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CONTRACEPTIVE SOCIAL MARKETING (CSM) ASSESSMENT

Volume 1: WORLDWIDE REVIEW
Volume 2: SIX COUNTRY REPORTS

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Preface

This report contains two volumes: the Worldwide Review of A.I.D.'s support to Contraceptive Social Marketing (CSM) programs and the Six Country Reports on A.I.D.-funded CSM programs in Asia: Indonesia and Pakistan; Africa: Ghana and Nigeria; and Latin America and the Caribbean: the Dominican Republic and Mexico.

EXECUTIVE SUMMARY

BACKGROUND

This assessment represents the first worldwide review of the Agency for International Development's (A.I.D.) many and varied efforts to provide family planning through its Contraceptive Social Marketing (CSM) program. Since 1972, the Agency has funded over 25 CSM projects. The assessment comes at a time when the Agency is focusing increasingly on involving the private sector in family planning efforts. Consequently, attention is being directed to this relatively new approach, whose core is to enlist the expertise and marketing infrastructure of the commercial sector in the sale of contraceptives.

Although the programmatic emphasis is on successful marketing, all CSM projects have a second and equally important purpose: to market contraceptives at prices that are affordable to lower income groups and ultimately to increase contraceptive prevalence. It is the intrinsic tension between these two goals --one commercial, the other social--that makes CSM projects difficult both to execute and to evaluate and that serves as the backdrop to this report.

CSM programs were first developed as an alternative to public sector programs, which were often overcrowded and undersupplied and thus were unable to meet the demand for family planning services. Presently, these programs are being carried out by six contractors: The Futures Group (with three subcontractors), which manages the Social Marketing for Change (SOMARC) project; Population Services International; Family and Planning International Assistance; Juarez and Associates; Triton; and RONCO Consulting Corporation.

The findings and conclusions in this report are based primarily on in-depth reviews of six CSM country programs. These were written by members of the large multidisciplinary team of specialists who subsequently prepared this synthesis. In addition, the team reviewed numerous reports and documents relating to other programs to provide a global perspective.

MAJOR CONCLUSIONS

The overriding conclusion of this assessment is that CSM programs are meeting their prime social objectives: Most programs are providing quality family planning methods at affordable prices and increasing availability and access through retail outlets. This approach is proving to be an effective way to increase contraceptive prevalence among lower income groups. As intended, CSM projects are generally complementing, not

replacing, other services. In addition, these efforts may be enhancing the acceptability of the other services. Their advertising efforts give a high profile to family planning and often serve to break down cultural barriers to its use. On the other hand, the program has not been fully successful with respect to its economic objective: that projects should recover their operating expenses.

A second conclusion is that CSM programs have demonstrated considerable initiative over the years and that their experiments with a wide spectrum of programming options have advanced considerably the level of understanding of what works and what does not work in CSM programming. The options have been many and varied. For instance, there are at least five different management configurations ranging from programs managed by governments to those managed totally by private sector companies. Marketing techniques have been more varied yet. Target populations have been rural or urban or a mixture of both. Advertising has ranged from the use of standard mass media to spreading the message on riverboat sails, in popular songs or at national sporting events. Products have included not just condoms but also more effective methods such as orals, IUDs and injectables. Products have been acquired not only from A.I.D. but also from commercial manufacturers. Distribution, although usually carried out through an existing for-profit organization, has also worked successfully when such nontraditional agents as village medical practitioners and doctors were employed.

The programming choices have been made largely in response to in-country needs and opportunities. The lessons that have been extrapolated from individual country experience, however, have applicability for other CSM efforts. Mistakes need not be repeated and successful approaches in one country can often be adopted elsewhere.

MANAGEMENT

Because the core of any CSM program is the successful marketing of contraceptive products, it is critical for CSM program managers to have strong marketing skills, or at least to have access to those skills. The corollary is that, of the five management options identified, programs managed by a commercial distributor have proven to have the greatest chance to market products successfully, in particular because they tend to offer the marketing skills and management flexibility inherent in a sound commercial operation. Commercial expertise is not enough to guarantee success, however. The companion lesson is that strong government support is important, particularly in countries where there is social or cultural uncertainty about family planning: Governments can hinder program success by erecting advertising or import barriers; likewise, they can give programs a strong boost if they lend support publicly. The conclusion is

that programs appear to work best when they are managed by a commercial distributor but also have strong government support.

Although marketing skills are the sine qua non in any implementing agency, programs also work better when the contractor and USAID staff are knowledgeable about marketing operations. Such skills enable these back-up parties to carry out their principal functions of providing policy advice and marketing in a professional and helpful way. Programs work best, however, if USAID and the contractor restrict their activities to these roles and leave the day-to-day management to the implementing agency.

No in-country CSM manager can be expected to possess the full panoply of marketing skills that will be needed as programs change and progress. Highly experienced commercial marketers have proven an essential ingredient in program progress to date and will continue to be needed over the long term.

MARKETING

Promotion and Advertising

Of prime importance to the success of any marketing effort is the promotion and advertising strategy employed. CSM marketers have done a particularly good job of taking into account cultural and religious barriers to advertising contraceptive products and ensuring that messages used are within the accepted bounds. They have learned that a nonconfrontational approach works best in most settings, but that often an explicit effort is needed to brief and educate the elite or influential groups in a community to enlist their support.

Managers have also been alert to the need to identify messages that will ring a responsive note among potential consumers; where the "small family, happy family" concept has become an outworn message, they have moved on to other appeals, such as maternal health or the economic benefits of a small family.

The most important lesson learned has been that a CSM program, like any commercial marketing enterprise, must base its advertising and promotion strategy on extensive research and planning. In practice, this means that more effort is needed to identify the potential clients' knowledge, attitudes and practice with respect to contraceptive use, and to test messages carefully before they are released. Other mechanisms to test consumer reactions, such as offering product samples, also need to be used more frequently. In particular, any national advertising effort needs to be predicated on a well-designed plan that includes an analysis of the expected cost-benefit ratio.

Many new ideas have arisen with respect to marketing channels. CSM products are being promoted not only through the mass media but also in popular settings such as on riverboat sails, at rallies, and at national sporting events. These unconventional channels not only reinforce the message when it is beamed over mass media; in places where there are restrictions on mass media use for family planning methods, they have provided a cost-effective alternative.

Products

CSM programs have carried a wide assortment of products, most commonly the condom and other nonprescription products (particularly spermicides and foam), but also several prescription items--pills, injectables, and IUDs. Issues have arisen with respect to both.

For condoms, the issue arises from the new focus on the condom as a prophylactic against AIDS, and the question is whether this use will tarnish the image of the condom as a family planning method that is appropriate within a marital relationship. The conclusion here is that CSM programs should continue to promote condoms but simultaneously increase their promotion of alternative methods. At the same time, CSM program managers should coordinate their promotion strategies with those of AIDS program managers, to mitigate any negative effects of the double message on condom programs.

For prescription products, the issue is whether products that have traditionally been distributed by medical personnel can be safely sold by such lay groups as pharmacists and retail sellers. Overall, the experience in CSM programs has shown that, supported by relatively short and inexpensive training, nonphysician vendors can safely and effectively supply contraceptive products (including oral contraceptives) in programs that enhance the coverage, acceptability, and delivery of family planning services. This training, together with such IEC techniques as informational packaging and countertop displays, has provided CSM workers with enough background and understanding of family planning methods to enable them to help each client make an informed choice regarding the appropriate method for herself (or himself).

CSM programs have traditionally relied on A.I.D. to provide subsidized contraceptives. This has enabled CSM programs to sell products at prices within the range of lower income groups. This reliance has had two drawbacks: 1) A.I.D. cannot supply some of the more effective ethical products; and 2) A.I.D. resources will be insufficient to meet the increased demands for contraceptives worldwide if, as anticipated, another 17 CSM programs are launched in the near future. Once again, with respect to product sources, CSM program management

resourcefulness has been evident. Various programs have made arrangements with commercial companies to purchase products at conciliatory prices, an alternative that deserves consideration elsewhere, particularly in Latin American and Asian settings.

Pricing

Product pricing is an area in which CSM program managers are proving to be increasingly sensitive to local conditions. The most valuable lesson learned to date is that it is important to provide a higher profit margin to the commercial companies distributing contraceptives to compensate for the products' lower unit prices. As with advertising and promotion, however, the need remains to apply marketing techniques more rigidly. This implies careful consideration and testing of all elements of the pricing decision and flexibility in the face of both marketing and broader economic trends.

Brand Names

Product branding is an area in which somewhat less experimentation has taken place. CSM programs have traditionally operated on the assumption that the use of local brand names enhances the cultural identity of a product and thus serves to increase sales. The option of world branding, so successful with products like Coke, Pepsi, Colgate, etc., might also work for CSM products: It could reduce expenses, add to product credibility, and help fill the gap where marketing expertise is weak. This is an option that warrants further exploration.

Distribution

With respect to product distribution, the customary reliance on existing commercial channels has stood most CSM programs in good stead. Private sector distributors have proved to be able to react quickly to changing market conditions. Furthermore, use of private sector distributors enables operating costs to be subsidized to some degree by other products. In rural areas or in countries where consumer interest is minimal, however, commercial distributors have sometimes not shown interest in promoting the CSM products. In such cases, program managers have turned successfully to other channels. One alternative has been to create an in-house sales force that promotes the product forcefully. Several nontraditional retail outlets have also been successfully exploited, including sales through village medical practitioners, medical representatives, and doctors.

Such experiences in marketing to hard-to-reach target groups are not as widely shared among program implementors and contractors as they should be. It may be necessary for A.I.D. to ensure that this communication takes place.

An important lesson learned in each of these arrangements is that the marketing of family products requires special orientation and training for all participants in the distribution chain. Orientation seminars for distributors and retailers have dispelled negative attitudes that these groups have might have had toward making contraceptives available and have generated enthusiasm for family planning that has helped make these groups effective salesmen of CSM products.

FINANCIAL ISSUES

The main reason that social marketing programs have been able to keep product prices low is that the contraceptives are subsidized, generally by A.I.D. or, in a few cases, by commercial pharmaceutical firms.

An important issue for any CSM program is whether its social goals can ever be reconciled with its marketing objectives, i.e., cost-recovery and/or self-financing. Stated differently, the question is whether, in the absence of external subsidies, prices can remain low enough to be within the financial reach of low income clients. The prognosis is not encouraging: To date, projects that have become self-sustaining appear to have moved from the lower level economic groups to those who can afford the higher cost of nonsubsidized contraceptives.

A technical obstacle to progress in this area is that costs of CSM programs are not well known. Moreover, efforts are not usually made to disassociate the business costs (i.e., distribution, packaging, and advertising) from the social costs (the price differential needed to put products in the reach of low income clients, special packaging for illiterate consumers, and the like). Despite the paucity of data, however, some research has shown that CSM projects are far more cost-effective than public sector family planning programs.

Since USAID support cannot be available indefinitely, an interim measure would be to involve other donors in supporting these programs. Over the long haul, however, CSM programs must develop a standard methodology for estimating, monitoring, and projecting costs that will enable them to plan realistically for the possible eventual withdrawal of external support.

RESEARCH AND EVALUATION

CSM programs can be evaluated on the basis of two questions. The first, whose answer is relatively easy to establish, is whether the marketing strategies (advertising, packaging, pricing, etc.), are resulting in increased sales. The second, and far more difficult to ascertain, is whether these programs are achieving their ultimate goal of increasing contraceptive prevalence.

With respect to the first, marketing research is a standard component of any marketing effort and is used both to help design the marketing strategy and test its effectiveness over time. Generally utilizing in-country resources, CSM programs have employed marketing research with varying degrees of commitment and success. Some types of research such as retail audit systems and ongoing tracking studies, however, are rarely used, although they are extremely effective ways of enabling program managers to assess consumer practices and attitudes towards products and to track product distribution. Ensuring that this research is undertaken and that its lessons are taken into account are jobs for the program manager.

Conversely, evaluation of a CSM program's achievements with respect to the effect on contraceptive prevalence is very complex. Calculating trends in contraceptive use, particularly trends attibutable to specific programs, has always been difficult. Results are inconclusive and can be contradictory. Calculations of couple years of protection based on surveys often differ from calculations of CYPs that arise from sales of contraceptives. It may be necessary to develop new indicators to measure program performance, both for CSM programs and for other family planning programs. Certainly, this is an area that will need considerably more attention if reliable data are to be made available.

A complete list of recommendations is provided in Volume 1, Chapter IX.

CONTRACEPTIVE SOCIAL MARKETING (CSM) ASSESSMENT

Volume 1
WORLDWIDE REVIEW

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GLOSSARY

AED	Academy for Educational Development
A.I.D.	Agency for International Development
AFR	Africa (region)
ANE	Asia and the Near East (region)
BA	Births averted
CDC	Commercial distribution of contraceptives
CRS	Contraceptive Retail Sales
CSM	Contraceptive Social Marketing
CYP	Couple years of protection
DHS	Demographic and Health Surveys
DPN	Doremus, Porter and Novelli
FDA	Food and Drug Administration
FOF	Family of the Future
FPA	Family Planning Association
FPIA	Family Planning International Assistance
IPPF	International Planned Parenthood Federation
ISTI/POPTECH	International Science & Technology Institute/ Population Technical Assistance Project
JSA	John Short and Associates
KAP	Knowledge, attitudes, and practice
LAC	Latin America and the Caribbean (region)
OC	Oral contraceptive
PSI	Population Services International
PVO	Private voluntary organization

REDSO	Regional Economic Development Support Office
SOMARC	Social Marketing for Change
SOW	Scope of work
STD	Sexually transmitted disease
TA	Technical Assistance
TFG	The Futures Group
UNFPA	United Nations Fund for Population Activities

I. INTRODUCTION

I.1 Purpose of Assignment

The purpose of this assessment of the Agency for International Development's (A.I.D.) Contraceptive Social Marketing (CSM) programs was threefold:

- To prepare a synthesis report that analyzed and compared various CSM approaches, results, and lessons learned;
- To recommend improvements and modifications for CSM programs; and
- To examine alternative CSM contraceptive management and marketing approaches and to compare them with older, more traditional CSM programs.

I.2 Assessment Team Composition and Countries Visited

A multidisciplinary team of specialists worked together from September 28 to October 23, 1987 assessing A.I.D.-financed activities. The team was divided into three groups, one each for Africa (AFR), Asia and the Near East (ANE), and Latin America and the Caribbean (LAC) regions. This assessment marks the first time A.I.D.'s CSM program has been reviewed on a worldwide basis. Each team visited two countries. The team composition for country visits is provided below.

- AFRICA (Ghana and Nigeria)
  Vincent Brown - Team Leader, evaluator/generalist
  Barbara Janowitz - social science analyst
  Carl Allen - marketing expert
  Stella Goings, MD - medical specialist

- ASIA (Indonesia and Pakistan)
  Tennyson Levy - Team Leader, evaluator/generalist
  Peter Donaldson - social science analyst
  Imtiaz Taj Kamal - medical specialist (Pakistan)
  Terry Peigh - marketing expert
  Does Sanpoerno, MD - medical specialist (Indonesia)

- LATIN AMERICA/CARIBBEAN (Dominican Republic and Mexico)
  Constance Carrino - Team Leader, evaluator/generalist
  Sergio Díaz-Briquets - social science analyst

Darío Mejía - marketing expert
Alberto Rizo, MD - medical specialist

Vincent Brown was overall team leader responsible for the organization and coordination of the national and synthesis reports, and served as one of the principal editors of these reports.

Matthew Friedman, International Science and Technology Institute/Population Technical Assistance Project (ISTI/POPTECH) researcher, participated in the organization of the study, prepared many of the briefing materials, and played an active role in the debriefing and preparation of the national and synthesis studies.

Nicolas Wright, MD, MPH, prepared the protocol for the CSM medical assessments in the countries visited, and Dr. Stella Goings, a CSM team member, prepared the synthesis of the results of the individual country responses to the medical protocol.

Annette Binnendijk, author of A.I.D.'s Evaluation Special Study No. 40, "A.I.D.'s Experience with Contraceptive Social Marketing: A Synthesis of Project Evaluation Findings," participated in organizing the assessment and in briefing the team.

I.3 Methodology

Briefing sessions in advance of the country visits were provided by six organizations that are involved in CSM programs: The Futures Group (TFG) and its three subcontractors: Academy for Educational Development (AED); Doremus, Porter and Novelli (DPN); and John Short and Associates (JSA), which together are responsible for the Social Marketing for Change (SOMARC) program; Population Services International (PSI); and Family Planning International Assistance (FPIA). In addition, two other contractors, Juarez and Associates and Triton, supplied briefing materials and sent a representative to one of the briefing sessions. Representatives of the Office of Population also participated in the briefing sessions.

The briefing included a thorough review of the scope of work (SOW), the outline for the country reports, and the role of the country visits as preparation for writing the synthesis report. To broaden the team's background and to pretest the outline for the country reports, desk reviews were prepared on six well-established programs (Bangladesh, Egypt, Guatemala, Honduras, Jamaica, and Nepal).

Field visits took place from October 3-17. The teams met with representatives from the host governments, USAID missions, local and international private voluntary organizations (PVO), the United Nations Fund for Population Activities (UNFPA), the World Bank, International Planned Parenthood Federation (IPPF) affiliates, and with staff from implementing agencies and their subcontractors (advertising, research, and training), as well as wholesalers, retailers, and consumers. In addition, teams visited pharmacies, retailers, and marketplaces and reviewed reports, project descriptions, planning documents, and the like. In each country, prior to departure, the teams briefed the USAID missions, local implementing institutions (including government officials where applicable), and representatives of A.I.D. cooperating agencies who accompanied some teams during field trips.

On return from the field, the teams wrote up their country reports for Ghana, Nigeria, Indonesia, Pakistan, the Dominican Republic, and Mexico and then agreed on the major points to be included in this synthesis report. A brief overview of the synthesis findings was presented to A.I.D./Washington population officials on November 30, 1987. This report addresses most of the questions that arose during that meeting.

Appendix A includes matrixes with comparative data regarding the CSM programs in the six countries visited and the desk review countries. The titles of the matrixes are as follows: Demographic and Socio-Economic Indicators; CSM Program, Distribution and Promotion Information; National Contraceptive Prevalence Survey Results; and Couple Years of Protection and Births Averted.

II. BACKGROUND ON CSM PROGRAMS

II.1 CSM as a Private Sector Endeavor

A.I.D.'s policy paper on population assistance calls for private sector involvement in the delivery of family planning services.[1] CSM programs use existing private sector organizations to market contraceptives and complement (but do not replace) other family planning activities such as government and private voluntary programs, community-based delivery systems, and the private sector. The specific organization and structure may vary from country to country, but "whatever the name, this approach to family planning is an attempt to harness the existing marketing infrastructure and techniques of the commercial sector to achieve greater contraceptive prevalence at low cost."[2]

II.2 CSM Goals

CSM programs have three goals:

- To use existing commercial methods and networks for the marketing of contraceptives in order to make these products more widely available at affordable prices to lower income groups (C and D customers).
- To assist in increasing contraceptive prevalence and lowering fertility by fostering knowledge of, favorable attitudes toward, and correct usage of contraceptives.
- To establish a contraceptive delivery system that is able to recover some program costs.

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[1] "A.I.D. intends to capitalize on the flexibility and innovativeness of the private sector as an important channel for the development and delivery of safe, effective contraceptives. A.I.D. also stresses the involvement of local institutions and supports efforts to strengthen them." U.S. Agency for International Development, A.I.D. Policy Paper: "Population Assistance" (page 1), Bureau for Program and Policy Coordination, Washington, D.C., September 1982.

[2] Binnendijk, Annette L., A.I.D. Evaluation Special Study No. 40: "A.I.D.'s Experience with Contraceptive Social Marketing: A Synthesis of Project Evaluation Findings," Center for Information and Evaluation, PPC, Agency for International Development, Washington, D. C., April 1986.

II.3 History/Status

In 1967, the Government of India, with assistance from the Ford Foundation, initiated the first national CSM program. Following the success of this experiment, which used the Nirodh condom, A.I.D. began funding several U.S.-based organizations to support this approach. In 1972, PSI initiated a program in Kenya that also sold condoms. A year later, a similar project was initiated in Sri Lanka in which both condoms and pills were made available. IPPF and Westinghouse set up similar programs in Colombia (1973) and Jamaica (1974).

The concept of social marketing grew out of several factors. First, it was felt that the public sector clinics could not always meet the demand for contraceptive services. These clinics were often overcrowded and undersupplied, and each visit involved a long wait for the client. Because people seeking family planning are not ill, most do not need clinic services. In addition, many women feel embarrassed about going to a clinic because of the stigma associated with using free services.

The use of the commercial sector offered an alternative to the public sector approach. Moreover, existing commercial retail networks often reach people who are not covered by the government programs, providing retail centers that are more convenient and numerous than public health clinics. In addition, CSM initiatives were seen as a means to recover some of the program costs of providing contraceptive products to the general public.

Since 1972, A.I.D. has funded more than 25 CSM projects. A.I.D. generally provides 1) funds for technical assistance from contractors with expertise in social marketing; 2) operating support to fund local CSM implementing agency staff and subcontracts with advertising, packaging, and market research firms; and 3) donated contraceptive commodities. Today, CSM programs are operating in 22 countries, with another 10 expected to initiate contraceptive sales in 1987-88. Development work is under way in an additional 7, making a total of 39 developing countries involved in CSM programs.

Table 1 provides an overview of the status of CSM projects by specific countries in the LAC, ANE, and AFR regions.

Table 1

STATUS OF A.I.D.-FINANCED CONTRACEPTIVE SOCIAL MARKETING PROGRAMS
AND SOURCE OF FUNDS

Region/ Country	Active Sales	Agreement	Favorable Feasibility Assessment	Future Targets of Opportunity
LAC				
Caribbean Regional	(B)			
Colombia	(P)			
Costa Rica	(U)			
Guatemala	(U)			
Dominican Rep.	(C)			
Jamaica	(U)			
El Salvador	(U)			
Honduras	(U)			
Mexico	(C)			
Trinidad & Tobago		(B)		
Bolivia		(C)		
Peru	(C)			
Ecuador	(B)			
Panama			(B)	
Brazil		(B)		
Paraguay			(B)	
Haiti				(C)
Belize				(C)
Asia/NE				
Indonesia	(U&C)			
Bangladesh	(U)			
Egypt	(U&C)			
India	(U&C)			
Nepal	(U)			
Pakistan	(U)			
Sri Lanka	(P)			
Thailand	(P)			
Tunisia	(U)			
Morocco		(C)		
Jordan			(U&C)	
Turkey				(C)
Yemen				(C)
Burma				(C)
Philippines				(C)

Region/ Country	Active Sales	Agreement	Favorable Feasibility Assessment	Future Targets of Opportunity
Africa				
Cape Verde				(C)
Ghana	(U)			
Zimbabwe	(C)			
Nigeria	(C)			
Zaire	(U)			
Liberia	(U)			
Somalia		(C)		
Rwanda		(U)		
Malawi			(C)	
Mali			(C)	
Niger			(C)	
Kenya			(U&C)	
Sudan			(C)	
Senegal			(C)	
Guinea				(C)
Botswana				(C)
Cameroon				(C)
Mauritius				(B)
Swaziland				(C)
Zambia				(C)

Key: Source of A.I.D. funds: C=Central, U=USAID Mission, B=Bureau, P=Private

Note: All centrally funded activities (C) except Nigeria (FPIA) are funded from the SOMARC project. Colombia, Sri Lanka, and Thailand (P) were helped by A.I.D., but no longer receive A.I.D. assistance.

Source: AID/S&T/POP November 1987

III. MANAGEMENT

III.1 Overview

Principal responsibility for management of CSM programs falls to the in-country implementing agency. Two other organizations also play a role: the contractor and A.I.D. The contractor is responsible primarily for providing technical assistance to the implementing agency staff in all aspects of marketing. A.I.D. provides financing for both technical assistance and supplies and thus plays an essential role in the viability of CSM programs, particularly during the start-up phase. From a management standpoint, however, A.I.D. and USAID mission personnel normally have little involvement in the day-to-day implementation of the program. Their assistance is generally in the area of relations between the contractor and the in-country implementing agency and between both and the host country government. In addition, in those programs that use A.I.D.-supplied contraceptives, logistic arrangements for these supplies are the responsibility of A.I.D.

III.2 Role of the Contractor

A.I.D. now uses six firms to provide technical assistance to in-country CSM programs. TFG's SOMARC project, with 13 programs either under way or scheduled to begin operations in 1988, has the widest geographic and programmatic experience. PSI, with programs in Bangladesh and Pakistan, is responsible for some of the largest programs from the standpoint of value of contraceptives being distributed (Bangladesh). Other contractors include FPIA, Triton, Juarez and Associates, and RONCO Consulting Corporation.

The contractors have three roles. The first, from a chronological standpoint, is to carry out the program exploration that is necessary to establish the program (see Chapter V). Their second and principal role is to assist in-country implementing agencies in the technical aspects of program implementation, with respect to both management and marketing (e.g., the Ghana and the Dominican Republic bilateral projects have made use of the centrally funded SOMARC project to obtain technical help from consultants qualified in CSM marketing and research). A third role, closely related to the second, is to monitor CSM programs and provide on-site assistance as problems occur. These varying responsibilities assume the need for strong management expertise on the part of contracting agency staff.

Management arrangements differ. In some instances

(Bangladesh, Honduras, the Dominican Republic, Indonesia), the contracting agency may provide an expatriate resident advisor. More commonly, however, the contractor sends staff representatives on monitoring trips and hires a host country national to represent the contractors on a day-to-day basis.

III.3 Role of A.I.D. and USAID Missions

A.I.D. officers in Washington make strategic design decisions at the outset of a project and are charged with monitoring each program.

The extent and quality of USAID mission involvement in CSM implementation varies significantly among programs. Generally, mission officers limit their involvement to being informed, leaving the major monitoring process to contractors. On occasion, however, USAID monitors have made decisions on product line additions, packaging, and distribution mechanisms. This is not an appropriate role for USAID. Rather, decisions on such issues should be made by the implementing agency with technical help provided as needed.

The differing levels of USAID involvement reflect

- the expertise, personality, and interest of A.I.D. monitors and supervisory personnel, and
- the level of interest and investment of USAID missions in the CSM program (through bilateral funding, parallel programming, etc.).

Although A.I.D./Washington and mission personnel play a secondary role in day-to-day implementation of CSM programs, even their monitoring and advisory capacities require some knowledge and expertise in marketing.

III.4 Role of the In-Country Implementing Agency

III.4.1 Overview

Five different management models can be identified among the CSM programs currently in operation:

- managed by a government agency;
- managed by a semi-autonomous or quasi-governmental agency;

- managed by private family planning associations;
- managed by private sector organizations established specifically for the purpose; and
- managed by an established commercial distributor.

Country conditions and available resources normally govern the choice of the management structure that is found, and therefore A.I.D. and contractors are seldom able to exercise much discretion in this area. Program experience appears to show, however, that it is possible to predict how well each model works with respect to five important characteristics: marketing performance, staff stability, management flexibility, cost, and political receptivity to the program. These characteristics will determine both how well the implementing agency should be able to carry out the program and how much support A.I.D. and the contractor will need to provide.

The following description, together with Table 2, represents an attempt to analyze what can be expected with respect to the performance of each of the five management models.

- Managed by a Government Agency

Government-managed programs are run by civil servants, with the advertising, packaging, and distribution components contracted to private sector companies. Although an advisory board with nongovernment representation may be used, such a board often does not have any direct control over the project. Both India (Ministry of Health) and Jamaica (Ministry of Health and Environmental Control) have government-managed programs.

An advantage of this approach is that government support for the program makes it easier for the program to avoid registration obstacles, reduce or eliminate potential tax and duty fees, convince commercial firms to participate, and minimize advertising restrictions (see Section V.4.1). Second, many developing countries have government personnel who have family planning expertise.

A major disadvantage of this management structure is that government bureaucracies, with their checks and balances, are often unable to keep pace with market conditions. This reduces program flexibility. Because civil service salaries are usually low, staff turnover of qualified managers for better paying jobs in the private sector is often high, and there are frequent intergovernment transfers. Where marketing expertise is available in government, potential marketers are drawn to the higher paying private sector jobs.

