. The impression is that condoms are purchased more as a prophylactic than as a contraceptive.

b. Pills

Pharmaceutical regulations require a prescription for the purchase of the pill. However, a clinic card or the packaging from a cycle of pills could also be accepted in lieu of a prescription. Products are available in single-cycle or 4-cycle presentations with more than 15 different brands available. The most popular brand is Microlut used by breastfeeding mothers and retails at K3 to K3.50 per cycle. Microgynon, Nordette, Norinyl and Triquilar are also relatively popular among pill users and retail between K3 and K4 per cycle (K9.70-10.30 for a 4-cycle pack). Very rough guesstimates of sales through pharmacies amount to 50,000-60,000 cycles per year. Indications are that consumers purchase a predetermined brand usually on the advice of a peer, relative or neighbor, sometimes on the recommendation of the clinic. Brand choice is not likely to be made or influenced at the point of sale. Manufacturers representatives (Schering, Wyeth, Syntex), detail doctors and private clinics, but no promotional or educational material was in evidence.

c. Injectables

Private sector sales of Depo-Provera are relatively low, mainly to private clinics and sometimes as a back-up for out-of-stock situations in the public sector. The product wholesales for K5.30 (retail K7) and is only supplied on order.

d. Other Contraceptives

Pharmacies reported carrying "a few" IUDs (Lippes Loop and Copper T280) as well as the diaphragm. Delfen foam was displayed in all pharmacies and retails for approximately K15-K16 for a 20-gram package. Indications are that these methods are required mainly for expatriate residents.

F. Some Constraints to Family Planning

The family planning situation in PNG is complicated by a number of constraints that limit the effectiveness of existing services. Some of these constraints are currently being addressed, but should be listed anyway.

- o One of the most important constraints is probably the **lack of training** for the majority of **health workers** in family planning services and counseling. This appears to be a problem even at the medical student and nursing level, since few students have the opportunity or facilities to practice and develop such clinical skills as IUD insertion. A vigorous training program for government health workers would probably have to be undertaken before any promotional activities begin to ensure high-quality services for those who seek help at government health centers. This is addressed in the plan outlined later.
- o The lack of a specific population policy does not seem to be a major constraint today, although it could become more important when family planning activities become more visible in the future. It would be a useful protection for family planning activities if the policy could be promulgated soon.

Of more immediate concern are some health department guidelines concerning the delivery of health services:

- Currently government health workers will not provide **family planning services to unmarried men or women**. Although a circular signed by the Secretary of Health has been sent rescinding this "policy," this will need reemphasis in any retraining program.
- In order for a woman to receive family planning services from a government health post, her **husband must** accompany her to the post to **give his permission**.
- **Injectable contraceptives are not provided to women with fewer than four children**. This is apparently in response to a fear that Depo-Provera produces infertility. Although Depo-Provera is banned in the U.S., it is a very popular method in more than 90 other countries in the world, especially considering that the risk of pregnancy-related deaths far outweighs the controversial health concerns raised. The fears may be due to lack of information and training about return to fertility or due to concurrent high levels of secondary infertility. The above policy deserves review as one of the constraints on an increase in contraceptive use.

- o **Oral contraceptives are considered prescription-only drugs.** This regulatory constraint would need to be addressed to provide the widespread availability of the pill through the private sector. Although this regulation is often ignored in practice, it would become an issue particularly if a social marketing program were implemented.

- o **A responsive and consistently available contraceptive supply system** must be assured in the public health clinics to ensure that those clients who decide to try family planning find both the public and private sector prepared to serve them. Even advertising for specific contraceptive brands often has a "halo" effect in increased family planning visits to the public sector.

IV. HOST COUNTRY RESOURCES

A. The Distributive Sector

There is an efficient, well-developed and competitive distributive sector involving large importers/agents, a wholesale network and retail operations that penetrate to the villages. It is estimated that there are approximately 250 established wholesalers, approximately 3,000 permanent trade stores (hundreds more are seasonal or transient) and 25 pharmacies. Very large operations such as Steamships and Burns Phillips import and handle their own distribution of a wide range of merchandise, e.g., vehicles, machinery, food, pharmaceuticals, raw materials, cosmetics, etc. Other importers specialize in pharmaceuticals, health and beauty aids, and still others in food and household items. Custom duties are imposed on most imports, ranging from 110 percent on large cars, 80 percent on luxury items such as electrical goods to 8.5 percent on rubber products, including condoms. Additionally, sales taxes are imposed by some provincial governments and levied at the point of purchase. (Eastern Highlands imposes a 3 percent sales tax.) To better understand the distribution system, interviews were held with three pharmaceutical distributors and two distributors of general merchandise.

- o Johnston's Pharmacies. Based in Port Moresby, Johnston's handles a very wide range of ethical and OTC products including contraceptives. The company owns eight pharmacies in Moresby and other urban centers, distributes to wholesalers and has a thriving mail order business. There are approximately 40,000 post office boxes (no delivery of mail) which become part of the distribution network. The organization has a large, efficient warehouse and a computerized management information system. Orders are received over the phone, in person or in the mail--there is no sales force. Pharmaceutical manufacturers provide their own staff of detailers to cover doctors and pharmacists. Operating margins are as follows:

Distributor	-	15% on CIF
Wholesaler	-	25% FOB Moresby
Retailer	-	Up to 85%

The purchaser (wholesaler or retailer) always covers the cost of transportation.

Johnston's currently handles 14 different brands of oral contraceptives (average sales of 500 cycles per month), nine different brands of condoms (average sales of 11,500 per month), Depo-Provera and other contraceptive methods. The organization has the necessary capability to be a potential distributor for a social marketing program.

- o New Guinea Wholesale Drug (Morobe Pharmacies Pty. Ltd.). Based in Lae, this organization owns eight pharmacies as well as being agents for ethical and OTC products. They are the largest pharmaceutical distributors in the New Guinea mainland area, with a sales staff of two persons, a large warehouse and computerized systems. The company distributes regularly to about 100 wholesale outlets concentrating distribution in the mainland area and the islands.
- o North Solomons Pharmacies Pty. Ltd. New and relatively small, this organization is based in Moresby. Their intention is to provide distribution for own-manufactured products as well as being the agent for imported products. The organization also owns two pharmacies. Like all other commercial organizations, business is run by expatriates, with its own warehouse and computer system.
- o Sullivan's Pty. Ltd. Based in Lae, Sullivan's is a large distributor of general merchandise, listing among their brands--Nestle, Heinz, Johnson & Johnson and Colgate-Palmolive. The company operates from three major centers--Morobe Province and the Highlands, with a warehouse in Lae; the islands serviced from Rabaul; and the Gulf region serviced from Port Moresby. Sullivan's distributes directly to approximately 40 wholesalers, who in turn sell to more than 2,000 retail customers. Other customers phone in and/or collect orders from the three distribution centers.

Advertising and promotion activities are paid for by the principals but supervised by Sullivan's. Although they do not carry ethical products, they do service pharmacies, and would represent a very viable option as a potential distributor for the social marketing products.

- o Colgate-Palmolive (PNG) Pty. Ltd. Colgate has a manufacturing plant and warehouse in Lae to handle an extensive line of household detergents (liquid and powder), toilet soaps

and toothpaste. The company sells to approximately 200 wholesalers but reports that 80 percent of sales are accounted for by 15 wholesalers. Colgate allows a wholesale margin of 5-20 percent (depending on whether the product falls within price control regulations) and retail margins of up to 40 percent. Colgate also develops packaging in PNG for some of its brands, including design and production. The advertising and promotion budget for one of their largest brands (Cold Power Laundry Detergent) is approximately K200,000 in above the line expenditures and K115,000 in below the line activities.

The company was very receptive to the possibility of distributing contraceptives and would certainly bring a tremendous amount of marketing skills to a CSM program in PNG.

B. Advertising and Promotion Services

The advertising and promotion services available are of a fairly high standard and more than sufficient to meet existing demand. Most of the services are owned and managed by expatriate Australians and are associated with an organization in Australia. An Advertising Act controls the industry including the media. For example, the Act requires that 80 percent of the production value of a commercial be generated in PNG which effectively protects the fledgling production industry. The total advertising market is estimated at K10 million, with 25 percent of the total allocated to sports sponsorship.

- o David Delaney and Associates. Formerly a branch of its Australian operation, this Agency was recently purchased by its current proprietors--Rod Miller and Peter Colman who intend to change the Agency's name to "SAVI." The Agency has a staff of 14, half of whom are in creative services and lists Coca-Cola, Shell, Gillette, and Westpak Bank among its clients. Total billings are approximately K1.5 million, the majority of which is through television. The Agency operates on a 10 percent commission on media placement and a 10 percent Agency fee, which is negotiable depending on the size of the budget.

Creative strengths seem to be in television, with print and package design close behind. The Agency does not appear particularly comfortable with radio though they have some attractive jingles.

