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**THE FEASIBILITY OF EXPANDING THE
EGYPTIAN CRS PROJECT**

**A Report Prepared By:
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EXECUTIVE SUMMARY

Malcolm Donald and Timothy Seims were sent to Egypt by the American Public Health Association at the request of USAID/POP/Cairo; John Thomas, Health and Population Advisor, USAID/Jordan, joined them in Cairo. The team assessed the International Planned Parenthood Federation assisted Community Based Family Planning Services (CBFPS) Project, also known as the Contraceptive Retail Sales Project (CRS) for Greater Cairo. USAID wanted to determine the feasibility of expanding the project to other urban areas of Egypt, perhaps eventually linking up with family planning service programs and projects being developed in rural areas.

The team evaluated several key project elements, including:

- product selection;
- branding;
- packaging;
- pricing;
- marketing research;
- promotion;
- distribution; and,
- management.

Concurrently, the team held extensive discussions with advertising specialists, commercial distributors, doctors, pharmacists, professors of medicine, government officials, members of the project staff, USAID officials, and the project Board of Directors.

The team recommended unanimously that USAID/POP/Cairo support the CBFPS Project's consolidation of Greater Cairo activities and the eventual expansion of the project to other urban areas of Egypt. The project has matured enough to warrant USAID/POP/Cairo's support in funding and technical expertise, and in the supply of commodities. The provision of such support would be consistent with the basic rationale for AID involvement in other CRS projects around the world.

The team recommended that a United States contractor, non-resident in Egypt, be engaged to facilitate USAID support of CBFPS. Use of the contractor vehicle seems to be the only practical choice, given AID staff limitations in Washington and Egypt, the intricate continuing relationships with Government of Egypt (GOE) officials, and the complicated coordination of activities which must be carried out with IPPF-London, IPPF-Regional Office (Tunis), the Egyptian Family Planning Association, and the CBFPS Board of Directors. The project requires the rapid provision of expert technical services. Marketing research, advertising, promotion, volunteer operations, accounting, and management skills are among the types of expertise required to successfully operate a CRS project. A major contractor responsibility will be to judge when and where to apply resources. The effectiveness of AID's investment would be greatly diminished if these skills are not applied appropriately.

I. PRODUCTS

Copper T

Egypt has the only CRS program marketing an IUD (the Copper T), which is also its most important product in both sales value and impact on couple years of protection. (See Table II, which indicates the relative impact of each contraceptive product.)

The Copper-T is marketed through a combination of three activities:

1. Promotion and sales to physicians and hospitals by the project's detailpersons.
2. Promotion of the "Copper" IUD, always in conjunction with other contraceptives, to the general public.
3. Creation and promotion of a moderately low established price for insertion of the Copper T among private physicians.

The Copper T is nicely packaged in Egypt and sold by a four-person sales force to 280 of the 400 gynecologists in Cairo. It is also available to the public through drugstores. Drugstores account for about 20 percent of the total sales volume, but of that figure, a considerable number are doctor-prescribed.

The doctor-patient relationship in the IUD decisionmaking process is very complex and needs marketing research study in order to determine the proper mix of public and ethical promotion. At one extreme, the patient cautiously requests birth control advice and is counseled by the doctor to make the appropriate choice, perhaps a Copper T. At the other extreme, the patient buys the Copper T at the drugstore and then shops for a doctor to insert it. Both of these scenarios contain elements of truth.

It is the consultant's impression that promotion of the Copper T is reinforcing a trend of increased acceptance of IUDs in Egypt. Apparently, the Copper T's private competitors have also been enjoying increased sales since the project's promotion began. Government clinic distribution of the Lippes Loop seems to be increasing,

though we could not verify this during our visit. Verification should be made as soon as information is available to determine whether some of the increase in IUD use among "newer" IUDs is at the expense of the Lippes Loop.

Certainly, among doctors and patients, Copper IUDs seem to have a better image than the Lippes Loop which was widely provided (in one size only) before introduction of the Copper T and is still present, particularly in the public sector. The loop's major marketing (not medical) disadvantage is that it is not sterile-packed.

The low insertion fee (5 LE* or less, including necessary follow-up) is "enforced" through the following measures:

1. Doctors are asked to commit themselves personally to the 5 LE insertion fee which is reinforced directly at each subsequent sales visit. (This does not apply for a few key physician opinion leaders.)
2. Doctors participating in the program receive referrals from rallies held by program volunteers.
3. Doctors are always free to charge more for insertion of competitive, more expensive IUDs.
4. The general public is told that the "participating" doctors' insertion fee is "low."

Frequently, and especially in hospitals, patients are actually charged less than the suggested 5 LE fee. Any more formal control of physician insertion fees would probably cost more in physicians' good will and support for the program than it would be worth.

The importance to the potential patient of the low insertion price needs further study. There is no way, for example, for the patient to know in advance that her doctor will charge a low insertion fee for the Copper-T, or even whether her doctor will provide it. Perhaps physician participation could be made more visible. However,

* 1 Egyptian Pound (LE) = \$1.40 U.S.

the price of LE5 or less for insertion seems firm. The 5 LE figure should be reviewed at least annually to ensure that it is realistic and that the CRS project retains credibility among and support of physicians.