Additionally, because there is no real profit motive, there is little incentive for CSM staff to make the effort to promote sales. Thus, more extensive technical assistance may be required to develop a marketing capability, which creates a need for a higher initial investment in the program.

- Managed by a Semi-Autonomous or Quasi-Governmental Agency

The semi-autonomous or quasi-governmental management type falls somewhere between government and private sector control. Often, these CSM programs are run by nonprofit organizations but are accountable to an advisory board that includes both government and nongovernment representatives. The use of an advisory board has been effective in Bangladesh and Egypt because it keeps the government in touch with the program without its being involved in the day-to-day marketing activities of the project.

A major advantage of this approach is that it allows for communication between project staff and the government while creating the possibility for some marketing flexibility. When the Nepal program was transferred from government control to a semi-autonomous nonprofit organization, the new flexibility led to significantly increased sales.

A disadvantage of this management scheme is that the representatives on these boards do not always have marketing skills that would enable them to understand the need for the implementing agency to make quick, market-oriented decisions. In addition, these organizations are often bound by government operating regulations. Thus, this arrangement does not always provide the kind of flexibility needed to respond rapidly to changes in market conditions.

- Managed by Family Planning Associations (FPA)

Several CSM programs are managed by FPAs, including those in Honduras, El Salvador, and Colombia. An advantage of this approach is that FPAs often have extensive family planning experience and a strong commitment to CSM social objectives, especially at the grassroots level. Many FPAs also enjoy a fair amount of political strength without being under the government's direct control. This gives the program day-to-day flexibility, which helps to minimize potential problems with regard to distribution, registration, and taxes and duties.

On the other hand, FPAs often lack marketing expertise, and this can hinder their effectiveness in reaching target markets. Also, FPAs are often involved in a number of other

family planning efforts, with the result that the CSM project may be given less priority. FPAs also generally pay low salaries, which makes it difficult to recruit experienced marketers. Finally, the initial investment for the program and the technical assistance requirements are often high on the organizational and marketing side.

- o Managed by Private Sector Organizations Established Specifically for the Purpose

In Nepal, Thailand, and Guatemala, private (for-profit and not-for-profit) organizations have been established to manage the CSM program. These programs provide many of the same advantages and disadvantages of the exclusively commercial sector programs. These programs may also have more political support, especially if they were once part of the government's family planning activities, as in the case of the Nepal program.

There are a few differences between these private organizations and those in the commercial sector, however. For example, more technical assistance is usually required because these organizations are new and have little family planning or marketing expertise. As a result, the initial investment is frequently high. In addition, in some cases it has been necessary to establish a distribution network.

- o Managed by an Established Commercial Distributor

The Caribbean CSM program represents an example of a project that is managed solely by private sector commercial distributors. A major advantage of this approach is that the project has a great deal of flexibility in carrying out marketing activities without government involvement. In addition, because higher salaries are often provided to private sector employees, these companies are able to attract people with extensive marketing expertise and staff turnover tends to be lower. The profit motive also tends to provide a greater incentive for sales. As a rule, the initial investment for this approach is moderate, because less technical assistance is needed to develop a marketing capability.

One disadvantage of this approach is that commercial distributors often do not have extensive political influence. Thus restrictions on contraceptive advertising may be difficult to change. Without government support, these factors could severely hinder the program's overall effectiveness.

Last, commercial firms often do not possess family planning expertise or detailed knowledge about the contraceptive

product line. These skills must be acquired to market contraceptive products effectively and safely. Usually some outside technical assistance and training financed by A.I.D. is required, as these activities go beyond what a commercial firm would normally be willing to invest to market these products.

III.4.2 Conclusions Regarding the Management Alternatives

A review of Table 2 shows that in the progression from programs managed by a government agency to those managed by an established commercial distributor, the advantages shift from strengths in family planning expertise and ability to foster a benign or welcoming political environment to strengths in staffing stability, management flexibility, and marketing performance. In short, these two approaches are virtually mirror images of one another.

The conclusion is that although each management approach must be adapted to local conditions, on balance CSM works best when managed by an established commercial distributor with strong government support. Where no such distributor is available, alternative management approaches should be as private sector-oriented as feasible.

Recommendations[3]

Implementing Agency

1. The implementing agency should be fully involved at all stages of the project's development, design, and implementation. Implementing agencies should also be allowed the flexibility and freedom to carry out the day-to-day activities, hire staff, and make the necessary management decisions without interference from the government or USAID.

2. CSM program management should be as private sector-oriented as possible, with technical assistance and training provided to fill any gaps in experience and knowledge about family planning and contraceptive products (see Recommendation 5).

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[3]The bold typeface is used for the portion of recommendation text that is repeated in the final chapter of this report, Chapter IX, "Summary, Conclusions and Recommendations." The recommendations are numbered consecutively throughout the report, corresponding with their listing in Chapter IX.

Table 2

Strengths and Weaknesses of Five Management Approaches

		MANAGED BY GOVERNMENT AGENCY		MANAGED BY SEMI-AUTONOMOUS OR QUASI-GOVERNMENTAL AGENCY		MANAGED BY FAMILY PLANNING ASSOCIATIONS (FPA)		MANAGED BY PRIVATE-SECTOR ORGANIZATIONS ESTABLISHED SPECIFICALLY FOR THE PURPOSE		MANAGED BY AN ESTABLISHED COMMERCIAL DISTRIBUTOR	
CATEGORY	CHARACTERISTICS	CATEGORY RANK	IMPACT ON AID	CATEGORY RANK	IMPACT ON AID	CATEGORY RANK	IMPACT ON AID	CATEGORY RANK	IMPACT ON AID	CATEGORY RANK	IMPACT ON AID
1. Staff stability	o Salaries of Employees	Low	(-)[1]	Low	(-)	Low	(-)	High	(+)	High	(+)
	o Staff Turnover	High	(-)	Moderate	(o)	High	(-)	Low	(+)	Low	(+)
2. Management Flexibility	o Government Involvement	High	(-)	Moderate	(o)	Moderate	(o)	Low	(+)	Low	(+)
	o Program Flexibility	Low	(-)	Moderate	(o)	Moderate	(o)	High	(+)	High	(+)
	o Distribution Ease	Low	(-)	Moderate	(o)	Moderate	(o)	Moderate	(o)	High	(+)
3. Marketing Performance	o Incentive to Sell (profit)	Low	(-)	Moderate	(o)	Moderate	(o)	High	(+)	High	(+)
	o Marketing Expertise	Low	(-)	Moderate	(o)	Moderate	(o)	High	(+)	High	(+)
	o Need for Technical Assistance	High	(-)	High	(-)	High	(-)	Moderate	(o)	Low	(+)
4. Initial Investment	o Initial Investment	High	(-)	High	(-)	High	(-)	High	(-)	Moderate	(o)
5. Political receptiveness	o Registration Ease	High	(+)	Moderate	(o)	High	(+)	Low	(-)	Low	(-)
	o Family Planning Expertise	High	(+)	Moderate	(o)	Moderate	(o)	Low	(-)	Low	(-)
	o Taxes and Duties	Low	(+)	Moderate	(o)	Moderate	(o)	High	(-)	High	(-)
	o Political Clout	High	(+)	High	(+)	High	(+)	Moderate	(o)	Low	(-)

[1]Note: The +'s and -'s represent a composite overall rating for each of the categories relating to the potential for achieving A.I.D.'s objectives. This latter rating includes the potential burden the category puts on A.I.D. to furnish technical, material and financial resources.

Source: CSM Assessment Team, 1987

3. The implementing agency should employ or make available experienced marketing managers to work on the CSM project. Along with strong marketing skills, the managers need to be effective in working with government officials.

4. All CSM programs should ensure that the appropriate government agencies (such as health, planning, finance, and clearly population) clearly understand how the CSM program fits with other government sponsored population, family planning, and community-based activities.

Contractor

5. If qualified marketing expertise is not available on the implementing agency staff, the contractor should develop training programs and/or provide technical help so that the necessary skills are available to the local manager and his or her senior advisors. The goal is to ensure that marketing expertise is always available (see Recommendation 2).

A.I.D.

6. A.I.D. should ensure that its officers responsible for CSM projects have expertise in marketing or be given training in this area.

7. To ensure that USAID mission officers can monitor CSM activities effectively, regional training workshops should be held (such as those organized by SOMARC in Africa and LAC) for USAID personnel and CSM program managers. The purpose would be to review basic marketing principles. In addition, such workshops would provide an opportunity to share experiences.

USAID

8. The involvement of USAID missions in CSM implementation should be regularized. This process should include (1) clarification of A.I.D.'s and USAID's role in project design, implementation, and monitoring, (2) establishment of a scope of work to institutionalize this involvement, and (3) preparation of monitors and supervisors to carry out the SOW. USAID's role should be limited to facilitating the implementation process. More specifically, its role should involve, in order of importance, the following activities:

- protecting the interest and integrity of the U.S. government, particularly in contractual agreements;
- establishing and clarifying procedural issues, e.g., for bilateral arrangements and commodity procurement;

- establishing linkages between host country government and nongovernment organizations, CSM implementing agencies, and other donors where appropriate;
- identifying and providing technical assistance and other resources as required; and
- monitoring program deliverables.

IV. MARKETING

IV. MARKETING

IV.1 Overview

The core of any CSM program is the successful marketing of contraceptive products at affordable prices. Although social marketing uses the same marketing tools and strategies found in commercial marketing--a marketing plan, marketing research, product development, distribution, advertising, and so on--the job to be done is much more complex.

Successful marketing in the commercial sector implies simply motivating consumers to purchase a specific product and making a profit through the sales of that product.

A number of interrelated and sometimes incompatible social and commercial factors are at work in the CSM environment, however, that both increase the difficulty of the marketing task and decrease markedly any likelihood of making a profit. These factors include the following:

- CSM projects normally attempt to sell not only a product but also the concept of contraceptive use. This task is often complicated by resistance among the target population to using contraceptives, a reluctance that grows out of deeply ingrained traditions and cultural norms. Development of a strategy to change these beliefs may require not only standard marketing skills but also cultural sensitivity and experience in family planning.

- The cultural norms may be reflected in government restrictions on media access and options as well as limited access to some retail networks.

- CSM's commercial goal is often in conflict with its social one: increasing contraceptive use among low-income clients. The focus on low-income clients involves setting prices low, normally far too low to enable projects to be self-sustaining, let alone to make a profit.

- CSM product sales are often low-volume, low-value product categories, exacerbating the difficulty of revenue generation.

- CSM project management is often weak in the area of marketing skills.

It is this backdrop of conflicting and interrelated objectives that defines the narrow and difficult course that must be pursued by most CSM projects.

IV.2 Development of a Marketing Plan

Commercial marketing ventures are normally based on a detailed marketing plan that sets forth the sales, promotional, research, and evaluation actions anticipated. This plan is based on the institutional, legal, and distribution realities that exist within the marketing area. Information on the existing infrastructure should have been gathered during the selection/assessment process (see Chapter V). The plan normally projects both inputs and expected outputs.

Development of a marketing plan requires not only a considerable amount of time (perhaps up to six months) but also a high level of marketing expertise. CSM programs have not always included the level of detail that would make these plans useful as program guides. One of the reasons may be that the expertise is not available in the implementing agency. It is also possible that sufficient effort has not been made by the contracting agency to ensure that such plans are in place before a project gets under way.

Recommendations

9. Increased efforts should be made to lay the groundwork for CSM programs by developing regular comprehensive marketing plans for each program.

10. CSM contractors should be required to submit formal marketing plan updates on a yearly basis to A.I.D./Washington. This would help assure that the in-country planning is thorough and well conceived. Also, it would establish goals against which the subcontractors could be evaluated.

IV.3 Potential Customers

In general, CSM targets are identified as fertile couples, ages 18-45, in the less advantaged socioeconomic groups who wish to contracept. This target, however, is by no means homogeneous. There are significant differences created by varying levels of education, occupation, access to health/family planning services, ethnicity, and area of residence (urban or rural). These in turn result in significant differences in knowledge, attitudes, and practice (KAP) with regard to contraceptive usage. To be successful, marketing strategies must

defined in advance of the project launch in order to identify the various marketing segments, establish the needs for each segment, and devise appropriate channels of delivery for both methods and messages.

CSM projects have had varying levels of success in carrying out these three steps. The Microgynon project in the Dominican Republic has done a good job of targeting C and D consumers (see Section IV.6.2). Cross-country research studies carried out by SOMARC indicated that low-income customers in the Caribbean, Indonesia and Mexico represented 67 percent, 88 percent, and 95 percent, respectively, of the people served by the program. The percentage of new users ranged from 30 to 47 percent in these countries. On the other hand, the Nigeria program has no mechanism for targeting consumers.

After initial targeting, periodic assessments are useful in helping to refine the strategy or confirm that it is achieving its objectives (see Section VIII.2.2). Focus groups, intercept studies, household surveys, and qualitative research are all appropriate. In Indonesia, for instance, KAP studies conducted after the project launch have sharpened the marketing strategy. In the Dominican Republic, a recently completed intercept study indicated that the intended target group was, in general, being served.

Recommendation

11. The marketing strategies of CSM projects should take into account the specific needs of the different segments of the target population.

IV.4 Advertising and Promotion

IV.4.1 Environmental Constraints

Where leaders lack a good understanding of the purposes and benefits of family planning programs or where restrictive cultural or religious forces come into play, (see Section VI.2.2), problems can arise with respect to advertising and promotion (see Section IV.4.4.1). Many host governments have erected barriers to the advertising and promotion of family planning products. The barriers may reflect sensitivity to open discussion of sexual matters, religious objections, or unstable political climates. CSM programs throughout the world, however, have found ways to circumvent many of these obstacles and are making excellent progress in conveying their messages to the public via mass media. In the Family of the Future (FOF) program in Egypt, for example, project managers advertise oral

contraceptives (OC) through television to the medical community instead of to the user, which in Egypt is not permitted.

CSM project managers have learned that a non-confrontational approach is essential in gaining media access. This includes working closely with key government ministers or ministries early in the life of the project to ensure that the final, recommended advertising has the full support of responsible government agencies. Several CSM programs have also made effective use of public relations programs to acquaint various influential groups with the project and to desensitize them to upcoming contraceptive advertising. For example, in Indonesia special attention was given to desensitizing religious, political, and social influentials through slide presentations and conferences that were based on noncontroversial themes. This effort has been effective in reducing negative reactions to the advertising campaign. Prior to launching its campaign, the Nepal Contraceptive Retail Sales (CRS) program screened the advertising messages with government and private groups in order to get their approval. On the other hand, a very successful media campaign in the Dominican Republic, which had not been cleared by the government, was extremely controversial and had to be withdrawn.

Mexico has been successful in using the results of copy testing in focus groups to answer potential government questions about advertising, and Ghana has created a public relations campaign specifically aimed at desensitizing government officials.

Although mass media promotion of CSM products is often controversial, its potential for effectiveness is enormous. In Egypt and Bangladesh, 80 and 60 percent of the population, respectively, listens to the radio. Newspapers, cinema, and television are viewed by millions of people on a daily basis. Although CSM project managers must make a major effort to enlist support of host country governments and elite and influential groups, this effort is well worth the time and trouble involved.

IV.4.2 The Positive Message

- <u>Developing the Concept</u>

Just as political constraints help decide what to avoid in advertising, so other factors will help determine what to accentuate. Specifically, CSM managers must decide on a positive message that must in turn be based on an underlying marketing concept that will convey convincingly the promise and the benefit of the product.

A wide range of appeals exists, ranging from endorsement of family planning for the general or family good to the identification of specific benefits that might accrue to the consumer as a result of the use of family planning. Among the concepts are

- population control (reducing growth rate);
- development objectives (improving quality of life of the nation);
- family welfare, for example, "small family, happy family";
- maternal/child health;
- preventive health (primary health care);
- child spacing (can reduce infant mortality); and
- economic benefits of having a smaller family.

There are at least two good ways to identify and define an appropriate marketing concept. One is through focus groups in which alternative motivational approaches are presented to identify the one that most appeals to the sample group. The second is by analyzing results from national contraceptive prevalence surveys and KAP studies to determine which benefits are most desired by the target group.

o <u>Developing the Message</u>

Although the familiar, well-worn "small family is a happy family" theme approach was probably necessary at the beginning of some projects in order to avoid a public backlash, several new and more appropriate strategies are now in use.

There is considerable variation among these messages in different countries. In Indonesia, for instance, post-launch work revealed that although the "small family, happy family" concept was successful in desensitizing the public to CSM, it did not succeed in motivating families to use contraception. More specific consumer benefits such as "better health for mothers," or "richer and more successful life for existing children" may be more appropriate in this setting. In Pakistan, careful analysis of social pressure and target needs convinced CSM program managers to use the male responsibility concept. In Ghana, program coordinators determined that the family health concept was more appropriate than the issue of the costs of a large family. In the Caribbean/Barbados CSM project, studies and analysis have helped develop the adolescent (teenage) sexual responsibility concept. In Mexico and the Dominican Republic, the safety, effectiveness, and quality of the products are stressed.

o Marketing Research

To determine the effectiveness of a particular message, quantitative surveys and focus groups can be used. In Bangladesh, pretesting alternative messages determined that those focusing on family economics and the son's future were favored over messages that stressed the benefits to the wife's health. Retesting these messages periodically determines whether consumer attitudes have changed over time. For example, as acceptance of family planning concepts increases in low-prevalence countries, emphasis can be shifted from messages that seek to change behavior to efforts that ensure continuance of the new behavior.

In-country advertising firms are usually employed to develop the promotion campaigns. Because of their experience in a given country, they can tailor an approach to the unique cultural norms or consumer benefits of their target population. In addition, they often know what media mix has been shown to yield the best results.

IV.4.3 Alternative Channels

Experts agree that projecting a similar message in different communication channels improves sales. Such repetition reinforces the message and provides a consistent product or brand image that remains lucid in the consumer's mind. A number of CSM programs have successfully adopted this approach, using a number of other channels in addition to the traditional mass media approaches that are favored for reaching the largest number of potential customers (TV, radio, newspapers, billboards).

In Jamaica, for example, a CSM brand-name product has been promoted in a popular reggae song. In remote areas of Nepal, jeeps are decorated and loudspeakers play audio messages to promote the products. The Bangladesh program advertises its condom brands using riverboat sails. Young volunteers in Egypt, recruited and trained by FOF, organize large CSM rallies that serve to introduce the concept of family planning and to convince people that family planning is important for one's home, health, and family. Since 1979, over 9,000 of these rallies have been held, reaching an estimated half a million people. The use of these alternative approaches appears to be beneficial, especially where there are restrictions on mass media approaches. Moreover, they can provide a cost-effective complement to the more expensive mass media approaches.

Again, in cases where brand-name advertising is not permitted on television or radio, point-of-purchase displays, brochures, posters, and colorful dispensers can be effective.

They draw attention to the product, help to emphasize brand identity, and are relatively inexpensive.

The distribution of free product samples to the target market consumers is recognized as an effective means of encouraging product use. The Mexico CSM program has been particularly imaginative, distributing free condom samples during the World Cup football series and at May Day celebrations. In Nepal, to publicize the Dhaal condom, contests have been held that use frisbees displaying the condom logo. The Egyptian program has also promoted its products during sports events through the distribution of condoms and foaming tablets.

Several CSM projects have fielded well-designed promotions with other products. These have included cross-promotions with razor blades, cough syrup, and infant medication. These types of promotions can be successful in obtaining new CSM product distribution and bringing in new users.

IV.4.4 Generic Advertising and Promotion for Local Sellers

For countries that already sell low-cost contraceptives without actively marketing these products, an alternative approach to developing a full CSM program has been proposed. This approach, which has not yet been implemented, would provide generic advertising and promotion to support contraceptive sellers in countries where affordable commercial contraceptives were readily available to C and D consumers. This idea is under consideration for Brazil and might be appropriate for other Latin American countries.

The generic advertising approach is not feasible in low-income countries because usually the private sector sale of contraceptives is negligible in such settings. It might be appropriate, however, for low-prevalence countries when a need exists to develop additional demand by actively promoting the use of contraceptives.

IV.4.5 Media Budget and Media Plan

Studies carried out in Egypt, Kenya, and Colombia support the notion that a relationship exists between sales levels on the one hand and advertising and promotion activities on the other. These studies are corroborated by experience in Guatemala, India, El Salvador, Jamaica, and Bangladesh, where a significant drop in sales followed a suspension or reduction of advertising. The challenge for CSM managers is to determine the media budget and mix that balances the benefits of advertising

with its high cost. In Indonesia, the advertising budget was not based on any in-market experience to test what investment would be cost effective. Thus, over $625,000 was spent on advertising between March and December 1986, although the 1987 sales year was projected to reach only $250,000.

In most countries, media plan testing to determine appropriate budget levels has not been carried out.

Recommendations

12. A better job needs to be done in briefing and educating influential groups in the community. The understanding and approbation of these groups is important to ensure the success of contraceptive advertising campaigns.

13. Consumer benefit statements (such as better health for mothers) should be developed to provide a foundation for advertising concepts. These statements must be based on up-to-date information on contraceptive knowledge, attitudes, and practice and should be tested.

14. Consumer sampling should be used to encourage product trial and use.

15. To help set proper spending levels and design a plan that accommodates goals for the scope and frequency of advertising messages, alternative media budgets and media plans should be tested prior to national implementation.

IV.5 Products

IV.5.1 Product Availability and Source

The choice of product or products to be used in each CSM project should ideally arise from an analysis of potential customers, with an effort to provide the products that are most acceptable to and needed by each target group. Several products should be offered, to enable clients to chose the one most appropriate for their particular circumstances.

In fact, however, CSM projects do not always have a great deal of leverage over the types of products they can provide. In order to keep prices at a level commensurate with the buying power of the target groups, they do not generally buy contraceptives from the commercial sector. Instead, typically, contraceptives are supplied free or at low cost from one of three sources: from A.I.D., from some host governments, or sometimes from the manufacturer.

The most frequently used source is A.I.D., but programs depending on A.I.D.-supplied commodities must accept the limitation of the A.I.D. commodity program: heavy dependence on condoms (some programs are provided only condoms); unavailability of some products (e.g., Depo-Provera, whose distribution by A.I.D. is prohibited); and the ever-present threat, resulting from A.I.D.'s procurement policy, that the product may change from one year to the next, confusing the customer and undoing advertising work that has been used to develop loyalty to a specific product.

Given the prospect of increasing needs worldwide for contraceptives and the static or falling resources of CSM programs, CSM programs have moved away from dependence on A.I.D. to procurement of contraceptives at low cost from alternative sources. In Indonesia, for example, the government purchases the Dualima condom from Korea and sells it to the CSM program distributors at acquisition cost. In the Dominican Republic, the program obtains Microgynon OCs directly from the manufacturer, Schering, at conciliatory prices (with support from IPPF). Similar approaches are being developed in Peru and Ecuador with manufacturers that sell in the region. Whether conciliatory pricing here will be feasible, however, remains in question. U.S. pharmaceutical firms have been asked to consider similar arrangements but have not responded with specific proposals. Programs using alternative sources of contraceptives are appropriate for low-prevalence countries. They may not be feasible for low-income countries, however, because these may not have a developed private sector that can provide an alternative source of contraceptives.

In some countries (e.g., Brazil and Panama), contraceptives are readily available through commercial channels priced within reach of C and D consumers. If these prices are lower than those that could be achieved by using A.I.D. or manufacturer- or government-supplied condoms, the CSM project could conceivably eliminate the marketing and distribution components of a CSM program and simply provide generic advertising to promote use (see Section IV.4.4).

To sum up, however, the CSM programs all lack some flexibility with regard to both the type and the brand of contraceptives that they can market.

IV.5.2 Types of Products

Products carried by CSM projects can be separated into two categories: nonprescription and ethical products. Condoms and spermicides are the major nonprescription products and can be

purchased and used without any medical supervision. Hormonal contraceptives (pills, injectables, and implants) and IUDs are classified as ethical products and often require a prescription (at least for first use); can be retailed only through registered pharmacies, drug stores, or medical practitioners; and are often prohibited from advertising in the mass media (see Chapter VI for further details on the medical aspects).

By and large, ethical contraceptives are more effective than nonprescription products. Therefore, in most cases, to bring about a significant improvement in prevalence rates, CSM programs have needed to expand beyond the condom and to include ethical methods because of their acceptability and effectiveness.

IV.5.2.1 Nonprescription Contraceptives

o Condoms

-- Role in CSM Programs

The condom, although not likely to have a major effect on contraception, is for two reasons usually a good product with which to launch a CSM effort. First, because they are not viewed as a medical intervention, condoms do not arouse the criticism from doctors, midwives, and pharmacists that may be provoked by other methods. Second, because they require male participation, they tend to quell male opposition to family planning that is often common in male-dominated societies. Instead, by making an early, overt appeal for men to be more responsible in the planning of their families, programs promoting condoms have begun to establish a wide, firm support base for family planning and in turn have paved the way for greater acceptance of female contraceptives. For example, in Bangladesh, after the introduction of the condom, the acceptability of OCs began to increase, presumably because male resistance to contraception had lessened. The major drawback of condoms is their association with extramarital relations. To counter this image, condoms are actively being promoted as safe, effective, and appropriate for married couples.

-- Effect of AIDS on the Condom as a CSM Product

The advent of AIDS as a major health threat in many of the countries where CSM condoms are being marketed has recently begun to create problems for CSM program managers. In the past, one of the major inhibiting factors to condoms as a family planning method has been its image as a prophylactic. In light of this constraint, social marketers have invested heavily in trying to establish the credibility of condoms as a family planning method. Promotion of condoms to prevent the contracting

of AIDS, however, once again relates to sexual activity outside matrimonial relationships and thus is undoing the message, assiduously promoted by CSM programs, that condoms should be viewed as a family planning method.

The issue is whether family planners should capitalize on the fear of AIDS and include the prophylactic message with the family planning message. It might be argued that the fear of contracting AIDS is more compelling than the fear of an unwanted pregnancy and that such an approach might increase condom sales. What is not known is whether this approach might also have a reverse impact on the prevalence of condom use for family planning. The expectation is that it will. More research on this issue is urgently needed.

Because of the danger that sending two messages on condoms will confuse consumers and detract from the method's credibility,[4] the soundest approach may be for CSM programs to promote condoms only as contraceptives. Managers of AIDS prevention programs and CSM program managers should work closely together to develop campaigns that mitigate any negative effects of emphasizing condoms as a prophylactic against AIDS. In Mexico and the Dominican Republic, SOMARC has already begun providing inputs to assist in the design of AIDS campaigns being developed within these countries. In Nigeria, planning for AIDS-motivated advertising campaigns promoting condoms is also under way. If the AIDS issue becomes so compelling as to become the primary purpose of condom usage, however, CSM programs should concentrate on other contraceptive methods while not abandoning condoms as a family planning method.

- Spermicides

Vaginal tablets or suppositories represent a second type of over-the-counter nonprescription contraceptive. The advantage of this method is that it has virtually no side effects, is usually not under any government restrictions, and has an antibacterial effect that can help prevent certain sexually transmitted diseases (STD), perhaps even AIDS. If misused, however, spermicides have a failure rate as high as 10 to 25 percent. Although this method is not very popular, it is often emphasized for couples who have coitus infrequently, e.g. where husbands are employed away from home. Some of the CSM programs that sell vaginal tablets are Nepal, Guatemala, Egypt, Ghana, Nigeria, Bangladesh, and Honduras.

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[4]SOMARC is currently conducting research on this issue as part of its "Special Studies" portfolio.

IV.5.2.2 Ethical Contraceptives

o Oral Contraceptives

OCs are much more effective than condoms in preventing pregnancy. Other advantages of OCs are reversibility, ease of use, and convenience. The oral contraceptive also has beneficial side effects other than preventing contraception. For example, women using the pill have a low incidence of ovarian cancer, pelvic inflammatory disease, and rheumatoid arthritis. In addition, the monthly menstrual flow is generally less. Disadvantages include short-term side effects (dizziness, headaches, spot bleeding, nausea), and the need of a prescription in some countries (see Chapter V).

o Intrauterine Device (IUD)

In Egypt, the FOF project provides the Copper-T and Gravigard IUD at subsidized prices to Egyptian physicians. The Egyptian program also provides medical personnel with the training needed to insert the IUDs at its five clinics. Between 1986-87, nearly 600,000 IUDs were sold by the FOF. The IUD is effective for people who may not be motivated to take a pill every day or use a condom and want a method that does not require them to do anything. Although IUDs provide a high level of protection against pregnancy (1 to 3 percent failure rate), they are also associated with potentially severe side effects, which include pain, bleeding, pelvic inflammatory disease, and expulsion of the IUD.

o Injectables

Injectables have been sold in a number of CSM countries including Bangladesh (Noristerat), Egypt (Depo-Provera), Mexico (Protektor--earlier program) and Colombia (Noristerat). The advantages of this method are that it is convenient and does not interfere with milk production in lactating women. Although it is very effective in preventing pregnancy (2 to 4 percent failure rate), this method must be administered through a medical facility and may result in side effects. Because A.I.D. does not supply injectables, these are supplied through other donors or commercial sources.