- o Human Resource Development (HRD). The Agency is part of a service group including production, promotion, retailer training and market research services with a total staff of 30 persons. The driving force of the Agency is Chris Wiley supported by Dale Rutstein, Creative Director. The major clients are Colgate-Palmolive and Johnson & Johnson for whom they produced an excellent documentary, "Baby and You," addressed to new mothers and incorporating family planning messages. The Agency's strengths are radio production and marketing. They also have been developing an expertise in social marketing, handling the ORS campaign for the Ministry of Health. The Agency works on a commission on media, plus a mark-up on production costs.
- o Walkabout Marketing (Part of the HRD Group). This is a traveling promotional troupe that carries commercial messages through product promotions into communities not effectively reached by mass media. Walkabout derived from the "Raun Raun Theatre" troupes who entertained villages but always incorporated a social message. Walkabout is currently being used by Colgate to promote the concept of brushing teeth and building brand awareness. A typical contract would cover six months and allow for the promotion of three products, seven days a week, two performances per day for three weeks in the month, costing K10,000.
- o Television Production. Production facilities are available through advertising agencies, EM TV and Pacific View Productions. Average production costs for a 30-second spot are approximately K6,000.
- o Print Production. Very high quality full-color print facilities are available. Color separations are usually prepared in Singapore (more economical than Australia). Packaging production can be obtained from New Zealand or locally.

C. Market Research Services

- o McNair-Anderson, a member of AGB Research Plc, a UK company with branches throughout the Asia-Pacific region. The company is represented in PNG by Zenith Sales and Marketing which provides fieldwork and client services. A full array of research

services are available with technical inputs and data processing being handled in Sydney.

Illustrative costs are as follows:

Focus Groups - K500 per group
Retail Audits - K500-600 per round

Quantitative Studies

Sample 2500 - K6,000-10,000

The company recently completed a television audience survey for EM TV.

- o First, part of the HRD group, also provides a range of research services, but specializes in focus groups leading to concept development. First recently prepared quantitative studies on AIDS awareness and family planning--both for the Department of Health.

D. Media Facilities

With a population of 3.5 million, PNG is known to have at least 700 different languages. Communication therefore becomes a challenge even among clans in adjoining areas. Pidgin English has evolved into a common language among the masses while the educated are schooled in "proper" English. Accordingly, the mass media on a national basis uses both Pidgin and English while the provincial media is more parochial with the language.

1. Radio

Varying mass media surveys agree that radio reaches into 80 percent of households throughout PNG making it the most popular and possibly the most influential media. The combined average audience (FM and AM) is approximately 900,000. Peak listening times are 6-7 a.m. and 7-8 p.m. The radio network is publicly owned and consists of three branches.

- o KALANG, an FM commercial channel using a "pop" format which makes it more popular with the under-35 year olds, especially those in urban and peri-urban areas. Base rate for a 30-second prime-time spot is approximately K70 (U.S. \$83). Audience size is affected by the terrain--the FM signal does not penetrate Highland Regions, and the fact that there are relatively fewer FM receivers in homes (see Appendix 5).

- o NBC KARAI, the national public broadcasting channel which carries news, features, information and education programs. The AM service provides 12 hours of broadcast daily and links with the provincial stations. All the government's propaganda is covered by KARAI which makes it at one and the same time either interesting or boring. The station is severely hampered by a lack of resources, materials, equipment and manpower. Although they do not accept commercial messages, station management would favorably consider utilizing prerecorded programs promoting family planning.
- o Kundu, a network of 19 independent AM provincial stations. Each station originates six hours of broadcast daily--the rest of the day is linked to KARAI. The majority of Kundu listeners are older rural residents who are more comfortable with broadcasts in their local dialects. The stations do not accept commercial messages.

2. Television

EM TV is a relatively new operation serving the major centers of Port Moresby, Lae, Goroka and plans for full national coverage. The service is in color using the European PAL system. The average household viewing audience is about five people but communal viewing in villages is the norm. The station is privately owned and run on a commercial basis offering opportunities for advertising spots, program sponsorship or original programming. A peak-time 30-second commercial reaching an estimated audience of approximately 280,000 would cost between K400 and K500 (U.S. \$470-\$590). Program content is dominated by U.S. series ("Cosby Show," "Miami Vice," "A-Team," etc.) with local content provided through news, sports coverage, and five weekly general interest programs (see Appendix 6).

3. Press

There are two daily newspapers and two weeklies all produced in a good quality off-set process. The largest is the Post Courier with a weekday circulation of 34,000 and weekend (Friday) of 40,000. The paper is a tabloid format with advertising page dimensions of 38 cm x 7 columns. The advertising base rate is K2.66 (U.S. \$3.14) per column centimeter or K707.56 (U.S. \$835) for a full-page ad. Spot color rates are K250 for each color. Volume discounts are available up to a maximum of 25 percent.

Niugini Nius is the other daily tabloid with a weekday circulation of 16,000 and a weekend circulation of 18,000. The casual (base) rate is K1.90 per column centimeter with a spot color rate of K175.

Wantok is a weekly tabloid published in Pidgin with a paid circulation of about 10,000. The other weekly is the Times, about the same circulation, and is used by the Ministry of Health to print and distribute "Health News."

It is generally accepted that newspapers have a pass-on rate of about 3:1 which would produce average readership of dailies of about 150,000.

4. Cinema

Primarily attended by young urban patrons, audiences average about 100,000 yearly. Advertising (35 mm film and slides) varies greatly between cinema houses depending on size, location and sometimes even the feature being shown.

5. Outdoor

Bus shelter and billboard advertising is possible, with costs negotiated according to size, location and quantity.

6. Direct Mail

Because of the absence of postal delivery services the post office rents approximately 39,000 P.O. boxes to businesses and private individuals. It is anticipated that an average of four persons would receive mail through P.O. boxes, providing a potential reach of more than 200,000 persons. Advertising agencies provide area specific direct mail services inclusive of the design and production of direct mail material.

E. Potential Implementing Agencies

The implementing agency, a prime contractor in a social marketing program, has the major responsibilities of program planning, management, marketing and monitoring. The organization must therefore possess the necessary resources and skills to effectively execute such responsibilities. In reviewing potential implementing agencies, the assessment team considered organizations from the private sector, the public sector, NGOs and PVOs. Of particular interest were two regional organizations--the Pacific Islands Planned Parenthood Affiliation (PIPPA) and the South Pacific Alliance for Family Health (SPAFH).

In the case of PIPPA, the organization comprises eight family planning family health organizations situated respectively in: Cook Islands, Fiji, Papua New Guinea, Solomon Islands, Tonga, Tuvalu, Vanuatu, and Western Samoa. The affiliation is organized by IPPF and supervised through the ESEAOR field office in Papua New Guinea. Programmatically and administratively, PIPPA is as strong as its local participants. Unfortunately the FPA in Papua New Guinea is presently undergoing a management restructuring, has limited resources and would find it very difficult to undertake additional services especially ones like social marketing, where they have had no former experience.

The South Pacific Alliance for Family Health initiates and manages maternal, child health and family planning activities particularly in the areas of policy development, IEC, training and research. The organization is made up of ten member nations: Cook Islands, Fiji, Kiribati, Niue, Papua New Guinea, Solomon Islands, Tonga, Tuvalu, Vanuatu and Western Samoa. Each territory is represented by a board member, usually the Permanent Secretary or Director of Health or their nominees. In Papua New Guinea, Dr. Daniel Johns, Director of Family Health Services in the Department of Health, is the SPAFH representative. The Alliance is based in Tonga with a staff comprised of secretary general--Mr. Joseph Sukwianomb, one program officer and program support staff. SPAFH designs programs and implements activities through in-country resources. At present, the Alliance is managing two regional projects, a number of country specific projects and is being considered by USAID RDO SP for the management of a large regional health and family planning initiative. In essence, SPAFH functions as a regional version of SOMARC. However, it is hardly likely that, given their current manpower and potential responsibilities, they would be able to assume further program management responsibilities for social marketing. It is important, though,

to establish firm linkages with SPAFH in specific program areas (e.g., policy development and research) where combined efforts will enhance success, share resources and economize on costs.

The private sector holds the greatest potential for providing a management and marketing structure for a social marketing program. Already in existence are sales, distribution, promotion and management skills and systems that could be applied to a CSM program. The advantages are that there would be minimal support required from the public sector, reduced implementation costs through the use of existing resources, and a greater potential for sustainability.

V. FAMILY PLANNING TRAINING, COMMUNICATION AND MATERIALS PRODUCTION

A. Meetings with Government of Papua New Guinea Officials (GoPNG)

Family Health Services

The team met with Sister Shirley Gideon and Sister Dawa Masere of Family Health Services in Port Moresby to discuss their activities and priorities at the national level. Srs. Gideon and Masere stated that there is a great need for information, education and communication (IEC) materials at all levels from service providers to clients. There have been little or no materials produced since the Health Education Section was abolished in 1982. Virtually no IEC materials for family planning (FP) exist in the country, a fact confirmed during field visits to four provinces.

They also confirmed that there have been few recent in-service training sessions on any aspect of family planning and that there was a need for upgrading the FP clinical skills of health workers as well as their FP knowledge and interpersonal communication and counseling skills. FPS provides funds in the amount of K2,000 (approximately U.S. \$2,350) per year to each of the provinces for training. The two sisters are available as resource people for these trainings and their expenses are paid from central funds outside of this amount. They each travel two or three times per year to assist with training sessions in the provinces.

