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**PRELIMINARY ASSESSMENT OF THE POTENTIAL
FOR COMMERCIAL AND SUBSIDIZED MARKETING
OF CONTRACEPTIVES IN THE IVORY COAST**

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I. EXECUTIVE SUMMARY

A SOMARC consulting team visited the Ivory Coast February 17-27, 1986. The team was charged with:

- o Assessing the existing and potential commercial markets for contraceptives
- o Establishing potential for some type of contraceptive social marketing program.

The Private Sector Contraceptive Market

A small, well-developed commercial market now supplies contraceptives at reasonable prices (US\$1.25 to US\$1.50 per cycle of pills for popular brands) to a market equivalent to 2 percent of married women of reproductive age. Sales are now about double those implied by the 1980-1981 Fertility Survey. Contraceptives are readily available in about 175 pharmacies in urban areas throughout the country and at about 70 drug depots in smaller towns. Oral pills, which generally require prescription, are the dominant product, representing over 80 percent of the market.

Prospects for a CSM Program

The basic picture for a CSM program is mixed. On the one hand, quality facilities for mounting a program are available including distributors, wholesalers, retailers, and advertising and market research agencies. Advertising media have adequate penetration. Urban incomes provide adequate purchasing power for a CSM program. A free market atmosphere generally prevails, although there are visible barriers to market entry.

On the other hand, desired and actual family sizes are large, even in urban educated segments. Knowledge about modern contraception is limited and intention to use it even more limited. Government population and family planning policies are nonexistent. Distribution of contraceptives of all types is rigidly limited to pharmacies, and their prices are rigidly controlled. No advertising of drug products (OTCs or ethicals) is permitted, except at point of purchase.

Recommendations

SOMARC recommends that two studies be carried out in the short term to better understand the socioeconomic dynamics of contraceptive knowledge, attitudes, and practices; and that in the longer term limited social marketing activities be undertaken. The two studies would target (1) the health delivery community including pharmacists and (2) the potential consumer market.

Longer-term activities would include the potential funding of contraceptive detailing, point-of-purchase advertising, and limited generic family planning advertising achieved through the auspices of a larger national family health program. The possibility also exists of running a test program that would be part of a national Oral Rehydration Solution (ORS) program, and would be closely monitored. This is explained in detail in section VIII, Summary and Recommendations.

II. PURPOSE OF MISSION

The SOMARC team was charged with conducting an assessment of the existing commercial channels of contraceptives to determine:

- o "Current types of contraceptives sold, product lines, origins, types of retail outlets, types of wholesale outlets, distribution channels, extensive information on pricing, types of advertising, regulations for retailing, warehouse costs, levels of duty, customs classification, and import restrictions."
- o Whether the political, economic, and social climate and development of the Ivory Coast would at present or in the future lend itself to the establishment of a successful CSM program.

The team members were:

- o Professor John Farley, Columbia University and Executive Director of Marketing Science Institute, Cambridge, Mass.
- o Dr. Allan Kulakow, Academy for Educational Development, Washington, D.C.
- o Patrice van de Walle, The Futures Group, Washington, D.C.

III. THE CURRENT DEMOGRAPHIC SITUATION

A. An Overview of Population Dynamics

The Ivory Coast, a West African nation that borders on the Atlantic, has an estimated 1985 population of 9.8 million in an area of 322,000 square kilometers. This accounts for a relatively low population density of 30 people per square kilometer. The fertility rate is around 6.7 children per woman, accounting for a natural rate of growth of the population that is around 3 percent. The overall rate of growth nears 4 percent when migration is taken into account. During the 1970s, according to World Bank statistics, the Ivory Coast had the second-highest population growth rate in the world. From 1980 to 2000 the World Bank projects the Ivory Coast will continue to have one of the four highest growth rates in the world. Tables B.1 to B.6 in Appendix B provide the reader with a more extensive background of the demographic profile of the Ivory Coast.

The Ivory Coast remains somewhat of an economic success in Africa. The GNP per capita is high (US\$950 in 1982) with the top 40 percent of the families estimated to have about 80 percent of the income.

Estimated 1985 adult literacy rates--53 percent for men and 31 percent for women--are relatively low given the level of economic development. Education is not yet compulsory, but over 75 percent of children now attend some school. There are indications of change, however, with 39 percent of women aged 5 to 19 in school and 41 percent of women in the labor force.

An indigenous religion is practiced by 63 percent of the population; 25 percent are Muslim and 12 percent are Christian.

A key demographic feature of the Ivory Coast is a labor shortage and a population of nearly 3 million non-Ivorian Africans living in the Ivory Coast. Representing 19.4 percent of the total population in 1975, 25.2 percent in 1980, and close to 30 percent today, this immigrant population is becoming an increasingly sensitive issue in the Ivory Coast. By 1990, projections are that over one-third of the population will be composed of foreigners, and this will possibly grow to one-half by the year 2010 (Tables B.3, B.4, and B.5).

