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A PRELIMINARY ASSESSMENT OF THE POTENTIAL FOR A SUBSIDIZED CONTRACEPTIVE MARKETING PROGRAM IN RURAL THAILAND

A Report Prepared By:
John Farley, Ph.D.

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Introduction

The author made a preliminary assessment of the potential for a subsidized contraceptive marketing program in rural Thailand. He found that such a program would be feasible and cost-effective. The potential is adequate to justify a full-scale feasibility study to develop a draft marketing plan for the program. Steps should be taken to increase the distribution of pills outside pharmacies (this is mandatory in a functioning and successful subsidized marketing program) and to institute produc-specific advertising in the media (this is desirable but not a requirement).

In undertaking this study, the author sought answers to three questions:

1. Is there adequate market potential to justify detailed development of a plan for a subsidized commercial contraceptive marketing scheme in Thailand?

   a. Describe the current knowledge about and practice of family planning.

   b. Define a potential market that is not now served.

2. What are the program options? Discuss:

   a. product configuration;

   b. brand and package development;

   c. distribution and advertising options;

   d. breakeven volumes for a national program under two program configurations;

   e. the possibility for regionalization; and

   f. one possibility for program management.

3. How would a subsidized contraceptive marketing program fit into present and anticipated contraceptive delivery? Examine:

   a. the government health system;

   b. the voluntary Community-Based Family Planning Services (CBFPS) system;

   c. the commercial market; and

   d. the new village health volunteer system.

It is important to note that this is a preliminary report; the estimates are only rough approximations. The bulk of the author's time in Thailand was devoted to the CBFPS evaluation. The coup that occurred during the consultancy reduced the time available to the author, inhibiting particularly contact with Thai officials.

1. Is there adequate potential to justify the development of a detailed marketing plan?

Although current practice is high, adequate potential exists to develop such a plan, even if one uses a tight definition of currently unserved markets.

Current Knowledge and Practice

Recent research* indicates high levels of awareness about and experience with contraceptive products that would favor the success of any program based on increased access to appropriately priced contraceptives. More than 90 percent of women of reproductive age--from all regions, all age groups, all education groups, employed and unemployed--are aware of the pill and female sterilization. More than 90 percent know of at least one source of supply for contraceptive products.

Contraceptive use (current and ever) is also high. Interview reports reveal that 70 percent of women of reproductive age have practiced some form of fertility limitation, and that approximately 50 percent are current users. The methods used are:

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* CPS report, Thailand, 1978.

Pill	40%
Female Sterilization	25%
Injectables	9%
Rhythm and Withdrawal	8%
Male Sterilization	7%
Condom	4%
Others	7%

Pills and injectables seem to be the most favored contraceptive methods. Rural dealers' enthusiasm for and the rate of usage of condoms and suppositories are low. Given these facts, one would conclude that pills must be the primary product of a subsidized commercial marketing program.

Potential Market

Despite the impressive levels of knowledge and practice, one can identify significant new primary and secondary markets for a subsidized commercial program. The methods used to develop the estimates are shown in Exhibit I.