Other topics of discussion included the need for male health workers to take the initiative to do more outreach work, especially targeted to males, and the constraints of the program insofar as it is an integrated program in which FP is only one part of the whole range of health services to be provided by each health worker.

Training Division

A meeting was held with Acting Assistant Secretary for Training Dr. Andrew Emang. It is the role of the Training Division to coordinate all training although the actual implementation of training is left to FPS and to the provincial training units. FP is a component of all basic, post-basic, in-service and midwifery training for nurses. PNG has 2,000 nurses at present and the goal is to have a total of 3,000 trained by the year 2000.

National Training Support Unit (NTSU)

The team met with Ms. Mary Biddulph, Health Educator, along with staff members Ken Cramer, Principal Curriculum Officer, Florian Yambilafuan, Training Curriculum Writer and Peppa Koka, Curriculum Development Officer. NTSU assists in developing curriculum for various in-service courses as required and also has a media unit that has facilities to design, typeset and print posters, brochures and pamphlets upon request of the DOH. NTSU is also involved in the translation of the MEDEX curriculum for the training of the new Community Health Workers (CHWs) and development and implementation of a distance education curriculum developed by the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) for in-service training of health workers.

Training at the provincial level is the responsibility of four people, one of whom is full-time and three others who have other jobs and responsibilities. These people are trained in a ten-month course held at Goroka Teachers College.

University of Papua New Guinea (UPNG)

Members of the team were requested to meet with Dr. Das and Dr. Klufio, Professors of Obstetrics and Gynecology at UPNG. It was the feeling of the doctors that not enough opportunity was given during the medical training courses for the students to have practicums in IUD insertions and sterilization procedures. One suggestion was that if there was an FP clinic at the University which provided FP services on a daily basis, this would provide the opportunity for the students to practice and gain confidence in clinical techniques. They also said that there is a definite need for a training of trainers course in interpersonal communication and counseling skills.

Department of Finance and Planning

The team met with Dr. Frank Agaru, Foreign Aid Management, and Joe Pohory of Health and Social Programs to discuss the regulations governing foreign aid coming into the country. The Department of Finance and Planning manages all foreign aid programs and allocates funds among the various departments. The team was informed that all outside aid should fit with the

government's plans for development and that the Department of Health (DOH) has a ceiling for the amount of aid money it receives in any given year. The government has no specific policy regarding funding of nongovernmental organizations (NGOs) and funding for these is done on an ad hoc basis.

The team was also informed by Dr. Agarú that the Guidelines on the National Population Policy had not yet gone up to the Cabinet level. They expected that the Guidelines might be approved in about one year's time.

Central Province

In Central Province the team visited a Health Sub-Center in the village of Tubusereia and the Central Province Health Department. Discussion with the nurses at the Health Center revealed that they had no posters, flipcharts or motivational materials for clients. They also lacked any reference materials for themselves on contraceptive methods and had not had any courses in interpersonal communication skills and family planning counseling. They said they would welcome any IEC materials and training that could help them to carry out their duties more effectively.

The team met with Assistant Secretary of Health for Central Province Dr. S. Bieb to discuss needs in this province. Central Province has 26 health centers of which 12 are government owned and operated. Dr. Bieb is the only physician in the public sector in the province. Dr. Bieb said that his priority for the province would be a family planning awareness campaign and then training for health workers in FP information and counseling. He also said that there were no IEC materials available on FP and that many of the health workers had forgotten their FP training.

Morobe Province

Meetings in Lae, Morobe Province, were held with Dr. Likei Theo, Acting Assistant Secretary of Health, Dr. K.D.P. Jayatilake, Regional Epidemiologist, Matron Ruth Lunniss, Community Health Activities Coordinator and Louis Sokalamis, Acting In-Service Training Coordinator. The primary IEC needs expressed by all of these people were an FP awareness campaign and IEC materials for both providers and clients since no materials were available in the province. It was their feeling that appropriate FP messages should deal with issues such as education expenses, shortage of land

and lack of job opportunities. They also stressed the need to target males and to use existing male health workers such as APOs and CHWs to speak to men about FP.

Local radio was seen as the best medium for an awareness campaign. The provincial radio station in Morobe broadcasts in Pidgin, not the local dialect.

Buimo Urban Health Center was also visited. This center has a staff consisting of five mission sisters, four nurse aides and one hospital orderly. They average about 25 new acceptors per month and hold a family planning clinic one morning a week.

Eastern Highlands Province

Meetings were held in Goroka with Ben L. Haili, Provincial Health Extension Officer; Julie T. Liuiko, Provincial Nursing Officer; and Opa Kairu, In-Service Training Officer, to discuss needs and priorities in Eastern Highlands Province. They reported that contraceptive prevalence in the province is about 4 percent of married women of reproductive age. Some 40 nurses in the province have had some training in FP clinical skills during an INTRAH training in 1985. Provincial health officials see the main hindrance to increased FP acceptance as the inability of the health workers to effectively motivate clients to accept FP methods. They felt that a training course in interpersonal communication and counseling skills would greatly benefit the health care providers.

When asked about the availability of IEC materials, they said that none existed and that there was a definite need for flipcharts, posters, and provider and client materials which have not been available since health education was eliminated in 1982.

They all expressed a willingness and enthusiasm to be part of any project that would enhance the abilities of the health workers to encourage more clients to accept FP.

The team was also able to visit a Health Sub-Center which was more than an hour's drive up a dirt road in the mountains outside of Goroka to see the type of services existing in the more rural areas. This center had a full-time nurse along with three nurse aides and provided pills, injectables (for women who already had five living children) and condoms.

The team also had meetings in Port Moresby with Dr. Carol Jenkins, a Medical Anthropologist from the Institute for Medical Research in Goroka. Dr. Jenkins is very well versed in the Highlands cultures of Papua New Guinea and gave the team some valuable insights as well as offering to provide studies and bibliographies of research already conducted on the different target populations. It was her feeling, based on her research and contact with the people, that the major FP messages for the Highlanders, representing approximately one-third of the total population, should deal with the problems of division of land, cost of raising and educating children, and the health of mothers. The density of population is the greatest in the Highlands area and less than one-third of the land is arable. She also felt that men should be specifically targeted and that they can and will take responsibility if they are reached.

Dr. Jenkins stressed that there were many traditional practices which have kept birth rates in balance, the most important being the strict taboo against a husband sleeping with his wife while she was still breastfeeding. Since breastfeeding traditionally lasted at least two to three years, birth spacing was ensured. With increasing urbanization and the breakdown of some of the traditional clan authority, this practice is increasingly being ignored. The team was scheduled to meet with Dr. Jenkins again in Goroka but was unable to do so due to scheduling problems caused by a local airline strike.

Madang Province

The team visited Madang Province where they were able to meet with Mr. Dick Bart, Assistant Secretary of Health for Madang; Henry Noan, Health Educator; Dr. Walter Ban, Head STD Clinic; Dr. Ken Yaku, TB and Leprosy Clinic; and Dr. Andrew Baniaw, Medical Supervisor of Madang Hospital. During discussions the main points that arose were that: FP awareness is very low, especially in the rural areas; clinic staff have so many duties to perform that they have very little time to talk about family planning; providers have not been trained how to effectively motivate clients; and, there are no IEC materials available. The group also felt that it is especially important to reach men where they work and live since only women come to the clinics.

They felt that messages should focus on economics and education and that division of land was not a problem in Madang. There is a regular weekly health program on the local radio station which is broadcast in Pidgin. There is also a local Raun-Raun theater group which could be tapped to promote FP messages.

An intended visit to the Lutheran-operated Gaubin Hospital and CHW Training Center on Karkar Island was not possible. The ferry to Karkar did not operate on Monday which was a public holiday.

B. Meetings with Other Organizations

Australian High Commission

Mr. Whitney met Mr. Rod Irwin, Assistant Director General for the Pacific and Papua New Guinea for the Australian International Development Assistance Bureau. Mr. Irwin is based in Canberra and is in charge of programming the development budget for the region and PNG. He said that his office was interested in collaborating on family planning programs with other international donors including USAID and Japan. He suggested that Mr. Whitney contact Mr. Laurence Engel, Counselor for Development Assistance in PNG.

In a subsequent meeting with Mr. Engel, Engel stated that, although they did not currently fund much in the area of family planning, FP was an area in which they had an interest, especially in the support of training. He said that the request for assistance should come from the Government of PNG and that the Ministry of Finance and Planning would also have to approve such funding and increase the ceiling for the allocation of Australian funds for the DOH.

World Health Organization (WIO)

Discussions were held with Dr. Barry Karlin, Health Educator for the World Health Organization (WHO), regarding the type of support and the types of projects sponsored by WHO. Dr. Karlin is providing health programs to EM TV which they air free of charge in three time slots per week. These health programs are produced elsewhere and cover a variety of topics. WHO, in conjunction with EM TV, is also producing a series of health spots, and the air time will be provided free by

EM TV. In separate discussions with EM TV, the team was told that EM TV would continue to provide free air time for public service messages until such time as the relatively young network could fill its commercial time slots with paid advertisements.