Recommendations

16. Product sources within the private sector, including local, U.S., and foreign suppliers, should be evaluated to assess available options. Steps should be taken for the CSM program to import its own contraceptives without recourse to A.I.D. financing, where suitable.

17. In markets in which condoms are promoted as prophylactics against AIDS, CSM programs should continue to promote their use as contraceptives while moving toward encouragement of other methods such as OCs as rapidly as possible. CSM and AIDS program managers should also work closely together in order to mitigate any negative effects of the double message on CSM condom programs.

IV.5.3 Pricing

IV.5.3.1 Elements of the Pricing Decision. CSM program managers tend to set prices with an eye primarily to making their products affordable to low-income groups. In the process, they use the following three guidelines:

1) The price of one month's supply of contraceptives should be no more than one percent of the monthly household income of lower income groups.

2) Prices for the CSM contraceptives should be similar to prices of other frequently purchased items such as soap, toothpaste, and bread.

3) Prices of CSM products should be about half the price of other commercially available contraceptives.[5]

These guidelines result in very low pricing. For example, in Mexico, the price of the product is set at a level lower than the commercial market price. In Pakistan, condom prices are very low, in line both with the cost of the other basic consumer staples, such as soap, matches, and tea, and with the daily wage of a laborer. Although this approach tends to put the CSM product within easy financial reach of low-income consumers, it fails to address longer term cost recovery issues.

This is not to say that all CSM prices need to be raised to facilitate long-term sustainability. In most cases, a major price increase would force many low-income consumers from the CSM program. If more careful revenue and cost analyses were undertaken in the initial stage of program planning, however, all program participants (A.I.D., contractors, distributors) would be more aware of the program's ability to meet social goals and recover costs (see Chapter VII).

A considerable amount of information exists on pricing, some of which has been incorporated into CSM programs. For

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[5]Binnendijk, A.L., A.I.D. Evaluation Special Study No. 40.

instance, most of the newer CSM programs have put into practice a valuable lesson learned from the older programs: that it is important to provide a higher profit margin to the commercial companies distributing the product to compensate for the CSM product's lower unit price. This margin structure has proved successful in generating incentives among distributors, wholesalers, and retailers. The Nigeria program, for example, recently adjusted the suggested retail prices of contraceptives in order to provide a more competitive return to retailers.

Other lessons, however, have not been well disseminated. For instance, operations research, using qualitative studies and sample surveys in Bangladesh, Egypt, and Jamaica, has shown that products sold at prices lower than the norm were considered poor in quality. This is an important piece of information that deserves consideration in the pricing equation. Again, when faced with inflation and project cost increases, program managers need to be aware of the research that shows that small price increases do not affect sales, but that larger increments can sharply alter the market. None of the programs observed, however, had management systems that encouraged flexibility in pricing, a must in countries where high inflation and exchange rate fluctuations affect the market. This is important because when a program falls behind the inflationary rate, it is difficult to catch up because a large price increase may significantly affect sales.

IV.5.3.2 Two-Tier Pricing for the Condom. In an effort to generate more revenue for the project, increase retail presence for the CSM condom brand, and reach more condom users, several CSM programs have or are considering adding a higher quality, higher priced condom to their lines.

Whereas this strategy might significantly enhance the exposure of the brand name and strengthen overall distribution, it is not without risk. Before introducing a higher priced condom, CSM programs must evaluate and test whether the new brand might damage the overall program by reaching only higher income men, failing to bring in new contraceptors, or diverting valuable management attention from the priority low-income target. In some cases, the high-priced product has forced out the lower priced one. For example, in an attempt to increase revenues, the Sri Lanka and early Mexico programs began selling higher priced brands. Later, when the lower priced brand was discontinued, revenues grew but sales dropped, reducing the overall effectiveness of the programs in increasing prevalence of the priority target group.

Recommendations

18. The pricing structure should allow for profit margins that are attractive to distributors, wholesalers, and retailers in order to compensate for the lower unit price of contraceptives and provide incentives for the trade to promote the products.

19. Pricing structures should remain as flexible as possible, especially in countries where general prices undergo frequent changes.

20. CSM project managers should consider all elements of the pricing decision and test alternative price points for their impact on revenue, market penetration, and product image.

21. A second, higher priced contraceptive brand should not be introduced unless the priority low-income target group is, and will continue to be, well supplied with the original brand.

IV.5.4 Product Packaging

IV.5.4.1 Local Branding. One of the assumptions typically made in CSM programs is that a locally branded (named) product enhances cultural identity and thereby significantly increases product sales. In addition, local branding serves to protect the product and can carry government-required information. When well-conceived and executed, CSM packaging confers a high quality image on the product, thereby helping to neutralize any image problems that could easily result from low product pricing. The value of local branding has been demonstrated in Mexico, where the use of the Protektor name (both the individual unit of sale and the retail dispenser) has helped condom sales.[6] By contrast, in Nigeria, where special packaging was not provided for foaming tablets and oral contraceptives, there have been problems with development of brand recognition and instructions for use.

Among the drawbacks of local branding is the cost. Local packaging, which involves local research, development, and packaging costs, can consume between 10 and 30 percent of the CSM budget (e.g., in Nepal, a high 30 percent was spent in this area). Second, sometimes a problem arises with respect to product image, wherein a locally branded package may contain a contraceptive with an international commodity name (e.g., a generic A.I.D. condom was packaged with the local Majestic label

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[6]This has worked well, although A.I.D. limited the project to two colors of the three that tested well.

in Bangladesh). Finally, when poorly conceived, local branding can hinder the entire marketing effort.

IV.5.4.2 World Branding. World branding has often proved a viable alternative to local branding, not only for such well-known products as Pepsi, Coke, Johnson's Baby Powder, Colgate, and Honda but for such contraceptive products as Microgynon and Durex. Even some social marketing brands, for example, Panther, Kamal, and Perle (Perla), are beginning to gain global market recognition.

World branding is based on a consistent, coherent brand strategy and implementation developed by international marketers. The desired image, target markets, and communication framework are carefully established and consistently implemented wherever the product is marketed. There are a number of advantages to world branding:

- World branding facilitates greater efficiencies in the production of outer packages. For example, a new program marketing Panther condoms can be provided finished products at the start of the program, significantly reducing the program start-up (investment) costs.

- The production efficiency and economies of scale should lead to higher volume and lower commodity costs.

- Brand presence in international markets adds to the credibility of product quality and projects a positive cosmopolitan image: Most Third World markets attach a higher perceived value to an imported product, or a product with an imported image.

- Using a world brand name avoids the problem of a commodity name being different from the package brand.

- Given the paucity of good marketing managers in existing CSM programs, world branding with a global marketing strategy significantly reduces the risks of marketing errors and often improves marketing performance. Also, it provides an opportunity to share advertising between countries; for example, Ghana, Nigeria, and Jamaica could possibly use the same Panther commercial. Such a global strategy would have to be centrally developed and monitored (e.g., by SOMARC) and, therefore, would require good international marketing expertise at that level.

Recommendation

22. **A.I.D. and CSM managers should explore the potential applications of a world branding strategy for CSM projects.**

IV.6 Distribution

IV.6.1 Distribution Channels

o Private Sector Channels

In the main, distribution of the CSM products is through independent, for-profit organizations that also distribute other consumer goods. The absence of day-to-day control by a governmental bureaucracy enables these private distributors to react quickly to changing market conditions. Moreover, their profit motive clearly works to the advantage of the CSM products. The use of commercial networks also means that operating costs are subsidized to some degree by other products and that an effective supply network is already in place. Generally, distribution is handled by a company with extensive experience in marketing health products and in servicing the classes of trade that are important for contraceptives (i.e., pharmacies).

The marketing company's management and marketing skills, not distribution experience or capabilities, are the key components for program effectiveness. Where the distributor has very good management and marketing skills (as is the case in Barbados and Peru), the program is being effectively implemented. Where these skills are less developed (as in Indonesia and Ghana), the distributor has proven to be less able to respond to varying market circumstances. In some countries, selection of a distributor may have been conditioned by the distributor's ability to distribute OCs (i.e., ethical drugs) even in circumstances under which nonethical contraceptives (condoms, vaginal tablets) were the only products being marketed (e.g., in Morocco and Indonesia). This is not necessarily a valid basis on which to chose a distributor.

o In-House Distributors

For some CSM programs, the use of commercial distributors has proven problematic. For example, the Bangladesh, Egypt, and Nepal programs started with commercial distributors but later changed to an in-house distributor when it became clear that the wholesalers were not ready to make an effort to distribute products for which there was little consumer demand. Local retailers, as well, resisted carrying contraceptive products in the belief that current customers would be alienated, particularly in rural areas. The vast rural populations in Bangladesh and Nepal make rural penetration a particularly important issue.

To overcome this problem in Nepal, a contraceptive retail sales (CRS) force was recruited and trained to go door-to-door persuading shopkeepers to sell CRS products. This sales force sells and distributes directly to wholesalers and retailers in various locations including retail shops, tea stalls, and medical establishments.

The advantage of the in-house approach is that it allows sales personnel to emphasize promotion and sales of CSM products exclusively and to reach markets not covered by the commercial sector (including rural areas). Through commissions, high sales levels have also been achieved. There are also disadvantages, however, including high fixed cost, extensive time spent training and recruiting, need for vehicles and warehouses, and difficultly in managing.

Finally, in Pakistan and Honduras, CSM products are distributed through a combined in-house/commercial approach.

- Government Distribution Approaches

In addition to commercial and in-house distribution channels, government or quasi-government approaches have also been used. Whereas these enjoy government support and can carry controversial products, they also suffer from absence of profit motive, high turnover, and extensive red tape and thus tend not to be very effective.

- Nontraditional Retail Channels

CSM programs are also exploiting channels other than traditional retail outlets, sometimes with great success. In Bangladesh, CSM products are being sold by program personnel to village medical practitioners, and in Colombia and Sri Lanka contraceptives are being distributed through village distributors. Egypt's FOF program also sells IUDs to medical representatives, and in the LAC region, pharmaceutical firms such as Schering provide OCs directly to doctors without advertising so as to keep a low profile. (This approach has an added benefit, as women stay with the OC first prescribed to them by a physician.) In Indonesia, where the law prevents oral contraceptives from being sold at retail stores without a prescription, the CSM project team is also considering plans to distribute contraceptives to doctors but plans to promote such availability through advertising.

IV.6.2 Distribution in C and D Areas

In regions with concentrated populations of class C and

D people, retailers often have small stores and are unwilling to carry a new product unless they are assured it will move. Not surprisingly, some of the CSM projects have experienced difficulty in gaining a high level of product distribution in these areas. This problem is a difficult one, but its solution is important to the success of CSM projects. Such methodologies as sampling, cross product promotions, offering free CSM products with other purchases, and more frequent deliveries may serve to make these small retailers more receptive to carrying CSM products.

In the Dominican Republic, the combined efforts of PROFAMILIA and Schering Dominicana have been effective in expanding the market for oral contraceptives in general and for Microgynon in particular. Television advertising and other promotional efforts succeeded in bringing to the attention of young women the availability of a low-dose oral contraceptive at a low price. A recently completed consumer intercept study in this country indicates that the intended C and D target group, in general, is being served.

IV.6.3 Trade Sales Meetings

Many of the CSM projects have held advance, in-depth seminars for the participants in the distribution chain. A prime purpose has been to dispel negative attitudes (social, religious, and/or cultural) that their distributors might have toward making contraceptives available. By talking about the project's importance to the nation and its support from national leaders and by presenting the proposed advertising and packaging, the CSM teams were able to dispose of many potential problems in advance. This kind of education and training has also served to make the retailers more enthusiastic about the project and better prepared to answer consumers' questions relating to family planning. For example, sales meetings held with retailers in Pakistan were the first ever conducted by any marketer in that country. Good communication with retailers in Pakistan has resulted in their exhibiting notable support for the program.

To conclude, among the distribution methods discussed, the commercial approach appears to be the most successful, because it provides an existing infrastructure that keeps costs down. Where the commercial sector has been unwilling or unable to meet the needs of the CSM program (reach rural populations), however, alternative approaches have been used successfully when tailored to the country's unique situation.

Recommendations

23. CSM projects should continue to use commercial distributors. If other low cost channels outside of the commercial retail trade are available to expand the program, however, project managers should be willing to explore them.

24. Training and orientation in CSM should be strengthened for both distributors and retailers throughout the project period. These activities should attempt to dispel negative attitudes toward making contraceptives available.

25. The experiences in marketing to hard-to-reach target groups should be shared among the contractors and local implementors, and A.I.D. should develop a mechanism to facilitate this communication.

V. COUNTRY SELECTION

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V.1 The Process

Although there is some variation among contractors, the country selection process appears to follow two principal steps: A.I.D. identifies a country for possible program involvement and the contractor assesses that country to determine program feasibility.

The identification process has in the past been related to a variety of factors, some political, some demographic, and some economic. There appears to have been no consistent rationale or uniformity in the approach to determining priorities among countries. Once a country has been selected by A.I.D., a feasibility assessment is generally done by a contractor to determine whether it meets a more specific set of criteria deemed necessary to implement a CSM program successfully.

V.2 Selection Criteria

V.2.1 Overview

Historically, three sets of criteria have been used to determine the feasibility of a CSM program: demographic and economic need, facilitating factors related to program feasibility, and so-called political considerations. From one country to another, there appears to be a great deal of variation with regard to the criteria that are given the most weight.

V.2.2 Criteria

- Demonstrated Need

In identifying countries for CSM selection, program developers first attempt to demonstrate a demographic and economic need for the project. This information is often collected from sources such as contraceptive prevalence surveys or censuses. Because the objective of CSM programs is to provide contraceptives to C and D consumers at subsidized prices, the criteria related to need have included low income (C and D consumers), high fertility rates, low contraceptive prevalence, high population density, and an absence of other affordable contraceptive sources. In Bangladesh and Pakistan, demographic need was considered an essential criterion in supporting the country selection decision. In both countries, the fertility, income, and contraceptive prevalence levels all favored the establishment of a new way of delivering contraceptives.

o Contextual Factors

Once the demographic need has been determined, programmers generally look at a variety of external factors relating to the program's potential for success. These might include the stated population policy/program environment; regulations restricting CSM activities (such as bans on mass media advertisement, ethical drug registration, or price setting); the existence of a viable private sector infrastructure capable of supporting the program (distribution network, marketing capability, media alternatives, etc.); and population density. Government support, the existence of a viable infrastructure, and an urban population are all generally helpful in enabling CSM programs to meet their goals, but this is not always the case. Examples of the somewhat inconsistent effect of these various factors are provided below.

-- Host Country Support

With respect to the stated population policy/program environment in Kenya, because the government was unwilling to make a commitment to CSM, the program was terminated several years after its inception in 1972. On the other hand, in Pakistan, political support was not demonstrated initially, but this stance changed following several years of working with the government.

Restrictive government regulations can often affect CSM programs. In a number of countries, including Egypt, Nepal, and Ghana, restrictions on advertising have reduced the program's overall effectiveness in reaching target groups. In Guatemala and Peru, excessive product registration procedures delayed program implementation for extended periods. In Jamaica, where contraceptive prices are controlled by the government, long delays in approving price increase requests restricted the program's ability to generate revenues to keep up with inflation. Other regulations that can affect CSM programs include restrictions on the sale of A.I.D.-donated commodities (e.g., in Zimbabwe), taxes, and prescription requirements for ethical drugs. In many cases, CSM program managers have been successful in obtaining modifications and changes in regulations, or in circumventing many government restrictions, thus helping to make family planning more accessible to C and D consumers (see Section IV.4.1 for further information on government restrictions on advertising).

In several instances, government leaders and representatives of other groups (e.g., religious) did not appear as well informed on family planning issues as might have been desirable. Although responsibility for briefing these groups

should be shared with other family planning providers, lack of knowledge on the part of host country leaders can hinder the success of CSM programs.

-- Availability of Marketing Infrastructure

The availability of an existing marketing and distribution infrastructure is another important criterion for determining the feasibility of a CSM program. In a number of countries, including the Dominican Republic, Nigeria, Indonesia, and Ghana, effective programs were initiated as a result of a well-developed private sector capable of managing the distribution, promotion, and marketing activities. Where private sector resources were not adequate, such as in Nepal and Bangladesh, however, successful programs have also been initiated. In these cases, extensive A.I.D. resources have been needed to assist in the development of a marketing and distribution capability.

-- Urban Concentration

Another criterion is the density of the population within a given country. At present, many CSM programs are based in urban areas because distribution systems are generally more readily available. For example, Nigeria was considered an excellent candidate for a CSM program because of the country's large urban concentration. Despite this urban emphasis, a number of programs have been successful in distributing CSM products in rural areas, including Bangladesh and Nepal.

o <u>Political Criteria</u>

Aside from the facilitating factors used in the assessment process, other criteria that figure in the country selection process fall into the category of so-called political considerations. This grouping covers factors unrelated to identified need or facilitating factors, representing instead the priorities and needs of A.I.D.'s geographic bureaus in Washington, Regional Economic Development Support Offices (REDSO) and USAID missions in the field, or local (government or PVO) interests. Over the CSM program life, these miscellaneous factors have often been given a great deal of weight in the selection process.

The Mexico CSM program represents a good example of a country selection process that was based on political considerations instead of a visible need. For the most part, Mexico was selected because it is considered a high-priority program by A.I.D. in general. Although a case could be made for having a program in this country, a stronger case could be made

for not having one. For example, over 20 different brands of condoms are sold in Mexico. A number of these condoms are sold at prices affordable to the C and D consumers. In addition, the government grocery store chain used by the CSM program is not as effective as the private sector distribution schemes used by other manufacturers of condoms.

V.2.3 Regional Differences in Country Selection

At present, there does not appear to be a specific set of parameters for identifying country characteristics by region. This omission appears to overlook an important fact, namely that although countries may vary widely with respect to the three sets of criteria used in the country selection process, countries within a given region often seem to have much in common. For example, Latin American countries generally have well-developed private sectors, strong government support for family planning activities, and a high concentration of urban areas. On the other hand, in Africa, the private sector is fairly rudimentary and not all countries strongly support family planning activities. Therefore, all selection criteria cannot be applied with the same strictness in all regions. Indeed, if the same criteria were to be used by A.I.D. for all the regions, many African countries would not be eligible for CSM programs.

Conclusion

It is difficult to predict at the outset the degree to which the facilitating factors listed here will affect program outcomes. Government restrictions can be modified and changed and governments can be persuaded of the desirability of CSM efforts about which they may have initially been dubious. Likewise, large inputs of program funds for technical assistance and training have helped compensate in some cases for a lack of available marketing expertise. Finally, although focus on the urban population, including important market towns, seems appropriate for most CSM programs, there are some successful rural programs. On the other hand, it is fairly clear that total disregard for these factors, and emphasis only on political factors, may result in an unsuccessful CSM effort.

Recommendations

26. Greater discipline must be brought to the country selection process. Consideration should be given to developing a set of parameters on a regional basis that would weight selection criteria, as appropriate, on the basis of regional capabilities.

A.I.D should apply these criteria to country selection.

27. CSM projects should not be approved if there is evidence that the host government will actively resist or interfere with the program activities.

VI. MEDICAL ASPECTS

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VI.1 Issues

Historically, national family planning programs have been established as the primary responsibility of governments, with medical practitioners and medical associations working to stimulate government action and to foster public approval of family planning efforts. By contrast, most CSM programs rely heavily on the provision of contraceptive products by commercial vendors.

The handling of ethical products by lay people, however, presents a number of problems. The first is a concern stemming from the universally accepted notion that all health care providers have a responsibility to provide sufficient information about drugs and therapies to ensure that patients are properly informed about their use. The corollary is that CSM programs have an obligation to provide correct, adequate contraceptive information to users about contraindications and proper use of the contraceptive that has been selected.

The second issue relates to the process of selecting a contraceptive and arises from the commonly accepted idea that the choice of contraceptive method is determined in considerable part by how much information is available to the consumer on each of the various methods that is being offered. The conclusion here again is that CSM programs have a responsibility to provide access to the information necessary to enable consumers to make informed decisions about contraceptive use.

CSM programs are thus facing two challenges: to ensure that the information that is available to sellers and clients is correct and understandable (primarily an educational concern) and that the information is widely disseminated in a clear and convincing way (primarily a marketing concern).

CSM programs have encountered problems in their educational and promotional efforts to help alleviate medical concerns associated with family planning methods. First, they are often dealing with populations that are largely illiterate and minimally informed about the reproductive processes. Moreover, because these programs are dealing in areas that have traditionally been associated with the medical profession, there is considerable potential for the development of adversarial relationships between the profession and the CSM program managers. Physicians consider both the sale of oral contraceptives and the provision of health counseling and advice their special purview. Therefore they may be reluctant to share

these tasks with people who have not had extensive training in these areas.

VI.2 Strategies

CSM program managers have developed a number of strategies to deal with the medical aspects of their programs. These include training of providers, providing informational and educational materials to consumers, with particular stress on packaging, and involving the medical community in their programs. These are discussed below.

VI.2.1 Training

The level of training and knowledge about family planning and contraceptive technology among both the medical fraternity and retailers varies tremendously from one country to another.

In programs in which physicians and nurses are trained in family planning practice and provide the majority of services, CSM programs may offer some additional training to these medical personnel. For example, in Indonesia where the CSM program was developed in close collaboration with the Ministry of Health, refresher training has been provided to physicians, nurses, and midwives, and there is vendor training for pharmacists. Likewise, in Bangladesh and Sri Lanka, CSM programs are training medical and traditional Ayurvedic practitioners to sell OCs and condoms. In Egypt, the CSM program sells IUDs to physicians and provides training in insertion of this method at the five program clinics.

The more common pattern in CSM programs, however, is distribution by nonmedical personnel, and here is where the need for training is most clear. The Ghana and Mexico programs provide good examples of this sort of training.

- Ghana

The training program in Ghana links the expansion of service delivery points to the provision of training. Specifically, the government has agreed, on a demonstration basis, to allow proprietors of pharmacies to sell OCs to customers without a prescription once they have successfully completed the training program offered under the project.

This approach is time- and labor-intensive. It is, however, gradually producing a well-informed sales force capable of providing counseling, making referrals, and offering general

sex education to consumers. Course instructors emphasize the vendor's role as part of the health delivery network and stress professional identity and affiliation. Local government officials have been active participants in the development of the curriculum and are currently exploring the use of this trained cadre to support selected aspects of the primary health care program.

- Mexico

Mexico's CSM program has focused on the training not only of store managers but also of administrators and training coordinators. The expectation here is that trainees will routinely share the information they are provided during the training with others who function directly as vendors.

In a number of other countries, for example, Colombia, Egypt, Honduras, and Nepal, CSM staff provide instruction to retailers covering OC side effects along with a description of the high-risk groups who should not receive this method. Often, these programs also provide training to physicians who are prescribing OCs.

Conclusions

Overall, the experience in CSM programs has shown that nonphysician vendors play a valuable role in the delivery of family planning services. Supported by relatively short and inexpensive training, CSM workers are safely and effectively supplying contraceptive products (including oral contraceptives) in programs that are enhancing the coverage, acceptability, and delivery of family planning services.

Effective training programs emphasize patient screening and counseling and make appropriate referrals to the health care system. Specifically, topic areas of emphasis in such programs include

- introduction to the family planning programs available in the country;
- anatomy and physiology of reproduction (brief, but explicit);
- review of available methods of contraception, mechanisms of action, and pharmacology;
- screening techniques and criteria;
- counseling techniques for families and individuals; and

- when and how to refer patients to the health care system.

VI.2.2 Information, Education, and Communication (IEC)

CSM programs also attempt to deal with the issue of side effects and health implications of family planning through IEC efforts directed both to the community at large and to the medical community. This information helps customers to make an informed choice on use of family planning methods.

Egypt is doing a particularly effective job in this regard. Its CSM program attempts to target low-risk groups by widespread promotion of oral contraception for "active and healthy women." In general, however, more could be done by way of supporting public discussion and consideration of the various health issues that are part of any family planning program.

A second method, this one more common, is providing instructions on contraceptive use within the product packages. Although the packages normally carry inserted sets of directions, what is often missing is information suitable for people with minimal or perhaps no education. For instance, in the Dominican Republic, where private pharmaceutical firms do their own packaging, the inserts provided are not necessarily suitable for the illiterate or semiliterate segments of the population who use the products.

A third mechanism, again used in Egypt, is informational materials designed for consumers and the seller or just for the seller. Such materials are used in the Pakistan CSM program. Here, the project team developed a number of brochures to inform doctors, nurses, distributors, retailers, and consumers about family planning methods. Brochures available to consumers provide a great deal of useful information that simply cannot be given through the mass media and make it very easy for people to get answers to family planning questions that are often difficult to discuss openly. The brochures distributed to the medical and retail community serve to acquaint or desensitize these groups to the CSM program and help encourage them to support actively the contraceptive product.

A fourth method is countertop displays. In Egypt, OC displays of this sort provide a checklist of contraindications on the back to assist pharmacists and retailers in identifying potential health risks for women using this method. The checklist provides a set of questions relating to a woman's smoking habits and medical history and directs the seller to respond in a particular manner depending on the answer. For

example, if a woman answers yes as to whether she has ever had high blood pressure, she would be instructed to see a physician before taking the pill. Materials such as these have been reported to be effective in supporting the sellers should they forget some of the specific points provided during the training exercise.

VI.2.3 Involvement of the Medical Community

The attitude of the medical profession can be an important factor in whether a CSM program is successful. If the medical community casts doubt on CSM efforts, sales may suffer. If, by contrast, the medical community is enlisted as an ally in the effort to promote family planning, the CSM program will gain credibility and consequently effectiveness. Although this issue has particular relevance to efforts to promote use of OCs, the proposition that the medical community must be involved is valid for the entire CSM effort.

Many CSM programs are actively seeking the support of the medical community. One of the most common approaches has been through the training efforts described above. This training is normally given in conjunction with efforts to distribute a specific product (e.g., OCs) through the medical community. In Egypt, for example, the FOF project is keeping the medical community informed of its objectives through project staff visits with physicians and pharmacists. A similar effort was carried out in Bangladesh with the specific aim of dissuading medical practitioners from discouraging their clients from using the OC because of adverse side effects.

Much could be gained from even greater support from the medical community. Professional groups might take a greater interest in the delivery and promotion of all national family planning programs, participate in the formulation of program policy, and provide public support to CSM programs in the face of possible negative political, religious, or social reactions.

<u>Recommendations</u>

28. Training should be strengthened both for medical personnel and for pharmacists and retailers in the use of contraceptives and criteria for use. In particular, special emphasis on developing vendors' skill in screening customers for contraindications to the use of OCs is essential for safety and the continued acceptance and credibility of the program.

29. Social marketing strategies should be coordinated with host government and/or A.I.D.-sponsored IEC campaigns. The IEC

should provide an overview of all contraceptive methods and their advantages and disadvantages to ensure that CSM customers are able to make an informed choice. It should alert consumers to possible contraindications with specific methods (see recommendation 1) and provide information on correct and consistent product usage (i.e., pills, condoms, and vaginal tablets). If the IEC program were successful in carrying out all these functions, then the social marketing program would only be responsible for motivation, distribution, and support to service providers.

30. Additional written materials and/or drawings are needed on the medical aspects of CSM programs; they need to be developed for physicians, retailers, and customers, with special attention to illiterate clients.

31. CSM programs should develop working relationships with established medical and medical support organizations and practitioners.

VII. COST RECOVERY/SELF-FINANCING

VII. COST RECOVERY/SELF-FINANCING

VII.1 Overview

An important issue for any CSM program is whether its social goals can ever be reconciled with its cost-recovery/self-financing goals. Translated into programmatic terms, the question is this: If (or when) the project begins to operate without external support, can product prices be set at a level that will be within the financial reach of the target C and D economic groups?