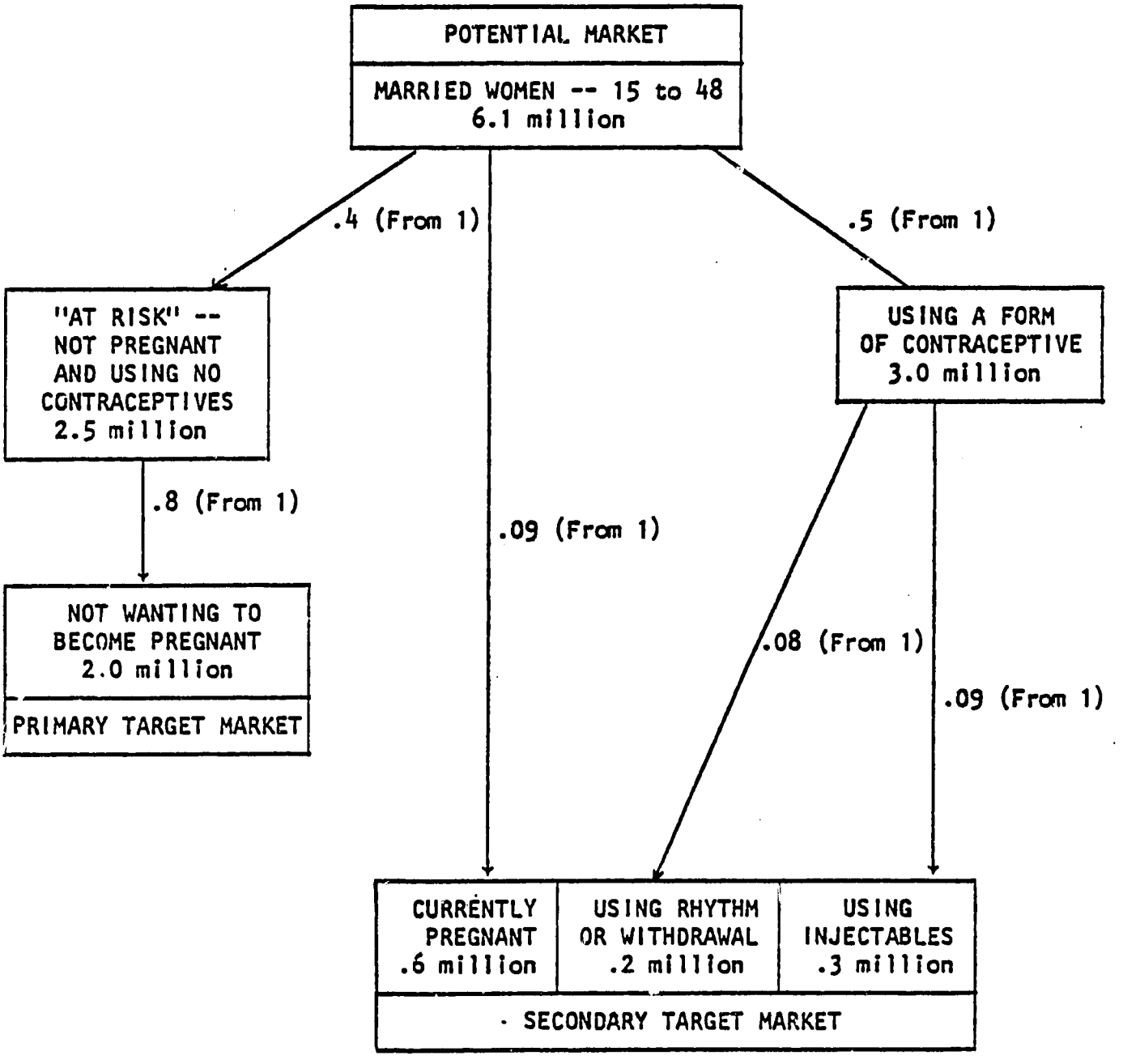
The primary market includes the 2.5 million currently-married women at risk (e.g., women not practicing any form of contraception minus the 500,000 women who desire to be pregnant). The secondary markets include:

- 240,000 women now using rhythm or withdrawal as the primary method;
- 600,000 women who are pregnant at this time; and
- 280,000 women who are now using an injectable (they are a potential market for subsidized commercial products if the injectables come into short supply, as is rumored).

The primary target market, which is predominantly rural, will grow at an annual rate of approximately 3 percent (or 300,000 women) in five years. Target markets of this size have been adequate to justify programs with long-range potential to be self-sufficient, except for product cost, in, for example, Jamaica, Guatemala, Morocco, and Sao Paulo, Brazil.