There are indications that the government is beginning to react to this immigration. Although most immigrants from West Africa can obtain access to the Ivory Coast as a result of regional accords, the border control of passports and visas is being tightened and enforced. In addition, the attainment of the Ivorian nationality is being made more difficult through rigid requirements.

B. Population Activity and Policy

The government does not have a population policy that deals directly with family planning issues. The population policy outlined in the 5-year plan is targeted toward the maximization of human resources. To attain this global policy, the government has fixed three major objectives: to promote, socially and economically, the Ivorian national; to increase the participation of nationals in the process of development; and to assure continued high growth in the economy. No mention is made of limiting population growth or of family planning.

As of yet, there are no family planning clinics in the country, although one will be opened in the Treicheville neighborhood of Abidjan shortly. Contraceptives are available at fee-for-services clinics as well as through private practices. In any case, very little information is available to the public about contraception.

C. Unmet Needs for Family Planning

Three studies were consulted by the assessment team for information on contraceptive knowledge and use: Population et Sante de la Reproduction en Cote d'Ivoire, 1985, by S. Diarra et al.; Femmes, Famille et Population en Cote d'Ivoire, Contribution a l'Elaboration d'un Programme National d'Education a la Vie Familiale, 1984, by A. Traore et al.; and the Ivory Coast World Fertility Survey, completed in 1980-1981. The information presented in these studies is often divergent from one another which makes it difficult to determine accurately the unmet needs for contraception. The following discussion highlights some of the findings.

The potential market for contraceptives composed of women of reproductive age numbers approximately 2.5 million, of whom between 80 percent and 90 percent are married. According to the 1980-1981 WFS, approximately 80 percent of women

had heard about some type of contraceptive method, although only 20 percent had heard of modern methods. Only 3 percent of the women had ever used a modern contraceptive and only .6 percent were actively using a method at the time of the survey. These figures differ from the later Traore et al. study, which found that 12.3 percent of both men and women had used a modern contraceptive. The Diarra study surveyed 5,000 women in maternity wards in urban hospitals and found that 8 percent of these women said they had used a modern contraceptive (5.8 percent of which was the oral pill). After giving birth, the desire for contraception rose to 40 percent, and 51 percent for women with four or more children.

Table B.6 demonstrates that the percentage of women desiring no more children is very low. The 1980-1981 WFS found that the desired family size is between 8 and 9. Undertaken in an urban setting, the Diarra study found that the desired family size was 6.7

Finally, the Traore study found a crushing majority of 75 percent answered in the affirmative to the question, "Must one accept all the children that one can have?" But of those answering this question who had some higher education, 57 percent answered yes and 41 percent answered no.

Because of the contradictions in the available data, it is difficult to ascertain precisely what the unmet needs for family planning are. Of the two million married women of reproductive age, a small but seemingly increasing number of these women are seeking protection from pregnancy. Finally, we learned that although there are no prohibitions restricting sex education or family planning information, very little information is easily available to the public concerning contraceptives. In fact, most women surveyed reported learning about contraception from friends rather than family or physicians. This situation is complicated by an increasingly serious problem of often-fatal abortions especially in women under the age of 20. All this points to a possibly larger interest and need for family planning services than are available and consulted today.

IV. THE EXISTING COMMERCIAL MARKET

The existing contraceptive market makes available through pharmacies a wide range of contraceptive products at relatively modest prices. However, the commercial market serves only about 2 percent of married women of reproductive age as defined above.

A. Products and Prices

A range of oral contraceptives, condoms, and spermicides is available to the consumer at relatively modest prices (Table 1).

Prices to consumers are rigidly controlled, set (in CFA) at 108.85 times the landed price FOB of the product in French francs. The CFA is pegged at 50 FF; therefore, the factor approximately doubles the landed price. Pharmaceuticals are imported duty-free, while drug products without visas are subject to 65 percent duty.

The range of contraceptive products available is large, as illustrated by the list of oral contraceptives found in one of Abidjan's principal pharmacies (Table 2). However, many of these brands are sold in very small volumes, and brands are often discontinued because of lack of demand.

Almost all (80 percent) pharmaceuticals (and all contraceptives--except for condoms--are classified as pharmaceuticals) are imported by wholesalers Laborex and GOMPCI (Groupement Outre-mer Pharmaceutique Cote d'Ivoire). The average monthly sales volume of various contraceptives for the two wholesalers combined are also shown in Table 1. The total monthly sales for all orals is 40,000 cycles per month, or about 2 percent of all fertile women in the Ivory Coast. Wyeth (France) has about two-thirds of the market, Schering about one-fifth. The rest of the market is shared by a large number of brands from other manufacturers. Other types of contraceptives are less important, with condoms, spermicides, and injectables available but now protecting at most .5 percent of all fertile women.