Examination of the two sides of the equation--the operational costs of CSM programs on the one hand and the possibilities of generating substantial income on the other--suggests that reconciliation may not be possible. The historical record confirms this thesis: The only cases in which CSM projects have become completely self-sustaining are those in which sales appear to have moved from the lower level economic group to the A and B groups who can afford the higher cost of nonsubsidized contraceptives. Regional differences are significant. CSM programs in countries with higher per capita incomes (generally in Latin American) have come much closer to sustainability than those with lower per capita incomes (mostly in Africa).

VII.2 Costs

The overall costs of CSM programs are not generally well known. Programs vary with respect to how well they keep track of their operating costs. With respect to contraceptive commodities, although A.I.D. may know the wholesale value of the commodities in any given program, it does not know the add-on costs including transportation, logistics management, warehousing, and so forth. Therefore, the total cost of any given CSM program is nearly impossible to calculate.

VII.2.1 Initial Costs

Introducing a new product line is always very expensive. Most firms lose money for the first several years until the new product(s) is established and the volume of sales is sufficient to cover operational costs and make a profit. These initial costs tend to be even higher for CSM products than for commercial ones. This is partly because of the nature of the products themselves, as training and education are required to inform the retailers and sales force of contraceptive product use

and safety precautions (see Chapter VI). In addition, the promotion and advertising costs may be higher for CSM programs than for a commercial undertaking because the messages must not only promote the product but must also promote family planning per se (see Chapter IV).

VII.2.2 Recurrent Costs

The major recurrent cost in any CSM program is for the contraceptives that are being sold. Ironically, as CSM programs become more successful, the demand for contraceptives increases, requiring greater external funding to meet the expanded product needs. In addition, there are the usual ongoing packaging, advertising, and distribution costs that accompany any commercial venture.

VII.3 Financial Resources

CSM programs look to three funding sources to contribute to covering program costs: external inputs from A.I.D. including technical assistance and contraceptives; use of existing marketing systems; and revenues from sales. Of these, external support remains the single most critical ingredient. Of the three sources, A.I.D.'s support in financing both technical assistance and commodities is seen as the one essential factor in the viability of CSM programs, particularly during start-up.

VII.3.1 External Support

VII.3.1.1 Technical Assistance (TA). Typically, A.I.D. will finance the marketing and distribution costs of project start-up. For example, it may finance technical assistance to help design a CSM project and to provide training for pharmacists, retail shop owners, vendors, and so on. It may also help plan the operational market research needed to identify target groups and their needs and to prepare the briefs for advertising and other promotional work. In addition, A.I.D. will normally supply the necessary contraceptives. Starting up a typical CSM project probably costs A.I.D. approximately $500,000 a year in local and international TA costs and anywhere from $200,000 to $2,000,000 for contraceptives.

VII.3.1.2 Contraceptives. All individuals interviewed believe continued external underwriting of the cost of contraceptives is essential to the financial well-being of the project. For example, although implementing agency officials expressed some optimism about the medium-term capability of their

projects to share a higher percentage of program costs, they pointed out that this achievement would need to be predicated on continued provision of contraceptives free of charge.

The provision of contraceptives from other sources obviously represents a welcome savings for A.I.D. (see Section IV.5.1), but even in these programs a form of subsidy exists, and therefore the more basic question remains as to whether projects can expect to be entirely self-sustaining without the provision of contraceptives.

VII.3.2 Use of Existing Marketing Systems

The use of an existing distribution system represents a low-cost delivery mechanism for the contraceptive product line (see Section IV.6.1). Although it is difficult to estimate the financial implications of this kind of support, it is clear that using these companies enables A.I.D. to avoid the considerable fixed cost inputs required with nascent public or voluntary programs.

VII.3.3 Cost Recovery from Product Sales

Once sales of contraceptives are under way, the income generated can help pay local operational costs. Cleared revenue, however, is not necessarily stable. Some pharmaceutical houses, for example, encounter patterns in which a specific product (i.e., a new pill formulation) may break even at various periods throughout the product's life.

An instance when income fluctuated dramatically from the expected level occurred in Nigeria, where devaluation resulted in a major drop in purchasing power. As a result, the project was unable to market its products. This was particularly devastating because the marketing plan anticipated commercial distribution of contraceptives, postponing advertising and market research costs until revenues were available to cover them. With the devaluation, this approach had to be modified.

CSM project managers and A.I.D. officials would like to see CSM projects do a better job in recovering costs and therefore often build cost recovery into program design. CSM project objectives, for instance, often include cost recovery, or a move towards sustainability, as a project objective (especially when CSM income is seen as a means to support other family planning initiatives as in PVO programs in the Dominican Republic, Colombia, and Egypt). Marketing plans often include cost-recovery targets, derived from estimates of local project

costs with estimated sales revenue subtracted (e.g., in Egypt, Mexico, the Dominican Republic, and expected in Ghana). Some CSM programs even calculate cost per CYP as a balanced measure of how well the project is recovering costs while expanding sales (Bangladesh).

The historical record, however, suggests there are distinct limitations to the proportion of costs that can be recovered from sales of contraceptive products. For instance, although it is true that the cost per CYP has decreased in Bangladesh over time, the only programs operating without outside subsidies are those in which the marketing targets have been switched from C and D to A and B groups. Specifically, in Colombia, it is believed that the PROFAMILIA program, which is now operating without A.I.D. support, is marketing to more affluent customers. In Mexico as well, when international donors discontinued subsidizing the early CSM project, the project became a private business. It now caters to higher income clients, boasts the largest share of the country's condom market, and is selling pills both within and outside the country, particularly to various Caribbean countries.

In short, it seems that the need to serve low-income clients must remain a barrier to project self-sufficiency. From a marketing standpoint, removal of all external help in most developing countries would price the C and D groups out of the market and shift the focus to the higher income A and B economic groups.

VII.3.4 Other Donor Involvement

Although the CSM approach is being actively promoted to developing country governments, very little attempt has been made to influence other donor organizations to share in or execute social marketing programs.

During the early 1970s, major donors and cooperating agencies (The Population Council, the Ford Foundation, IPPF, PSI, Westinghouse, UNFPA, United Nations Industrial Development Organization, and A.I.D.) reviewed the possibility of expanded commercial distribution of contraceptives. There was also talk of setting up a new international agency to promote commercial and social marketing activities. Because the amount of funding required to initiate such programs was considered to be high, and because a reluctance existed to working with profit-making private sector firms, most of the donors and cooperating agencies abandoned the idea. Aside from A.I.D.'s commitment to CSM, only IPPF has taken steps in this area, through establishment of a small unit in its London headquarters to promote a variety of community-based distribution projects.

VII.4 Cost Effectiveness of the CSM Approach

Although full self-financing may be beyond the reach of the standard CSM project, there is evidence that CSM is a cost-effective way to deliver family planning products. In a 1980 study in Colombia, for example, the CYP cost for the CSM program was estimated at $1.03, compared with costs per CYP of $15.27, $18.70, and $3.42 respectively for the clinic, rural community-based, and urban community-based programs. A similar study in Bangladesh showed equally good results. The advantages of CSM programs compared with public sector programs include the following: CSM does not require an expensive clinic infrastructure or extensive staffing; retail sales revenue can cover program costs of distribution, promotion, management, and so on; and CSM managers tend to be more cost-conscious than do government managers.

Although it is possible to compare the cost effectiveness of the CSM approach with that of public sector programs, it is not easy to compare the cost effectiveness of one CSM program with another. The variables among programs such as their stage of development and their size have such a profound effect on ability to recover costs that such comparisons are virtually meaningless. Newly established programs, for instance, have such high operational costs that it is unlikely that a sales level can be reached that will bridge the gap between costs and revenues. Larger programs tend to have lower operating costs than do smaller programs. Likewise, if the emphasis is on higher priced products, the additional revenues lower the program cost.

VII.5 Financial Projections

Partly because base costs are not well understood (see Section VII.2), CSM programs do not have reliable projections of costs or expected revenues. With respect to costs, program managers make little effort to project the costs of the commodities that will be needed to meet rising demands for contraceptives. If attention is not paid to this issue, the cost of contraceptives may unexpectedly become a constraint on supply. Likewise, A.I.D. could benefit from developing a methodology that would allow for distinguishing the social costs of the program from the private or commercial costs. If such analyses were done routinely, project managers would have a better idea of how reduced external support would affect the project's ability to continue to meet its social goal and would thus be better able to plan for phase-down or phaseout of A.I.D. assistance.

Likewise, on the revenue side, CSM project managers seldom update projected estimates of revenues or make the

necessary comparisons of contraceptive needs to increasing numbers of users. This lack of financial data may be one factor inhibiting CSM programs from devising better strategies for cost recovery.

Recommendations

32. Future CSM program designs should reflect the likelihood that donor (USAID) assistance may not be available forever and should therefore contain measures designed to alleviate the impact of an eventual phase-down or phaseout. Target dates should be specified, taking into consideration the individual country situation.

33. A.I.D. should develop a standard approach and methodology for estimating, monitoring, and reporting the cost of CSM projects, taking into consideration all inputs. These should be put into a data system and be continually updated. Inputs might include but not be limited to the following:

Technical Assistance:	Salaries of U.S. and local staff, subcontracts and subgrants, noncontraceptive commodities, travel and per diem, and percentage of overall contract management and overhead.
Commodities:	Cost to A.I.D. of commodities, commodity procurement costs, warehousing, transportation, and costs of estimating demand.

34. Standard business costs related to marketing should be separated from those costs related to the social aspects of CSM. This would involve identifying costs on the private or business side of the project (e.g., distribution, packaging, advertising) and distinguishing them from costs on the social side (e.g., evaluative research, packaging inserts, and special price subsidies needed to reach low-income consumers). Cost-recovery efforts might then be designed in stages, with recovery of private costs first, followed by recovery of social costs.

35. Faced with limitations in resources--physical, financial, and human--A.I.D. should actively invite the participation of other international donors. A conference might be held at which A.I.D. could provide other donor agencies with a detailed description of CSM programs and principles.

36. Although CSM projects should not continue to depend exclusively on A.I.D.-donated commodities if alternative sources are available and can be financed through non-A.I.D. funds,

decisions on alternative sources and their impact on prices should be approached with caution so that contraceptives continue to be affordable for the C and D groups.

37. Other plans to increase cost effectiveness and sustainability should be reviewed carefully to ensure that they do not compromise CSM's social and contraceptive prevalence goals.

VIII. RESEARCH AND EVALUATION

VIII. RESEARCH AND EVALUATION

VIII.1 Overview

Marketing research is an integral part of any successful marketing effort, commonly used both to help design the marketing strategy and to test its effectiveness over time. The purpose is to get consumer input with respect to the targeting, pricing, packaging, distribution, and promotional strategies that are either under consideration or in place. The concern is whether the various components of the marketing strategy will be successful in helping to lead to increased sales and contraceptive use.

Marketing research, on the other hand, does not address the issue of whether the CSM projects are leading to increased contraceptive use: that is, it is not a method of program evaluation. Although a major concern of program planners, this vastly more difficult question of measuring increased contraceptive prevalence due to CSM programs, involves a far more complicated research undertaking and should not concern in-country project management.

VIII.2 Marketing Research

VIII.2.1 Use in Planning

Although the level of sophistication and depth of information obtained varies from country to country, generally project directors are committed to marketing research, particularly early in the project life. During this early period, program planning research is frequently carried out to identify the status of the marketplace and the needs of potential customers. Most project teams have recognized the value not only of quantitative baseline studies identifying knowledge, attitudes, and practice of various groups toward family planning, but also the utility of qualitative research techniques like focus groups for better understanding of marketing issues that are difficult to assess through quantitative measures. This research has also been used to select and guide decisions concerning pricing, packaging, distribution, and promotion. When possible, initial research of this type allows for similar issues to be explored periodically on the same subject to assess change over time (see Sections IV.3 and IV.4.2).

VIII.2.2 Use in Monitoring

Program monitoring represents a second type of research. This is used to review such program aspects as distribution approaches, advertising effectiveness, and consumer use of the product. The purpose is to help managers make periodic marketing adjustments. Examples of such research include panel surveys covering the awareness and use of CSM products and focus group discussions and consumer intercept studies that provide a detailed look at consumer attitudes and test the validity of the messages that have been developed. Over the years, the Egypt and Bangladesh programs have used intercept surveys to collect data on special information requirements. Panel studies have also been carried out in Egypt to follow CSM trends, wherein the same group of individuals is interviewed on a periodic basis to determine any changes in attitude and behavior over time.

One of the problems that is characteristic of CSM programs is that although project teams are encouraged to continue to rely heavily on market research, they sometimes are not able to avoid the temptation (which often arises after a marketing project is a couple of years old) to rely solely on management's judgment. Marketing family planning products is not, by any means, a simple task, even for the most experienced commercial marketers. To disregard input from the consumer is to overlook one of the most valuable tools available to a marketer.

A number of other problems have been associated with marketing research activities. For instance, research has been carried out but not used. This occurred in Pakistan, where urban audiences were being exposed to the same marketing inputs as rural audiences even though their levels of family planning knowledge and attitudes, as revealed in a KAP study, differed considerably. Also in Pakistan, research was not available in time to be considered when the design of the advertising and marketing campaigns were developed. Elsewhere, in Ghana and the Dominican Republic, studies were very sophisticated and time consuming.

Finally, there are two other types of research that could strengthen the ability of CSM programs to make additional modifications in their strategies and operation, both under-utilized. One type is the post-introductory tracking study. This would be helpful in enabling management teams to assess levels of brand awareness, trial by various groups, repeat users, loyalty, attitudes toward the CSM and other products, and very important, the ability of the CSM program to bring in new contraceptors (i.e., degree of substitution effect). The Indonesian and Dominican Republic CSM tracking studies serve as

good models for other projects. A second type is the retail audit system that indicates not only what is sold to distributors but also what is sold to which customer. Bangladesh is the one program that has developed this system, thanks to long-term support from SOMARC. As of December 1987, three of the four phases envisaged for this technical assistance had been completed, and the final stage was under way. Thus far this approach has been helpful for following and explaining changes in the sales of condoms and oral contraceptives at the retail level.

VIII.2.3 Research Resources

Generally, CSM teams have been successful in obtaining in-country research companies that are experienced in commercial marketing. Use of local firms has helped the teams to benefit from the commercial sector's knowledge in assessing consumer reaction to retail products.

For example, in Egypt and Nepal, where the SOMARC program has provided marketing research assistance, in-country firms have been contracted to carry out specific research tasks. In Egypt, involvement of local firms has helped enable FOF to develop an appropriate strategy with respect to communication, image advertising, generic child-spacing messages, product-specific messages, and product planning approaches and skills.

In Nepal, the research carried out sought the answer to marketing questions relating to the effectiveness of the project's current distribution approach, the potential for expanding into rural distribution channels, and the possibility of diversification into other revenue-generating areas. The technical assistance has led to the creation of an indigenous marketing research firm, the Center for Development Education. Through practical experience, this support has helped to develop the program's capacity to carry out qualitative and quantitative research and communication tracking. Prior to the assistance, the program had done no message testing and had at its disposal little research or tracking expertise.

There is a tendency, however, not to make use of the expertise of S&T/POP operations research contractors and various family planning organizations operating within the country. These people could be helpful in such areas as designing studies and wording sensitive questions to avoid respondent confusion or rejection.

Recommendations

38. CSM program managers should use marketing research to test the validity of marketing strategies throughout the life of the project and should ensure that results of marketing research are incorporated in project implementation.

39. Where possible, CSM projects should establish a retail audit system and an ongoing tracking study during the first year of the project, which should be used for the life of the project.

40. CSM teams should continue to use in-country firms to do marketing research but should also attempt to work with family planning organizations and S&T/POP research contractors operating in-country to develop better operational strategies.

VIII.3 Evaluation

VIII.3.1 Overview

Whereas marketing research focuses on the success of marketing techniques to increase sales, evaluation of the impact of CSM programs seeks to ascertain whether these programs have brought about an increase in contraceptive use. To provide a comprehensive picture of program effectiveness, such assessments should also take into account the origin of CSM program clients, i.e., whether they are new users or have switched from other programs, and the effectiveness of the methods in use.

The two standard evaluation approaches are household surveys and sales data converted to CYPs and births averted (BA). Both are flawed to some degree. In addition, tracking studies and consumer intercept surveys undertaken as part of the process of marketing research may provide some insights into program effectiveness. Program managers, however, should not be expected to undertake the impact evaluations based on this research. Their responsibility should be limited instead to ensuring that marketing strategies are effective, with impact evaluations better left to outside programs that have the time, money, and expertise to undertake them.

VIII.3.2 Household-Based Surveys

VIII.3.2.1 Overview. Household-based survey data with relevance for CSM programs can be acquired in two ways: either from existing sources that provide secondary data (e.g., Demographic and Health Surveys [DHS], government census reports, and the like) or through special research efforts that provide

primary data on contraceptive use in program areas. Although using information from existing studies may be less expensive than mounting special studies, it is frequently impossible to find secondary data that provide the information needed to show program effectiveness. On the other hand, it is seldom possible to conduct the original research that would provide reliable data for any given project.

VIII.3.2.2 Secondary Data. Almost all countries have had at least one DHS or similar survey from which it may be possible to extract information on contraceptive use, source, brand, and price. Other sources of secondary data might include large-scale research surveys and reports prepared by in-country family planning organizations, reports prepared by private sector companies that manufacture contraceptive products, and government census reports and studies. When DHS data are available from two different years, changes in overall contraceptive use or in the use of particular methods can be calculated. Information on source, price, and brand can be used to calculate changes in market shares for any particular method. These data can be very useful in assessing program progress. The growth in the use of particular methods and in the source of this growth (CSM program, community-based distribution program, etc.) can be calculated.

The advantage of using secondary data is the reduction in the time and funds needed for the collection of data, which in turn means that the evaluation process is less expensive. These surveys also provide information relating to consumer patterns that provides marketers with a better understanding of the country's marketing environment.

The use of such surveys as sources of secondary data, however, has some important disadvantages: The data must cover two separate years; they may be outdated; their quality cannot always be assessed; and these surveys often focus on information that relates only indirectly to CSM issues, leaving gaps in information.

Furthermore, to be able to use secondary data not specifically collected for CSM purposes, a fairly large sample and a reasonably high level of contraceptive use or both may be required. In some countries in Africa where overall contraceptive use is low, it may not be possible to assess program progress by using data obtained from nationwide surveys without increasing the sample size significantly.

A specific shortcoming of using DHS project surveys to measure effectiveness of CSM programs is that they focus on women, usually in union. Women, however, are not a very reliable

source of information with regard to the most important contraceptive provided by most CSM programs: condoms. Even married women may underreport condom use, and a considerable proportion of condom use can probably be ascribed to unmarried men or women or to married persons who engage in extramarital sex. Consequently, surveys that focus on women in union can provide only limited data on an important method provided by CSM programs. Even if the wife reports use accurately, if the husband purchases the product, she may not know the brand or the price. Therefore, increased use in various programs providing condoms may be difficult to ascertain with information obtained from surveys of women.

VIII.3.2.3 Primary Data. There are two sorts of special operational research that can be carried out to assess the effectiveness of a CSM program in a given program area: 1) operations research that compares a program area with a control area at two different times and 2) tracking studies that show changes in product use over time by comparing baseline data with data gathered after the program has been in place for a period of time. Although useful where they can be implemented, neither of these methods can be used on a large-scale basis.

- Operations Research

Probably the best way to evaluate the impact of a CSM program would be to choose comparable areas, implementing a program in one area and using the other as a control area, and then conducting baseline surveys with follow-up surveys conducted X number of years later. The difference in the increase in contraceptive use between the experimental and the control area might then be attributable to the program. One such study, undertaken in rural Kenya in 1970, indicated that the presence of the CSM program had significantly increased knowledge and use of contraceptive products. It is extremely difficult to find a good control area, however.

- Tracking Studies

Surveys can also be designed to cover the more limited geographic areas at which programs are targeted. These surveys, often referred to as tracking studies, use baseline data followed up by household surveys and are normally used to assess the effectiveness of various marketing strategies (see Section VIII.2). Although the sample is usually quite small, a SOMARC tracking study in Ghana included a large enough number of households that the findings are being used experimentally to assess whether there has been an increase in contraceptive use in the program area. The advantages of this approach, where

practicable, are that it is cheaper than nationwide surveys and that interviews with the same number of households in a CSM area will provide more information on contraceptive users than would a DHS or other nationwide survey.

VIII.3.3 Sales Data

The standard indicators used to measure the impact of CSM programs--in particular CYPs and BAs--are inexact at best. These indicators are derived by converting sales data into figures for contraceptive usage. Calculating a CYP by using the number of condoms (or other contraceptive) needed to provide one year of protection against pregnancy, depends on assumptions concerning coital frequency and contraceptive wastage, which in turn depends on a variety of factors including the cultural norms and behaviors of the contraceptive recipients. The standard measure is 100 condoms a year, but this has often proved misleading. In Sri Lanka, for instance, the coefficient used for calculating condom use is 62, whereas in Bangladesh it is 144. Similarly questionable coefficients are used for other methods.

These assumptions become further complicated when calculating BA, when the effectiveness of products (including product and user failures) and fecundity of the product user are brought into the equation.

In addition, both these measures assume that sales of contraceptives and BAs by use of these methods are net increments; that is, any contraceptives sold by the program results in a net increase in contraceptive protection provided. This may be a fairly reasonable assumption in countries in which contraceptive use is low and services for similar methods are not easily accessible. Most countries in Africa are in this category. It is not a realistic assumption, however, in countries in which contraceptive use is moderate or high, as in many countries in the LAC region (e.g., Honduras [35 percent] and the Dominican Republic [50 percent]).

In such countries, particularly in the early program stages, the first purchasers may be drawn from other programs. Intercept surveys, which are easy to conduct in countries in which retailing outlets are readily available, are an excellent means to distinguish switchers from new acceptors. Two such studies, conducted in the Dominican Republic and in Honduras, showed that a high proportion of purchasers are switchers (both from the commercial sector and from government or subsidized

family planning programs).[7] Even those who did not previously purchase contraceptives, particularly young users, might have acquired them from other sources if the program had not been instituted. In both surveys, new users of the program were typical of new users of contraception--younger and of lower parity than switchers--suggesting that at least some of them would have chosen a different source if the program had not been instituted. Additional analysis of data on new users might have determined precisely what proportion started to contracept because of new service provision. If an estimate of this proportion had been made, then an estimate of the proportion of sales directly attributable to the program could have been calculated.

In general, however, the fact remains that in countries where contraceptive prevalence is high or even moderate, a considerable proportion of the CYPs and BAs cannot be attributed to the program. Consequently, across-country comparisons of CYPs or BAs may not only prove inaccurate in assessing program performance but may overstate differences if high-prevalence countries have higher sales mainly through attracting switchers whereas low- prevalence countries have lower sales but mostly attract new users.

These measures (CYP and BA) become even more problematic in calculations of the percentage of eligible couples served by CSM programs when they become the numerator, with the denominator "women in union." Like condoms (see Section VIII.3.2.2), spermicides are often purchased by men and women who are not in union or by men or women who use them for sex outside of marriage. Also, the number of condoms or spermicides likely to provide a CYP is generally lower for single than for married persons; surveys conducted of young adults show that sexual activity of unmarried young adults is infrequent.

Finally, the sales data themselves may be unreliable, skewing the CYPs and BAs generated from them. The nature of these data has been brought into question in instances when CYPs or BAs generated from sales appeared to be increasing but when consecutive surveys showed no increase in contraceptive use.

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[7]Switching is not necessarily a negative indicator. Indeed, switchers from the public sector represent a plus, as the CSM delivery system they are using is less costly to donors than heavily subsidized public programs. On the other hand, CSM programs should seek insofar as possible to avoid attracting users from the commercial sector, as they were already paying the full cost of the contraceptives.

Even if contraceptive use has increased, this increase may still be attributable to growth of other programs.

The weaknesses in these indicators are widely recognized, and some efforts are under way to develop new ones. No promising alternatives have been suggested to date, however, and the issue remains important, particularly for large CSM programs (Bangladesh and Egypt) where substantial financial investments have been made.

Recommendations

41. Efforts to evaluate the impact of CSM programs on contraceptive prevalence should be left to outside organizations, not undertaken by CSM implementation staff.

42. Additional efforts need to be made to develop indicators other than CYPs to measure program performance. An indicator should be developed that reflects not only the couples in union who use CSM products, but also the other groups served by CSM programs, e.g., single men and women, extramarital users, etc. To identify effective indicators, A.I.D. should consider sponsoring a series of working group meetings with experts in the field of social marketing.

43. Consideration should be given to expanding the use of consumer intercepts in situations in which lists of retail outlets are easily available.

IX. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

IX. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

IX.1 Summary

This worldwide review has brought into sharp focus the wide spectrum of options that exist for any CSM programming endeavor. Table 3 portrays this array, listing the principal elements that are included in CSM programs and the several ways in which each element can be implemented. For the seven key ingredients that must be included in every CSM program, between two and five different programming options are identified. As pointed out in Chapter III, there are five different management structures alone. With respect to the six aspects of marketing that are identified, there is an equal amount of variety. Table 3 lists five formulas for carrying out advertising and promotion and five types of product, four ways products might be provided, and three ways they might be distributed.

Looked at from a worldwide perspective, the CSM program has exhibited a high level of initiative and resourcefulness. Individual country programs have experimented with innovative management and marketing approaches to meet specific needs and have adopted traditional methods to suit in-country conditions. Out of this process, now in its 18th year, has evolved a clear picture, not only of the options that are available to CSM programmers, but also of the strengths and weaknesses of each. These are reviewed below.

IX.2 Conclusions

Overall Assessment

o Because CSM provides quality family planning methods at affordable prices with widespread availability and access through retail outlets, this approach is effective in increasing contraceptive prevalence among the lower income groups (C and D consumers). Thus, it can be judged successful with respect to its two social objectives: to make contraceptives available at prices affordable to low-income groups and to increase overall contraceptive prevalence.

In addition, CSM programs can

- develop a high profile for family planning;
- help reduce barriers to contraceptive advertising;
- influence male attitudes and behavior pertinent to family planning; and
- provide education and training to pharmacists, retailers, and vendors, which support family planning

Table 3
CSM PROGRAM ELEMENTS

MANAGEMENT	**MANAGEMENT STYLES** - Managed by government agency - Managed by semi-autonomous agency - Managed by family planning association - Managed by private sector organization established specifically for the purpose - Managed by an established private sector organization
MARKETING	**TARGET AREA SERVED** - Urban - Peri-urban - Rural - Mixture
	ADVERTISING AND PROMOTION - Standard mass media - Point-of-purchase approaches - Other approaches (billboards, riverboat sails, etc.) - Mixture of one or more - No advertising
	PRODUCTS - Condoms - Vaginal tablets - Orals - Other (IUDs and Injectables) - Mixture of one or more
	PRODUCT SOURCE - USAID donated - Purchased at an alternative source - Available locally - Mixture
	PRICE - Government dictated price - Project sets price - Market price
	PACKAGING - World Branding - Local Brands
	DISTRIBUTION - Commercial distribution - In-house distribution - Non-Traditional Retail Channel - Government Distribution Channel - Mixed distribution (both commercial and in-house)

in general, and which promote the safe and effective use of contraceptive products in particular.

On the other hand, CSM programs appear to be less successful in achieving a third goal: that of recovering program costs.

Management

o CSM programs work best when they are managed by a commercial distributor but have strong government support.

o Although A.I.D., USAID missions, and the contractor can all contribute to the success of a CSM project, these programs work best when day-to-day management decisions rest with the implementing agency.

o For best results, CSM program managers must have good marketing skills. This competence is important not only for the implementing agency but also for the contractor and USAID staff charged with providing policy advice and monitoring CSM program operations.

o There is also a need for outside advice from highly experienced commercial marketers as the program evolves and progresses.

Marketing

o The heart of a CSM program is the successful marketing of contraceptive products at affordable prices. Given the conflicting priorities inherent in the social and marketing goals of CSM programs, on the whole they are doing a good marketing job. In some cases, however, effectiveness would be greater if commercial marketing techniques were used more consistently. Specifically, CSM marketing plans are not always comprehensive or sufficiently heeded; the target population is not always well defined; advertising and promotional messages are not always well designed for the various target groups; and prices are sometimes set too low, particularly when inflation is a factor.