Exhibit I

DEFINITION OF PRIMARY AND SECONDARY MARKET



Source: Thai Contraceptive Prevalence Study, 1978.

2. *What are the program options?*

Options are available for advertising, branding, and pricing. There do not appear to be options in the product line or in the need to expand the current channels of distribution.

Product

Given the prevailing patterns of use, the pill must be the primary product of a subsidized commercial contraceptive marketing program. Other products (condoms, suppositories, etc.) should be included, although their potential in the rural market appears to be inconsequential. Injectables are quite popular, but it is not likely that they can be incorporated into a village-level program that uses general retail stores as outlets.

Brand Development

The CBFPS village distribution program has marketed simple, colored cards of pills, known popularly as "gold pill," "silver pill," etc. These popular names might be used to advantage and would fit well with current efforts in subsidized village distribution schemes; however, it would be worthwhile to develop and test alternative brand names with stronger promotional possibilities.

Prices

The current CBFPS prices, which, on the basis of interviews with retailers and sales results, appear to be acceptable to consumers, are ฿5, ฿7, and ฿9 per cycle of pills. The cheaper pills sell best; therefore, ฿6 is used as the average price.

Price to Consumers	฿6.0
Retail Margin*	฿1.5
Price to Retailer	฿4.5
Distributor Margin*	฿1.0
Net to Program/Cycle	฿3.5
Packaging	฿0.5
Net to Program	฿3.0

* Estimated on the basis of discussions with an advertising specialist, a distributor, and market researchers. The retail margin is higher than that now used by the CBFPS.

Indications are that slightly higher prices may be acceptable to consumers.

Advertising and Distribution

One of three different configurations can be chosen for the subsidized commercial contraceptive marketing program.

1. A program in which contraceptives are distributed through pharmacies using no advertising will offer pills that sell for one-quarter to one-third of the commercial price of pills now offered by the same outlets. Pharmacies and health centers are redundant distribution structures, because both are located in urban areas. Even if the pharmacies enthusiastically embrace the new product, it is not likely that the program will generate significant incremental sales of pills, particularly in rural areas. If distribution does not expand, the prospects for a subsidized contraceptive marketing program will not be favorable.

2. A program using broader distribution and no media advertising will make pills available at the village level, presumably through carefully selected stores. Retailers would receive some training. This program would require changes in current policy on pharmaceutical sales. It could provide access to virtually every village through the more than 100,000 village stores, although it would probably not provide 100 percent coverage of remote villages. Most of the larger storekeepers who were interviewed in the CBFPS evaluation travel to a market several times a week; thus, resupply should be relatively easy. If the impact is anything like that of the CBFPS program, which sells pills to 8 percent of women in these project areas, self-sufficiency should be possible. (Details on costs and revenues are presented elsewhere in this report.)

3. A program using non-pharmacy distribution and media advertising would have all the advantages of the first two programs. Moreover, it would be more likely to reach a significant part of the primary target market. With support from the media, products would be distributed more widely. Changes would, however, be required in laws and trade practices that prevent direct advertising of pharmaceuticals to consumers. To visualize the potential of advertising, one must understand that Thai media penetration is high and expanding. The daily penetration of television in urban areas outside Bangkok has reached 50 percent, and four new stations are scheduled to open soon. Even up-country penetration (defined as having seen television in the last week) is 60 percent for females, for age groups 15 and

older, and for households with incomes of $100-$200 per month. The production quality of Thai television advertising is excellent. Radio penetration is even deeper, with 323 stations broadcasting and penetration (about the same for urban and rural areas) ranging from 65 percent in the northeast to 85 percent in the central region. Print penetration is more shallow, although newspapers reach almost half the population.

Program Costs and Revenues

Such programs have two kinds of costs: fixed initial costs (initial advertising and promotion, brand development, marketing research) and ongoing expenses (maintenance advertising and promotion, sales expense, and administration). The following are rough, first-cut estimates calculated for planning purposes only.