B. Distribution

Orals, condoms, and spermicides are available at 175 pharmacies throughout the country. While half of the pharmacies are located in the Abidjan area, there is at

Table 1
 PRICES AND VOLUMES
 OF PRINCIPAL CONTRACEPTIVE PRODUCTS

Brand and Quantity per Package	Supplier	Average Monthly Volume	Retail Price (U.S.)
<u>Orals</u>			
Adepal (1)	Wyeth	1,650	1.54
Adepal (3)	Wyeth	2,680	4.00
Milli-Anovlar (1)	Schering	250	1.06
Milli-Anovlar (3)	Schering	480	2.59
Gynovlan (1)	Schering	60	1.30
Gynovlan (3)	Schering	100	3.45
Minidril (1)	Wyeth	1,300	1.35
Minidril (3)	Wyeth	1,900	3.17
Miniphage (1)	Schering	1,750	1.87
Miniphage (3)	Wyeth	1,950	4.97
Stediril (1)	Wyeth	2,005	1.29
Stediril (3)	Wyeth	3,700	3.16
Trentovlar (1)	Schering	40	1.16
Trentovlar (3)	Schering	100	2.63
Anovlar (1)	Schering	60	1.65
Anovlar (3)	Schering	60	4.49
<u>Spermicides</u>			
Goupil (6)	NA	1,360	1.89
Goupil (12)	NA	500	3.71
Tarocap (6)	Soekami	180	5.91
Tarocap (18)	Soekami	60	15.25
Tarocap (30)	Soekami	20	20.99
Pharmatex (10)	Pharmelac	600	5.86
Pharmatex (20)	Pharmelac	10	10.09
Pharmatex/Tube (6)	Pharmelac	10	5.13
<u>Condoms</u>			
Select (6)		2,000	2.24
Select-Lubrif (12)		1,000	4.14
Ola (6)		200	3.00

Table 2
ORAL PILLS STOCKED BY A PRINCIPAL ABIDJAN PHARMACY

Brand	Manufacturer
Adepal comprime	Wyeth-Byla
Anovlar comprime	Schering
Diane 21 comprimés	Schering
Milli-Anovlar 21 comprimés	Schering
Milligynon	Schering
Minidril	Wyeth-Byla
Miniphase	Schering
Norquentiel comprime	Gremy-Longuet
Ovamezzo comprime	Organon
Ovanon comprime	Organon
Ovariostat comprime	Organon
Ovostat - 28	Organon
Ovulene 50 mg comprime	Scarle
Pauseril comprime	Wyeth-Byla
Physiostat comprime	Organon
Stediril comprime	Wyeth-Byla
Trentovlane comprime	Schering
Triella comprime	Cilag
Varnoline comprime	Organon

least one pharmacy in all towns with populations of 5,000 or more, and nearly 45 percent of the population lives in such urban areas. In addition, about 70 depots in smaller towns stock a limited supply of over-the-counter products (including condoms) and can order ethical products for which prescriptions are available.

Prescriptions are generally required for orals, although pharmacists may supply products in cases such as when prescriptions are lost.

Laborex and GOMPCI each handle a wide and competing range of contraceptives. Each company takes orders by telephone and delivers on a regular route in the big cities daily or more frequently and at least twice a week in smaller towns. Each wholesaler has about half of the overall pharmaceutical market.

There is no indication of chronic stock-out of pharmaceuticals in general at wholesale or retail levels, but there are indications that distributors stock-out on occasion, despite an attempt to hold about three months of buffer stock at that level. One or two pharmacies specialize in direct importation of products and are recognized as reliable sources of supply.

Clear contrasts in both channel costs and reach are shown in a comparison of the distribution system for oral contraceptives and a deeper system for local manufactured Union Carbide batteries in Figure 1. The battery market has two manufacturers competing in a market closed to import except for one size. Union Carbide maintains a salesforce of 14 men who earn approximately \$500 per month and are permitted to sell at retail as well. Wholesale margins are practically nil, but wholesalers receive an annual rebate of 2 percent for small wholesalers to 10-12 percent for large wholesalers, who handle about 80 percent of the volume. Maximum retail prices are set by application to the government, but selling prices are often in fact lower. In addition to conventional retailers, batteries are available in markets and through street vendors.