Country Selection

o No consistent methodology has been developed to guide selection of countries for CSM programs. On occasion, political considerations appear to be given more weight than issues of need or the existence of in-country factors conducive to successful program implementation.

Medical Aspects

o From an ethical standpoint, CSM programs have an obligation to ensure that information on the medical aspects of the contraceptives they distribute is correct and understandable. From a programmatic standpoint, they serve to benefit if the medical community is enlisted as an ally in the project.

Financing

o A.I.D.'s support in financing both technical assistance and commodities plays an essential role in the viability of CSM programs, especially during the investment or start-up stage.

o The need to serve low-income clients remains a barrier to project self-sufficiency. From a marketing standpoint, removal of all external help would price the C and D groups out of the market and shift the focus to the higher income A and B economic groups (in most developing countries).

o CSM programs compare very favorably with other family planning programs with respect to cost effectiveness. A.I.D., however, does not have as clear a picture of the total cost of CSM programs as is needed, and CSM program managers do not always make an adequate effort to project costs and revenues.

Research and Evaluation

o Although CSM programs have attempted to conduct marketing research both for planning and for monitoring marketing strategies, managers do not always continue throughout the life of the project to use research to monitor programs. In some cases, the findings of marketing research efforts have also been disregarded.

o It is very difficult to evaluate the effect of CSM programs on contraceptive prevalence. No totally satisfactory methodology exists to carry out such studies.

IX.3 Recommendations

Overall

CSM programs should be continued and expanded. They should be considered an important segment of a country's family planning program and be closely coordinated with other family planning activities.

Management

1. The implementing agency should be fully involved at all stages of a project's development, design, and implementation. Implementing agencies should also be allowed the flexibility and freedom to carry out day-to-day activities, hire staff, and make the necessary management decisions without interference from the government or USAID.

2. CSM program management should be as private sector-oriented as possible, with technical assistance and training provided to fill any gaps in experience and knowledge about family planning and contraceptive products.

3. The implementing agency should employ or make available experienced marketing managers to work on the CSM project. Along with strong marketing skills, the managers need to be effective in working with government officials.

4. All CSM programs should ensure that the appropriate government agencies (such as health, planning, finance, and clearly population) clearly understand how the CSM program fits with other government sponsored population, family planning, and community-based activities.

5. If qualified marketing expertise is not available on the implementing agency staff, the contractor should develop training programs and/or provide technical assistance so that the necessary skills are available to the local manager and his or her senior advisors. The goal is to ensure that marketing expertise is always available.

6. A.I.D./Washington should ensure that its officers responsible for the CSM program have expertise in marketing or be given training in this area.

7. To ensure that USAID officers can monitor CSM activities effectively, regional training workshops should be held (such as those organized by SOMARC in Africa and LAC) for USAID personnel and CSM program managers. The purpose would be to review basic marketing principles. In addition, such workshops would provide an opportunity to share experiences.

8. The involvement of USAID missions in CSM implementation should be regularized. This process should include (1) clarification of the role of A.I.D./Washington and USAID missions in project design, implementation, and monitoring, (2) establishment of a scope of work to institutionalize this involvement, and (3) preparation of monitors and supervisors to carry out the SOW. USAID's role should be limited to facilitating the implementation process.

Marketing

Planning

9. Increased efforts should be made to lay the groundwork for CSM program implementation by developing formal comprehensive marketing plans for each program.

10. CSM contractors should be required to submit formal period marketing plan updates on a yearly basis for review and approval to A.I.D./Washington.

Targeting

11. The marketing strategies of CSM projects should address the specific needs of the different segments of the target population.

Advertising

12. A better job needs to be done in briefing and educating influential groups in the community. The understanding and approbation of these groups is important to ensure the success of contraceptive advertising campaigns.

13. Consumer benefit statements (such as better health for mothers) should be developed to provide a foundation for advertising concepts. These statements must be based on up-to-date information on contraception knowledge, attitudes, and practice and should be tested.

14. Consumer sampling should be used to encourage product trial and use.

15. To help set proper spending levels and design a plan that accommodates goals for the scope and frequency of advertising messages, alternative media budgets and media plans should be tested prior to the start of a national advertising effort.

Products

16. Product sources within the private sector, including local, U.S., and foreign suppliers, should be evaluated to assess the available options. Steps should be taken for CSM programs to import their own contraceptives without recourse to A.I.D. financing, where suitable.

17. In markets in which condoms are promoted as prophylactics against AIDS, CSM programs should continue to

promote their use as contraceptives while moving towards encouragement of other methods such as OCs as rapidly as possible. CSM and AIDS program managers should also work closely together in order to mitigate any negative effects of the double message on CSM condom programs.

Pricing

18. The pricing structure should allow for profit margins that are attractive to distributors, wholesalers, and retailers in order to compensate for the lower unit price of contraceptives and provide incentives for the trade to promote the products.

19. Pricing structures should remain as flexible as possible, especially in countries where general prices undergo frequent changes.

20. CSM project managers should consider all elements of the pricing decision and test alternative price points for their impact on revenue, market penetration, and product image.

21. A second, higher priced contraceptive brand should not be introduced unless the priority low-income target group is, and will continue to be, well supplied with the original brand.

Packaging

22. A.I.D. and CSM managers should explore the potential applications of a world branding strategy for CSM.

Distribution

23. CSM projects should continue to use commercial distributors. If other low cost channels outside of the commercial retail trade are available to expand the program, however, project managers should be willing to explore them.

24. Training and orientation in CSM should be strengthened for both distributors and retailers throughout the project period. These activities should attempt to dispel negative attitudes toward making contraceptives available.

25. The experiences in marketing to hard-to-reach target groups should be shared among CSM contractors and local implementors; A.I.D. should develop a mechanism to facilitate this communication.

Country Selection

26. Greater discipline must be brought to the country

selection process. Consideration should be given to developing a set of parameters on a regional basis that would weight selection criteria, as appropriate, on the basis of regional capabilities. A.I.D should apply these criteria to country selection.

27. CSM projects should not be approved if there is evidence that the host government will actively resist or interfere with the program activities.

Medical Aspects

28. Training should be strengthened both for medical personnel and for pharmacists and retailers in the use of contraceptives and criteria for use. In particular, special emphasis on developing vendors' skills in screening customers for contraindications to the use of OCs is essential for safety and the continued acceptance and credibility of the program.

29. Social marketing strategies should be coordinated with host government and/or A.I.D.-sponsored IEC campaigns. The IEC should provide an overview of all contraceptive methods and their advantages and disadvantages to ensure that CSM customers are able to make an informed choice.

30. Additional written materials and/or drawings are needed on the medical aspects of CSM programs; they need to be developed for physicians, retailers, and customers, with special attention to illiterate clients.

31. CSM programs should develop working relationships with established medical and medical support organizations and practitioners.

Financing

32. Future CSM program designs should reflect the likelihood that donor (USAID) assistance may not be available forever and should therefore contain measures designed to alleviate the impact of an eventual phase-down or phaseout. Target dates should be specified, taking into consideration the individual country situation.

33. A.I.D. should develop a standard approach and methodology for estimating, monitoring, and reporting the cost of CSM projects, taking into consideration all inputs, including costs of technical assistance and of commodities, logistics support, transportation, warehousing, and so forth. These should be put into a data system and be continually updated.

34. Standard business costs related to marketing should be separated from those costs related to the social aspects of CSM. This would involve identifying costs on the private or business side of the project (e.g., distribution, packaging, advertising) and distinguishing them from costs on the social side (e.g., evaluative research, packaging inserts, and special price subsidies needed to reach low-income consumers). Cost-recovery efforts might then be designed in stages, with recovery of private costs first, followed by recovery of social costs.

35. Faced with limitations in resources--physical, financial, and human--A.I.D. should actively invite the participation of other international donors. For instance, a conference might be held at which A.I.D. could provide other donors with a detailed description of CSM programs and principles.

36. Although CSM projects should not continue to depend exclusively on A.I.D.-donated commodities if alternative sources are available and can be financed through non-A.I.D. funds, decisions on alternative sources and their impact on prices should be approached with caution so that contraceptives continue to be affordable to the C and D consumers.

37. Other plans to increase cost effectiveness and sustainability should be reviewed carefully to ensure that they do not compromise CSM's social and contraceptive prevalence goals.

Marketing Research

38. CSM program managers should use market research to test the validity of marketing strategies throughout the life of the project and should ensure that results of marketing research are incorporated in project implementation.

39. Where possible, CSM projects should establish a retail audit system and an ongoing tracking study during the first year of the project, which should be used for the life of the project.

40. CSM teams should continue to use in-country firms to do market research but should also attempt to work with family planning organizations and S&T/POP research contractors operating in-country to develop better operational strategies.

Impact Evaluation

41. Efforts to evaluate the impact of CSM programs on contraceptive prevalence should be left to outside organizations, not undertaken by CSM implementation staff.

42. Additional efforts need to be made to develop indicators other than CYPs to measure program performance. An indicator should be developed that reflects not only the couples in union who use CSM products, but also the other groups served by CSM programs, e.g. single men and women, extramarital users, etc. To identify effective indicators, A.I.D. should consider sponsoring a series of working group meetings with experts in the field of social marketing.

43. Consideration should be given to expanding the use of consumer intercept studies in situations in which lists of retail outlets are easily available.

APPENDIX A

Matrixes of Comparative Data for 12 CSM Countries (6 Country Reports and 6 Desk Reviews)

Table 1: Demographic and Socio-Economic Indicators

Table 2: CSM Program, Distribution and Promotion Information

Table 3: National Contraceptive Prevalence Survey Results

Table 4: Couple Years of Protection and Births Averted

Table 1: Demographic and Socio-Economic Indicators

COUNTRY	TOTAL POP. IN (000s)	WOMEN AGES 15-49 YEARS IN (000s)	WOMEN IN UNION AGES 15-49 YEARS (000s)	WOMEN IN THE WORKFORCE (000s)	% OF NATURAL INCREASE	CRUDE BIRTH RATE (/000s)	TOTAL ANNUAL LIVE BIRTHS (000s)	INFANT MORT. RATE (/000s)	% POP. URBAN AREAS	POP. DENSITY PER Km	GNP PER CAPITA (US$)	INCOME DIST. (LOWEST 20 %)	PERCENT. ADULT ILLIT.	# OF RADIO RECEIVERS IN USE PER 1000 INHAB.	ETHNIC DIVERSITY (LANG.)	RELIGION
Egypt	46,909	11,056	10,116 (91.5%)	1,199 (5.2%)	2.3	32.8	1,539	85	46.4	47	720	5.8	55.5	173	Arabic English French	Sunni Muslim (90%) Coptic Christ.
Ghana	13,588	3,015	2,005 (66.5%)	2,015 (29.4%)	3.35	46.9	677	90	31.5	55	350	NA	74.0	174	English Tribal	Traditional (45%) Christian (43%) Muslim (12%)
Nigeria	95,198	20,779	15,771 (75.9%)	13,073 (27.5%)	3.48	50.5	4,807	105	23.0	103	730	NA	57.6	79	English Hausa Ibo Yoruba	Muslim Christian Indigenous Africa Beliefs
Bangladesh	101,147	21,938	20,938 (95.0%)	1,959 (4.0%)	2.61	41.7	4,218	119	11.6	702	130	6.6	66.9	8	English Bangla	Muslim (83%) Hindu (16%) Christ/Buddist (1%)
Indonesia	166,440	41,245	29,696 (72.0%)	19,846 (23.8%)	1.74	28.6	4,760	74	25.3	87	540	6.6	74.4	138	Indonesian (most speak Javanese)	Muslim (90%) Christian (5%) Hindu/Buddist (3%)
Nepal	16,482	3,659	3,403 (93.0%)	2,359 (29.4%)	2.27	39.4	649	128	7.7	117	160	NA	25.9	25	Nepali & 12 others	Hindu (90%) Buddist

Table 1: Demographic and Socio-Economic Indicators (Cont.)

COUNTRY	TOTAL POP. IN (000s)	WOMEN AGES 15-49 YEARS IN (000s)	WOMEN IN UNION AGES 15-49 YEARS (000s)	WOMEN IN THE WORKFORCE (000s)	% OF NATURAL INCREASE	CRUDE BIRTH RATE (/000s)	TOTAL ANNUAL LIVE BIRTHS (000s)	INFANT MORT. RATE (/000s)	% POP. URBAN AREAS	POP.. DENSITY PER Km	GNP PER CAPITA (US$)	INCOME DIST. (LOWEST 20 %)	PERCENT. ADULT ILLIT.	# OF RADIO RECEIVERS IN USE PER 1000 INHAB.	ETHNIC DIVERSITY (LANG.)	RELIGION
Pakistan	100,380	22,559	16,175 (71.7%)	3,412 (7.0%)	2.66	40.4	4,055	109	29.8	125	380	NA	70.4	78	Urdu,English Punjabi,Sindhi Pushtu,Balchi	Muslim (97%) Buddist Hindu
Dominican Republic	6,243	1,542	847 (54.9%)	255 (8.2%)	2.38	30.9	193	65	55.7	128	970	NA	22.7	201	Spanish	Roman Catholic (97%)
Guatemala	7,963	1,737	1,490 (85.8%)	341 (8.7%)	3.2	40.8	325	59	40.0	73	1,160	NA	45.0	43	Spanish 23 Indian Lang.	Roman Catholic Protestant Traditional Mayan
Honduras	4,372	953	579 (60.8%)	225 (10.3%)	0.09	39.4	172	69	40.0	39	700	NA	40.5	49	Spanish	Roman Catholic Protestant
Jamaica	2,336	576	496 (86.1%)	501 (42.6%)	2.05	26.0	61	18	53.8	213	1,150	NA	3.9	394	English Creole	Anglican Baptist Protestant
Mexico	78,996	18,731	12,025 (64.2%)	7,054 (17.9%)	2.47	31.2	2,465	47	69.6	40	2,040	2.9	9.7	290	Spanish	Roman Catholic (97%) Protestant

Table 2: CSM Program, Distribution, and Promotion Information

COUNTRY	FIRST TECHNICAL ASSISTANCE ACTIVITY	DATE OF PROJECT AGREEMENT SIGNING	PRODUCT LAUNCH DATES			AGREE-MENT END DATE	STATUS OF SALES	STATUS OF SUPPORT	TECHNICAL ASSISTANCE CONTRACTOR	GEOGRAPHICAL TARGET REGION	PROGRAM IMPLEMENTING AGENCY	DISTRIBUTION SYSTEM	POINTS OF PURCHASE	MEDIA PROMOTION APPROACHES USED
Egypt	(1980)	(9/80)	Condom:	Golden Tops		(79)	Active	USAID	Triton (TA ended 12/84)	National	Family of the Future	Commercial	3,240 Pharmacies	National television, Radio, Newspapers, Magazines, Outdoor Posters, Cinema, Bus Cards
			Orals:	Norminest		(83)								
			IUDs:	Copper T		(79)								
				Copper 7		(81)								
			Tablets:	Amaan		(79)								
Ghana	(7/84) Assessment	(4/86) Bilateral Agreement	Condom:	Panther	5/86	(89)	Active	USAID/MF&EP & AID Central	Futures Group	Urban (10 cities)	Danafco	Commercial	Pharmacies, Private Clinics Maternity Homes, Chemical Sellers	Point of Sale Displays eg: Leaflets, Posters Radio, & Press Ads
			Tablet:	Kamal	1/87									
			Orals:		6/87									
Nigeria	(6/84)	(6/85)	By method/product		NA	(92)	Active	Self-Sufficient	FPIA	National	Sterling Drug Ltd.	Commercial (Pharmaceutical)	Pharmacies Patent Shops	TV, Radio, Print Media Newspaper, Posters, Stickers
Bangladesh	(6/79)	(6/79)	Condom:	Raja	11/75	(92)	Active	USAID,	PSI	National Joscep, Gov of BGD	Family Planning Social Marketing Project	In-house sales force	Pharmacies General Stores Grocery Stores Pan Shops	Radio, Press, Billboards, Mobile Film Unit, Posters, Cinema
				Panther	2/83									
				Majestic	84									
			Orals:	Maya	11/75									
				Ovacon	6/80									
			Tablet:	Joy	5/79									
			Inject:	Noristerat	10/84									
Indonesia	(6/85) Assessment	(3/86)	Condom:	Dualima	4/86	(89)	Active	AID/BKKBN	Futures Group	Urban (10 cities)	Mecosin	Commercial	Drug stores (toko obats) Pharmacies (apotiks)	Point-of-Purchase Displays, Direct Mail, Radio, Print, Posters
Nepal	NA	(7/76)	Condom:	Dhaal	78	NA	Active	USAID	Westing-House Health Systems (76-83)	National	Contraceptive Retail Service Company Ltd	In-house	Over 8,000 Pharmacies and other Retail Shops	Product Posters, Wall Paintings, Billboards, Bus Shelters, and Radio and Newspaper Ads
				S. Dhaal	80									
			Oral:	Gulaf	78									
				Nilocon	8/82									
			Tablet:	Kamal	12/82									

Table 2: CSM Program, Distribution, and Promotion Information (Cont.)

COUNTRY	FIRST TECHNICAL ASSISTANCE ACTIVITY	DATE OF PROJECT AGREEMENT SIGNING	PRODUCT LAUNCH DATES	AGREE-MENT END DATE	STATUS OF SALES	STATUS OF SUPPORT	TECHNICAL ASSISTANCE CONTRACTOR	GEOGRAPHICAL TARGET REGION	PROGRAM IMPLEMENTING AGENCY	DISTRIBUTION SYSTEM	POINTS OF PURCHASE	MEDIA PROMOTION APPROACHES USED
Pakistan	(12/85)	(01/86)	Condom: Sathi 1/88	(90)	Active	GOP & USAID	PSI Mktg Assoc.	National	W. Woodward	In-house & Commercial Distributors	Pharmacies, Food Stores General Stores, Misc.	Cinema, other Point of Purchase, (Radio, TV & Posters Delayed)
Dominican Republic	(02/85)	(05/85)	OC: Microgynon 3/86	(88)	Active	AID	Futures Group	Santiago & Santo Domingo	Profamilia	Commercial	Pharmacies (Pharmaceutical)	Point-of-Purchase Stickers, Radio, TV Press ads, Posters
Guatemala	(12/83)	(12/83)	Condom: Scude 7/85 Panthera 1/87 OC: Perla 7/85 Tablet: Lirio 7/85	(88) Ext. from 12/86	Active	USAID	Juarez & Associates	National	IPROFASA	In-house	650 Pharmacies & Retail Outlets	Point-of-Purchase Promotions Brand specific Radio and Press Ad Spots, Keychains, Pamphlets
Honduras	(01/82)	(12/81)	Condom: Tahiti 12/84 OC: Norday 3/84 Norminiest 1/87	(86) Ext. Given	Active	AID	Triton	National	ASHONPLAZA	Commercial (84-86) In-house (1/87)	250 Pharmacies; 170 Medical Points-of-Purchase; 40 Supermarkets, Liquor Stores	Radio, Billboards, Posters, Keychains (condom), Pillowcase (OC)
Jamaica	NA	(1974)	Condom: Panther 79 OC: Perle 79	NA	Active	NFPB & USAID	NFPB (GOJ)	National	Grace-Kennedy Inc	Commercial	300 Retail Outlets & 150 Pharmacies	NA
Mexico	(06/85)	(11/85)	Condom: Protektor 3/86	(88) Ext. to 9/89	Active	AID	Futures Group	National (22 cities)	Conasupo	Government Distribution	14,500 Conasupo Supermarket Chain Stores	Radio, Posters, Shelf Displays, Football Game Promotions

Table 3: National Contraceptive Prevelance Survey Results

COUNTRY	YEAR OF SURVEY	TOTAL WOMEN IN UNION AGE GROUP MEASURED	CONTRACEP-TIVE PRE-VALENCE RATE (%)	RATE BY METHOD					
						STERILIZATION			
				ORAL	CONDOM	MALE	FEMALE	INJECTABLE	IUD
Egypt	84	15 - 49	30.3	16.5	1.3	-	1.5	0.3	8.4
Ghana	79/80	15 - 49	12.4	3.1	0.8	-	-	0.6	0.4
Nigeria	81/82	15 - 49	5.7	-	-	-	-	-	-
Bangladesh	83	15 - 44	19.1	3.3	1.5	1.2	6.2	0.2	1.0
Indonesia	81	15 - 44	36.2	22.5	-	0.5	0.5	0.6	10.0
Nepal	86	15 - 49	15.0	1.1	0.6	6.0	6.6	0.5	0.2
Pakistan	84	15 - 49	9.1	1.4	2.1	0.0	2.6	0.6	0.8
Dominican Republic	86	15 - 44	50.0	9.0	1.0	-	33.0	-	3.0
Guatemala	85	15 - 44	25.0	4.7	1.2	0.9	10.2	-	2.6
Honduras	84	15 - 49	35.0	12.6	0.7	0.2	12.0	0.3	3.9
Jamaica	83	15 - 49	51.4	19.3	7.6	0.0	10.9	7.6	2.2
Mexico	82	15 - 49	47.7	14.2	0.9	13.7	-	-	6.6

Table 4: Couple Years of Protection and Births Averted

COUNTRY	YEAR OF PROJECT	SOURCE	DATE OF DATA COLLECTION	METHOD & PRODUCT BRAND	UNIT SALES	TOTAL CYPs PER YEAR	RANGE OF "EFFECTIVE" CYPs[1] High	RANGE OF "EFFECTIVE" CYPs[1] Low	EST. NO. OF CYPS REQUIRED TO AVERT ONE BIRTH[2]	ESTIMATED NO. OF BIRTHS AVERTED BY CSM[3] High	ESTIMATED NO. OF BIRTHS AVERTED BY CSM[3] Low
Egypt	8th	Futures Group	1/86 - 12/86	Condom:	15,305.9						
				IUD:	284.0	877.6	853.8	822.0	5.6	152.5	146.8
				Tablet:	1,450.2						
			1/87 - 12/87	Condom:	18,782.8						
				IUD:	330.2	1,027.2	998.5	961.4	5.6	178.3	171.1
				Tablet:	1,393.3						
Ghana	2nd	Futures Group	6/86 - 12/86	Condom: Panther *	1,138.8	11.4	10.2	9.1	3.1	3.3	2.9
			1/87 - 12/87	Condom: Panther	2,225.0						
				Tablet: Kamal	753.8	29.8	26.8	23.5	3.1	8.6	7.6
Nigeria	2nd	FPIA	11/85 - 10/86	Condom: NA	8,414.3						
				Oral: NA	768.9	152.6	142.2	128.8	3.3	43.1	39.0
				Tablet: NA	941.4						
			11/86 - 10/87	Condom: NA	2,408.4						
				Oral: NA	49.5	30.0	27.3	24.4	3.3	8.3	7.4
				Tablet: NA	209.3						
Bangladesh	12th	PSI	1/86 - 12/86	Condom: Raja	73,007.2						
				Panther	2,419.2						
				Majestic	5,993.1						
				Oral: Maya	1,163.9	1,028.6	940.2	842.8	5.0	188.0	168.6
				Ovacon	1,135.4						
				Tablet: Joy	3,561.5						
				Inject: Noristerat	8.1						
			1/87 - 12/87	Condom: Raja	76,697.7						
				Panther	1,747.8						
				Majestic	5,691.4						
				Oral: Maya	1,397.9	1,100.1	1,008.7	906.8	5.0	201.7	181.4
				Ovacon	1,612.2						
				Tablet: Joy	2,529.6						
				Inject: Noristerat	7.5						

Table 4: Couple Years of Protection and Births Averted (Cont.)

COUNTRY	YEAR OF PROJECT	SOURCE	DATE OF DATA COLLECTION	METHOD & PRODUCT BRAND	UNIT SALES	TOTAL CYPs PER YEAR	RANGE OF "EFFECTIVE" CYPs High	RANGE OF "EFFECTIVE" CYPs Low	EST. NO. OF CYPS REQUIRED TO AVERT ONE BIRTH	ESTIMATED NO. OF BIRTHS AVERTED BY CSM High	ESTIMATED NO. OF BIRTHS AVERTED BY CSM Low
Indonesia	2nd	SOMARC	3/86 - 12/86	Condom: Dualima *	2,231.0	22.3	20.1	17.8	6.2	3.2	2.9
			1/87 - 12/87	Condom: Dualima	4,952.7	49.5	44.6	39.6	6.2	7.2	6.4
Nepal	9th	SOMARC	1/86 - 12/86	Condom: Dhaal	4,233.3						
				S. Dhaal	0.0						
				Oral: Gulaf	105.9	55.6	51.0	45.8	5.2	9.8	8.8
				Nilocon	41.3						
				Tablet: Kamal	199.6						
			1/87 - 12/87	Condom: Dhaal	3,317.1						
				S. Dhaal	0.0						
				Oral: Gulaf	22.6	39.6	36.1	32.1	5.2	6.9	6.2
				Nolocon	37.9						
				Tablet: Kamal	178.0						
Pakistan	1st	Triton	1/87 - 12/87	Condom: Sathi *	36,000.0	360.0	324.0	288.0	5.0	64.8	57.6
Dominican Republic	2nd	SOMARC	3/86 - 12/86	Oral: Microgynon *	50.5	3.9	3.8	3.6	4.4	0.9	0.8
			1/87 - 12/87	Oral: Microgynon	195.8	15.1	14.8	13.9	4.4	3.4	3.2
Guatemala	3rd	SOMARC	1/86 - 12/87	Condom: Scudo	382.4						
				Oral: Perla	50.5	13.0	12.0	10.7	4.6	2.6	2.3
				Tablet: Lirio	531.9						
			1/87 - 12/87	Condom: Scudo	480.1						
				Oral: Perla	55.6	13.7	12.7	11.2	4.6	2.7	2.4
				Tablet: Lirio	463.4						

Table 4: Couple Years of Protection and Births Averted (Cont.)

COUNTRY	YEAR OF PROJECT	SOURCE	DATE OF DATA COLLECTION	METHOD & PRODUCT BRAND	UNIT SALES	TOTAL CYPs PER YEAR	RANGE OF "EFFECTIVE" CYPs High	RANGE OF "EFFECTIVE" CYPs Low	EST. NO. OF CYPS REQUIRED TO AVERT ONE BIRTH	ESTIMATED NO. OF BIRTHS AVERTED BY CSM High	ESTIMATED NO. OF BIRTHS AVERTED BY CSM Low
Honduras	4th	Triton	1/86 - 12/87	Condom: Tahiti	453						
				Oral: Norday	192	20.9	20.2	18.7	3.3	6.1	5.7
				Norminest *	21						
			1/87 - 12/87	Condom: Tahiti	776						
				Oral: Norday	172	25.8	24.6	22.9	3.3	7.2	6.7
				Tablet: Norminest	63						
Mexico	2nd	SOMARC	6/86 - 12/86	Condom: Protektor	970	9.7	8.7	25.0	4.9	1.8	1.6
			1/87 - 12/87	Condom: Protektor	2,500	25.0	22.5	20.0	4.9	4.6	4.0

* New Product launch

[1] Range of "Effective" CYPs (High and Low) - To complete this column, the Unit Sales data was "corrected" to take into consideration the contraceptive effectiveness rate. This was done by multiplying the high and low effectiveness percentages provided for each of the methods, which include: condoms 90% to 80%; pill 98% to 92%; and tablet 90% to 75%. (Rates based on low range of rates found in demographic literature). Once the unit sales data was corrected, the total CYP was re-calculated by adding up the corrected CYPs.

[2] CYP Required to Avert One Birth - To calculate this number, the following equation is used.

$$\frac{\text{CYP}}{\text{CYP} \quad \frac{\text{Overall Births}}{\text{Women in Union}}} = \text{No. of CYPs required to avert one birth}$$

[3] Estimated Number of Births Averted by CSM (High and Low) - To calculate this total, the CYP figures which were corrected to take into account their contraceptive effectiveness, were divided by the "CYP Required to Avert One Birth".

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PREFACE

This text, vol. 2 of the Contraceptive Social Marketing (CSM) Assessment, contains reports on A.I.D.-funded CSM programs in six countries: Dominican Republic, Ghana, Indonesia, Mexico, Nigeria, and Pakistan. Each country report includes an executive summary, findings, conclusions, and recommendations. These country reports provided the foundation for Vol. 1, Worldwide Review, of the overall CSM assessment.