The cost advantages of the IUD (See Table V) and the project impact (See Table II) are dramatic. They are based on couple use estimates of one Copper T every 1.9 years,* 100 Amaan or condoms per year, and 13 pill cycles per year.

In Cairo the IUD is inserted almost exclusively by gynecologists. Outside the city, general practitioners (GPs) do the job because there are not enough gynecologists. Currently, GPs are insufficiently trained to insert IUDs. Searle, which markets Copper 7 in Egypt, overcomes this problem by requiring their detailpersons to show an audio cassette training module on Copper 7 insertion technique. The CRS project will probably have to train doctors more comprehensively since the detail force is untrained and has no established reputation among doctors. It is anticipated that in collaboration with universities outside Cairo, a version of the voluntary sterilization training program will be designed and implemented. The program will include several theory sessions and at least five supervised IUD insertion sessions.

Social marketing of the IUD should be replicable elsewhere. Unless paramedics perform insertions, the IUD may not attain the considerable importance in other countries' social marketing projects that it has in Egypt because of the more than adequate number of physicians in Egypt. Nevertheless, its impact on invested resources is likely to be high anywhere. Also, the availability of an ethical product to a CRS project makes the detailing of physicians by the CRS salesforce more credible and acceptable. The medical community's support is often crucial to the success of other contraceptives as well, especially the pill, even if the pill is publicly promoted.

* The CYP of 1.9 was estimated from data from 15 countries reported in Family Planning Perspectives, (Vol. 11 No. 6, Nov./Dec. 1979), which indicated that the expected number of months protected by the Copper IUD was 18 months for each insertion with 70 percent remaining inserted after two years. An estimate of six remaining months after two years was used since some doctors counsel replacement after two years and some after three years.

Foaming Tablet

The CRS project is now selling Neo-Sampoon under the brandname Amaan, which means safety in Arabic. IPPF has supplied tablets in tubes of 20 tablets and in an attractive box of ten unlabeled individual foil-wrapped tablets. The 20-tablet tubes have been selling for 30 piasters and the boxes of ten for 18 piasters.

Acceptors, doctors, and pharmacists perceive Amaan as a good product although further marketing research is needed to determine just who the consumers are and why they like the product. We were told it is preferred because it has no known side effects, is ideal for infrequent contraceptive use (over oral contraceptives)--for example, when husbands return for vacations from work abroad--and for post partum use, and because Egyptian women are used to the insertion into the vagina of herbal concoctions.

Unfortunately, due to lack of product, Amaan's sales performance has been poor. The initial stock of 25,000 boxes of ten were distributed in the first month after marketing began. The 20-tablet tubes lasted longer. Total tablet sales were 280,010 in July; 133,000 in August; 8,320 in September; 760 in October; 120 in November; and 5,300 in December. Project staff knew they were going to run out of the product in August, but the minimum order delivery time is 90 days and additional supplies were not received until December. The supply problem should be alleviated somewhat by the arrival in February of 500,000 AID-supplied foil-wrapped tablets and 2,000,000 similar tablets due to arrive by sea in March.

There have been other problems with Amaan. First, Egyptian law makes it illegal to sell the same pharmaceutical product under two different brand names. The registration problem with Amaan seems to be exacerbated by communication problems among the project director, IPPF London commodities staff, and Eisai, Tokyo. As consultants, we must stress the urgency of resolving this problem, even at the expense of international phone calls and perhaps of legal advice in Cairo. Supposedly, this

problem can be solved if high GOE officials intervene. Second, the promotion of Amaan has created a great demand for Neo-Sampooon; after a long hiatus, the local Eisai distributor is again importing 20-tablet tubes and selling them at a price that effectively puts a ceiling on the cost of Amaan. Project staff have decided to phase out the tubes, thereby giving the Eisai agent the market for Neo-Sampooon in that configuration.

The CRS project wants to market Amaan in boxes of 6 and 12, at 18 and 30 piasters, respectively. The IPPF project officer has suggested 6- and 12-tablet boxes be sold for 45 and 80 piasters respectively. Obviously, pricing strategy should be carefully researched because sales of over 21 million tablets over the next three years have been projected.

Promotion of Amaan has been complicated. The fully developed advertising campaign never got off the ground because the project was not allowed to use its advertising slogans "Amaan For Women" and "Tops For Men" on television and radio. It was allowed to use the brand names without reference to sex and to offer a vague explanation of the products, but apparently this raised numerous questions but sold little Amaan. The complete description plus brand name were allowed in the equivalent of radio talk shows. These problems have all been compounded by lack of available product.

Distribution has been a larger problem. The distributor literally is begging for the product. Pharmacies to which he is selling his whole line of products are refusing to buy anything unless he supplies them with Amaan. Consumers are demanding Amaan, and some pharmacists have managed to horde small quantities for their favorite customers.

Undoubtedly if Amaan supply problems can be resolved, use of Amaan will contribute significantly to the project's success.