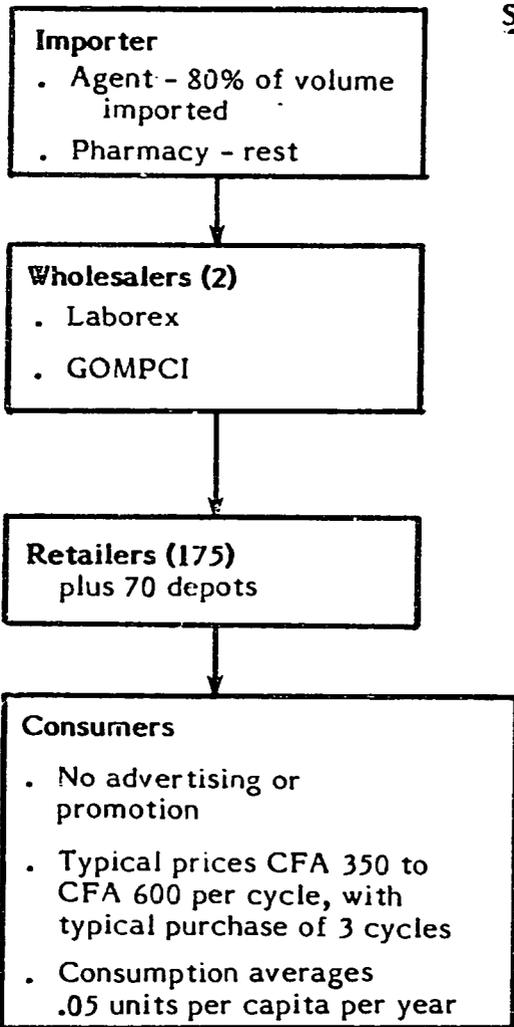
C. Advertising and Promotion

There is no advertising or promotion of drug products (ethical or OTC) to consumers outside the pharmacy. Point-of-purchase promotion is common, and we did see one poster for Depo-Provera that identified Upjohn, although the poster described all types of contraceptives.

FIGURE 1

TWO DISTRIBUTION STRUCTURES

ORAL CONTRACEPTIVES

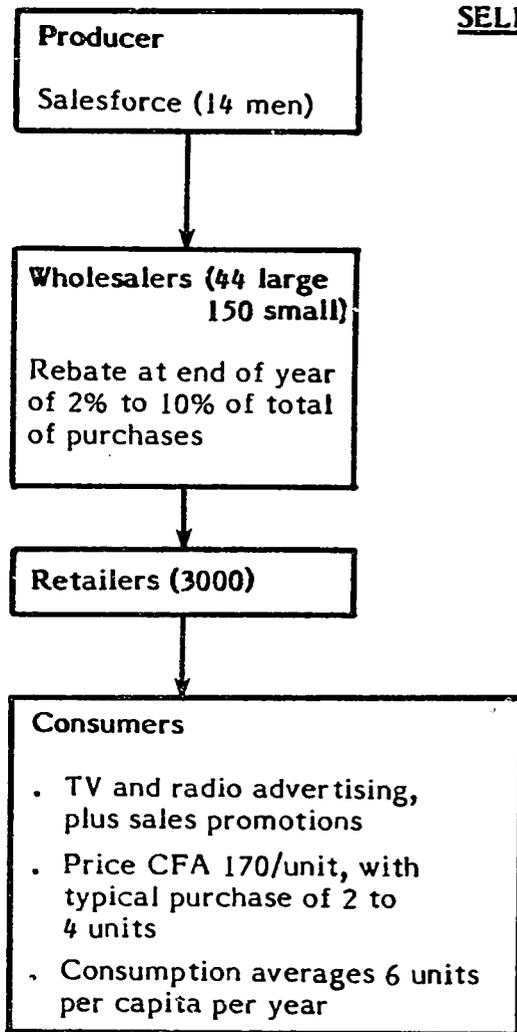


MARGIN AS A FRACTION OF FINAL SELLING PRICE

10%

40%

BATTERIES



APPROXIMATE EFFECTIVE FRACTION OF FINAL SELLING PRICE

1% to 5%

20%

Drug houses have medical representatives who call on doctors and pharmacists, but detailing of contraceptives is apparently minimal. We were unable to identify a Wyeth representative, and Wyeth had not contacted one leading pharmacy for more than five years. A leading government gynecologist said he is never detailed on contraceptives, but he frequently receives representatives promoting other products.

The wholesalers are basically order takers and do no active selling and no promotion. They depend completely on importers to register, introduce, and promote products.

D. Registration

Registration of pharmaceuticals with the Ministry of Health is required. With issuance of a five-year visa, pharmaceuticals can be imported duty-free. Condoms are apparently imported as rubber goods and are subject to 65 percent duty. Registration, however, can be a very lengthy process requiring considerable documentation and taking up to two years to complete. It is possible that companies in the market could contribute to delays or refusals for new competing products.

V. THE MARKETING INFRASTRUCTURE

Overall, the Ivory Coast can boast of an excellent marketing infrastructure. A relatively well developed transportation network assures countrywide distribution channels for products. Quantitative as well as qualitative insights can be obtained from several topnotch market research agencies. The ubiquitous presence of radio and, to a lesser extent, television, combined with a national daily newspaper and several weekly and monthly publications allow for an active advertising forum.

A. Distribution

As mentioned above, the two pharmaceutical wholesalers, Laborex and GOMPCI, have extensive and very similar distribution networks. Outside of Abidjan, which is supplied by their central office, both companies have divided the country into three regions. Each region has a central depot from which, at a minimum, biweekly distribution runs are made that cover all the major towns in the country. Both wholesalers use their own fleet of trucks and drivers. Figure 1 illustrates the distribution structure for Union Carbide batteries and provides the reader with an example of the versatile marketing structures that can exist in the Ivory Coast.