A team of multidisciplinary specialists was assembled to conduct the worldwide assessment. The team was subdivided into three regional groups--Africa, Asia, and Latin America/Caribbean--and each group was assigned two country programs for on-site assessment. As preparation for their field visits, team members met in Washington, D.C., to attend briefings and conduct desk reviews of some of the more established CSM programs (Bangladesh, Egypt, Guatemala, Honduras, Jamaica, and Nepal). In the field, each group was joined by a medical specialist.

During the field visits, each team met with representatives of the host government, USAID staff, local and international private voluntary organizations (PVOs), staff of the World Bank and the United Nations Fund for Population Activities (UNFPA), and affiliates of the International Planned Parenthood Federation (IPPF). The team also met with the implementing agency and its subcontractors (e.g., advertising, research, and training) as well as distributions, wholesalers, retailers, and consumers.

GLOSSARY

A.I.D.	Agency for International Development
AAO	A.I.D. Affairs Officer
CBD	Community-based distribution
CSM	Contraceptive social marketing
CYP	Couple year of protection
DHS	Demographic and Health Surveys
FHI	Family Health Initiatives
FPIA	Family Planning International
IEC	Information, education and communication
IMF	International Monetary Fund
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
KAP	Knowledge, attitudes and practice
NGO	Non-Governmental organization
OC	Oral contraceptive
ORT	Oral rehydration therapy
PVO	Private voluntary organization
SES	Socioeconomic status
SOMARC	Social Marketing for Change
TFG	The Futures Group
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WFS	World Fertility Survey
WHO	World Health Organization

ASIA

INDONESIA
PAKISTAN

I. INDONESIA (IKB-SOMARK Project)

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The IKB-SOMARK project is an urban contraceptive marketing program (condoms only) implemented by private sector organizations. Oversight is provided by the Indonesian government through the National Family Planning Board (BKKBN) and by A.I.D. through TFG/SOMARC. The BKKBN sells the contraceptive product (imported from Korea) to the project, establishes the operational framework of the program, and assists in setting and monitoring policy. A.I.D. provides funding for operational costs and technical assistance in developing specific operational skills and deliverables.

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ANNEXES

A: Persons Contacted
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GLOSSARY

BKKBN	National Family Planning Board
GBHN	General State Policy Guidance
IKB-SOMARK	SOMARC project in Indonesia
Rp	Rupiah, unit of currency
SRI	Survey Research Indonesia

ACKNOWLEDGMENTS

The assistance of numerous people and their organizations was essential to this assessment. In particular, the team is indebted to Mr. Gani Perla, IKB-SOMARK, for his assistance in organizing and carrying out the assessment. A list of the people who gave of their time to assist us is included as Annex A. We are grateful for their support.

EXECUTIVE SUMMARY

BACKGROUND

Indonesia provides a favorable climate for family planning activities. The National Family Planning Board (BKKBN) is a well-established, professionally competent organization with good links to the country's policymakers and its rural population. Its staff has experience in all aspects of family planning program design, implementation, and evaluation.

Significant resources have been provided for family planning by the Indonesian government and by a variety of foreign donors, including the World Bank, which is currently providing a U.S. $41.4 million loan to strengthen the activities of BKKBN, and the United Nations Fund for Population Activities (UNFPA), which provides several million dollars of assistance to government family planning activities. In 1987, A.I.D. assistance focused on the expansion of voluntary sterilization services, urban contraceptive social marketing (CSM), training, and village family planning services. A total of $6 million was proposed for FY 87 by A.I.D.

GOALS AND OBJECTIVES

In its fourth five-year development plan, the Indonesian National Family Planning Program established the following goals, among others:

- Increase contraceptive prevalence among eligible couples to 65 percent.
- Reduce the annual rate of population growth to 1.5 percent.
- Transfer 20 percent of family planning services and service delivery costs away from the public sector and to the service user.

Within this context, IKB-SOMARK project goals are as follows:

- Increase contraceptive prevalence in the 10 largest urban centers in Indonesia.
- Maximize cost recovery and self-sufficiency of project activities in order to assist the project in becoming self-sustaining.

MAJOR FINDINGS AND RECOMMENDATIONS

Management and Organizational Structure

The organizational structure for the project involves two masters and one servant. One master is the BKKBN, representing the government, which provides the contraceptives and exerts strong policy influence. The second master is TFG/SOMARC, which provides capital, management supervision, and technical assistance. The implementing agency responding to these two masters is PT Mecosin, a private pharmaceutical manufacturer, which is responsible for marketing, distributing, and promoting the product. Mecosin, however, as a pharmaceutical manufacturer is prohibited by Indonesian law from distributing products. Consequently, all the responsibilities assigned to Mecosin are subcontracted; specifically,

- distribution is handled by PT Sawah Besar,
- promotion and advertising are handled by PT Fortune, and
- market research is handled by Survey Research Indonesia (SRI).

Of importance, advertising and research are conducted under direct contract to TFG/SOMARC, not Mecosin, which lessens the latter's control over the implementation process.

The project organization includes two other layers of supervision above the implementing agency. First, an Advisory Council, consisting of BKKBN, SOMARC, Mecosin, and USAID, sets and approves policy and implementation. Second, a management group, consisting of BKKBN, SOMARC, and Mecosin, makes day-to-day operational decisions for the project. This management group is a replication of the Advisory Council and an attempt to manage by committee.

This organizational structure constrains Mecosin's activities, yet the company has all programmatic responsibilities. At the same time, however, Mecosin has limited marketing and management capabilities. Given the fact that Mecosin holds a five-year contract with BKKBN (and only a one-year contract with SOMARC), every effort needs to be made to redress the limitations of the organizational structure and Mecosin's management capabilities.

Recommendations:

- Management and marketing leadership within Mecosin

should be strengthened through the provision of an experienced project/marketing manager, and the skills of the existing product manager should be upgraded through training.

- When the management capabilities within Mecosin are strengthened, control and responsibilities now vested in SOMARC should be transferred to Mecosin.

- Representation on the Advisory Council must be broadened to incorporate the capabilities and perspectives of a wider base of private sector organizations and private voluntary organizations.

- Consideration should be given to eliminating the management group once the management capabilities of Mecosin are strengthened.

Target Market

The target market is males, especially those not currently using contraceptives, in the C, D, and (upper) E income groups living in 10 of Indonesia's urban centers. The monthly expenditures of households in these income groups range from (150,000 rupiahs (about U.S. $90) to 50,000 rupiahs (about U.S. $30.) Approximately 56 percent of urban households are in the targeted groups. Studies conducted by SRI indicate that there is a good match between the customers targeted by the program and those who actually purchase the project's condoms (DuaLima brand).

Recommendation:

- The project should explore the possibility of involving wives more directly in purchasing condoms and as "target customers." Such a strategy may further legitimize the use of condoms as a family planning method.

Product Mix

The marketing of condoms has helped to develop a greater sense of responsibility for contraception among men and, in turn, has broadened the support base for contraception and family planning. However, because of its low preference and prevalence rates, the condom alone cannot have a substantial impact on fertility reduction.

Recommendation:

- Despite marketing barriers, (which are not insurmountable), every effort should be made to include other contraceptive methods in the product line.

Distribution, Pricing, and Advertising

After approximately 15 months of sales, DuaLima has attracted a 16 percent share of the market, which makes it the second most popular condom in Indonesia. Of importance, 30 percent of DuaLima users are new contraceptors. Thus, the product has effectively expanded the condom market. The product is currently available in over 80 percent of pharmacies and drug stores (about 1,500 retail outlets) in the project cities. Although C, D, and E customers will purchase drugs and contraceptives from these retail outlets, there is an opportunity to improve condom sales substantially by distributing them to other retail outlets (e.g., small variety shops and grocery stores) frequented by the target customers.

The product is priced at 100 rupiahs, 25 percent below its cheapest competitor and 187 percent below the highest priced condom. The retail price covers commodity costs (purchased from BKKBN) and sales margins, but it does not generate any income to be returned to the project. Consequently, the objective of sustainability cannot possibly be met at the existing retail price (see discussion of cost recovery below).

Using an extensive media campaign, the project has achieved high brand awareness and positive consumer attitudes toward DuaLima. Although a direct "small family/happy family" message was successful in desensitizing consumers and demonstrating to government officials that condoms could be advertised without adverse consequences, it is time to develop advertisements that reflect specific, product-related benefits from family planning.

Finally, the program has shown the great value of implementing a public relations campaign prior to launching the product. Other CSM efforts should make use of similar activities to gain support for social marketing.

Recommendations:

- Additional energy and resources should be directed toward increasing product availability in small shops and grocery stores.

- The project team should consider a supplemental advertising effort directed to women.

- The project should develop advertisements that stress specific benefits to be derived from family planning.

Research

The research strategy has focused on ways to increase DuaLima's market share and document its effect on contraceptive use in urban Indonesia. The research was designed to assist in decision making, and SOMARC's technical assistance advisors have promoted the programmatic and marketing benefits of research results among project participants. Use of research to establish initial marketing strategies and to make mid-course corrections is not usual practice in the Indonesian marketplace, however. Strengthening of local management and marketing leadership through training should make the project less dependent on technical assistance impetus for use of research results.

Recommendation:

- More attention should be paid to incorporating the findings of project-sponsored research into project decision making.

Medical Aspects

All hormonal contraceptive methods are registered on the government's "G-list" (ethical products) and can be obtained from a pharmacy or drug store only with a prescription. Re-supplies of oral contraceptives can be obtained without a prescription. All general practitioners, paramedics, pharmacists, and midwives have been provided basic training in family planning services by BKKBN, and relevant information has been made available. The support system needed to market oral contraceptives is in place.

Cost Recovery

An analysis of cost recovery indicates that the program is moving in the direction of cost efficiency. Specifically, the ratio of direct in-country costs to gross sales revenue has improved by more than 50 percent in one year, from 16.5:1 ($16.50 in expenses per $1 of sale) to 6:1 in 1987. Accordingly, the cost per CYP (based on in-country direct costs only) has been reduced from $33.62 to $12.56. Such efficiencies will not, however, achieve the objective of project sustainability. Whereas direct costs are included in the product cost and, therefore, are recoverable through sales, other major costs are

not, and they will not be recoverable unless there is an adjustment in the ratios (margins) of earnings.

Some technical assistance advisors expressed concern during project planning that a program limited to the sale of condoms (a relatively unpopular contraceptive method) and targeted to males (a group not actively involved in family planning) would not have a good chance of achieving self-sufficiency nor discernible impact on prevalence. However, the BKKBN and USAID/Jakarta decided that it was not politically feasible to introduce other contraceptive products at that time.

Recommendations:

- Increase the retail price of the product to allow for a return to project funds to offset direct in-country costs.

- Introduce other contraceptives to spread overhead costs and contribute to cost recovery through improved earnings.

The project team should proceed with caution on these two fronts, however, because such activities may not be consistent with meeting the social goals of the project.

I. INDONESIA

I.1 Background

I.1.1 Socioeconomic Context

Indonesia's 173 million people make it the world's fifth most populous nation. Java, the island on which the majority of Indonesians live, is one of the most densely populated areas of the world: more than 100 million people live in an area the size of New York State.

Indonesians are predominately of Malayan stock, but they include many related but distinct cultural and linguistic groups. Indonesia's annual per capita income is estimated to be about U.S. $600. More that 40 percent of the population lives at levels below the World Bank's absolute poverty base. Unemployment and underemployment are widespread, and rapid population growth has created a need to absorb 2 million entrants into the labor force each year.

I.1.2 Family Planning Context

There are an estimated 41.2 million women aged 15 to 49 in Indonesia. The total fertility rate in 1985 was estimated to be 4.1. Contraceptive prevalence at that time was 38 percent, and is probably higher now.

Beginning in the 1960s, Indonesian planners identified rapid population growth as an important barrier to national development. Government family planning activities, supported through the National Family Planning Board (BKKBN), began in 1970.

The primary objective of current Indonesian policy with respect to population is to reduce the rate of growth and achieve a major redistribution of the population. Priority in national policy has been given to family planning for curbing fertility. The government is focusing on community participation and the integration of health and nutrition education into the family planning program to establish a "small, healthy, and happy family" norm. Tax disincentives, income-generating programs for acceptors, a minimum legal marriage age, and efforts to improve the status of women are other measures introduced to help reduce the annual rate of population growth to 1.5 percent by 1990.

The BKKBN is a well-established, professionally competent organization with good links to the country's policy-

makers and its rural population. Its staff has experience in all aspects of family planning program design, implementation, and evaluation. Family planning activities have been well implemented by BKKBN through a series of field offices throughout the country. Special recruitment campaigns, strong research and administrative support, and the backing of Indonesian leaders have led to the development of a strong family planning program.

Significant resources have been provided for family planning by a variety of foreign donors. The World Bank is currently providing a loan (U.S. $41.4 million) to strengthen the activities of BKKBN, and the United Nations Fund for Population Activities (UNFPA) provides several million dollars of assistance to the government's family planning activities. In 1987, A.I.D. assistance focused on expanding voluntary sterilization services, urban contraceptive social marketing (CSM), training, and improving village family planning services. A total of $6 million was proposed for FY 87 by A.I.D.

I.1.3 Legislative

Throughout this chapter reference is made to two elements in the Indonesian legal code that have an important impact on CSM activities. First, all hormonal contraceptives are listed on the so-called "G" (ethical products) list, which means they can be distributed only by licensed pharmaceutical distributors and require a doctor's prescription for retail sale. The advertising and promotion of ethical products are also limited: advertising of oral contraceptives, for example, is not allowed. This regulation is widely ignored by pharmacists and by the public at large. It does mean, however, that advertising for contraceptives is greatly limited. The criminal law, which prohibits dissemination of information on contraceptive methods, is in fact superceded by the General State Policy Guidance (GBHN), which has established family planning as a national program and, de facto, paved the way for the dissemination of information on contraceptives.

A second important legal restriction in Indonesia is a prohibition against advertising brand products on television. Thus, although television is increasingly popular throughout Indonesia, and especially so in the country's urban areas, social marketing activities cannot take advantage of this medium. Although changes in the regulations governing TV advertisements are rumored, it is difficult to judge what the prospects are in this regard.

Both regulations have significant detrimental effects on the ability of the CSM program to reach potential customers.

Other regulations are more favorable, however. Indonesia, for example, does not tax imports of contraceptives. Such duties may be levied in the future, however, as local manufacturing of contraceptives increases and pressure to protect local industry grows.

I.1.4 Conclusion

Indonesia provides a favorable climate for family planning activities. Its commitment to family planning and its success at program implementation, together with the high level of support from international donors, provide a solid foundation for CSM efforts.

I.2 CSM Goals and Objectives

In the fourth five-year development plan (Pelita IV 84/85-88/89), the Indonesian National Family Planning Program established the following quantitative objectives:

- Reduce the crude birth rate from 28.6 to 22 per 1,000 by the end of the plan period.
- Reduce the annual rate of population growth to 1.5 percent by the end of the plan period.
- Increase contraceptive prevalence among eligible couples to 65 percent.
- Transfer 20 percent of the cost of family planning services from the public sector to the user of the services.

Within this context, the IKB-SOMARK project, which is only one element of Indonesia's National Family Planning Program, established two goals, namely:

- Increase contraceptive prevalence in project areas (10 major urban centers).
- Maximize cost recovery and self-sufficiency of project activities to assist the project in becoming self-sustaining.

To accomplish these goals, two objectives were defined:

- Increase the overall awareness of family planning methods in Indonesia's urban centers.

- o Increase male acceptance of and responsibility for family planning.

The IKB-SOMARK project was given a key role to play in the Indonesian master plan for family planning intervention. Although quantitative targets were not specified, the project was directed to concentrate on increasing contraceptive usage in urban areas, particularly among males. Moreover, it is the intention of the BKKBN to transfer the cost of contraceptive service delivery from the public sector to the consumer. Consequently, the IKB-SOMARK program objective of maximizing cost recovery will help shape the policy and modus operandi of the project as it seeks to attain self-sufficiency.

Recommendation:

- o Redefine IKB-SOMARK objectives to quantify the degree of change projected in contraceptive prevalence and the specific level of self-sufficiency anticipated. The new targets should be made known to all project staff.

I.3 Management/Organizational Structure

I.3.1 Project Organization

The IKB-SOMARK project is a cooperative venture between the Government of Indonesia (represented by BKKBN) and A.I.D. (represented by TFG/SOMARC and USAID/Jakarta). The implementing agency is PT Mecosin, a private pharmaceutical manufacturing company.

BKKBN sells condoms obtained from Korea to the project, establishes the operational framework of the program, and assists in setting and monitoring program policy. A.I.D. provides funding for operational costs and technical assistance in implementing project activities. BKKBN, Mecosin, USAID, and SOMARC form the Advisory Council, which sets policy guidelines, reviews project activities, and approves market plans and budgets. Although BKKBN, especially its chairman, exerts very strong influence on the project, and sometimes the executing agencies, there is nevertheless a healthy and mutually respectful relationship between USAID and BKKBN.

Mecosin is responsible for marketing, distributing, and promoting the contraceptive product. It is under contract to BKKBN for product distribution and to SOMARC for marketing. Because legal restrictions in Indonesia prohibit pharmaceutical

manufacturers from distributing products, this activity has been subcontracted by Mecosin to Sawah Besar, a major local distributor. Other critical program deliverables, particularly advertising and market research, are controlled directly by SOMARC, which has contracted PT Fortune for advertising and PT Survey Research Indonesia (SRI) for market research.

Because of a paucity of marketing and management leadership at both Mecosin and Sawah Besar, SOMARC has hired a resident advisor to coordinate and oversee day-to-day operations. The advisor has no direct line authority. His job is to facilitate the execution of project activities. Additionally, a management group comprising BKKBN, SOMARC, and Mecosin approves all activities and plans, under guidance from the Advisory Council. In this way, Mecosin is allowed some involvement in areas outside its contractual agreement.

I.3.2 Organizational Shortcomings

The project's organizational structure was developed following relatively rapid negotiations by SOMARC and BKKBN. The result has led to shortcomings in capabilities and unclear lines of accountability. SOMARC, for example, is accountable to AID/Washington for its use of funds and the technical quality of its CSM assistance, but it has been instructed by USAID/Jakarta, the BKKBN, and local implementors to distance itself from project oversight and to leave project management to the Indonesian participants. This has sometimes left technical assistance advisors without sufficient leverage to promote the use of good marketing techniques. The major organizational shortcomings are identified below.

I.3.2.1 Implementing Agency. Mecosin, a manufacturer, is limited in its marketing capabilities and therefore requires support and training to enhance management and marketing effectiveness. Mecosin, under contract to BKKBN and SOMARC, must respond to two masters. Of critical importance is the fact that the BKKBN/Mecosin agreement is for five years and includes an automatic five-year renewal clause, but the Mecosin/SOMARC agreement is for one year and is renewable annually. Thus, Mecosin can be torn between meeting the short-term objectives of SOMARC and developing longer term relationships with BKKBN.

The scope of work under each contract is also different, though related. Under current arrangements the SOMARC contract is of relatively less importance because the product comes from BKKBN.

I.3.2.2 Contractor. Although Mecosin has overall responsibility for program performance, SOMARC contracts directly for two primary resources--advertising and market research--because of Mecosin's lack of expertise in these two areas. Especially in regard to research, SOMARC has given Mecosin only a limited opportunity to help shape the program. Further, SOMARC approves and pays bills from Washington; thus it exerts rather remote control over program activities. This tends to slow response time and inhibits program responsiveness.

1.3.2.3 BKKBN. There appears to be very little institutional involvement by BKKBN in the program: the chairman's personal interest and participation help propel the project. Should the chairman no longer be able to participate, the project could suffer because other linkages are not being forged between IKB-SOMARK and BKKBN.

Recommendations:

- Strengthen the management and marketing leadership within Mecosin through the provision of an experienced project/marketing manager and training opportunities for the product manager.

- With the provision of the adequate leadership, transfer the responsibilities now vested in SOMARC to Mecosin. This would effectively centralize responsibility and accountability and make for better management and monitoring of the project.

- Build institutional bridges between the project and BKKBN, commencing possibly by seeking advice from BKKBN staff or making use of BKKBN staff capabilities in interpersonal communication, training, manpower development, family planning research, and the like.

- Broaden the representation in the Advisory Council to incorporate the expertise of other private sector organizations (e.g., management, accounting, marketing, or manufacturing firms) and the perspectives of community and cultural organizations. All of these could enrich the planning, policy, and decision-making capabilities of the council.

- Disband the management group once the management capabilities of Mecosin have been strengthened. This group appears to be a replication of the Advisory Council and an attempt to manage by committee.

1.4 Marketing Objectives and Strategies

Below are the 1987 marketing objective and strategies for the DuaLima condom, as either officially stated or inferred by the assessment team.

Objective:

- To increase DuaLima sales to 48,000 gross (6.9 million units) in 1987 while reaching more lower income, currently noncontracepting urban males.

Strategies:

- To implement innovative promotions geared to increasing distribution and trial usage of the product.
- To target the "warungs" (small variety shops) for increased distribution.
- To maintain high levels of brand awareness.
- To continue efforts to improve perceptions of the condom and establish its role in helping couples to realize the benefits of family planning and child spacing.

I.5 Potential Customers

I.5.1 Estimates of Customer Base

The potential customers of CSM products in Indonesia include a large proportion of all sexually active men and women in the C, D, and upper E income groups. The poorest members of the population (mid and lower levels of E) will need continued free supply. The most affluent members of the society (levels A and B) will doubtless continue to use full-priced commercial goods. But for almost everyone else, a case can be made that the CSM-supplied products represent an attractive option.

According to a SOMARC estimate, there was a potential demand for 525,000 gross of CSM-marketed condoms.[1] This would represent between 600,000 and 945,000 new users, depending on one's assumptions about coital frequency and condom use. The accuracy of this estimate, however, is difficult to judge. The

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[1]B. D. Deolaliker, SOMARC Country Assessment, Indonesia, June 24-July 8, 1985.

BKKBN distributes 25,000 gross of condoms each year through its free-product program. The private sector is estimated to sell between 100,000 and 250,000 gross per year. Thus, there does appear to be a sizable population of C-, D- and E-level males who would purchase CSM condoms, but SOMARC's estimate may be overly optimistic. It assumes that 10 percent of 19 million males aged 20 to 35 are potential users of condoms on a regular basis. A more likely estimate is that for the foreseeable future condom use will not increase beyond 5 to 7 percent of men aged 20 to 35. Moreover, a segment of this estimated condom market is not using the product for family planning purposes. Recent IKB-SOMARK reports estimate a much smaller condom market than initially projected.

I.5.2 Target Groups

Target customers for the IKB-SOMARK product, as noted, are men in the C, D, and (upper) E income groups who are living in Indonesia's 10 largest cities, especially those who are not currently contracepting. (The cities are Jakarta, Bandyng, Surabaya, Medan, Semarang, Malana, Solo, Padang, Palembang, and Ujung Pandung.) Approximately 56 percent of urban Indonesian households are in the C, D, and (upper) E income groups,[2] and their monthly expenditures range from 50,000 rupiahs (Rp) to 150,000 rupiahs (about U.S. $30 to $90).

I.5.3 Selection Criteria

It is difficult to determine exactly how the target group was chosen. BKKBN has an interest in increasing program participation in urban areas and the target group clearly serves that purpose. SOMARC endorsed the target because "it behooved SOMARC politically to choose the target BKKBN told us to choose", rather than for any compelling programmatic reasons.[3] Given the overall goals of CSM and Indonesia's KB Mandiri ("self-reliant family planning" program), there is an air of inevitability surrounding the target group. As BKKBN was prepared to distribute only condoms, men were the natural audience. Also, the marketing orientation required customers with some disposable income, but program leaders did not want a full-priced product to be marketed through CSM.

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[2]SRI Media Index, 1985.

[3]IKB-SOMARK--Indonesia, no date.

Urban couples are not as likely to practice family planning as their rural counterparts, so the focus on urban areas is appropriate. Men are also an appropriate target, especially so in Indonesia, where they exercise significant influence over their wives' contraceptive choices.

I.5.4 Target versus Actual Customers

Consumer research conducted by SRI in March 1987 revealed that 88 percent of all DuaLima users were in the target group (82 percent of the total male population is in this group). Thirty-seven percent of the men who purchased DuaLima were in the C income group, 28 percent were in the D group, and 23 percent were in the E group. SOMARC data indicate that 30 percent of their sales were among men who had never used a contraceptive. One-fifth to one-third of males in households with monthly expenditures under 200 Rp who had ever used condoms had used DuaLima. Thus, there appears to be a good match between the customers targeted by the program and those who actually purchase the DuaLima condoms.

I.5.5 Conclusion

IKB-SOMARK has successfully implemented a CSM program that serves lower and moderate income consumers and complements the free services provided by BKKBN and the products available in the commercial market. Two recommendations follow, however.

Recommendations:

- The IKB-SOMARK team should aggressively continue its efforts to reach the target groups.
- The project should explore the possibility of involving wives more directly in purchasing DuaLima and as "target" customers. Such a strategy may speed the acceptance of condoms as a family planning product (see also section I.9.3).

I.6 Product

Family planning prevalence was estimated to be 38 percent among married couples, but the rate varies considerably between urban and rural areas (20 percent and 65 percent, respectively). Among users of modern methods, the IUD is reported to be the main method, used by 14 percent, followed by oral contraceptives at 13 percent, injectables at 12 percent, and

condoms at 7 percent. This pattern holds for the lower income groups (C, D, and E) as well as for higher income groups.

I.6.1 Findings

The IKB-SOMARK project, as noted, is currently marketing one contraceptive product -- the DuaLima condom. The product is 49mm in length, clear, and available at retail stores in 3- and 12-unit packs.

In the Indonesian condom market, the Young-Young brands (premium priced, selling for upwards of twice the DuaLima price) hold the largest market share -- 58 percent. DuaLima accounts for 16 percent of sales, followed by Kingtex at 9 percent, and Jelia at 8 percent. Reported trial levels (among married men) for individual brands are all under 10 percent. In terms of consumer awareness of these products, awareness of the DuaLima brand is by far the highest (see section I.9).

The priority target group has shown good acceptance of the DuaLima product. In terms of the "brand purchased last," DuaLima's level is highest among group D (34 percent) and lowest among groups A and B (14 percent and 17 percent, respectively). Research also indicates that a high number of users rate the product as having "good quality." With this relatively high level of acceptance and positive attitudes toward the brand, the project has been able to broaden the support for contraception in general. Moreover, this new support is among men, a key influencing agent in Indonesian family life.

The Indonesian CSM project is unique in that the contraceptives are purchased by the Indonesian government from Korea, at a cost of Rp. 27/unit (approx. U.S. $ .015), and forwarded to the local marketing manager, Mecosin. To date, no problems have been reported in obtaining an adequate and timely supply of the product from Korea.

Mecosin is interested in introducing other CSM contraceptive products, but a constraint exists. Current pharmaceutical regulations place a "class G drug" label on contraceptive pills, implants, and injectables, which means they can be distributed only by licensed pharmaceutical wholesalers and require a doctor's prescription for retail sale. The "G" classification also places restrictions on advertising and promoting such goods. In light of this, one alternative being pursued by the project is to seek removal of the advertising restriction and then encourage people to buy oral contraceptives from their doctors.

Plans are under way to introduce another condom brand in late 1987. This brand would have "super thin" properties and be offered at retail for about 200 Rp. (twice the price of the "regular" DuaLima). It is hoped that this brand extension will provide greater in-store visibility for the DuaLima trade name and better meet, in conjunction with "regular" DuaLimas, the needs of the target group. At question is whether this brand extension will have an impact on prevalence among the target group or merely be a source of increased revenue.

I.6.2 Conclusion

Given that the marketing of condoms has helped develop a greater sense of responsibility for contraception among men and, in turn, has broadened the support base for contraception and family planning, the selection of the condom as the first product offered by the CSM program appears sound. However, because condoms are less reliable than other modern medical contraceptives and have image problems, and thus lower prevalence, condoms alone are not likely to have a substantial effect on contraceptive prevalence in Indonesia.

Recommendations:

- The CSM project team should continue its efforts to expand the product line beyond condoms. To do so, however, it will be necessary to reverse some or all of the restrictions on promoting and distributing oral contraceptives, IUDs, and injectables.