Condoms

The condom product TOPS is a Durex-crimped, colored, and lubricated condoms repackaged in packages of three. Its sales performance has been mediocre because of the inherent difficulties in marketing a condom anywhere (especially in a country with "machismo-oriented" sexual mores) and because it is sold at a low price under a possibly suboptimal brand name.

Tahiti, a Japanese, and Czech condoms are abundant; these supposedly sell for 1½ piasters for three--which is much lower than the TOPS price, 5 piasters. However, the condoms are actually sold for 10p for three or four--above the TOPS price. Financially, TOPS is not interesting enough to receive much promotion from retailers. Given a higher price and a developed advertising campaign, the project should be able to expand the market for these condoms.

If USAID offers commodity support for the project, an uncolored, unbranded condom would be made available. The new product would have to be repackaged and marketed at a new price under a new brand name (a subject for marketing research). Establishment of the brand name is especially important because it enables a customer to ask for a condom without being embarrassed. Theoretically, it is easier to ask for three TOPS than for three "French letters." However, experience with other CRS projects indicates that a less foreign-sounding brand name may be advisable. The project is not locked into using a variant of the TOPS name for the next condom.

Expanding the distribution of the condom will increase sales of the product. Current marketing strategy has been to make 1980 the year of emphasis on TOPS. This is appropriate in view of the supply problems with Amaan and the use of different promotional tools for the Copper T.

However, supplies of TOPS, which are Durex condoms, are not procurable through AID, and are potentially exhaustible. Given Amaan's more favorable marketing

position, it would be advisable to switch the promotional emphasis to Amaan as soon as a two-year supply can be guaranteed. If Amaan does as well as expected in Egypt, the project will have a good chance of attracting supplies two years from now. In any event, the supply can be controlled by coordinating distribution efforts with the Eisai dealer, who can bring in Neo-Sampoo--albeit at a higher price and without promotion--to satisfy those who will use nothing else.

The Pill/Oral Contraceptive

A large variety of locally assembled oral contraceptives, ranging in price from 5p to 40p, with a cluster at 18p, is available. The pill seems to be the preferred choice of Egyptian couples and was used by over 60 percent of the current users of contraceptives in 1978. Although its use may be stabilizing, even declining, we believe that total pill distribution would increase if the Egyptian CRS project introduced another publicly-promoted pill. The Egyptian government has established the precedent of advertising a pill by mass media, so there appears to be no formal legal restriction.

With public promotion, a medium price (E.G. 25p) and a brand image, we believe that a new pill would enjoy good sales and stimulate total pill sales at both higher and lower price levels.

A pill would naturally complement the other contraceptives in the project line. The specific type of pill introduced, whether mini/microdose or not, and its procurement should be studied further. The Egyptian government's pharmaceutical company assembles pills locally and might allow the project to market a pill for it, or it might permit AID to supply finished goods imports. The dosage question is both a medical and marketing research question.

It would be reasonable to expect a promoted pill to share about 15 percent to 25 percent of the subsequently expanded market. The Egyptian government subsidizes

the pills priced at 5p, and these are currently the subject of discussions on the effectiveness of the low-price strategy. The impression of the market is that the recent price decrease to 5p may have depressed pill usage by discouraging distribution and tarnishing the product image. It would be neither wise nor necessary to introduce a new pill before early 19981, although discussion would be timely.

III. PROMOTION

Three major promotional tools are available to the program:

1. The detail sales force (mostly pharmacy graduates).
2. Mass media advertising (mostly print ads).
3. A force of volunteers who organize promotional rallies.

CRS's use of a group of volunteers is unique, though other CBD family planning efforts frequently use volunteers. The approximately 80 volunteers receive LE15 per month, ostensibly to cover their transportation costs. Their chief responsibility is to organize rallies at factories and offices where an appropriate figure, such as the project's medical director, a detail person, or a religious leader, will speak. Many volunteers are social work graduates awaiting jobs. The volunteers handle the "nitty gritty" of a rally, usually with cooperation of the factory's clinic doctor. The volunteers also do store checks, report on market intelligence, and package products. They are supervised by two levels of slightly higher compensated volunteer supervisors.

The use of volunteers seems to be an innovative and cost-effective promotional technique, which works well in Egypt, where unemployment among well-educated youth is high. Adequate supervisory systems and control mechanisms ensure the top performance of the volunteers. However, the volunteers' effectiveness can be improved through increased motivation and training, especially during the meeting process. It may also be possible to create visual aide modules for the rallies. Creative full-time management by a paid staff member at sales manager level would be useful and is necessary in view of the opportunities and cost of the total volunteer program, which is comparable to the sales force's expenses. A new volunteer manager could be trained with the help of an outside consultant familiar with the management of large groups of non-professional volunteers.

The promotional message of the majority of the project's advertising efforts is "You will be happier and wealthier if you have a small family--and any of our three products can help you achieve that small family." A few other ads have a less diffuse message, but in general, development of a carefully segmented, well researched advertising strategy has been subordinated to the projects's start-up problems.