B. Market Research

We contacted three firms that are able to provide market research of a qualitative and quantitative nature. The first, l'Institut Ivoirien d'Opinion Publique (IIOP), is involved primarily with research as opposed to the other two, which are attached to larger advertising firms. The IIOP has extensive experience in market research, working on contracts for Unilever branch companies, Nestle, R. J. Reynolds, Guinness, and others. They also have done work as consultants for United Nations agencies (UNDP, UNFPA, ILO, UNICEF) such as basic needs assessment, project conception, and implementation and communication strategy development.

The other market research agencies contacted were branch offices of advertising companies: Filiane, the market research arm of Editions Publicite, and the Acajou advertising company.

IOP, Filiane, and Acajou are each able to put together interview teams that can cover most urban regions of the Ivory Coast with most of the main languages spoken in the country. Each also has considerable experience in running focus groups and other qualitative research. The costs that were cited by each company were competitive as well as reasonable.

C. Advertising

The Ivory Coast boasts a multitude of advertising agencies. The team contacted three that are considered among the best and provide the fullest range of services: Lintas, Editions Publicite, and Acajou.

The Lintas Abidjan agency became a member of SSC&B Lintas Worldwide as recently as a year ago. Since then, it has promoted a long list of Unilever brands using television and radio, as well as the print media. Its campaign to promote the detergent product Omo led to the agency capturing several advertising awards in its first full year in service.

Editions Publicite, established since 1973, serves a range of international companies and their local branches including Union Carbide, Nescafe, Wrigleys, Blohorn, and Ivoiral.

Acajou in three years has managed to become the fourth-largest advertising agency in the Ivory Coast. Its clients include Vicks, Nivea, and the Ministry of Commerce. In addition to advertising services and market research capabilities, it also offers promotional and marketing support through a subsidiary company--WACA.

Media Coverage

Television

There is estimated to be between 400,000 and 500,000 television sets in the Ivory Coast. Eighty-three percent of urban dwellers watch television regularly and in a family setting, while in rural areas television watching remains an event that can be described as a "spectacle collectif." A peak-time 30-second spot costs 370,000 CFA (approximately US\$1,000).

Radio

Eighty-eight percent of the population listen to radios in a given week, and 67 percent do so every day. A peak-time 45-second spot costs between 46,500 and 69,500 CFA (between US\$130 and US\$200).

Press

There is one daily newspaper, Fraternite Matin, with a circulation of between 80,000 and 90,000. There also are several weeklies and monthly publications that offer advertising.

Outdoors

There is also the possibility of advertising outdoors on buses, at bus stops, kiosks, billboards, and at the Felix Houphouet-Boigny stadium in Abidjan.

VI. KNOWLEDGE, ATTITUDES, AND PRACTICES REGARDING FAMILY PLANNING IN THE IVORY COAST

Background and context insights into the cultural context against which a possible SOMARC project might be developed were provided by the advertising and market research agencies with which we talked, the pharmacists we interviewed, Dr. Daniel Kadja and his study: Femmes, Famille et Population en Cote d'Ivoire. Dr. Samba Diarra and his study: Population et Sante de la Reproduction en Cote d'Ivoire, the medical director for the national railroad (RAN), and a few representatives of the Ministry of Health who provided the official position of the government. Like so many other countries in Africa, the Ivory Coast is experiencing considerable cultural change because of rapid urbanization, active involvement in international trade, increased participation in the modern sector through expanding educational opportunities, and growing exposure to radio and television images of the modern world. This reality was expressed very clearly by a young pharmacist's assistant in the small town of Boafle: "Nous avons opte pour le modele francais" ("We have opted for the french model"), as he explained why he thought there was active interest in contraception among young people in the Ivory Coast.

A. Traditional Values Concerning Children

The study by Traore et al. points out that traditional attitudes of Ivorian ethnic groups interpret the inability to have children as placing the individual and especially the woman in a state of "non-being" (p. 147). In their sample of over 1,800, more than 75 percent responded affirmatively to the question, "Must one accept all the children that one can have?" Only 22 percent answered "no." Interestingly, those who have had university training are divided: 56 percent, "yes," and 41 percent, "no." The "yeses" are those who seem to be wealthy enough to take care of a large number of children. The authors feel that these data confirm the strength of traditional values.

B. Use of Contraceptives

Of the sample, only 39 percent have used some family planning techniques, 56 percent have never done so; of the 39 percent who had used a method, 31

percent had used a modern method. Significantly, the largest percentages of users were those legally married (49 percent) and bachelors (39 percent). The authors explain these data as illustrating a stronger sense of the responsibility that having children imposes and a relatively stable psychological, emotional, social, and material environment (pp. 150-151).