There is a definite need for IEC materials at all levels. Development of materials should include training in pre-testing of materials as part of the design process. In addition to flipcharts, posters and brochures, it was suggested that it might be possible to locally produce a low cost film on FP to be distributed through the commercial market. A variation on this theme would be to locally produce an FP video to be distributed through the growing video rental market.

C. Recommendations for Training, IEC Materials, Development and FP Awareness Campaign

As a result of meetings with Department of Health personnel at both the national and provincial levels, Family Planning Association staff, and representatives of various donor agencies involved in family planning and maternal child health programs, the following activities are recommended as areas in which the Johns Hopkins University Population Communication Services (JHU/PCS) has the expertise to provide technical assistance to the Government of Papua New Guinea's Family Health Services family planning program. The areas of assistance discussed below are designed to precede and to pave the way for the social marketing program and will complement and support the social marketing project.

Training

A need expressed by everyone with whom the team met was for training of health workers in interpersonal communication skills (ICS) and counseling for family planning. In order to be able to effectively deal with the increase in demand expected as a result of an information campaign on the benefits of family planning, it is essential that health workers be trained to answer questions on family planning methods and help potential clients to choose a method suitable for them.

JHU/PCS has developed a set of training of trainers (TOT) modules in ICS and counseling which have been successfully implemented with trainers and health personnel in a number of countries in Africa as well as in the Philippines. This curriculum would be modified to be Papua New

Guinea-specific based on the training needs expressed at the provincial level. Appropriate curricula would be developed for the Health Center Sub-Center and Aid Post levels.

It is proposed that a series of TOT courses be conducted in order to develop a cadre of trainers at the provincial level who will then conduct training courses for the health personnel at the Health Center/Sub-Center levels as well as for the Aid Post Orderlies and the new Community Health Workers.

It is also proposed that the TOT include trainers from the centers where the new Community Health Workers (CHW) are being trained with the idea of incorporating ICS and counseling modules in the curriculum used for training this new group of health workers. This will ensure that the CHWs have these skills when they are posted and will not require additional training in ICS.

Information, Education and Communication (IEC) Materials

In discussions with health and family planning workers it was found that no family planning IEC materials exist for health care providers or for clients. It is proposed that print and possibly video materials be developed for both providers and for clients. Possible materials could include flipcharts for use by health workers in motivation activities, method specific information booklets for health workers, leaflets or brochures for clients, including materials for nonliterate, and videos on methods and/or counseling skills. Development of materials will include careful pretesting and revision before final production.

Once materials are produced, training in the effective use of these materials will be included in the proposed ICS training courses. Distribution of materials to the field is also provided for in the illustrative budget.

Family Planning Awareness Campaign

Before contraceptives can be successfully marketed it is necessary to "sell" people on the concept of family planning. Since family planning awareness in PNG is low, it is recommended that an awareness campaign precede the contraceptive specific campaign.

Messages will be carefully designed based on the findings of the market research which will be conducted prior to the campaign and will be targeted to specific audiences. Pretesting and revision will be part of the design process before final production. Media to be used will include television, national and provincial radio, and newspapers as well as theater groups such as Raun-Raun Theater and/or "Wokabout Marketing" to reach rural populations. Productive discussions were held with representatives of the above media and great support and enthusiasm for the promotion of family planning messages was expressed.

The awareness campaign will include spot announcements and print ads as well as materials for the "Tingim Helt" health program for which free weekly air time is provided to the Department of Health by EM TV. Production and placement of media materials will be contracted out to a local advertising agency using standard agency bidding practices. It is proposed that both the awareness campaign and method specific marketing campaign use the same advertising agency to ensure that the media materials have consistency and the same "look" so that they are mutually reinforcing.

E. Evaluation

Evaluation of the media campaign will be done by means of baseline, mid- and post-surveys to determine changes in knowledge, attitude and practice as well as to allow for midcourse corrections, if necessary, in the materials. Knowledge changes as a result of training will be measured by pre- and post-tests. Instruments to assess the effectiveness of the IEC materials will also be developed as appropriate to the individual materials.

VI. RECOMMENDATIONS FOR SOCIAL MARKETING IMPLEMENTATION

It is difficult to project the expected impact of the CSM program in Papua New Guinea until the exact program design and initial research have been completed. However, tentative projections can be made by drawing on the experience of CSM programs in other countries. The projections made here are based on two different methods. The first method uses a CSM forecasting model that is under development as part of SOMARC Special Studies. The second approach compares PNG with other similar countries. These projections should be considered as illustrative only. A more detailed set of projections to be used for project planning will be prepared once the project design is decided.

A. SOMARC Forecasting Equations

The SOMARC forecasting model is not yet complete; however, several forecasting equations have been developed that can be used to provide preliminary estimates of the impact of a CSM program in PNG. These equations were developed using data from 23 programs. They relate the prevalence contributed by CSM programs to a number of country characteristics related to program performance. Among the country characteristics included in these equations are:

- o The total prevalence rate
- o The percentage of the population living in urban areas
- o The crude birth rate
- o The strength of the population program effort as measured by the Mauldin-Lapham-Berelson index
- o The coverage of the health system as measured by the number of people per physician
- o The percentage of the population who do not want any more children
- o The strength of the commercial sector

In addition, several program specific variables are considered, including:

- o Demand creation (promotional) activities
- o The number of years the CSM program has been in existence

- o Whether the program supplies only condoms or a variety of methods
- o Whether the program is limited to urban areas or is national in scope

The final projection equations have not been completed yet; however, several preliminary equations have been used with PNG data to indicate the likely impact of the CSM program. These equations indicate the following pattern:

TABLE I

Year of Program	Prevalence Contributed by CSM Program (%)	
	<u>Low Estimate</u>	<u>High Estimate</u>
1	0.3	0.6
2	0.6	1.3
3	1.0	1.9
4	1.5	2.5
5	2.0	3.2

B. Comparison with Other CSM Programs

CSM programs have been implemented in over 20 countries. However, most of these countries are quite different from PNG. Among the characteristics of PNG that would strongly affect the impact of a CSM program are:

- o The rugged geography of the interior, making transportation and communications difficult;
- o The diversity of language and cultures;
- o The low percentage of the population in urban centers;
- o The relatively limited training of government health workers in family planning;
- o The extremely low level of prevalence; and
- o The low percentage of the population that participates in the cash economy.

Two countries that share some of these characteristics are Nepal and Ghana. Nepal shares with PNG a difficult terrain, low prevalence and a low percentage of urban dwellers. The Ghana

program, with its emphasis on training of chemical sellers, is included here to indicate the impact that might be expected from a program that emphasizes training.

The following table compares these three countries across a number of development indicators related to CSM program impact. The reference year refers to the start of the CSM program.

TABLE II

<u>Indicator</u>	<u>PNG</u> <u>1990</u>	<u>Nepal</u> <u>1978</u>	<u>Ghana</u> <u>1986</u>
Prevalence (%)	2	2	12
TFR	5.3	6.2	6.0
Family planning effort score	weak	weak	very weak
Population per doctor	16,052	28,767	7,245
Percent of births attended by health personnel (%)	34	10	73
Mean duration of breastfeeding (months)	24	24	16
Health expenditures as % of total budget	9.4	6.2	6.0
GNP per capita (\$)	618	142	379
Literacy (%)	45	25	50
Percent urban	16	7	39

The impact of the programs in Nepal and Ghana are shown in the table below.

TABLE III

Year of Program	CSM Prevalence (%)	
	<u>Nepal</u>	<u>Ghana</u>
1	0.4	0.6
2	1.1	2.8
3	0.9	3.2
4	1.4	
5	1.9	

C. Projections of CSM Prevalence

Combining this information with the projections from the forecasting equations discussed above suggests that the expected program impact would be in the following range:

TABLE IV

Year of Program	CSM Prevalence (%)	
	<u>Low</u>	<u>High</u>
1	0.3	0.6
2	0.6	2.8
3	0.9	3.2
4	1.4	3.2
5	1.9	3.2

This table projects the prevalence directly attributable to the CSM program through its sales and distribution. Two other effects of the program are possible, substitution and halo effects.

Substitution occurs when people, who are already using contraceptives from another source, switch to the CSM product. In this case there is no increase in prevalence, just a change in source. There does not seem to be much likelihood of any significant substitution in PNG since commercial sales of contraceptives are thought to be extremely small.

The halo effect occurs when people are motivated by the CSM promotion to begin using family planning but get their supplies from a different source, such as a government health clinic. In this case there would be an increase in the number of users above those that are reflected in the program's sales figures. Several factors make it likely that there would be a significant halo effect in PNG. First, the promotion campaign will need to include a generic message promoting the concept of family planning as well as specific brands. Second, the number of family planning users has actually declined since 1980, probably because of poor service in the health posts. This indicates a latent demand that could be rekindled through promotional activities. Third, it is unlikely that the CSM distribution will be able to reach all the population reached by the promotional messages. Fourth, there have been no major promotional efforts in the past.

It is difficult to estimate the size of the halo effect that might occur in PNG. It could well produce as many or more new acceptors for the government clinics than for the program's outlets. A conservative estimate would be that it would produce half that amount.