The current management recognizes the need to develop a more sophisticated strategy to overcome the restrictions on explicit description of contraceptives on television and radio. There is an urgent need for major market research on advertising strategy.

It would appear that the marketing research design from which the advertising strategy should drop out would have to come from outside technical assistance whereas any necessary survey operation could be handled easily by a number of Egyptian organizations, including the State Information Service without the prolonged presence of outside assistance. It would be advisable for the project to create its own advertising strategy and carry that to an ad agency for implementation since Egyptian ad agencies seem to have more experience in producing and placing ads than in creating message strategy.

One of the priority organizational needs for the project is the integration into the marketing management team of a product manager. This person would be responsible for marketing research and advertising and could employ a graphic artist or survey supervisor if necessary.

III. DISTRIBUTION

The distribution chain in Egypt involves a detail force and a distributor. The detail force sells Copper Ts directly to doctors and hospitals. This accounts for 29 percent of the sales in EPs and 39 percent in CYP. A general Cairo distributor delivers products directly to retail pharmacies and hospitals. Currently, all retailed products are confined to pharmacies, but that is not a serious problem in urban Egypt since there is an unusually high density of pharmacies. Legally, the IUD and Amaan are pharmacy-only products, as is the pill. However, condoms are still sold by candidates for non-pharmacy distribution. Street vendors now sell competitive condoms. An experiment is being conducted to test the feasibility of distributing TOPS in street kiosks. Expanded distribution of TOPS is a priority for that product line.

Outside Cairo, products may be distributed in one of three ways, each of which seems feasible:

1. Extending the present Cairo distributor's franchise to the remainder of urban Egypt (to which he is already delivering).
2. Relying on local non-contractual distributors who pick up products at a cash-and-carry warehouse in Cairo.
3. Building a physical distribution system into the CRS project itself (i.e., buying two to four trucks and maintaining accounts).

Of these, the recommended choice can be determined later: the second will most likely be selected. By using local distributors, the cost of distribution may be reduced.

The distribution price structure was reported as follows:

	<u>PRESENT DISTRIBUTION</u>		<u>LOCAL DISTRIBUTION</u>	
	<u>Margin</u>	<u>Price</u>	<u>Margin</u>	<u>Price</u>
To Public	-	1.00	-	1.00
To Retailer	15%	0.85	20%	0.80
To Distributor	20%	0.68	10%	0.72
Average (With Bonuses)	2.5%	0.67	2.5%	0.70

The distribution, from external supplier to saleable goods in the Cairo warehouse takes about six months; this could be shortened to about four months if products are shipped by air. This assumes the immediate availability of supplies from a manufacturer, which cannot be guaranteed.

The order cost encourages quarterly orders. Therefore, it is advisable to maintain at least a six- to eight-month sales inventory. A review of the current inventory (see Table III) indicates a need for another order of Amaan, since the distributor and retailer pipelines are exhausted. Problems in registering and ordering this product should be resolved as soon as possible. A new supply of Copper T should also be ordered.

IV. PROJECT MANAGEMENT

Assessing CRS project management is complicated because it directly involves a major source of tension in social marketing--operating a public sector program by private sector rules. Although few agree on what type of person should manage a program, the required skills are widely acknowledged.

Social marketing experts agree that a CRS project director should be an entrepreneur, a risk-taker. The CBFPA project in Egypt is directed by Effat Ramadan, who is an entrepreneur.* He and the project board of advisors have created a project that is in place and operating. Moreover, they have weathered successfully that dangerous starting-up period when a CRS project can be terminated by a simple telephone call.

The management is adequate for the present scope of project activities, but several problems are apparent. First, too many individuals report directly to the project director--a phenomenon of management in different countries. Although the plan is to make Dr. O. Wahibeh assistant director, the project director needs subordinate line managers so he can devote more time to planning and running the project.

Second, the management information systems are very poor. The project director does not have the information he needs to run the project efficiently. It took an inordinate amount of time to develop sales figures for us. This is a serious problem, but it can be corrected easily with technical assistance.

* The CRS project is de jure a part of the Egyptian Family Planning Association. It is anticipated that the project will be reconstituted as an independent legal entity before any AID contractor becomes directly involved.

V. IPPF SECTION

In conjunction with the Egyptian Family Planning Association (EFPA), IPPF-London founded the CBFPS project in Egypt. They created it, managed it, and funded it. It is proud of the project, and staff not only wish to stay involved but also to learn from the experience.

Discussions with IPPF officials and an examination of recent events show that although conceived as a pilot project, CBFPS became a fully operational project almost overnight. Its rapid development has caused certain problems. One, incremental funding requirements now exceed IPPF's resources. Two, IPPF lacks the experienced CRS technical personnel needed to monitor and assist in the management of the project in Egypt.

The team cites other problems stemming from a basic philosophical misconception of the program. First, any venture, project, or business must be capitalized properly. Often, the initial investment determines how much success a project will have. The initial investment, particularly in commodities required for the Egyptian CBFPS project, was clearly underestimated.