A. Initial Costs

The rough estimates of initial costs (excluding overhead and foreign management costs, if any) are listed below.

	Program With Expanded Distribution	Program With Expanded Distribution Supported By Consumer Advertising
Sales Expense (18 months)	$225,000	$ 200,000
Advertising Expense	--	700,000
Advertising Production	--	75,000
Brand Development and Promotion	100,000	50,000
Market Research	30,000	35,000
Office Expense	60,000	40,000
TOTAL	$415,000	$1,100,000

Sales expenses are based on respective sales forces of 30 men and 20 men. The advertising expense is at a rough level that might support the routine launching of a consumer-packaged-goods product. The promotional expense is based on the assumption that 25,000-35,000 outlets will be reached, with point-of-purchase materials playing a more important role in the program not supported by advertising. The costs should be viewed as up-front investments over 12-18 months; they will not be recovered in revenue.

B. Ongoing Costs

The ongoing costs of each option are listed on page 9.

For comparison, CBFPS program areas have a net increase in pill use of 3 percent, despite limited distribution and no advertising. Thus, even if one uses conservative estimates of revenue and a stringent definition of the target market, it would not be unreasonable to expect the program to become self-sufficient, except for product costs, no later than one or one and one-half years after sales begin. The CBFPS program distributes pills to 8 percent of fertile women; more than one-half of these products appear to be diverted from commercial channels. If the sales displaced from the commercial sector are considered, the subsidized commercial contraceptive retail sales program might well generate $100,000-$300,000 in excess cash.

Regionalization

Given the media patterns and distribution structure, it is practical to consider implementation of a regional program. However, it is not feasible to be as selective at the district level as the CBFPS program is. Some costs will not be reduced significantly by regionalization (e.g., media production, package and brand development, senior management), but the major costs (selling, promotion, and media, if any) should be more or less proportional to the population. For example, the northeastern region contains 35 percent of the population, or approximately 700,000 persons in the primary market and approximately 1 million persons in the combined primary and secondary markets.

A comparison of the costs of a regional program with expanded distribution only and of a regional program with expanded distribution and media expansion is given on page 10.

	Program With Expanded Distribution	Program With Expanded Distribution Supported By Consumer Advertising
Sales Expense	$110,000	$ 70,000
Advertising Expense	--	250,000
Promotion	50,000	30,000
Office, Secretary, and Accountant	20,000	20,000
	$180,000	$370,000
Breakeven Number of Consumers Required to Make Program Self-Sufficient, Except for Product Cost	90,000*	185,000*
Breakeven as a Percent of:		
Primary Potential Market	4.5%	9.3%
Primary and Secondary Potential Market	2.9%	6.0%
Approximate Cost per Customer of Initial 18-Month Marketing at Breakeven	$4.60	$6.00

* All calculations are based on annual revenue of $2 per client.

	Regional Program With Expanded Distribution Only	Regional Program With Expanded Distribution and Media Expansion
Initial Costs for Promotion, Packaging, Media, and Initial Selling (one and one-half years)	$200,000	$500,000
Ongoing Selling and Media Costs	90,000	135,000
Breakeven Number of Customers Required to Make Program Self-Sufficient, Except for Program Cost	45,000	68,000
Breakeven as a Percent of:		
Primary Potential Market	6.5%	9.7%
Primary and Secondary Potential Market	4.5%	6.8%
Approximate Cost per Acceptor of Initial Investment	$4.50	$7.35

Program Management

Who would manage the subsidized commercial retail sales program? This is an important question, both because of the impact on cost and the need to understand the Thai marketing structure.

The author did not have sufficient time to seek candidates. However, it is useful to note that the CBFPS runs an urban condom marketing program through pharmacies which produces revenue that covers the variable program cost. This program and the village volunteer program show that the CBFPS has significant experience with subsidized commercial contraceptive marketing.

It is not likely that expatriate management would be required.