Of the 39 percent who have used contraception techniques at least one time, 31 percent used modern contraceptives and 9 percent used traditional methods. More men use modern contraceptives (33 percent) than women (29 percent) (p. 153). Of those who have used contraception, 41 percent are Christian; 36 percent, Muslim; and 35 percent, Animists. Of those refusing, 61 percent are Animists; 57 percent, Muslims; and 53 percent, Christian (p. 154).

Of those who have used contraceptives, only 15 percent did so on the advice of a doctor. Most people have learned about contraception from friends, parents, midwives, or spouses (p. 156).

However, when the sample was asked, "If you do not use any method of contraception at present, would you want to do so in the future?," nearly half (44 percent) answered "yes," in contrast to 35 percent who did not plan at all to do so. Of those who answered "yes," 45 percent were men and 43 percent were women. Levels of education seem to correlate positively with the percentage answering "yes": illiterate, 33 percent; read and write, 29 percent; primary school, 44 percent; secondary school, 56 percent; and university studies, 46 percent. The highest rate of future use is among bachelors, 51 percent. Among those who never intend to use contraceptives, 8 percent stated religious reasons for not being interested, and 17 percent referred to personal inconvenience. The authors, therefore, suggest that religion seems to play a very small role in deciding whether to use contraceptives.

C. Growth of the Family Planning Concept

Although there is no government policy in support of family planning, there is no active interdiction of contraception. "Nous sommes une société libre" ("We are a free society"). As we have seen, there are no official obstacles to obtaining the entire range of contraceptive products. Although usage levels are low--1980-1981

prevalence rates were less than 1 percent--there seems to be a growing interest in and use of contraceptives by young people who are more and more involved in the modern economic sector and interested in smaller families of two to four children. In fact, current sales levels imply that usage rates of pills are about double the 1980-1981 rates.

Those Ivorians in favor of family planning programs believe that interest in family planning--child spacing, at least--is growing among not only the young modern urbanites but also the large number of poor who have moved to the cities and find difficult conditions that do not support large families. They stressed the traditional view of the central role of children in society but believe it is necessary to educate people to accept the idea of spacing so that they can have as many children as they feel able to support.

The interest in contraception is already established albeit in a very limited sector. Price is not an issue; knowledge and awareness of their availability seem to be the critical reasons for acceptance of contraceptives. According to the physicians we spoke with, Ivorians are very concerned about health, and if contraception is recognized as part of keeping healthy, people will buy contraceptives. They never shirk from the cost of health. The basic problem then is a lack of information about contraception rather than a lack of interest or the cost.

Today, most Ivorians learn about family planning from friends or family (according to Prof. Kadja, 80 percent of the women interviewed who reported using contraceptives said they learned about them from their mothers), not from physicians. People like Dr. Diarra and Dr. Kadja feel that national decisionmakers as well as physicians and health workers who go into the field all need information and training about family planning.

Generally, Ivorians are not reticent about discussing sexual behavior and contraception. Sex education is part of public primary school. Government does not seem to try to interfere with sexual mores but is not about to proclaim any policy that would reach into the sexual behaviors of its citizens.

Nevertheless, it would be difficult at this time to embark on a broad national social marketing project for contraception. There is no opposition to the concept of

social marketing. In fact, people in the Ministry of Health are very enthusiastic about a social marketing effort for oral rehydration. However, because the government of the Ivory Coast will not publish an official national family planning policy, the government will not accept a national family planning campaign at this time. However, this reticence is easing and is reflected in the more permissive attitude toward private contraception programs or sex education in public schools. Although traditional feelings about having as many children as God permits are very strong, modern realities and the usefulness of contraceptives to prevent unwanted pregnancies are becoming equally strong.

Conclusion

Generally, people interviewed felt that with more information about what is modern contraception, kinds of contraceptives, where they are available, their costs, side effects, and psychological and social impact on the users, the market automatically will grow. However, although there seems to be a potentially strong public interest in contraception, the lack of a national policy in supporting campaigns to increase usage is a serious constraint. Compounding this dilemma is the prohibition against advertising pharmaceutical products and the requirement that new pharmaceutical products must be registered, a process that could take up to two years and that might be blocked by the French. Yet the market might be increased "naturally" by the gradual communication of information about contraceptives within the various population groups.

There is some concern about the future impact of the growing immigrant population that today makes up 30 percent of the population, but by the year 2010 will probably reach 50 percent of the total population of the Ivory Coast. Although many of today's immigrant groups live traditional rural lives, there is a continuous migration into urban areas and confrontation with the impact of a dramatically new and often impersonal environment. This is a very sensitive subject now but may become an important political issue in the near future, possibly leading to government interest in a national population policy and family planning activities.