Second, many believe that because CRS programs are similar to commercial enterprises, they can become "self-sufficient." Clearly, in developed countries the private sector has been able to handle an overwhelming share of the burden of delivering contraceptives. In developing countries, price levels and the necessary investment in advertising normally make large-scale contraceptive marketing commercially unattractive--hence the need for subsidized CRS programs in the first place. In the case of the CBFPS in Egypt, self sufficiency may have been emphasized too strongly at the outset, thus greatly diminishing the project's chances for success. This misplaced emphasis probably generated questionable management decisions throughout the IPPF-CBFPS hierarchy.

Some of the more feasible and often discussed alternatives to full financial self-sufficiency are the generation of sufficient revenues to:

--cover all direct variable costs, except commodities, so that the program can maintain indefinitely at a low level of activity without outside funding;

--reduce total program costs per birth averted to a level well below those of alternative clinic distribution systems so that the host government can eventually absorb subsidy costs; and,

--cover all costs (except initial start-up costs), especially heavy early advertising costs.

As reported in London on February 8, 1980, IPPF wants to continue to participate in the project, but reduce its funding. Mr. Donald Lubin agreed to continue funding the project at present levels for the first six months of 1980; he is not opposed to USAID financial support in addition to the supply of commodities on which agreement was reached earlier.

Beyond this initial agreement, IPPF participation in and coordination of activities with AID/Washington and USAID/Egypt is less clear. Obviously, CCRS is an IPPF/EFPA project, and AID has a mandate to cooperate with IPPF, and with other international donors. IPPF would like to continue managing some aspects of the project, and to continue to draw upon the financial management talent in the regional office in Tunis. IPPF has also suggested using the director of the CBFPS in Bangkok as its principal consultant. The appropriateness of his experience to the Egyptian project is questionable, however.

Specific recommendations on the cooperation among and coordination between EFPA, IPPF, and AID follow. IPPF can contribute in ways AID cannot. For example, as a United States government agency, AID does not have to deal with the specific interests of private donors. But AID and IPPF probably share many interests; by working together they can enhance and eventually achieve the objectives and goals of the Egyptian project.

VI. RECOMMENDATIONS

The Donald, Seims, and Thomas team offer the following recommendations. The recommendations were prepared following extensive discussions in Washington, London, and Cairo, plus field visits in Greater Cairo and in El Zagazeeg, in El Sharkia.

1. Commodity Pipeline

The project will not operate efficiently if there is a shortage of commodities. The actual situation, as of February 1, 1980, is illustrated below.

<u>Type of Contraceptive</u>	<u>Inventory</u>	<u>In Transit</u>	<u>PROJECTED SALES YEAR ONE</u>
Copper T	12,000 Units	12,000 (3/26/80)	65,000
Foaming Tablet	140,000 Tabs	2,500,000 Tabs (3/80)	4,500,000
Condoms	374,400 Pieces	720,000 (3/80)	1,700,000

If AID decides to become involved in this project directly, the commodities situation should be rationalized immediately.

2. Expansion

AID should become involved in the expansion of this project over a three year period. The major project events should include:

- consolidation of activities in Cairo during Year One;
- launching of a new condom product during Year One;
- expansion to urban areas beyond Greater Cairo at the start of Year Two, beginning with Alexandria; and,
- careful study of an oral contraceptive for introduction in Year Two. If political and market elements are favorable, the oral contraceptive should be sold as a consumer product, advertised, and detailed to doctors.

3. Mechanism

The mechanism providing for AID involvement in the expansion should be as follows:

1. A contract, Mission funded, should be let by AID/Washington, with Tom Reese as CTO.
2. The contract should be incrementally funded once a year.
3. A United States contractor with social marketing experience should be engaged. Initially, the contractor's project director will spend a minimum of six weeks in Egypt. During the first year of the contract, he will spend two weeks, every two weeks, in the country.
4. Evaluations should be carried out during the life of the contract. One evaluation should be made before any expansion beyond Greater Cairo begins.

4. Marketing Research

Supplemental marketing research should be the first priority activity for Year One. (The marketing research priorities are listed in the body of this report.) If possible, marketing research design activities should be finished before the time-consuming RFP/Response/Contract Award process begins. Additional marketing research aimed at increasing sales should be carried out in Years One, Two, and Three.

5. IPPF

Since complete AID/IPPF cooperation is required to ensure the success of the Egyptian CRS project, immediate steps should be taken to define precisely the contributions of both organizations. AID can provide funding, most of the commodities, and some technical and management expertise. IPPF can make similar contributions. Preliminary budgets and sales projections exist, and most of the key personnel are in place.

However, if either of two organizations with somewhat different philosophies tries to manage the same project without the full cooperation of the other, the consolidation and expansion of the project may be jeopardized.