D. Projections of Number of Users

The population of PNG in 1989 is about 3.8 million. Reproductive age females comprise about 23.3 percent of the population. Approximately 80 percent of women aged 15-49 are married. Thus, the number of married women of reproductive age (MWRA) is a little over 700,000. Estimates of prevalence vary from 2 percent to 10 percent. The Department of Health estimates that the number of family planning acceptors has declined from a peak of 22,000 in 1980 to about 15,000 in 1984. The decline is attributed to the confusion and lack of services that followed the decentralization of the family planning program. In 1984, 15,000 users equaled a prevalence of about 2.3 percent. There is little indication of a major change in prevalence since then.

The table below shows the number of family planning users implied by a national prevalence of 2.5 percent augmented by the CSM program. The projection of MWRA assumes a constant fertility rate of 5.3 and a marriage rate of 80 percent of women aged 15-49. It is assumed that the CSM program conducts training activities in 1990 and begins promotion and marketing activities in 1991.

TABLE V
EFFECT OF CSM ON PREVALENCE (%)

<u>Year</u>	<u>Current Government Program</u>	<u>Halo Effect</u>		<u>CSM Program</u>	
		Low	High	Low	High
		1989	2.5	--	--
1990	2.5	--	--	--	--
1991	2.5	0.1	0.3	0.3	0.6
1992	2.5	0.3	0.6	0.6	1.3
1993	2.5	0.5	0.9	1.0	1.9
1994	2.5	0.7	1.2	1.5	2.5
1995	2.5	1.0	1.6	2.0	3.2

TABLE VI
NUMBER OF USERS (THOUSANDS)

<u>Year</u>	<u>MWRA</u>	<u>Current Government Program</u>	<u>Halo Effect</u>		<u>CSM Program</u>	
			Low	High	Low	High
			1989	883.5	22.1	--
1990	906.4	22.7	--	--	--	--
1991	929.8	23.2	0.9	2.8	2.8	5.6
1992	953.9	23.8	2.8	5.7	5.7	12.4
1993	978.5	24.5	4.9	8.8	9.8	18.6
1994	1003.8	25.1	7.0	12.0	15.1	25.1
1995	1029.8	25.7	10.3	16.5	20.6	32.9

E. Method Mix

The social marketing program intends to distribute nonclinical products to achieve the widest possible market penetration for the contraceptives. As a result, it is recommended that a low dose combination oral contraceptive and possibly a progestin only (mini-pill for lactating mothers) oral contraceptive as well as a lubricated condom and a spermicidal suppository be used in the social marketing program. The pill and the condom are already relatively popular in the public sector and through pharmacies. An insignificant quantity of vaginal spermicides is being distributed in either the public or private sector. The suppository is being recommended to strengthen the product line and offer viable alternatives to potential users. At the onset, it is expected that all three commodities would be donated to the program (from USAID or other international donor agencies). Hopefully when the market is sufficiently well established, private sector interests may be convinced to assume the provision of commodities. Assuming the ratio of method usage will closely follow that of the public sector, it is expected that method usage in the social marketing program would be:

Pills	-	65%
Condoms	-	25%
Vaginal Foaming Tablets (VFT)	-	10%

The following tables project acceptors by method and the resultant commodity requirements over five years.

TABLE VII

HIGH PROJECTION

CSM Acceptors by Method

<u>Sales Period</u>	<u>Total</u>	<u>Pill (65%)</u>	<u>Condom (25%)</u>	<u>VFT (10%)</u>
1991	5,600	3,640	1,400	560
1992	12,400	8,060	3,100	1,240
1993	18,600	12,090	4,650	1,860
1994	25,100	16,315	6,275	2,510
1995	32,900	21,385	8,225	3,290

CSM Commodity Requirements
Sales Only

<u>Sales Period</u>	<u>Pills</u>	<u>Condoms</u>	<u>VFT</u>
1991	47,320	140,000	56,000
1992	104,780	310,000	124,000
1993	157,170	465,000	186,000
1994	212,095	627,500	251,000
1995	278,005	822,500	329,000

570
Pills for 1995
5-1995

TABLE VIII

LOW PROJECTION

CSM Acceptors by Method

<u>Sales Period</u>	<u>Total</u>	<u>Pill (65%)</u>	<u>Condom (25%)</u>	<u>VFT (10%)</u>
1991	2,800	1,820	700	280
1992	5,700	3,705	1,425	570
1993	9,800	6,370	2,450	980
1994	15,100	9,815	3,775	1,510
1995	20,600	13,390	5,150	2,060

CSM Commodity Requirements
Sales Only

<u>Sales Period</u>	<u>Pills</u>	<u>Condoms</u>	<u>VFT</u>
1991	23,660	70,000	28,000
1992	48,165	142,500	57,000
1993	82,810	245,000	98,000
1994	127,595	377,000	151,000
1995	174,070	515,000	206,000

E. Pricing of CSM Products

Contraceptives are provided free of charge through government health clinics. The government's policy is not to charge for any medicines. At some health posts there are visit charges. For example, at the village of Tubusereia, a village of several thousand people about 15 miles outside Port Moresby, the charges are 20t (\$0.24) per adult and 5t (\$0.07) per child.

The FPA does charge for contraceptives. It charges K1 (\$1.20) per cycle of pills and K1 (\$1.20) per injection. Typical charges for contraceptives in pharmacies are K3.80 12 condoms and K3.5 per cycle of pills.

An examination of economic and pricing data indicates that contraceptive charges could be somewhat higher than the FPA's current rates and still be affordable to the majority of the population. The minimum wage is currently fixed at K140 per month in urban areas and K100 per month in rural areas. Typical costs for consumer items are 40t per soft drink, 70t for a small package of cigarettes (10 cigarettes) and 140t for a large package (25 cigarettes). These figures indicate the following price range for one month of protection:

1-2% of minimum wage = 140-280t urban
100-200t rural

2 soft drinks = 80t

2 packs of cigarettes = 140-280t

Another major factor in establishing product pricing is the objective of recovering some program costs with a view to achieving program sustainability in the long run. Those costs most often recovered through pricing include implementation expenses (excluding commodities, start-up capital costs and technical assistance). A third factor is to provide the necessary commercial incentives through margins (mark-ups) in order that distributors, wholesalers and retailers are sufficiently well compensated for selling the products.

Taking all the above into consideration, possible pricing levels for the products could be as follows:

TABLE IX

	<u>Pill</u>	<u>Condom</u>	<u>VFT</u>
Price to Distributor	.80	.11	.15
Distributor Margin - 20%	<u>.16</u>	<u>.02</u>	<u>.03</u>
Price to Wholesaler	.96	.13	.18
Wholesaler Margin - 25%	<u>.24</u>	<u>.03</u>	<u>.05</u>
Price to Retailer	1.20	.16	.23
Retailer Margin - 50%	<u>.60</u>	<u>.09</u>	<u>.12</u>
Price to Consumer	<u>1.80</u>	<u>.25</u>	<u>.35</u>
	(153 toea)	(21 toea)	(30 toea)

Based on average monthly usage of approximately nine condoms or VFTs per person, the monthly cost of contracepting, using these two products, may be considered a little high. However, because of the relatively low unit cost, especially when compared to other popular consumer purchases (one soft drink costs 40 toea), it is expected that consumers will readily be able to purchase the condom and VFT if sufficiently motivated to do so.

VII. PROGRAM INCOME, EXPENDITURE AND COST EFFECTIVENESS

A. Income

Net income derived from sales would range from a low of \$30,800 to a high of \$61,600 in the first year. At the end of the third year, assuming that the price of the products remains unchanged, annual income would range between \$108,000 and \$205,000.

After five years, accumulated income would range from a low of \$594,000 to a high of \$1.04 million.

This income would be deposited in an interest bearing account and used only as approved to cover in-country marketing cost in future years (see Table X).

B. Expenditure

Projected expenditure is comprised of SOMARC costs--(an expatriate resident advisor-manager, in-country marketing activities and technical assistance), PCS costs and commodities. As the summary (Table XI) below indicates, total expenditures, excluding commodities, amount to approximately \$2.8 million over three years. Commodities could add up to another \$192,000 over three years.

TABLE X

NET INCOME FROM SALES

High Projection

<u>Year</u>	<u>Total</u>	<u>Pills @ \$0.80</u>	<u>Condoms @ \$0.11</u>	<u>VFT @ \$0.15</u>
1991	61,656	37,856	15,400	8,400
1992	136,524	83,824	34,100	18,600
1993	204,786	125,736	51,150	27,900
1994	276,351	169,676	69,025	37,650
1995	362,229	222,404	90,475	49,350

Low Projection

<u>Year</u>	<u>Total</u>	<u>Pills</u>	<u>Condoms</u>	<u>VFT</u>
1991	30,828	18,928	7,700	4,200
1992	62,757	38,532	15,675	8,550
1993	107,898	66,248	26,950	14,700
1994	166,251	102,076	41,525	22,650
1995	226,806	139,256	56,650	30,900

*After Sales Margins.