- Prior to introducing the "super thin" DuaLima, the project should carefully test market the product to assess levels of cannibalization (i.e., likelihood of taking business from the current DuaLima product) and, most important, the product's ability to appeal to the low-income market. Maintaining a low relative price should stimulate interest among this important target group.

I.7 Distribution

The primary forms of retail distribution for health-related products are apotiks (pharmacies), toko-obats (small drug stores that sell nonethical products), warungs (small variety shops), and grocery stores. Market research indicates that about two-thirds of condom purchases have historically been made at apotiks and toko obats. The warungs serve the daily product needs of lower income people. These operations are very small,

however, and their owners are inclined to carry only products that they know will move quickly.

I.7.1 Findings

Distribution of DuaLima is handled by Sawah Besar, under contract to Mecosin. Through its 23 subdistributors, Sawah Besar has gained distribution primarily in apotiks, toko-obats, and some grocery stores. Toko-obats and apotiks were initially selected as priority outlets for DuaLima. Market penetration among these outlets is over 80 percent (about 1,500 outlets) in the project cities. The distribution and inventory mechanisms appear to pose no problems in maintaining product quality.

To increase the availability of condoms to men in the C, D, and E income groups, a special task force was fielded in 1987 to increase distribution through the warungs. Although success with this effort has been limited at this early stage, the project team will continue task force efforts that concentrate management attention on this problem.

Operationally, the sales force is given goals and monitored as to the number of sales calls made per day. In addition, sales are tabulated and reviewed weekly and incentives are offered through sales contests.

Cost/margin data for all participants in the DuaLima distribution chain are summarized in Table I.1.

Table I.1

COST/MARGIN DATA

	Rupiahs per gross (for purchases of 5-20 gross)		Margin	
	3-pack	12-pack	3-pack	12-pack
BKKBN	3,312 Rp	3,312 Rp	-	-
Mecosin	3,312	3,312	61 %	60 %
Sawah Besar	8,593	8,258	13.8	13.9
Wholesaler	9,979	9,590	2.7	2.7
Retailer	10,256	9,857	29	26
Customer	14,400	13,248	-	-

The product cost to all links in the distribution chain varies by volume purchased. This enables the retailer, for example, to obtain up to a 40 percent margin by buying a large quantity (20+ gross).

A major change in the pricing scheme was brought about in 1987, when the BKKBN reduced its price to Mecosin to its own acquisition cost. This enabled Mecosin to offer much more attractive, and competitive, margins to wholesalers and retailers and, in turn, to fuel greater trade "push" of DuaLima.

To increase trade acceptance and support of DuaLima, Mecosin also regularly holds trade presentations and contests. As part of the program to increase distribution in warungs, for example, the project managers have implemented an on-pack promotion with Goal razor blades -- a 12-pack of DuaLima is offered free with the purchase of a razor and package of blades. Beyond having a positive effect on distribution levels, such a promotion can also generate consumer trials in outlets currently distributing DuaLima. Point-of-sale materials (mobiles, posters, and decals) are also used widely to stimulate retail sales.

I.7.2 Conclusion/Lessons Learned

Gaining product distribution in those stores that best serve lower income males is difficult, yet important for program success. With the very small urban outlets, where condoms have historically not been available, marketers must exert pressure in two directions. First, they must aggressively stimulate customers to ask their local outlets to carry the product. Second, they should implement creative promotions, as was done by the project team when it provided special incentives for the outlet owner to carry the contraceptive product. Because condoms are a "hard to discuss" product, particular attention should be given to the latter initiative -- forcing distribution.

The CSM managers were wise in establishing goals for the sales force and in holding them accountable for attaining those goals. Increasing the margin available to Mecosin was another prudent move. Because DuaLima has a low relative price, its margin must be somewhat greater than that of other brands in order to gain the necessary trade interest and support.

Recommendations:

- Now that good distribution has been achieved in pharmacies and drug stores, additional energy and resources should be directed toward increasing product availability in the warungs.

- Cross-product promotions, like the tie-in with Goal razor blades, should be an ongoing component of the marketing plan. Because it is often difficult to gain distribution in outlets that serve lower income groups, promotions such as these become increasingly important to the distribution effort.

- CSM programs should consider creating special, ad hoc sales task forces if their current distributors are ineffective in accessing priority outlets.

I.8 Price

The Indonesian rupiah was valued at 1,640 to one U.S. dollar in September 1987. Only 15 percent of the population earns in excess of 200,000 Rp/month (U.S. $125). Inflation runs approximately 10 percent per year. As perspective, a pack of cigarettes is available for 450 Rp and a bottle of Coca-Cola costs 300 Rp.

I.8.1 Findings

The DuaLima condom currently retails for about 100 Rp each (6.2 U.S. cents) when purchased in the 3-pack; the unit price in the 12-pack is 92 Rp. These prices are fairly consistent among retail outlets. As seen in the following chart, all competitive brands are priced considerably higher.

Type	Brand	Unit Price
Plain	Jelia Skin	125 Rp
	Skinless Skin	150
	Kingtex	270
	Young 002	337
Dotted Ribbed	Young Super	215
	Jelia Ultra	200
	Young Hi-way	287
	Zero-0	200

The DuaLima price has been constant since the product was introduced, but it may be increased to 150 Rp to reflect currency devaluation. The additional revenue would revert to all parties in the distribution chain, beginning with the BKKBN. IKB-SOMARK will not receive any of the additional revenue.

I.8.2 Conclusion/Lessons Learned

Setting the product price in a CSM project is especially critical: the price must be low enough to accommodate the cash position of the low-income target group, but at the same time, not be so low that a poor-quality image is conveyed or that the net total program costs become excessive for the sponsoring agencies.

Recommendation:

- o Future consumer-tracking studies should include questions that enable the project team to assess the perceived value of DuaLima among the target group. How the product is perceived relative to its price should be carefully and continually monitored so that corrective steps can be taken, if needed, without delay.

I.9 Advertising and Promotion

Government regulations prohibit advertising any brand products on the nationally owned television station. There are no direct restrictions on advertising condoms in other media, but the BKKBN and government ministers are very sensitive to the tone and language of such advertising. Beyond the DuaLima advertising program, Indonesians are exposed to government-produced television programs promoting the benefits of family planning. In addition, the BKKBN and USAID recently requested that the Fortune agency develop a mass media advertising program to promote doctors as a source for a full range of contraceptive services.

In terms of media reach, approximately 60 percent of the urban population is regularly exposed to newspapers, radio, and/or television; of these media, radio reaches the most people (55 percent of total population).

I.9.1 Findings

DuaLima is advertised in newspapers and magazines, on the radio, on billboards and posters, and in stores. The advertising and public relations expenditures for launching DuaLima were high relative to other commercial products and to DuaLima's sales revenue. In addition, the advertising budget was not based on any in-market experience regarding what investment is necessary or most cost effective. Specifically, according to SOMARC records, $625,000 was spent between March and December 1986. In comparison, revenues for the entire 1987 sales year are

projected to reach only about $250,000. The BKKBN and other program participants decided that the political need for a major public relations effort (over U.S $100,000) -- an effort that had a positive impact on the introduction of Dualima -- justified this expenditure.

Notwithstanding the issue of cost efficiency, project-sponsored research indicates that the advertising campaign was effective in establishing the DuaLima name and the product's benefit -- improving family prosperity through child spacing. Unaided brand recall was 55 percent (higher than for all other brands), and 78 percent of condom users recalled the DuaLima advertising.

A key measure -- the advertising's ability to convey the product benefit -- was also positive; 15 percent of those surveyed said the product helped to improve family prosperity. In addition, over the course of the campaign the social image associated with condoms improved and negative attitudes declined somewhat.

All advertising efforts are directed to men. It is interesting, though, that over 30 percent of the men surveyed indicated that their wives made the condom purchases. The approach and language in the advertising are quite traditional and straightforward ("I have a happy family"), but it appears to have been politically important that the introductory advertising err on the side of conservatism. In so doing, the project has been able to desensitize the general public, government, and religious leaders to seeing and hearing advertising for family planning products.

Radio has been the most effective and efficient medium used by the project. Radio accounted for only 12 percent of the advertising budget, but it was responsible for generating 80 percent of the top-of-mind awareness.[4] In negotiating the purchase of DuaLima radio time, the project team was able to extend the value of their purchase by getting radio stations to include favorable references to family planning within the radio soap operas.

The introductory program also included an excellent public relations campaign directed to government officials, journalists, women's groups, and the armed forces.

Long-term planning of the advertising program, however, was not as refined and focused as possible. The project team did

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[4]IKB-SOMARK Marketing Plan, 1987.

not have a clear understanding of future demands on the advertising program and the strategic plans required to meet those demands. SOMARC's technical assistance advisors have tried repeatedly, but unsuccessfully, to elicit a focused, written plan from the local ad agency and project management teams.

I.9.2 Conclusions/Lesson Learned

- The mass media program for DuaLima has been very successful in quickly establishing brand awareness and building positive attitudes regarding the brand.

- When contraceptive marketing is first introduced to a nation, particularly a conservative one, special attention must be given, as was done in Indonesia, to desensitizing a number of audiences beyond just the intended product users. The IKB-SOMARK project successfully employed public relations, slide presentations, conferences, and a noncontroversial ad theme to introduce the CSM concept with a minimum of political, religious, and social controversy.

- The advertising message of DuaLima was creatively extended into a nontraditional ad form by contracting with the radio stations to include positive references to condoms and family planning practices in their radio soap operas.

- Media plans should reflect the ability of certain media to reach lower income groups more effectively and efficiently than other media. In Indonesia, for example, radio merits special consideration.

- The project team has shown, as discussed elsewhere, great skill in managing the distribution, public relations, and assessment components of the CSM program. Among all participants in the program's management, however, there appears to be a weakness when it comes to guiding and analyzing that component of the marketing mix that is most foreign to the team's training -- advertising. As a result, some of the short- and long-term advertising plans are not as focused as they should be.

Recommendations:

- Because women appear to have a significant role in the decision to contracept and in brand purchase, the project team should consider a supplemental advertising

effort directed to women. Such a program could further legitimize the use of condoms among married women and better establish DuaLima as the brand of choice for family planning.

- A part-time, local, commercial marketing person should be hired to augment the team's advertising capability.

- Prior to the national introduction of additional contraceptive products, plans should be made to test alternative media spending levels. Also, following common commercial marketing practice, alternative media combinations should be market tested.

- Radio has proven to be a very effective and efficient medium. Based on this, the project team will be increasing the role of radio advertising in the total communication program. As it does, the team should make available a greater number of radio commercials.

- Although the direct "small family/happy family" message was effective in desensitizing the public to CSM, the project team is advised to pursue ad strategies and messages that are less vague and more compelling. (One perspective in Indonesia in fact, is that, large families are the happiest. Simply stating the opposite in a general way is not likely to be compelling.) More specific consumer benefits, such as "better health for mother" or "richer and more successful life for existing children," should be tested.

I.10 Research and Evaluation

I.10.1 Overall Research and Evaluation Strategy

Since the start of the CSM program in Indonesia, research has been an important element of the program. The principal source of research has been SRI. The research strategy has focused on ways to increase DuaLima's popularity among the target group and on documenting the project's effect on contraceptive use in urban Indonesia. The research has been designed to assist program managers in decision making and has included studies dealing with all aspects of DuaLima's introduction and promotion, including brand identification, packaging, market testing, advertising, product-line extensions, and consumer-tracking studies.

I.10.2 Adequacy of the Strategy

IKB-SOMARK's research strategy was designed to assist in decision making. Ample information is available with which to monitor distribution and sales as well as consumer attitudes toward DuaLima and other contraceptive products and services available in the market. One weakness in the overall research strategy, however, is that too little attention has been given to research on different advertising strategies, particularly with respect to spending levels, media mix, and audience targeting.

I.10.3 Management Use of Research and Evaluation

SOMARC's technical assistance advisors have promoted the programmatic and marketing benefits to be derived from using research results, but it is difficult to determine the extent to which management at Mecosin, Sawah Besar, Fortune, and BKKBN actually made use of the SRI studies. Use of research to establish initial marketing strategies and to make mid-course corrections is not usual practice in the Indonesian marketplace.

Because of BKKBN's role in the project, research is less important for it than for other key actors. Mecosin and Sawah Besar, nevertheless, do not appear to make much use of SRI's research in developing and implementing their business plans. However, new product lines and DuaLima packaging have been designed, in part, in response to needs identified by project-sponsored research. Fortune appears to have made more use of the research: their modifications of the media plan, for example, were based on research results. Research results have also been used to organize distribution activities.

The major way in which research has an impact on project management appears to be through the work of the TFG/SOMARC representative in Indonesia. He is well acquainted with SRI research and with studies completed by other groups.

I.10.4 Data Retrieval

Data are available on the characteristics of the purchasers of CSM and commercial products and on the characteristics of the population as a whole. A good deal of information is also available on substitution effects, trial rates, and the like. The periodic omnibus surveys conducted by SRI appear to be a particularly valuable source of data.

Recommendation:

- More attention should be paid to incorporating the findings of project-sponsored research into project decision making. To this end, the IKB-SOMARK project team may wish to hold special research briefings to acquaint managers with research findings and discuss their implications.

I.11 Medical Aspects

The IKB-SOMARK project currently markets only condoms. The project does, however, have intentions of marketing oral contraceptives, injectables, IUDs, and possibly, implants. (Indonesia is one of the largest NORPLANT test market areas; current acceptors number approximately 70,000.)

I.11.1 Condoms

Condoms are freely distributed and sold by retailers who are not given any training. Usage information contained in the condom package, however, negates the need for any further consumer guidance.

I.11.2 Hormonal Contraceptives

All hormonal contraceptives (pills, injectables, and implants) must be registered as ethical products (G list) and can only be obtained with a doctor's prescription. As of May 1987, pills were transferred to the G-2 list, which means that follow-up supplies can be obtained from dispensaries without a prescription.

All general practitioners, paramedics, pharmacists, and midwives have been provided basic training (one to two weeks) in family planning services by the BKKBN. Additionally, a manual on family planning methods, which covers proper usage, advantages, and contraindications, is provided by BKKBN to paramedics and pharmacists.

The information provided to consumers through clinics and dispensaries is guided by the BKKBN manual and is usually factual. Further, oral contraceptives are packaged with easy-to-understand written information for consumers.

I.12 Project Costs

I.12.1 Direct and Indirect Costs

IKB-SOMARK project expenditures (excluding commodities) in 1986 (March to December) amounted to approximately U.S. $1,067,827, allocated accordingly:

In-country direct costs	$786,541	
Advertising, packaging of promotion, merchandising, etc.		$683,000
Miscellaneous		67,896
Market research		10,250
Distributor's fee		25,395
Ex-country costs		
Travel & technical assistance	$281,286	

BKKBN costs for purchasing and packaging the product sold to the project are recoverable in the retail price of the commodity. The budget for 1987 projected a total expenditure of $1,130,876, allocated accordingly:

In-country direct costs	$855,876
Ex-country costs	$275,000

Project sales for 1986 and 1987 are shown below:

1986 (actual)	16,248 gross
1987 (projected)	47,304 gross
1987 (Jan-June actual)	23,004 gross

An analysis of cost recovery indicates that the program is attempting to move in the direction of cost efficiency. Specifically, the ratio of direct in-country costs to gross sales revenue has improved by more than 50 percent in one year, from 16.5:1 ($16.50 in expenses per $1 of sales in 1986) to 6:1 in 1987. Accordingly, cost per CYP (based on in-country direct costs only) has been reduced from $33.62 to $12.56.

Some technical assistance advisors expressed concern during project planning that a program limited to the sale of condoms (a relatively unpopular contraceptive method) and targeted to males (a group not actively involved in family planning) would not have a good chance of achieving self-sufficiency nor discernible impact on prevalence. However, the BKKBN and USAID/Jakarta decided that it was not politically feasible to move ahead with the introduction of other contraceptive products.

I.12.2 Conclusion

The decrease in the ratio of expenditures to sales and in the cost per CYP indicates an improvement in the cost effectiveness of the program but does not necessarily indicate a substantial move toward cost recovery. Whereas the costs of BKKBN commodities and commodity packaging are included in the product cost and, therefore, are recoverable through sales, other major expenditures are not and will not be recoverable unless there is an adjustment in the ratios (margins) of earnings. Two actions are recommended:

- Increase the retail price of the product to allow for a return to project fund to offset direct in-country costs.

- Introduce other contraceptives to spread overhead costs and contribute to cost recovery through improved earnings.

The project team should proceed with caution on these two fronts, however, because such activities may not be consistent with meeting the social goals of the project.

I.13 Conclusion

The IKB-SOMARK project has achieved important results in a number of areas. It has clearly demonstrated the potential of CSM to increase the availability of contraceptives and to provide services at a reasonable and reduced cost to consumers, to the Government of Indonesia, and to A.I.D. The project may play a crucial role in encouraging the government to change its guidelines for the registration of oral contraceptives, a measure that has been discussed for several years but not yet acted upon. It is also possible that IKB-SOMARK may promote approval for television ads for contraceptives.

Condom DuaLima is well known in the 10 cities in which it is marketed. Although the advertisements would benefit from more explicit discussion of the health advantages of condoms and of small families, they have increased awareness of the condom in urban areas, and condom sales appear to have grown. Consumer profiles indicate that the customers are, in the main, in the C, D, and (upper) E income groups, the targeted DuaLima market. Also, DuaLima's sales do not come only from consumers who were already using another brand of condom.

It is too soon to judge IKB-SOMARK's demographic impact. Calculations of CYP or births averted depend on

estimates of continuation rates, coital frequency, and the pattern of contraceptive use, about which there is considerable dispute. The IKB-SOMARK project, however, is achieving its objectives of addressing the contraceptive needs of urban eligible couples and contributing to increased prevalence by attracting new users. Further, the program is beginning to improve its cost effectiveness and is already covering the major cost of commodities.

The organizational structure as currently constituted, the marketing and management capabilities of the implementing agencies, and the institutional linkages with BKKBN are major concerns, however. These concerns can be addressed through a significant strengthening of Mecosin's capabilities and by creating operational ties with BKKBN.

ANNEX A

PERSONS CONTACTED

Haryono Suyono, Ph.D.	Chairman, BKKBN
Dr. M. Voulgaropoulus	OPH/USAID
Dr. Carol Carpenter-Yaman	OPH/USAID
Mr. David Denman	OPH/USAID
Mr. William Bair	Consultant
Dr. Rita Leavell	OPH/USAID/BKKBN
Mr. Setyo Sabdono	Head Planning Div./BKKBN
Mr. Atir A. Haslim Sit	Managing Director, Mecosin
Mr. Toto Budiono	General Manager, Mecosin
Mr. Arifin Mochtar	Product Manager, DuaLima/Mecosin
Mr. Jahja A. Gunawarman	Sales Manager, Sawah Besar
Mr. Itandi Yanto Hamdani	Branch Manager, Sawah Besar
Mr. David Sparkes	General Manager, SRI
Mr. Mustafa Alatas	General Manager, Fortune
Mr. India Abidin	Managing Director, Fortune
Mr. Paul W. Karmadi	Sr. V.P., Matar, Inc.
Mr. Geofrey I. Gould	Partner, Price Waterhouse
Dr. Firmam Lubis	Executive Director, Kusuma Buana
Mr. Gani Perla	IKB-SOMARK

ANNEX B

DOCUMENTS CONSULTED

Assessment of Contraceptive Distribution Systems to Family Planning Private Providers, Pt. 1.

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Worldwide Report on Population Projects Funded by A.I.D., IPPF, and UNFPA

Contracts:

- Mecosin/Sawah Besar Agreement
- BKKBN/Mecosin Agreement
- SRI/TFG Agreement
- Fortune/TFG Agreement
- Mecosin/TFG Agreement

II. PAKISTAN (Social Marketing of Contraceptives Project)

Tennnyson Levy, Team Leader, Evaluator/Generalist
Peter Donaldson, Social Science Analyst
Imtiaz Taj Kamal, Medical Specialist
Terry Peigh, Marketing Specialist

The Pakistan CSM project is a national contraceptive marketing program (condoms only) implemented by private sector organizations. Oversight is provided by the Pakistani government through the National Development Finance Corporation (NDFC), and by USAID through PSI Marketing Associates (PSIMA), which also provides technical assistance to the project.

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ANNEXES

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GLOSSARY

DRB	Domestic Research Bureau
FPAP	Family Planning Association of Pakistan
GOP	Government of Pakistan
NDFC	National Development Finance Corporation
NGOCC	Non-Governmental Organization Coordinating Council
PCS	Pakistan Consultancy Services
PSI	Population Services International
PSIMA	PSI Marketing Associates, Inc.
PWD	Population Welfare Division
Rp	Rupee (17.58 Rp = U.S. $1)

ACKNOWLEDGMENTS

The team is grateful for the assistance it received from the staffs of USAID/Islamabad, Pakistan's Ministry of Planning and Development, the National Development Finance Corporation, Population Services International and PSI Marketing Associates, and M/S Woodward and its subcontractors. A list of the people who shared their expertise and facilitated the team's work in additional ways is included as Annex A.

EXECUTIVE SUMMARY

BACKGROUND

Four factors define the nature of the contraceptive social marketing (CSM) program in Pakistan. First is Pakistan's low per capita income and limited infrastructure (especially in health). Second is the widespread concern that family planning activities will offend the religiously sensitive or conservative members of the population. Third is the very low level of knowledge of family planning and of specific contraceptive methods, particularly in rural areas. Fourth is the fact that previous government-sponsored family planning efforts have had very limited impact, which suggests a very low demand for modern contraceptives.

Despite these circumstances, the Ministry of Planning and Development, supported by the USAID Mission in Islamabad, has patiently persevered and now, after many years, CSM has been implemented in Pakistan.

OBJECTIVES

In its sixth five-year plan (1984-89), the Government of Pakistan (GOP) elaborated a population policy that sought, among other objectives,

- to reduce the total fertility rate from 5.9 to 5.4 per woman, and
- to prevent 2 million births during the plan period.

In response to these national objectives, the Pakistan CSM program sought

- to provide a minimum of 2.1 million couple years of protection (CYP), and
- to avert at least 450,000 births during the project period.

MAJOR FINDINGS AND RECOMMENDATIONS

Management and Organizational Structure

The CSM project is implemented by a private sector manufacturing and distribution company, M/S W. Woodward

(Pakistan) Limited, under contract with the Government of Pakistan. The National Development Finance Corporation (NDFC) provides oversight for the GOP. Funding is provided by USAID, which has also contracted with PSI Marketing Associates, Inc. (PSIMA) to provide technical assistance and a resident advisor for the project. The program is responsible to an Advisory Board, chaired by the Minister of Planning and comprising representatives mostly from government, USAID, and the implementing agency. Of particular note are the marketing and management skills of the Woodward staff and the very positive support and guidance provided by PSIMA and NDFC. All subcontracts (advertising and research) are handled directly by the implementing agency. In short, total control and responsibility are vested in Woodward and the necessary machinery for GOP and USAID monitoring is in place.

The project went through a long and nervous gestation period. The process of getting government and other critical organizations to accept social marketing can be arduous. However long it takes, though, the government should be made to commit to the concept before the project is initiated. The lesson demonstrated in Pakistan is that early lobbying efforts with the host government can facilitate program implementation and progress.

Recommendation:

- The CSM project should make a greater effort to involve the private sector in planning and decision making through appointments of executives from private sector firms to the Advisory Board.

Target Market

The target market was defined as married couples who are under 40 years of age and are in the lower-middle and low socioeconomic groups. The total CSM target market was identified as 10 million potential and current contraceptive users nationally. To date, over 25 million Sathi condoms have been distributed; using Woodward's measure of 100 condoms per CYP, this would represent a potential CYP of 250,000. However, a substartial portion of the condoms distributed are still in the retail outlets. Further, nothing is known of the purchasers -- whether they fit the target group characteristics or whether they are users converted from products provided by government or private sector programs.

Recommendation:

- Operational research should be conducted to fill in the gaps in management knowledge so that the potential customer can be more precisely identified and targeted.

Product Mix

The project is currently marketing only one brand of condom, Sathi. It is sold in a four-unit pack for 1 rupee. The highest levels of contraceptive awareness in Pakistan are for condoms and contraceptive pills. The program is therefore considering plans to expand the condom line and to introduce an oral contraceptive and, possibly, an IUD.

Recommendation:

- The project should consider introducing a higher-count package of Sathi (e.g., 8 or 12 to a pack) to promote product loyalty and consistent usage and to lower packaging costs.

Marketing

Distribution of Sathi condoms commenced in December 1986, and the product is now available in 151 towns through approximately 49,000 retail outlets. The distribution system operates through an efficient network of 160 subdistributors and 800 wholesalers, who are supported by 40 sales promoters. Sales force training and effective merchandising are trademarks of the Sathi program. Sathi is the lowest-priced product after the government-distributed condom, Sultan, which often retails for as little as 1 rupee for 12 condoms.

There is no indication that Sathi's low price has had a negative impact on perceptions of quality. It is believed that a "low quality" perception has been averted through attractive, tasteful packaging and point-of-sale material. The price, in addition to covering all sales margins, returns a minimum of 4 percent and a possible 30 percent of retail value to project funds. Significantly missing from the pricing calculation, however, is the implementing agency's fee, which at this time remains a project investment.

The communication objective is to associate Sathi with child spacing, male responsibility, and the betterment of family health and family life. Advertising is through cinema commercials, in-store advertising, and brochures. Radio

advertising is expected to be introduced shortly and television advertising may be possible in the future. Advertising messages, however, have not been customized to reflect the great difference in contraceptive knowledge and practice that exist between rural and urban areas.

Recommendations:

- Careful attention should be paid to the communication strategies addressed to urban and rural customers. It may be necessary to devise specific messages aimed at the different target groups.

- In light of the importance of radio advertising in providing critically important educational and motivational messages, the project team should aggressively pursue a change in government policy to allow radio advertising of Sathi.

Research

A major baseline survey, as well as packaging and advertising testing, has been conducted. There is concern, however, that data are not being sufficiently analyzed and that the research organization is not being fully responsive to the constraints of timing nor to management's information needs. Further, it is important that a better understanding of Sathi customers be obtained through the implementation of appropriate research.

Medical Aspects

Oral contraceptives are available in retail outlets without a prescription and are dispensed without much attention to the contraindications of use of the method. Retailers and, to a lesser extent, doctors have little knowledge about contraceptive methods. The Pathfinder Fund is developing family planning curricula for various categories of health personnel on behalf of the Population Welfare Division (Ministry of Planning and Development).

Recommendation:

- If oral contraceptives and/or IUDs are included as part of the CSM product mix, a very strong training program should be implemented.

Cost-Recovery Potential

The ratio of direct costs to gross retail sales is 3:1 (three rupees of expenditure for every rupee of sales), which is projected to improve to 1.5:1 by FY 88/89. This implies that the project is capable of recovering a portion of its direct costs. In this regard, based on six months of sales, the project has accumulated a fund of U.S. $10,554 (Rp 185,541); at this rate of return the project will not be able to achieve self-sufficiency nor sustainability.

Recommendation:

- Should cost-recovery become a more important aspect of the project, the CSM team should test a somewhat higher price in one or two small cities. A higher price would enable the project to incorporate part or all of the implementing agency's commission in the retail price.

II. PAKISTAN

II.1 Background

II.1.1 Cultural Context

Most of Pakistan's 100 million people live in Karachi, in the fertile Indus River valley, and along an arch formed by the cities of Faisalabad, Lahore, Rawalpindi-Islamabad, and Peshawar. Punjabis are in the majority, and there are minorities of Indo-European peoples. The official language is Urdu, but it is spoken as a first language by only about 9 percent of Pakistanis. Pakistanis also speak Punjabi (65 percent), Sindhi (11 percent), and a variety of other languages (24 percent). English is widely spoken and used within the government, the military, and in many colleges and universities.

The fundamental fact of Pakistan's social and political life is Islam. Islam defines Pakistani nationhood for secularists and Islamists alike. Schoolchildren are taught that the ideological foundations of their nation were laid with the Moslem conquest of Sindh in the year 711. The textbook emphasis is on historical continuity over 12 centuries. Current debates concern the extent to which Pakistan was created as a homeland for Moslems and whether the role of religion is limited to providing a national identity or whether Pakistan should be an Islamic state with the constitution and laws subservient to the principles of theology. Forty years after independence, Pakistan has yet to resolve the division between the secularists and the Islamists.