The activities of the proposed contractor (undertaken in conjunction with an anticipated subcontract to the Egyptian CRS entity) should include, but are not necessarily limited to, the following:

- 1) Develop and implement an advertising strategy for all existing products, using necessary marketing research resources.
- 2) Recruit and train management staff for the positions of product manager and volunteer manager, using outside consultants whenever necessary.
- 3) Introduce a new condom product, including choice of pricing, packaging, brand name, and product image.
- 4) Determine the distribution mechanism for expansion to other urban areas, (beginning with Alexandria), and implement distributor arrangements.
- 5) Recruit and train detailpersons and volunteers (as well as necessary local supervisors) in other urban areas and introduce all products.
- 6) Begin a program to train GPs outside Cairo in IUD insertion.
- 7) Resolve any remaining registration and supply problems, especially with Amaan.
- 8) Introduce an oral contraceptive product by negotiating the procurement, choosing the proper product, and designing an effective and socially acceptable public promotion strategy.
- 9) Strengthen the volunteer force's effectiveness by providing additional training during the meeting process and meeting presentations, and by borrowing from the experiences of other non-professional voluntary organizations.

TABLE I

UNIT SALES	1979 (from mid June)	Plan Years			% Urban Married Couples of Reproductive Age in Year 3	3 Year Plan Total
		1	2	3		
Copper-T (Units, Thousands)						
Cairo	17	60	66	75	16%	
Other Urban		<u>5</u>	<u>25</u>	<u>40</u>	<u>7</u>	
Total		<u>65</u>	<u>91</u>	<u>115</u>	<u>14</u>	271,000
Amman (Tabs, Millions)						
Cairo	.4	4.3	4.9	5.7	5	
Other Urban		<u>.2</u>	<u>2.6</u>	<u>3.0</u>	<u>2</u>	
Total		<u>4.5</u>	<u>7.5</u>	<u>8.7</u>	<u>3</u>	20.7 million
Condoms (Pieces, Millions)						
Cairo	.8	1.6	1.8	2.0	1.5	
Other Urban		<u>.1</u>	<u>.6</u>	<u>.8</u>	<u>.6</u>	
Total		<u>1.7</u>	<u>2.4</u>	<u>2.8</u>	<u>.9</u>	6.9 million
Pill (Cycles, Millions)						
Cairo			.6	.7	4	
Other Urban			<u>.4</u>	<u>.5</u>	<u>3</u>	
Total			<u>1.0</u>	<u>1.2</u>	<u>3</u>	2.2 million

Notes: 1) Assumed a marriage rate of 65 percent in Cairo and 75 percent outside; 40 percent of population in reproductive age group; 9 million population in each Cairo and other urban.

TABLE II

SALES IN LE AND CYP (All figures in 000's)	1979 (From mid June)	Percent	Plan Years						Cumulative Total LE 3 Plan Years
			1	%	2	%	3	%	
Copper-T									
Price, LE	LE 1.50		2.00		2.50		3.00		
EP Sales	26	54%	130	37%	228	24%	345	28%	703
CYP	32	73	124	67	173	50	219	51	
Amman									
Price Average, piasters	2.4p		3.6		4.2		4.7		
LE Sales	10	21	162	46	315	34	409	33	886
CYP	4	9	45	24	75	21	87	20	
Condoms									
Prices, p	5/3		5,10 & 20/3		10 & 20		10 & 25		
Average Price	1.7	25	3.3		5.3		6.0		14
LE Sales	12	18	57		128		168		7
CYP	8		17		24		7		28
Pills									
Price, p					25		25		
LE Sales					250	27	300	25	550
CYP					77	22	92	22	
Total									
LE Sales	48	100	349	100	921	100	1,222	100	2,492
CYP	44	100	186	100	349	100	426	100	961

Notes: Constant exchange rate of U.S. \$1.42 = 1 LE throughout. 100 p = 1 LE 100 Amman or condoms or 13 pill cycles = 1 CYP. 1 Copper T = 1.9 CYP. Sales at price to public.

TABLE III
PLAN YEARS

COSTS OF SALES	PLAN YEARS												3-Year Cumulative FOB	
	Year 1				Year 2				Year 3					
	FOB	Landing	Pkg.	Total	FOB	Landing	Pkg.	Total	FOB	Landing	Pkg.	Total		
Copper-T														
per unit U.S. \$.80	.16	.14	1.10	.80	.16	.15	1.11	.90	.18	.154	1.23		
extended LE 000's	37	7	6	50	51	10	10	71	73	15	12	100	U.S. \$229	
Amaan														
Per unit U.S. ¢	6.5	1.3	.5	8.3	6.5	1.3	.5	8.3	6.5	1.4	.6	8.5		
extended LE 000's	206	41	16	263	343	69	26	438	398	86	36	520	U.S. \$1345	
Condom														
Per unit U.S. ¢	3¢	.6	1.7	5.3	3	.6	1.8	5.4	3.5	.7	1.9	6.1		
extended LE 000's	36	7	20	90	51	10	30	91	69	14	37	120	U.S. \$223	
Pill														
Per cycle U.S. ¢					16.8	3.4	6	26.2	18.5	3.7	7	29.2		
extended LE 000's					118	24	42	185	156	73	138	247	U.S. \$389	
Total														
U.S. \$ 000's	396	78	60	572	799	160	153	1,115	988	267	317	1,401	2,186	
LE 000's	279	55	42	403	563	113	108	785	696	188	223	987	1,538	

Note: Amaan is FOB Tokyo. Pills are FOB San Francisco, although local procurement is feasible. The GOE is currently retailing pills at U.S. 7.1¢ per cycle. Exchange rate for all years is U.S. \$1.42 = 1 LE.