TABLE XI

EXPENDITURE SUMMARY

	<u>1991</u> <u>(\$000s)</u>	<u>1992</u> <u>(\$000s)</u>	<u>1993</u> <u>(\$000s)</u>
<u>SOMARC COSTS</u>			
Resident Advisor	250	265	281
In-Country Activities	241	306	348
Technical Assistance	<u>202</u>	<u>191</u>	<u>191</u>
Sub-Total	<u>693</u>	<u>762</u>	<u>820</u>
<u>PCS COSTS</u>			
In-Country Activities	160	125	65
Technical Assistance	<u>110</u>	<u>85</u>	<u>30</u>
Sub-Total	270	210	95
<u>TOTAL IMPLEMENTATION</u>	<u>963</u>	<u>972</u>	<u>915</u>
<u>COMMODITIES</u>			
High Projection	25	55	112
Low Projection	12	25	44

(See Tables XIII and XIV for details.)

C. Cost-Effectiveness

The measure of cost-effectiveness is influenced primarily by the prevalence rate assumed to be feasible. If under the best of circumstances, the low projection were considered more possible, then the intervention could not be considered cost-effective. An amount of approximately \$333* would be invested in the first year to convert each new consumer, with this investment falling to \$82* by the third year. The value of the halo effect (see Projections of CSM Prevalence) would of course improve the cost-effectiveness of the social marketing program, but the overall cost in ratio to the impact remains too high. Expenditures could, of course, be reduced (i.e., dispensing with the resident advisor or cutting marketing costs) but this could have a negative impact on program efficiency and possibly result in a failure to achieve even the low prevalence projected. Even if the high projection were considered, the resulting cost per consumer rate of approximately \$161* in the first year, falling to \$38* after three years would still be comparatively high. (See Table XII.)

*Inclusive of JHU PCS costs but excluding cost of commodities.

TABLE VII

COST PER COUPLE YEAR OF PROTECTION

High Projection

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
CYPs	<u>5,600</u>	<u>12,400</u>	<u>18,600</u>
EXPENSES (\$000s)	963	972	915
INCOME (\$000s)	62	137	205
NET COST (\$000s)	901	835	710
COST/CYP	\$161	\$ 67	\$ 38

Low Projection

	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>
CYPs	<u>2,800</u>	<u>5,700</u>	<u>9,800</u>
EXPENSES (\$000s)	963	972	915
INCOME (\$000s)	31	63	108
NET COST (\$000s)	932	909	807
COST/CYP	\$333	\$159	\$ 82

TABLE VIII
EXPENDITURE PROJECTIONS

SOCIAL MARKETING	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>
<u>In-Country Activities</u>	<u>(\$000s)</u>	<u>(\$000s)</u>	<u>(\$000s)</u>
Packaging and Labor	10	20	25
Market Research	15	10	10
Public Relations	10	10	10
Training	10	10	5
Advertising and Promotion	100	150	175
*Salaries	49	67	78
Transportation	30	15	15
Administration	10	15	20
Total In-Country	234	297	338
TFG Fee @ 3%	<u>7</u>	<u>9</u>	<u>10</u>
	<u>241</u>	<u>306</u>	<u>348</u>
Resident Advisor	250	265	281
TFG Salaries	50	53	56
TFG Overheads	90	95	101
<u>Other Direct Costs</u>			
Consultants (20 Days)	5	5	5
Airfares (6 RTs)	30	20	15
Per Diem (126 Days)	23	15	12
TFG Fee ODC @ 7%	<u>4</u>	<u>3</u>	<u>2</u>
	<u>452</u>	<u>456</u>	<u>472</u>
Subtotal	<u>693</u>	<u>762</u>	<u>820</u>
JHU/PCS			
<u>DEMAND CREATION/TRAINING</u>			
IEC Materials	60	40	25
Materials Distribution	10	5	10
Media (Production and Air Time)	50	40	20
Training	30	30	5
Research and Evaluation	10	10	5
Technical Assistance	<u>110</u>	<u>85</u>	<u>30</u>
Subtotal	<u>270</u>	<u>210</u>	<u>95</u>
TOTAL IMPLEMENTATION	<u>963</u>	<u>972</u>	<u>915</u>

*Marketing Manager and Sales Promoters, all local hire.

TABLE XIV

COMMODITY COSTS

		<u>HIGH</u>	<u>LOW</u>
<u>1991</u>			
	Pill	13,463	6,731
	Condom	6,090	3,045
	VFT	<u>5,432</u>	<u>2,716</u>
	TOTAL	\$24,985	\$12,492
<u>1992</u>			
	Pill	29,810	13,703
	Condom	13,485	6,199
	VFT	<u>12,028</u>	<u>5,529</u>
	TOTAL	\$55,323	\$25,431
<u>1993</u>			
	Pill	60,341	23,559
	Condom	27,296	10,658
	VFT	<u>24,347</u>	<u>9,506</u>
	TOTAL	\$111,984	\$43,723

VIII. SOCIAL MARKETING PILOT PROJECT

Given the relatively high investment costs to implement a full-scale national social marketing program, and the relative uncertainty of the impact of such a program, it is recommended that a pilot test market project be undertaken in the first instance.

A. Objective

- o To determine the dynamics of the marketplace through actual experience, for example:
 - What are the prevailing and countervailing attitudes to contraceptive usage and how will they affect potential prevalence;
 - What are the best marketing strategies.
- o Test the systems and mechanisms for better program implementation;
- o Design and test IEC messages, service provider and client materials, as well as refining training of trainers and service provided curricula in interpersonal communication and counseling skills;
- o Get a more accurate fix on costs; and
- o Measure the impact so as to be able to more accurately project future effect on a national scale.

B. Implementation Strategy

Test Market Sites

The pilot project would be conducted in the provinces of Morobe, Simbu, Eastern Highlands and Western Highlands (see map). The four regions account for 34 percent of the population and 34 percent of the women of reproductive age. Contraceptive prevalence matches the national average of 3 percent. Lae, as a busy commercial town (main port of entry on the Huon Gulf) is serviced

by good communication and marketing organizations. The geographical and cultural diversities of the area would also provide a variety of challenges and experiences for a social marketing program (see Table XV).

TABLE XV
CONTRACEPTIVE USAGE IN THE PUBLIC SECTOR

	TOTAL		EAST	WEST	
	<u>PNG</u>	<u>MOROBE</u>	<u>HIGH'DS</u>	<u>HIGH'DS</u>	<u>SIMBU</u>
Total Population (1980)	3,006,800	310,526	277,180	262,886	178,490
Women of Reproductive Age (1988)	767,600	81,173	72,095	66,011	40,889
Contraceptive Users	27,380	2,830	3,490	1,115	830
Contraceptive Prevalence %	3.6	3.5	4.8	1.7	2.0
<u>Product Usage %</u>					
Pill	44	54	55	53	49
Injectable	25	36	26	23	30
Condom	17	1	0.5	2	0.4
Tubal Ligation	8	7	16	17	10
Ovulation	4	0.1	0.2	3	11
IUD	1.4	2	2	1	--
Vasectomy	0.6	0.1	*	0.3	--

Program Management

A private sector distributor would be appointed on contract to provide management, marketing and sales services to the test market project. SOMARC II would provide medium-term technical assistance to establish and monitor the project. In this regard a marketing consultant would reside in-country for up to four months at the beginning with scheduled monitoring visits thereafter as required. Necessary subcontracts with in-country advertising and research organizations will be established by SOMARC with assistance from the distributor. A project advisory group (maximum 8) with private and public sector representatives from all four provinces would provide guidance on sociocultural issues and matters of policy. Program management would be based in Lae.

Marketing

The three products--pill, condom and vaginal foaming tablet--would be distributed with brand names and marketing strategies determined with the assistance of baseline KAP and focus group research activities. If possible varying strategies could be tested, e.g., testing two different price levels to determine the most effective; and testing the effect of advertising levels on sales by varying the intensity in different provinces.

Training/IEC

Service provider training and IEC activities would be initiated by JHU PCS prior to the launch of the test market product sales.

Technical Assistance

In addition to the marketing consultant, SOMARC would provide the necessary technical assistance to support market research, advertising, retailer training and MIS. A mid-test and end-test evaluation exercise will also be provided.

Time Frame

The pilot test market would require twenty-six (26) months inclusive of at least twelve (12) months of product sales. Activities would be phased accordingly:

	<u>ACTION</u>
<u>Phase I</u> Months 1-8	
Training service providers	PCS
Development and implementation of family planning IEC campaign	PCS
Appointment of distributor and subcontractors	SOMARC
KAP and focus group research	SOMARC
<u>Phase II</u> Months 9-12	
Development of marketing strategies: packaging, distribution, promotion	SOMARC/ Distributor
Training selected retailers, pharmacies	SOMARC/ Distributor
Public relations program	SOMARC/ Sub-Contractor
<u>Phase III</u> Months 13-24	
Sales, advertising, promotion	Distributor/ Sub-Contractor
Monitoring	SOMARC
<u>Phase IV</u> Months 25-26	
Evaluation and management recommendations for future action	SOMARC, JHU/PCS, AID

C. Cost Estimates and Financing

The pilot test market, exclusive of commodity costs, is projected to cost approximately \$813,000 over the 26-month period.