VII. SUMMARY AND RECOMMENDATIONS

The Ivory Coast would seem to be a country that is ready for some type of family planning activity. The economy is composed of a healthy and active modern sector. On the supply side, we find all the necessary skills and facilities needed to mount a CSM program of any sort. Distributors, wholesalers, and pharmacists interviewed perceived a CSM program simply as a commercial venture.

On the demand side, we find that the existing commercial market of contraceptives is very small relative to incomes. Commercial oral prices are less than 1 percent of monthly income for a quarter of the households. The fraction of households is higher in the urban areas and lower in the countryside. This would seem to indicate a large potential for growth, especially in urban areas. It is possible that a CSM program that paid conventional Ivorian wholesale and retail margins and resulted in a price of about half of the current retail price could reach one-third of the overall market and nearly one-half of the urban market. In any case, it would seem that the market has been growing independently of a CSM program. Oral pill usage, at least, seems to have more than doubled since the WFS of 1980-1981.

The questions arise, how can we speed up this growth, and can we support commercial contraceptive markets without introducing American products. In any event, we have the impression that the government would not stand in the way of some kind of unofficial effort to increase interest in family planning. Ivorians have the impression that at present the Ivory Coast is not overpopulated and does not need to restrict family size. However, the feeling we got from our interviews is that there is a growing awareness in government that the population problem will become a serious issue in the future, and that some modest, "unofficial" effort in rational family planning would be welcomed.

The problems that remain obstacles to a CSM program in the Ivory Coast are: first and foremost, high-level government approval; second, the lack of advertising; and finally, the need for an import license. Of course, government approval would make these last two much easier to surmount.

SOMARC believes that further action should be undertaken in the Ivory Coast and recommends that studies be conducted in the short term to aid in the development of limited social marketing activities to be undertaken in the long term.

In the short term we believe that a greater understanding of both the health delivery community including pharmacists and of the consumer is necessary. We therefore propose that a series of interviews be conducted within the medical community to obtain a clearer idea of, among other things:

- o Their understanding of contraceptive technology available today
- o Their knowledge of contraindications in the use of contraceptives
- o Their attitudes toward contraception
- o Their knowledge and attitudes toward contraception as an integral part of maternal health
- o Their attitudes toward point-of-purchase advertising of products
- o Whether they would support an information campaign for general health which included family planning
- o Whether they would want a detail man bringing them information about contraceptive products

At the same time we propose to conduct a consumer survey that would determine, among other things:

- o Knowledge, attitudes, and practices concerning contraceptives in urban and rural settings, and of Ivorians as compared with foreigners living in the Ivory Coast
- o The effect that education has on knowledge, attitudes and practices of contraceptive use

- o Growth of contraceptive use in the last several years
- o Who influences the consumer to purchase contraceptives (midwives, pharmacists, physicians, families, media)
- o General unmet needs for family planning.

The information that can be obtained through two such studies will need to be placed in a format that can be used to approach officials in the GOIC with the expressed intent of initiating some limited social marketing activities.

Of course we will need to carry out the above-mentioned studies before we are sure about any long-term activities, but SOMARC feels that the following activities may be feasible, as well as successful in the Ivory Coast.

First, SOMARC is excited about the possibility of funding detailing for contraceptive products in the Ivory Coast. We have discovered evidence that segments of the medical community may be poorly informed concerning contraceptive technology (interviews with the medical community would clarify this hypothesis). The use of detailing would serve the double purpose of providing up-to-date information to health care deliverers and pharmacists as well as to help increase sales of contraceptives. In all likelihood, the products being detailed would be ones already available in the Ivory Coast. This would alleviate the burden of obtaining a license for any new products, and would decrease the opposition to our presence which we expect from French manufacturers currently selling in the Ivory Coast.

It is our opinion that due to the present political climate concerning family planning in the Ivory Coast, as well as the existing dominance and consumer acceptance of products manufactured by the French pharmaceutical industry, a traditional SOMARC program would be inappropriate at this time (i.e., the importation of AID-supplied American manufactured commodities, and their packaging, advertising and distribution through SOMARC technical support and funding).

Therefore, we believe there are other approaches that SOMARC could take that would be appropriate at this time. They are:

- o The development and funding of generic advertisement for family planning
- o To help arrange for and fund the detailing of contraceptive products already existing in the Ivory Coast
- o To help design and fund point-of-purchase advertising in pharmacies and health care delivery centers.

Finally, we found considerable interest in an oral rehydration solution program. If such a social marketing program ever occurs in the Ivory Coast, it would provide an ideal setting within which we could approach the GOIC with the concept of SOMARC. We would propose a regional and experimental program that could be closely monitored by the government. The existing ORS program delivery and monitoring infrastructures could be used to achieve such a test program.