TABLE IV

INCOME STATEMENT (LE 000's)	PLAN YEAR 1	PLAN YEAR 2	PLAN YEAR 3	3-YEAR SUM	CUMULATIVE % of SALES
SALES	349	921	1222	2492	100%
EXPENSES					
Distribution	115	295	391	801	32
Costs of Sales	403	785	987	2175	87
FOB in LE	279	563	696	1538	62
U.S.\$ shipping and handling in LE	55	113	188	356	14
local packaging and handling	42	108	223	373	15
Promotion Expenses	519	744	895		
Advertising	387	564	677	1628	65
Field Force (detailpersons)	31	69	77	177	7
Salaries	23	40	48	117	4
¹ Transportation	8	29	29	66	3
Volunteers	30	45	58	133	5
Transportation allowance	22	36	47	105	4
² Supervision and support	8	9	11	28	1
² Samples (Costs of sales)	18	31	38	87	3
Marketing Research	50	20	20	90	3
Training in IUD insertion	3	15	25	43	2
Administration	598	776	833	2207	89
Local Salaries	56	67	80	203	8
Rents & Overhead of Subcontractor	20	25	30	80	3
Consultants	46	20	22	88	4
³ Contractor Overhead	476	664	701	1841	74
Total Expenses LE	1635	2600	3106	7341	295
Total Deficit LE	1286	1679	1884	4849	195
⁴ U.S. Expenses (excluding commodities) in EP	513	680	719	1912	77
⁴ LE Cash Expenses	623	923	1202	2752	110
LE Cash Deficit	280	2	-20	265	11
(Total expenses - sales)/CYP in U.S. \$	U.S.\$ 9.79	U.S.\$ 6.81	U.S.\$ 6.20	U.S.\$ 7.16	

NOTES TO TABLE IV

1. Field force transportation would ideally be achieved by purchasing 12 vehicles for the sales force and allowing the salespeople to apply part of their transportation allowance towards the gradual purchase of the vehicles for themselves. Presumably, they would have to pay tax and title when they took personal title. Alternatively, the sales personnel could be expected to provide their own vehicles. The itemized transportation cost includes depreciation on 12 vehicles, which would be virtually the only item in the capital budget, estimated at approximately U.S. \$7,000 CIF each.

2. Sampling assumptions are 1 percent for Copper-T, 5 percent each for Amaan and the condom, and 2 percent for the pill.

3. Contractor overhead is estimated only for purposes of gauging total expenses for a possible RFP. It was estimated at 70 percent of cash expenses, including commodity FOB and landing costs.

4. Cash expenses include two estimates, i.e.,

 Samples CIF cost is 80 percent of total; and,

 Consultant costs are 20 percent in local currency.

Cash expenses exclude distribution expenses and all commodity costs except packaging.

TABLE V

YEAR THREE COSTS BY PRODUCT
(LE 000's)

	<u>Copper-T</u>		<u>Amaan</u>		<u>Condom</u>		<u>Pill</u>		
	LE	Allocation	LE	Allocation	LE	Allocation	LE	Allocation	TOTAL
Sales	345	28%	409	33%	168	14%	300	25%	100%
Distribution Expense	109	28	129	33	55	14	98	25	
Costs of Sales	100	10	520	53	120	12	247	25	100
¹ Cost of Sales/CYP U.S. \$.65		8.49		6.09		3.81		
Promotion Expenses	293	33	271	30	115	13	218	24	
² Advertising	190	28	223	33	95	14	169	25	100
Field Force	47	60	4	5	4	5	23	30	100
³ Volunteers	30	51	12	20	4	7	13	22	100
¹ Samples	1	3	26	68	6	16	5	13	100
Marketing Research	5	25	5	25	5	25	5	25	100
Training in IUD Insertion	20	80	1	5	1	5	3	10	100
Administrative Expenses	425	51	167	20	58	7	183	22	100
Total Expenses	927		1087		348		746		
Total Deficit	582		678		180		446		
Deficit/CYP U.S. \$	3.77		11.07		9.13		6.88		
Price/CYP U.S. \$	2.24		6.67		8.52		4.62		
CYP in Year Three	219	51	87	20	28	7	92	22	100
Notes: ¹ Allocated according to actual estimates.									
² Allocated by % of Sales in Year Three									
³ Allocated by % of CYP in Year Three									
Deficit/CYP without contractors overhead as indication of Year Four costs	1.46		3.77		6.64		4.50		3.95 Weighted Average

TABLE VI
SALARY AND BENEFIT PROJECTIONS
LE Pounds (\$1 = 1.40)