3. *How would a subsidized program fit into the present and anticipated contraceptive distribution channels?*

Contraceptives are now delivered through three major channels:

--the nationwide government health system;

--the nationwide commercial market; and

--volunteer distribution (primarily the CBFPS) in approximately one-quarter of the districts.

The new village health volunteers system is developing a new channel into each village.

Using pills as the most popular contraceptive products, distribution, by channel, would be:

	Entire Country	Rural Areas: With CBFPS Program	Rural Areas: Without CBFPS Program
Government Health Centers	17%	18%	17%
Commercial Sector	6%	1%	7%
CBFPS	2%	8%	0%

A. Government Distribution

Government health centers now deliver 75 percent of pills, despite limited hours, inadequate coverage by the 6,500 health and maternity centers in the country, and the concentration of centers in or near areas with large urban populations.

Pills are provided free of charge, although voluntary payment is requested sometimes. Health officials are not certain that pills will remain free permanently in this channel, although the stated goal is that they be provided at no cost.

B. The Commercial Market

The commercial market offers two dozen brands of oral contraceptives at retail prices that begin at ฿20, approximately three times the price in the CBFPS-subsidized market. Contraceptives are distributed through drug stores, which number between 5,000 and 8,000. These stores generally are located in urban areas. Located in the same area as health centers, they are redundant.

C. Voluntary Distribution

The CBFPS program operates in 160 rural districts (approximately one-quarter of all districts). It sells three brands of pills through village volunteers at prices ranging from ฿6 to ฿9. Volunteers also sell other contraceptives and some essential drugs. Volunteers are primarily storekeepers, although many represent other professions.

The system has had two effects:

- To increase pill usage by approximately 3 percent:

	Rural Districts	
	With CBFPS Program	Without CBFPS Program
Family Planning Practice	56%	49%
Pill Usage	27%	24%

- To replace the commercial sector as a source:

	Source of Pills in Rural Districts	
	With CBFPS Program	Without CBFPS Program
Government Outlet	18%	17%
Pharmacies	1%	7%
CBFPS	8%	0%

It is not likely that the CBFPS program will be expanded significantly beyond its current boundaries.

D. The Village Health Volunteers

A system is now being developed in which a village health volunteer from each of the 45,000 villages will be trained in a variety of health-related activities. Pills will be sold at a nominal price--perhaps ฿3, which is higher than the price at the health centers but half that of the product sold by CBFPS volunteers.

The entire system should be functioning in two to four years. At this time it is not clear how well the volunteers will perform their various duties. Health officials who were interviewed for the CBFPS evaluation generally feel that the CBFPS and village health volunteers can coexist.

Recommendations

The Thai health system has done an excellent job of providing contraceptives to urban and rural users. The commercial sector has also made a significant contribution. However, the experience of the CBFPS village distribution program indicates the existence of a potential unserved market, primarily located in villages, that is large enough to justify the first steps in implementing a subsidized commercial marketing program. To ensure the success of such a program, pills must be authorized for sale in village-level stores. It would be desirable to allow the program to do product-specific promotion in the broadcast media. Such a program should be considered a contingency, developed simultaneously with the village health volunteer system, and providing many of the same products.

The two-year, up-front, out-of-pocket costs for a subsidized marketing program would range from $400,000 to $1.1 million, depending on the use of media advertising. Regionalization is feasible, with costs approximately proportional to the regional populations. It is important to note, however, that these estimates are rough approximations and that a full-scale feasibility study is required to develop detailed revenue forecasts and costs.

A subsidized commercial contraceptive marketing program could:

--augment the free health system by making pills available in the villages and at more convenient hours than health or maternity centers;

--allow national, or at least regional, expansion of village-level distribution, in all likelihood at a lower delivery cost than that of the current CBFPS program; and

--provide a means for necessary village-level distribution while the effectiveness of the village health volunteer system as a channel through which pills are distributed is assessed.