APPENDIX A
List of Contacts

- A. USAID/REDSO
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 2. Duncan Miller, Assistant Director of Program Analysis and Development, REDSO
 3. Jim Sheppard, Regional Health Officer
 4. Sarah Clark, Regional Population Officer
 5. Ming Hung, MCH/FP Advisor
- B. U.S. Embassy
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 2. Fred Gaynor, Commercial Attache, Tel. 32-46-16
- C. Ministry of Health (GOIC)
1. Dr. Bouffard Bella, Director, Direction des Relations Exterieurs et Regionales
 2. Prof. Diarra Samba, Professor a la Faculte Gynecologue Accoucheur des Hopitaux, Clinique de Treicheville, Chef de la Service Gyneco-obstetricale, Tel. 36-91-82, Poste 231
- D. Ministry of Labour and the Ivoirisation of Professionals, Employment Section
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- E. Combatting Communicable Childhood Diseases (CCCD)
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1. Dr. Daniel M. Kadja, Director of Research, Centre Universitaire de Recherche et de Developpement (CURD), Tel. 43-90-00
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APPENDIX B
Demographic Indicators

Table B.1
POPULATION BY SEX AND AGE, 1985
(Thousands)

Age Group	Both Sexes	Males	Females
All Ages	9,797	5,006	4,792
0-4	1,806	907	899
5-9	1,444	724	720
10-14	1,172	586	586
15-19	987	493	495
20-24	822	427	395
25-29	677	351	326
30-34	564	297	268
35-39	526	279	247
40-44	436	231	205
45-49	367	197	170
50-54	300	161	140
55-59	237	124	113
60-64	173	90	83
65-69	130	66	65
47-74	84	40	43
75-79	44	21	23
80+	28	13	15

SOURCE: World Population Prospects and Estimates: Projections as Assessed in 1982, New York: United Nations, 1985.

Table B.2
DEMOGRAPHIC SITUATION AND PROJECTIONS
AS ASSESSED BY THE UNITED NATIONS

Variable	Year						
	1950	1960	1970	1980	1985	1990	2000
Total Population (000)	3,241	3,731	5,553	8,247	9,797	11,541	15,581
Total Fertility Rate	6.65	6.61	6.63	6.70	6.70	6.60	6.11
Natural Growth (%/yr)	1.23	1.85	2.35	2.79	2.92	2.99	2.91
Population Density (Persons per sq km)	10	12	17	26	30	36	48
Percent Urban	13.2	19.3	27.4	37.1	42.0	46.6	54.6

SOURCE: World Population Prospects and Estimates: Projections as Assessed in 1982, New York: United Nations, 1985.

Table B.3

PERCENT OF FOREIGNERS IN IVORIAN POPULATION
(* = Estimate)

1975	19.4
1980	25.2
*1985	27.8
*1990	30.6

SOURCE: Ivory Coast World Fertility Survey: 1980-81.

Table B.4

1975 DISTRIBUTION BY NATIONALITY
OF FOREIGN POPULATION LIVING IN IVORY COAST

Burkinabe	53%
Malian	24%
Guineans	7%
Ghanaians	3%
Other Africa	11%
Non-African	2%

SOURCE: Ivory Coast World Fertility Survey: 1980-81.

Table B.5

MAJOR ETHNIC GROUPS OF THE IVORY COAST

Akans	Kreu
Abrons	Guere
Lagunaires	Bete
Agni	Krou
Baoule	Dida
	Bakwe
Mande North	Godie
Malinke	
	Voltaic
Mande South	Senoufo
Dan	Lopi
Yacouba	Koulango
Toura	
Gouro	

Table B.6

PERCENTAGE OF WOMEN DESIRING NO MORE CHILDREN
ACCORDING TO AGE AND FAMILY SIZE

Age	Percentage of Women Desiring No More Children	Family Size	Percentage of Women Desiring No More Children
15-19	1.6	0	0.0
20-24	1.7	1	1.0
25-29	2.0	2	2.3
30-34	4.6	3	3.3
35-39	9.0	4	3.2
40-44	13.8	5	6.3
45-49	12.9	6	11.4
		7	15.6
		8	13.5
Total	4.3	9+	36.7

SOURCE: Ivory Coast World Fertility Survey: 1980-81.

APPENDIX C

Bibliography

Diarra, S., Welfens-Ekra, C., and Toure-Coulibaly, K., Population et Sante de la Reproduction en Cote d'Ivoire, Abidjan, 1985.

Economics and Finance Ministry, Government of the Ivory Coast, Enquete Ivoirienne sur la Fecondite, 1980-81, Abidjan, 1984.

Europa Publications Limited, Africa South of the Sahara 1986, London, 1985.

Foreign Areas Studies, The American University, Area Handbook for Ivory Coast, Second Edition, Washington, 1973.

Traore, A., Kouakou, N'G., and Kadja, M. D., Femmes, Famille et Population en Cote d'Ivoire, Contribution a l'Elaboration d'un Programme National d'Education a la Vie Familiale, Ivory Coast, Abidjan, 1984.

United Nations, World Population Prospects and Estimated Projections as Assessed in 1982, New York, 1985.

World Bank, World Development Report 1984, Washington, 1984.