	PLAN YEAR ONE		PLAN YEAR TWO	PLAN YEAR THREE
	Annual	Monthly		
Project Director	LE 14,286	(1,191) ¹	17,143	20,572
Assistant Director	7,200	(600)	8,640	10,368
Administrative Manager	3,600	(300)	4,320	5,184
Advertising/Research Manager	3,600	(300)	4,320	5,184
Sales Manager	3,600	(300)	4,320	5,184
Secretary	2,400	(200)	2,880	3,456
Field Supervisors	15,750	(175) ²	28,980	34,776
Accountant	2,400	(200)	2,880	3,456
Junior Accountant	1,800	(150)	2,160	2,592
Volunteer Supervisor	2,400	(200) ³	2,880	3,456
Research Administration Assistant	1,500	(125)	1,800	2,160
Administrative Assistants	3,900	(100 & 75)	4,680	5,616
Warehouse Duty Supervisor	1,080	(90)	1,296	1,555
Secretary	1,200	(100)	1,440	1,728
Clerks (2)	1,800	(75)	2,160	2,592
Drivers (2)	1,800	(75)	2,160	2,592
TOTAL	67,416		90,979	110,471
20% Social Tax	13,483		18,196	22,094
Grand Total	80,899		109,175	132,565
3 Year Total LE				322,639
3 Year Total \$				451,695

Notes on Salary Breakout

1. Mr. Ramadan is now paid the LE equivalent of \$8,700.00. If there is AID involvement, we recommend that his salary be increased to the LE equivalent of \$20,000. At a minimum, he could be earning \$15,000 in Egypt working for an Egyptian company in marketing or advertising doing more or less the same job. He has been offered \$25,000 by an expatriate company with better benefits.

Obviously, nobody is indispensable and Mr. Ramadan is making no formal demands. This is the classic case of mixing public and private sector programs. We do not agree with IPPF's contention that government officials will react in a hostile fashion if Ramadan is paid what we consider a proper salary.

2. These projections assume starting Year One with 6 Field Supervisors (as opposed to the present four), adding three additional Field Supervisors after six months, and adding three more at the beginning of Year Two. The three Field Supervisors starting to work at the start of Year Two will be starting at the rate of LE 175 per month while the other Field Supervisors will have received a 20 percent raise at the beginning of Year Two.

3. As inflation is running at 30 percent per annum in Egypt, all salaries have been increased 20 percent per annum for Years Two and Three. No allowance has been made for year end bonus or vacation.

Appendix B

PERSONS CONTACTED IN EGYPT AND THE UNITED KINGDOM

USAID Mission

Donald Brown, Director
Owen Clyde, Deputy Director
Stan Applegate,
Bud Shutt, M.D.
Thomas H. Reese
Laura Slobey

IPPF London

Donald Lubin, Deputy Secretary General
Juan Pascoe, Director, Program Strategy
Dermod Knox, Area Liaison Officer, Menar
Basharar Khokhar, Project Officer

Other London

Shahla Kaussari, Social Marketing International

CBFPS Project

Effat Ramadam, Director
Dr. Mohammed Aassan, Sales Manager
Dr. Wauby Wahibeh
Mrs. Aziza Hussein
Dr. Salaam
Dr. Fouda

Supreme Council for Population and Family Planning

Dr. Aziz Bindary
Dr. Mostapha El-Samma

Egypt Family Planning Association

Dr. Bawdawri, Director

Distribution

Mr. Maher Eskander, SOFICOPHARM

Private Sector

Farid Habib, Searle Manager for Egypt
Dr. George Z. Bargoud, Director of Scientific Bureau, Organon, Holland

Advertising

Aly Abdel Naby Ibrahim, Deputy General Manager Advertising Department,
Pyramid e Al Ahram
Dr. Kamal, Vice Editor Al Kahbar

SIS

Robert Higgins
M. Sharaf

Appendix C
VEHICLES FOR THE PROJECT

Vehicles will be required to expand the project. Vehicles may be obtained by various means. For example:

1. AID might supply vehicles of U.S. manufacture.
2. Vehicles purchased with USAID funds might be obtained locally.
3. IPPF might supply vehicles.
4. Another international donor might contribute vehicles to the project.
5. The field supervisors might be able to purchase their own vehicles over a three-year period, if some source of credit could be found. The private pharmaceutical scientific offices buy vehicles and then allow the detailmen to purchase the vehicles over a three-year period.

No decision was reached as to which method should be recommended.

Appendix D

REFERENCES

International Planned Parenthood Federation. Final Report: Research Findings and Guidelines for Implementing a Community Based Distribution Program in Metropolitan Cairo. December 1978.

Kaussari, Shahla. A Social Marketing Project for Greater Cairo. London: November 1979.

Kaussari, Shala. Community Based Family Planning Services. Egypt (Greater Cairo). Marketing and Operational Plan. London: February 1979.

Kaussari, Shahla. CBFPS Project- Greater Cairo: Assessments and Recommendations. London: July 1979.

Loudis, Joseph and Rochat, Roger W. The Import, Manufacture and Distribution of Contraceptives in Egypt. March 1977.

Population Information Program, The Johns Hopkins University. Population Reports, Series J, Number 21. Baltimore: January 1980.

U.S. Department of Health, Education, and Welfare, Public Health Service. Family Planning Use and Child Health in the Arab Republic of Egypt. Atlanta: October 1979.