Social Marketing Costs

Market Research	\$12,000
Public Relations	6,000
Retailer Training	6,000
Packaging/Labor	12,000
Advertising and Promotion	90,000
Transportation (In-Country)	12,000
Administrative	6,000
Evaluation	<u>15,000</u>

159,000

Medium-Term Marketing Consultant 125,000

Technical Assistance

Consultants (48 days)	12,000
Per Diem (36 days)	7,000
Airfares (6 RTs)	<u>30,000</u>

49,000

Subtotal \$333,000

JHU/PCS

FP-IEC/TRAINING*

In-Country Activities	\$285,000
Technical Assistance	<u>\$195,000</u>

Subtotal \$480,000

TOTAL IMPLEMENTATION \$813,000

Of the above costs \$350,000 could be financed from SOMARC II central funds, provided that USAID/RDO/SP initiates a buy-in to JHU/PCS to cover the training and IEC activities.

*See Table XIII for details.

IX. SOCIAL MARKETING AND AIDS PREVENTION

The SOMARC team was requested to review ways in which the family planning social marketing program may dovetail with AIDS prevention and control efforts. While in-country, the SOMARC and AIDSCOM teams met jointly with officials of the Department of Health, the media, and conducted joint fieldtrips to Central and Madang provinces. The opportunity was taken to understand the peculiarities of each intervention and explore areas of mutual concern.

Both programs would benefit from coordination in research, IEC, condom marketing and to some extent service provider training. Specifically quantitative research costs (KAP/KABP) could be reduced by covering both subjects in the same research initiative; IEC materials and programs where appropriate could address issues of family planning and AIDS prevention; condom marketing could position the product on a protection platform--as a prophylactic as well as a contraceptive; the training curriculum for some levels of health workers, particularly APOs or Community Health Aids could incorporate a syllabus on AIDS prevention and family planning; and some administrative costs (office and support services) could be shared given both projects operating in the same territories at the same time.

Until both programs are designed, it would not be possible to quantify the cost benefits of such coordinated efforts. Other than these discrete areas, the peculiarities of both interventions necessitate programming tailored to specific needs. For example, whereas both programs would require a resident manager, the functions, skills and disciplines needed for each program are significantly different, thereby negating the possibility of a single manager supervising both activities.

X. NEXT STEPS

- o GoPNG and USAID/RDO/SP/SUVA to consider the findings of the assessment and provide concurrence for the implementation of the test market activity.
- o USAID/RDO/SP to provide additional funding for JHU/PCS activities in test market as well as the required contraceptives for the test market effort.
- o GoPNG to continue to work toward the promulgation of a National Population Policy and addressing those constraints that may have a negative impact on growth in contraceptive prevalence.

SOMARC/The Futures Group and JHU/PCS are prepared to respond in the immediate future to a request from USAID and GoPNG for technical assistance in the further development of a family planning communication and social marketing project.

XI. PERSONS CONTACTED

U.S. Embassy, USAID/RDO/SP

Everett E. Bierman, Ambassador, U.S. Embassy
Angie Mulas, USAID/U.S. Embassy
Patrick C. Lowry, HPN Advisor, Suva
Manoa N. Bale, Assistant HPN Advisor, Suva
Amy Osborne, Regional Program Officer, Suva
Loel Callahan, PSC, Suva
Louis H. Kuhn, Assistant Director, Pt. Moresby

UNFPA/UNDP/ILO

Urmilla Singh, Program Management Officer, UNFPA, Suva
K. Paramanathan, Regional Advisor, ILO, Suva
Dirk Jena, Program Management Officer, ILO, Suva
Janusz Czmariski, Deputy Resident Representative, UNDP, Pt. Moresby
Phillipe Champassak, Assistant Resident Representative, UNDP, Pt. Moresby
Dorothy Ortlaf, Program Officer, UNDP, Pt. Moresby

WHO

James N. Mullally, STD/AIDS Unit, PNG
E. Dekal, Assistant Resident Representative, PNG
Barry Karlin, Health Educator, PNG
Dr. Elias, Epidemiologist

Department of Health, GoPNG

Central

Quinten Reilly, Secretary of Health
Levi Sialis, First Assistant Secretary, Primary Health Services
Timothy R. Pyakalyia, Assistant Secretary, Disease Control
Stephen L. Clein, Chief of Pharmaceutical Services
Tomkins Tabua, SMO STD/AIDS
Brother Andrew, Assistant Secretary, Mental Health
Byron Geniembo, Health Educator
Shirley Gideon, Family Health Services
Andrew Posono, Planning Division
Isaac Ahe, First Assistant Secretary, Administration Services
Dawa Masere, Family Health Services
Andrew Emang, Acting Director, Nurse Training Unit
Mary Biddulph, Health Educator, NTSU

Ken Cramer, JHPIEGO Distance Education NTSU
Florian Yambilafuan, Curriculum Developer, NTSU
Peppa Koka, Health Educator, NTSU
Dr. Bireb, Assistant Secretary of Health
Sister Elizabeth Kema, Health Sub-Center Tubusercia

Provinces

K.D.P. Jayatilake, Regional Epidemiologist, New Guinea Mainland Region, Lae
Likei Theo, Assistant Secretary Health, Morobe Province, Lae
Ruth Lunniss, Nuroung Coordinator Community Health, Lae
Ben L. Haili, Provincial Health Extension Officer, Eastern Highlands, Goroka
Julie T. Liuiko, Provincial Nursing Officer, Eastern Highlands, Gorok
Dick Bart, Assistant Secretary of Health, Madang Province, Madang
Henry Noan, Health Educator, Madang
Walter Ban, SMO/STD, Chairman Provincial AIDS Committee, Madang
Ken Yaku, SMO/TB, Madang
Andrew Baniau, Hospital Supervisor, Yomba, Madang
Philip Basse, Acting Medical Supervisor, Madang Hospital

Department of Planning and Finance GoPNG

Frank Agar, Foreign Aid Management
Thomas Lisenia, Foreign Aid Management
Joe Pohory, DOH Projects
Dorothy Devine, Programs Officer
Tony Keket, Planning and Programming

Miscellaneous

Amor N. Oribello, Program Officer, IPPF, ESEAOR, PNG
Ronald Wildman, CDC
Sam R. Perry, CDC
Robin Watling, Managing Director, Jais Aben, Madang
Andrew Piller, AED/Health Com, PNG
Bill Winkley, Country Director, Helen Keller Inter., PNG
Jim Crawford, PATHFINDER Foundation
Carol Jenkins, Institute of Medical Research, Goroka
Dianne Turner, Department of Anthropology and Sociology, University of PNG
Stephen Webb, Chairman National Advisory Committee on AIDS
Gabriel Kepas, Member Advisory Committee on AIDS

Private Sector

Marketing and Distribution

Johnston's Pharmacies, Pt. Moresby: Ron Holloway, General Manager
North Solomons Pharmacies, Pt. Moresby: Peter A. Baron, Managing Director
New Guinea Wholesale Drug, Lae: Kerry E. McDonough, Director
Sullivans Pty. Ltd., Lae: Chris Wilding, Agency Manager
Colgate-Palmolive (PNG) Ltd., Lae: Robert Taylor, Sales Manager

Advertising Agencies

David Delaney and Associates, Pt. Moresby: Peter Colman, Creative Director; Rod Miller,
Marketing Manager
Human Resource Development (HRD), Pt. Moresby: Chris Wiley, CEO; Dale Rutstein, Creative
Director; Phil Sawyer, Managing Director
Samuelson and Talbert, Pt. Moresby: Emile Misa, Managing Director

Market Research

Zenith Sales and Marketing, Pt. Moresby: Stan Joyer, General Manager
First, Pt. Moresby: Chris Wiley, Director

Media

EM TV, Pt. Moresby: John Taylor, General Manager; Kerry Morgan, Client Services Manager;
Eva Arni, Producer/Presenter; Rod Burgess, Director Sales
NBC-Radio, Pt. Moresby: Francisco Damien, Programs Director; Jimmy Veneo, Assistant Director;
Cosmua Peler, Supervisor, Health Programs
KALANG FM, Pt. Moresby: Wakon Luan, Head Copy Production
Walkabout Marketing, Pt. Moresby: Chris Wiley, Director
Post Courier Newspaper, Pt. Moresby: Nick Solomon, Assistant Advertising Manager
Niugini Nius, Pt. Moresby: Dickson Dobonaba, Sales Representative

Appendix 1

Appendix 2



THE FAMILY PLANNING INJECTION CAN BE USED BY WOMEN WITH FOUR CHILDREN

Designed & Distributed by the I.E.C. Unit F.P. Health Dept. Papua New Guinea

Appendix 3

SPOT 18.FAMILY PLANNING SPOT

Audience: For married couples

Voice 1. (female):

"Where are you going, Shirley?"

Voice 2. (female):

"I'm going to the health centre, Anna, to ask about family planning."

Voice 1. (female):

"Oh, don't you and your husband want another baby?"

Voice 2.

"Yes, we do. But we want to wait until our baby is two or three years old before we have another. In that way, the baby will have a better chance to grow up strong and healthy. And I will regain my strength too."

Voice 1.:

"Really, can a person space out children that way?"

Voice 2.:

"Yes, I heard that there are a number of safe and easy ways. I'll tell you what I learned at the clinic."

Voice 1.:

"Thank's Shirley. My husband and I will want to talk about this."

Appendix 4

SPOT 19. Second Family Planning Spot

Voice 1. (male):

"Hello, Peter. Why are you looking so sad?"

Voice 2. (WIFE)

"My wife is sick again and can't go to the gardens? She has been weak since the last baby was born."

Voice 1.

"Maybe you shouldn't have another baby until she regains her strength."

Voice 2.:

"Can a couple decide when to have a baby?"

Voice 1.:

"Sure. There are many modern ways for spacing out children. Why don't you take your wife to the health clinic for a check-up? While you are there, you can ask about family planning."

Voice 2.:

"Good idea! We will do that right away."

Voice 3. (male...authoritative)

"This message is from your Health Department."

Appendix 5

PACKAGES

R.O.S.			TARGET AUDIENCE												
30 x 30 Second			30 x 30 Second Plans												
RATE	ALL ZONES MON SUN		B	M	A	D	B	M	A	D	B	M	B	D	W/END DAY
5	(57)	1710	(59)		1770		(63)		1890		(61)		1830	(59)	1770
4	(50)	1500	(53)		1590		(57)		1710		(55)		1650	(53)	1590
3	(43)	1290	(47)		1410		(51)		1530		(49)		1470	(47)	1410
2	(37)	1110	(42)		1260		(46)		1380		(44)		1320	(42)	1260
1	(30)	900	(36)		1080		(40)		1200		(38)		1140	(36)	1080

DISCOUNTS: Accredited Agencies 10%

BASE RATES

MONDAY TO FRIDAY						SATURDAY					SUNDAY				
30 sec	B	M	A	D	E	B	M	A	D	E	B	M	A	D	E
5	82	62	62	67	72	67	72	82	72	67	62	82	67	62	55
4	75	55	55	60	65	60	65	75	65	60	55	75	60	55	48
3	68	48	48	53	58	53	58	68	58	53	48	68	53	48	41
2	62	42	42	47	52	47	52	62	52	47	42	62	47	42	35
1	55	35	35	40	45	40	45	55	45	40	35	55	40	35	28

HOW TO USE THE RATE CARD

- Base Rate.
- Personality Recorded Ad.
- Fixed Time.
- Live Personality Product Endorsement.
- Combined 3 & 4

(A) Copy deadline 24 hours prior to Broadcast.
 (B) Cancellations require 28 days notice
 (C) 50 Plan Packages on application.

SESSION TIMES

B Breakfast 5:30 AM — 9:00 AM
M Morning 9:00 AM Midday
A Afternoon 12:00 — 5:00 PM
D Drive 5:00 PM — 8:00 PM
E Evening 8:00 PM Midnight

STATION PROFILE KALANG F.M.

NEWS: On the hour every hour local & international
 Extended bulletins 7:00AM/7:00PM
 MUSIC: All types
 PROMOTIONS: Client & product oriented
 On air & outdoor campaigns available on request.

70

Appendix 6



EMTV — JULY 1989

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	
2 30PM	(9 00 - 10 00 AM SESAME STREET)							2 30PM
3 00PM	ADVENTURES OF TEDDY RUXPIN K130						JAZZERCISE K80	3 00PM
3 30PM	BONANZA K80						FRAGGLE ROCK K80	3 30PM
4 00PM				MUPPETS K80			ANIMALS K130	4 00PM
4 30PM	SPORTS WORLD K170						GHOST BUSTERS K130	4 30PM
5 00PM				KIDS KONA K130			BATMAN K130	5 00PM
5 30PM	THE WONDERFUL WORLD OF DISNEY K80							5 30PM
6 00PM				HIGH CHAPARALL			DANIEL BOONE K80	6 00PM
6 30PM	K500	K480	K480	NATIONAL EM TV NEWS K480	K310	K310	K310	6 30PM
7 00PM	THE BILL COSBY SHOW K500	FAMILY TIES K500	MORK & MINDY K500	MR MERLIN K500	WEBSTER K310	EM REPORT K310	WILLIAM TELL K310	7 00PM
7 30PM	MOVIE K500	THE FLYING DOCTORS K500	STAR TREK K500	HARDCASTLE AND McCORMICK K500	SIX MILLION DOLLAR MAN K310	FAME K310	THE A TEAM K310	7 30PM
8 00PM								8 00PM
8 30PM	DOCUMENTARY HORIZON K500	MINI SERIES K480	T J HOOKER K480	MOVIE K480	KUNG FU K310	MOVIE K310	ROCKFORD FILES K310	8 30PM
9 00PM			9 00PM					
9 30PM	BISNIS K170	TINGIM HELT	LIFE STYLE K480	EM TV SPORTS SCENE K170	MIAMI VICE K310	MOVIE K190	MOVIE K190	9 30PM
10 00PM			10 00PM					
10 30PM			BUSINESS WEEK K170	McCLOUD K170	RUGBY LEAGUE K190	VFL K190		10 30PM
11 00PM								11 00PM
11 30PM								11 30PM
12 00AM								12 00AM

N.B.: ABOVE RATES ARE FOR 30 SECONDS DURATION AT FIXED PROGRAM AND ARE AVAILABLE UNTIL 31/12/1989

PORT MORESBY

EM TV P.O. BOX 443 BOROKO
PAPUA NEW GUINEA PH: (675) 25 7322 FAX: (675) 25 4450

LAE

EM TV P.O. BOX 4084 LAE
PAPUA NEW GUINEA PH: (675) 42 4499 FAX: (675) 42 6401

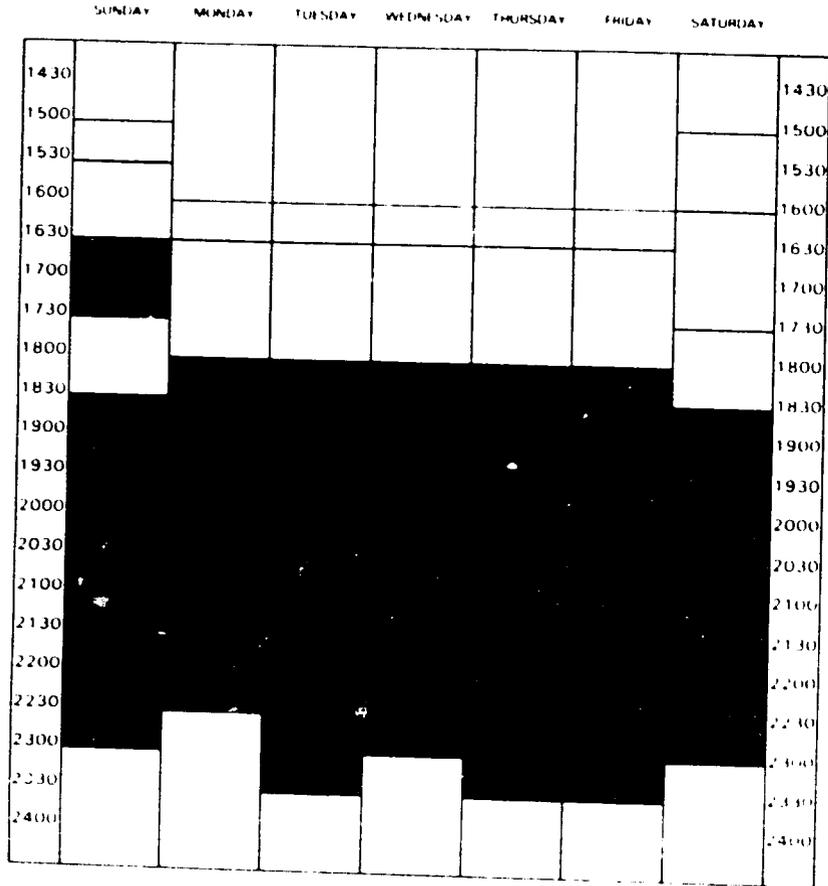


EM TV
NATIONWIDE

1/1/89

EMTV RATE CARD No.3/89

EMTV RATE CARD NO 3/89



VOLUME DISCOUNTS

5% K20,000
10% K50,000

15% K100,000
20% K150,000

RATES APPLICABLE TO A THIRTY (30) SECOND COMMERCIAL

ZONES		BASE	5%	10%	15%	20%
ZONE 1	W/C	60	57	54	51	48
	FP	80	76	72	68	64
ZONE 2	W/C	100	95	90	85	80
	FP	130	124	117	111	104

NOTE: W/C WEEK COMMENCING
FP FIXED PROGRAM

OTHER DURATION COMMERCIALS

- 10 SECONDS 65% OF 30 SECOND FIXED PROGRAM RATE
- 15 SECONDS 75% OF 30 SECOND FIXED PROGRAM RATE
- 20 SECONDS 85% OF 30 SECOND FIXED PROGRAM RATE
- 30/30 SECONDS 190% OF 30 SECOND FIXED PROGRAM RATE
- 60 SECONDS 185% OF 30 SECOND FIXED PROGRAM RATE
- 120 SECONDS 360% OF 30 SECOND FIXED PROGRAM RATE
- 180 SECONDS 520% OF 30 SECOND FIXED PROGRAM RATE