II.1.2 Family Planning Context

Pakistan's crude birthrate is estimated to be over 40, and the death rate is about 14. Estimates of natural increase range from 2.7 percent to 3 percent per year. The total fertility rate is over 5.

Since 1960, Pakistan has tried a number of strategies to lower the birthrate. A reduction in the population growth rate was one of the objectives of the first five-year plan (1960-64). Lower population growth was encouraged to increase the nation's capacity to save and invest and to improve the per capita availability of goods and services. Spacing children and limiting family size were promoted as important ways of improving the health of mothers and children. To decrease fertility levels, the population planning program was integrated into an expanded health infrastructure, and contraceptives were widely

distributed. These early efforts, however, achieved only disappointing results.

A target-oriented approach, which was tried during 1965-69, concentrated on promoting IUDs and using indigenous midwives as field workers. Contraceptive prevalence in 1969, however, was estimated to be only 6 percent. The continuous motivation system, employed between 1970 and 1973, used male-female teams to visit eligible couples quarterly, to deliver contraceptives and to encourage family planning. This program, also, was not effective. Between 1974 and 1977, Pakistan tried the contraceptive-inundation approach, which provided widespread access to all contraceptives and other methods through a network of shopkeepers, local agents, hospitals, clinics, and field workers. However, a 1975 Pakistani fertility survey showed that only 22 percent of eligible women knew about sources of contraceptive information and services. Family planning efforts then endured a hiatus for almost three years as the inundation approach was stopped, other projects were terminated, and U.S. assistance was suspended.

Between 1980 and 1983, Pakistan employed a multisector approach, which placed the population planning program under the umbrella of the Ministry of Planning and Development and made family planning available through health outlets of the government and non-governmental organizations (NGOs). The country has continued with a national population welfare program and the multisector approach, through which contraceptive services are provided (through) via a network of family welfare centers, reproductive health units (for surgical sterilization), and other contraceptive distribution outlets. Contraceptive prevalence is estimated to be between 7 and 10 percent of married woman of reproductive age. The government's current plan calls for a contraceptive prevalence rate of 18.6 by 1988.

Legislative and regulatory barriers to the provision of contraceptive services appear to be less important in Pakistan than in a number of other countries that are part of this CSM assessment. Oral contraceptives, for example, are freely available as part of the multisector approach.

The greatest barrier to increasing the distribution of contraceptives is the government's fear of offending sensitive religious members of the population. Advertising contraceptives is not allowed on radio or television, and few people are eager to challenge the existing system.

II.2 CSM Goals and Objectives

II.2.1 GOP Objectives

In its sixth five-year plan (1984-88), the Government of Pakistan (GOP) elaborated a population policy that includes among its objectives and strategies the following:

- Reduce the rate of population growth from an estimated 2.87 to 2.6 by the end of the plan period.
- Reduce the fertility rate from 5.9 to 5.4 per woman.
- Raise the contraceptive prevalence rate from 9.5 to 18.6 by the end of the plan period.
- Prevent 2 million births during the plan period.

In essence, the policy aims at creating a behavioral change in favor of a small family within an acceptable sociocultural framework.

Responsibility for implementation of the GOP's policy rests with the Population Welfare Division of the Ministry of Planning and Development. Cooperation and support are provided by the Ministry of Health and other relevant ministries and governmental organizations.

II.2.2 Project Goals and Objectives

The CSM goal for Pakistan is to increase contraceptive use by supporting the expansion of contraceptive availability and promotion through the private sector. During the project period, the primary objectives are as follows:

- Provide a minimum of 2.1 million couple years of protection (CYP).
- Avert at least 450,000 births.

II.2.3 Conclusions

The goal and objectives of social marketing within the context of Pakistan's population policy are clearly to achieve a demographic impact. The program has no pretensions of achieving self-sufficiency or profitability.

Recommendation:

- The demographic objectives of births averted and CYPs should be stated in terms of the target market, e.g., the number of births to be averted among women aged 18 to 40 years. Social marketing programs are usually intended as an intervention aimed at women of reproductive age who

are in low-income groups, desirous of contraceptives, and in need of family planning services. The target market, as identified by the sales target, should be reflected in the objectives.

II.3 Management/Organizational Structure

II.3.1 Project Structure

The CSM project for Pakistan is implemented through a private sector manufacturing and distribution company--M/S W. Woodward (Pak.) Ltd., which was selected jointly by the GOP and USAID through competitive bidding. The activities of the project are governed by an Advisory Board comprising the Ministry of Planning and Development (six representatives), the National Development Finance Corporation (NDFC; one), USAID (one), and Woodward (one).

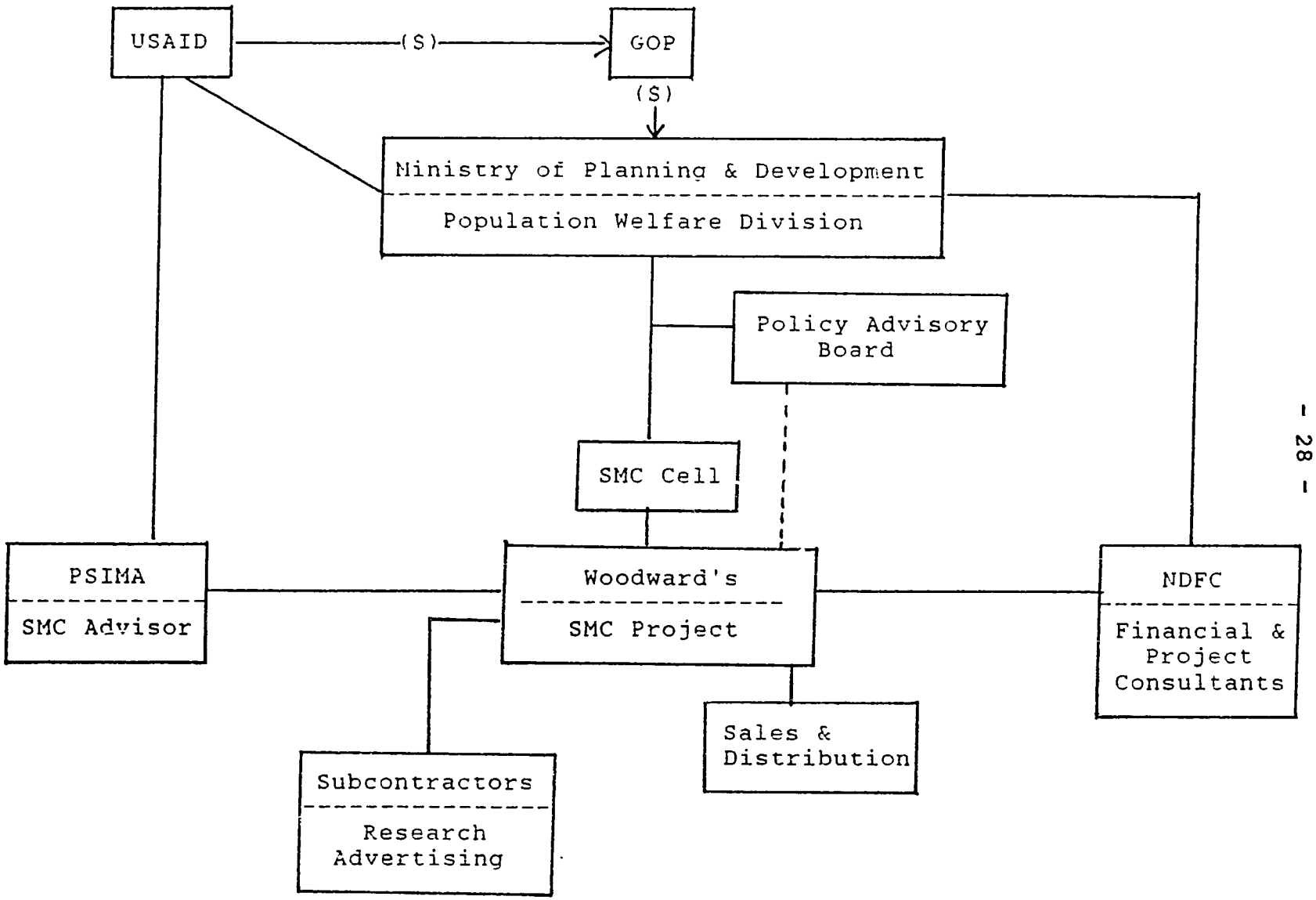
Woodward operates under contract with the GOP and in turn subcontracts directly with the necessary specialized organizations, for example, an advertising agency. The NDFC through Pakistan Consultancy Services (PCS), one of its service divisions, represents the interests of the GOP, particularly in matters of fiduciary conduct and management.

The project is further served by a resident advisor, provided by PSI Marketing Associates (PSIMA), and receives technical assistance from PSIMA, which also represents the interests of USAID. The Family Welfare Division of the Ministry of Planning and Development provides direct guidance in matters related to population policy and planning. The Minister of Planning is the chairman of the Advisory Board and a key person in the development and implementation of the project. (Figure II.1 depicts the organizational structure for the project.)

II.3.2 Development

The CSM project went through a long, careful development phase, which began in 1979 with a basic needs assessment (conducted by a UNFPA mission) and culminated on March 31, 1984, with the signing of a project agreement between USAID

FIGURE II.1: SMC PROJECT PAKISTAN



and the GOP. In between feasibility studies and implementation, plans for the program were developed by PSI in 1980, and a continued, patient, and fruitful lobbying effort was conducted within Pakistan by the Population Office, USAID/Islamabad. After the project agreement was signed, the resident advisor played a key role in charting a course to implementation, a process requiring another 12 months or more.

II.3.3 Organizational Relationships

The project is funded jointly by USAID (U.S. $20 million and the GOP (Rp 13 million). Additionally, USAID provides all commodities free to the project. All project expenditures (approved through the budget) are paid by USAID on approval by NDFC. The GOP funds cover the administrative costs of a CSM cell within the Ministry of Planning and Development and the NDFC. Additionally, USAID, through a direct contract with PSIMA, funds special project activities, such as research and technical assistance.

The implementing agency, Woodward, reports directly to the Advisory Board. However, the board's operational inputs and advice to Woodward are provided through PCS and PSIMA. An advertising agency and a market research company were appointed by and report directly to Woodward. (See Figure II.2 for Woodward's organizational structure.)

II.3.4 Capabilities

The organizational structure was devised specifically to respond to local circumstances and does so successfully. Specialized capabilities, especially marketing, management, and finance, are to be found both within the implementing agency and through PSIMA and the NDFC. The net result is a strong management network that has established a sound institutional environment. There are indications that the framework established will grow to serve the increased needs of an expanded program. Of concern, however, is the lack of private sector involvement in the management/organizational structure described above.

II.3.5 Lessons Learned

Two major organizational lessons have evolved from the CSM experience in Pakistan. First, the process of getting governments to accept social marketing as a viable and effective family planning intervention is arduous. However long it takes,

though, governments should be made to commit to the concept before the project is initiated. Early lobbying efforts with host governments can facilitate program implementation and progress. Second, the success of a project rests to a very large extent on its management capabilities. Good management can and will respond to problems and take advantage of opportunities. Being a good distributor or sales organization in no way implies good management or even good marketing skills.

Recommendation:

- Private sector representatives should be appointed to the Advisory Board to increase the project's expertise in finance, management, and marketing; local private sector technical assistance should also be used in addressing management and marketing issues.

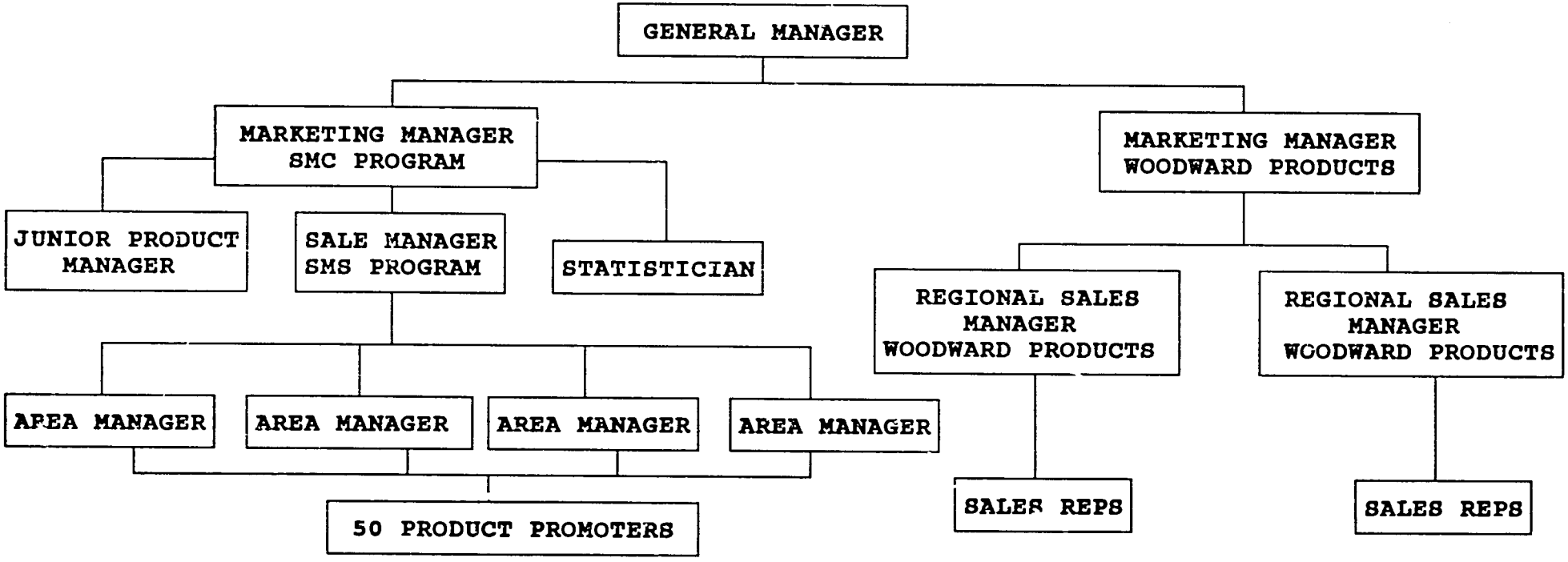
II.4 Marketing Objectives and Strategies

The marketing objectives and strategies, as stated in the 1986-87 Annual Marketing Plan, are as follows:

- Make condoms (Sathi brand) available to married, fertile-aged couples
  - -- at convenient locations frequented by them,
  - -- at prices affordable by lower income couples while retaining a quality image, and
  - -- by offering a reasonable return to trade to ensure active support for the product.
- Inform married, fertile-aged couples of widespread availability of condoms and that they are a safe, simple, and effective contraceptive.
- Motivate and persuade married, fertile-aged couples, through use of all available media, to use condoms and that they are a reliable contraceptive.

The "product concept" being established is that use of condoms is an effective way to space children.

Figure II.2
M/S Woodward's Organizational Structure



II.5 Potential Customers

II.5.1 Estimate of Target Market

According to information provided by Woodward's Pervez Said, the firm identified the total target market to be all fertile-aged, married couples, which, projecting from the 1981 census, is approximately 14 percent of the total population. The firm then assumed that 25 percent of the fertile-aged couples were "ineligible" because they were currently using an effective contraceptive method, were currently pregnant, were infertile, or were trying to have a child. The total target market for the CSM project would, therefore, be as shown below:

Total Population	95 million
Fertile-aged couples (14 percent)	13.3 million
Less "ineligible" couples	2.3 million
Total CSM target market	10 million

This target does not take into account differences by income group, an important factor and one that is evident to Woodward.

II.5.2 Target Group Selection and Characteristics

Very little research was done on the target group before the project was implemented. Nevertheless, a good deal is known about the segment of the Pakistani population at which the product was aimed. The target population is poorly educated; although most seem to approve of family planning in a general sense, they are not informed about different contraceptive methods, especially those people in rural areas. The GOP believed from the beginning that an important focus of this project was unserved customers in rural areas. This is precisely the group that tends to be illiterate and without knowledge of specific contraceptive methods. One indication of the lack of information is the fact that pre-project surveys found that the word "condom" was little known among all groups.

Very little attention appears to have been paid to careful definition of the target groups or the needs of various segments of that population. This is probably because the project was a long time being developed. Thus, one senses that everyone knew the group the project was trying to serve and no one thought it was necessary to spell that out. Indeed, from visiting shop owners and traveling with project staff, it appears

that the market of lower working-class Pakistani men is widely known and appreciated by project managers.

II.5.3 Appropriateness of Target Group

Given that the target group was not clearly identified, it is difficult to comment on its appropriateness in a specific way. The project's leadership understands the orientation of commercial social marketing. What is not clear, however, is how the members of the Advisory Board, on the one hand, and Woodward's sales force, on the other, perceive their target audience. It is the potential conflict between these two groups and the need to market the product to different groups that makes it essential that more attention be paid to specifying clearly who the target group is and the criteria by which it was selected.

II.5.4 Target versus Actual Customers

No research has been conducted on actual Sathi customers, so it is not possible to assess the extent to which they match the target population. This is a major shortcoming in the implementation of the Sathi project. Field visits to retailers suggest that customers are, in the main, males under age 40 who are members of Pakistan's working class, broadly defined. A lack of concrete data, however, limits the certainty with which this conclusion can be drawn. It is clear, therefore, that research on Sathi customers is an important next step for program managers to undertake.

II.5.5 Impact on Target Group

The lack of research clearly limits the extent to which the impact of the Sathi program can be judged. Moreover, the program is in the early stages of implementation, and although early results are promising, it would be a mistake, especially given the history of Pakistan's family planning efforts, to be overly optimistic. In general, the project appears to be doing a good job of reaching new customers, particularly given the absence of mass media advertising. Over 25 million units have been sold by Woodward, and Sathi display signs, posters, brochures, and other point-of-sale material are in evidence throughout the country. The project staff believes that most of the sales to date have been to users already practicing family planning. However, it is likely that the increased visibility of the product, together with the attractive display and a brochure that answers specific questions and provides concrete motivation

for family planning, has tapped some latent demand in the country. Moreover, it is clear, regardless of the extent to which current Sathi users represent additions to contraceptive prevalence, that the easy availability of the product has probably increased the awareness of condoms as a family planning method.

In general, the project appears to be doing a good job of reaching new customers, particularly given the absence of advertising. It is unlikely, however, that even the most optimistic accounts would credit as many as half of Sathi purchases to the "new user" category. Moreover, without information on patterns of use, it is impossible to say how many users are simply experimenting with the product and do not purchase additional supplies. A great deal of stock remains with the trade. Woodward is currently offering a particularly attractive promotion (a carton of its Grippe Water with every carton of Sathi), and thus retailers are obtaining and holding large inventories.

Recommendation:

- Operational research should be conducted to fill in the gaps in management knowledge so that the potential customer can be more precisely identified and targeted.

II.6 Product

Among those Pakistanis aware of artificial contraceptive methods, the condom and oral contraceptives are most widely known. Of the two, condoms are considered the more effective method. However, there exists a great disparity in urban versus rural areas in terms of awareness of contraceptive techniques. For example, a 1986 project survey of knowledge, attitudes, and practice (KAP) found that 60 percent of urban males knew of condoms, but the same was true for only 26 percent of rural males.

Both condoms and oral contraceptives are available in Pakistan through retail outlets. (Drug regulations permit dispensing oral contraceptives without prescription and condoms do not have to be approved as a drug product.) At one end of the condom market is the government-supplied product, the Sultan, which is available for as little as 1 rupee for a pack of 12 (6 U.S. cents/condom). Commercial brands, with many bearing sexually suggestive package illustrations, are widely distributed and cost about 1 to 3 rupees per condom (6 to 18 U.S. cents/condom). These commercial brands, however, are usually kept out of view of the retail customer and are available only on

request. Market share and size data for the condom market are not available.

II.6.1 Findings

The Pakistan CSM project is currently marketing only condoms; only one brand, Sathi, is now in distribution. It is available only in a four-unit pack and costs 1 rupee.

The Sathi condom is supplied by A.I.D. The inventory now in distribution is dated November 1984, a situation that has caused some concern among customers. (Woodward has submitted Sathi samples for testing; no product-reliability problems have been detected to date.) The project team is currently discussing the possibility of incorporating an additional condom brand and an oral contraceptive into the product line within the next two years.

Brand awareness, trial, and repeat-usage data have not yet been obtained, so it is impossible to assess the impact of Sathi on the target market. Although data on sales to the trade are available, data are not available on brand switching, substitution effects, impact on new contraceptors, or brand attitudes.

Also in question is the appropriateness of Sathi for rural versus urban males. Linked to this issue is the restriction on condom advertising through the broadcast media. As noted above, rural males have very low awareness of condoms. Merely putting condoms into distribution in rural areas without advertising their availability is, therefore, not a productive effort. The only advertising allowed to date has been cinema ads (which have had limited reach and impact) and in-store displays. Should broadcast advertising not be allowed in the future, the marketing of condoms to the rural areas would be severely constrained. Lack of access to radio, especially, is a grave threat to the project's future (see also section II.9).

II.6.2 Conclusions/Lessons Learned

Pakistani culture is very traditional and male dominated. As a result, the husband exerts great control over the decision to practice family planning. Beginning the CSM project with a male product, was an important first step toward (1) desensitizing the community to commercial contraceptive marketing and (2) broadening the support for use of contraceptives. (In this situation, had the CSM project begun with oral contraceptives, for example, the chance of a community backlash would have been greater.) As a result, female contraceptive products are likely to be more readily accepted in the home over time.

backlash would have been greater.) As a result, female contraceptive products are likely to be more readily accepted in the home over time.

Brand-penetration studies should be a required component of CSM programs, particularly early in the project's life. Without such data, it becomes impossible to assess the program's success or to establish effective marketing strategies.

Recommendations:

- To determine the impact of Sathi on the target group and, in turn, direct future marketing planning, a brand-penetration study should be conducted as soon as possible. Such a study will answer several critical questions: What is Sathi's trial level? Who are the triers? How is the product being used? Are triers new to contraceptives or merely switching from higher priced commercial brands?

- The project team should also consider introducing a higher-count package of Sathi (e.g., 8-, 10-, or 12-pack). The availability of such a pack will make it easier for brand acceptors to become loyal, regular users and will also lower packaging costs per unit.

- Once the CSM project team firmly establishes the Sathi program and resolves advertising and impact (urban versus rural) questions raised in this report, it should pursue the introduction of oral contraceptives.

II.7 Distribution

Product distribution, as noted, is handled by Woodward, which is a division of London Rubber Co. (makers of Durex condoms). Along with Sathi, Woodward markets Woodward's Grippe Water, a widely used, 100-year-old brand of infant colic medication, and a few less popular child-care products.

Woodward distributes Sathi condoms through 160 sub-distributors and 800 wholesalers. It employs (per an A.I.D. requirement) 40 sales promoters, whose primary job is to take retailer orders for Sathi and manage in-store merchandising. It is estimated that Sathi is now available in about 49,000 retail outlets nationwide (151 towns), including chemist shops and general provision stores.

II.7.1 Findings

Much of the success in gaining widespread distribution for Sathi can be traced to Woodward's use of seminars for introducing the program to wholesalers and retailers. At these meetings, Woodward's personnel review the purpose of the CSM project, its importance to the nation, the trade margin structure (see section II.12), promotion plans, and the proposed advertising. Noteworthy is the fact that this is, reportedly, the first time such seminars have been used for commercial products in Pakistan. These seminars were also helpful in that they raised the retailers' knowledge of contraceptives in general. As a result, when customers inquired about Sathi after seeing it in the store, the retailers were better prepared (and motivated) to answer their questions.

Also contributing to the excellent in-store availability of Sathi (in the urban areas; information on rural areas was not available) is the use of the 40 sales promoters. Although these sales people do take retailer orders for Woodward products other than Sathi, their regular presence in the market (urban stores visited every 10 to 14 days) and their active promotion of Sathi have contributed to a strong retail presence for the brand. As a result of this strong sales promotion as well as attractive, "neutral" packaging, Sathi was stocked in public view in all of the retail outlets visited. Prior to the marketing of Sathi, no condom products were in public view in retail outlets.

Woodward also plans to experiment with distributing Sathi through private health promoters who make personal visits to the homes of townspeople.

The following chart lists the prices for Sathi to distributors, wholesalers, retailers, and customers.

	4-pack price	Margin
Woodward sells to distributor	30 paisa	-
Distributor sells to wholesaler	45 "	33%
Wholesaler sells to retailer	55 "	18%
Retailer sells to customer	1 Rupee	45%

These margin levels are competitive with those of other commercial products.

All of Woodward's direct costs (advertising, labor, packaging) and indirect costs (overhead) associated with the project, as noted, are paid for by USAID. Its profit is derived from a 4.5 paisa/condom commission, which is also paid by USAID.

For 1987, this profit is estimated to be 1.2MM rupees, or about U.S. $68,000. After expenses incurred by Woodward for trade incentives (approximately 26 paisa/pack) are deducted, about 4 paisa/pack are returned to a GOP/A.I.D. fund (to be allocated to future development projects). (See section II.12 for program expenditures for first six months of 1987.)

II.7.2 Conclusions/Lessons Learned

The trade seminars held in advance of product launch were very successful in eliminating many of the questions and doubts distributors, wholesalers, and retailers had about carrying Sathi. This effort also appears to have helped raise the consumer's knowledge of condoms and their role in planning a family. Particularly in countries with strong religious, cultural, or social sensitivity to contraceptive marketing, trade seminars can mean the difference between program success and failure.

The cost-recovery/commission plan for Woodward is exceptionally favorable to the firm. With all costs covered and a sales commission on every unit sold, the firm is in a no-lose financial position. In establishing future relationships with product distributors, CSM projects are advised to consider contractual arrangements that are less expensive.

Recommendations:

- The project team should hold follow-up seminars with the trade in an effort to maintain interest in the brand, assess trade opportunities, and continue the trade's education in family planning, child spacing, and condom use.

- Since consumer awareness of family planning methods is very low in rural areas, a special education campaign should be implemented for rural retailers.

II.8 Pricing

The Pakistani rupee is valued at about 6 U.S. cents. As perspective, a bottle of Coca-Cola can be purchased from a street vendor for 3 rupees; a pack of inexpensive cigarettes costs 4 rupees. Inflation and currency devaluation have not been severe problems recently.

II.8.1 Findings

Sathi's retail price has been set at 1 rupee per four-pack, which converts to about 1.5 U.S. cents per condom. This price is printed on the package, thereby helping to ensure consistent pricing among retail outlets. The key criterion for pricing the product was to make it easily affordable to low-income customers without detracting from the image of a quality product. The cost of 100 Sathi, which is the measure Woodward uses for one CYP, is Rp 25, which does not exceed the daily wage of lower income laborers. The cost is in line with the cost of basic consumer staples, such as soap, matches, and tea. (The price of 1 rupee per pack has a secondary advantage--an embarrassed customer does not have to wait for change.)

As seen on the following chart, Sathi's price is very favorable relative to the competition.

Brand	Price per Pack	Price/Condom
Sathi	1 Rp/4 condoms	.25 Rp
Sultan (GOP-supplied product)	1 Rp/3-12	.33 - .08
Durex	3 Rp/3	1.0
Ribbed products w/explicit pkg.	6 Rp/2	3.0

There is no indication that Sathi's low price has had a negative impact on perceptions of quality. This may well be due to the use of attractive, tasteful packaging and point-of-sale material.

II.8.2 Conclusions/Lessons Learned

Selling a CSM product at a very competitive price has been shown to have a positive impact on a project's eventual success among low-income consumers. At the same time, it is important to avoid creating the impression that a product so inexpensive is of low quality or that it speaks ill of the person purchasing it. As shown with Sathi, these potential image problems can be overcome through the use of high-quality graphics, packaging, and promotional material.

Sathi's current price will make total cost recovery far from possible. Should cost recovery become a higher priority, it appears that there is considerable room to increase the price while still serving the low-income market.

Recommendation:

- o Upcoming product tracking studies should include a measure of perceived product quality/value. Should a problem be identified in the future, modifications can be made to Sathi's pricing, advertising, and/or promotion.

II.9 Advertising

The advertising media available in Pakistan include TV (one national station), radio (one national station and several regional stations), cinema, newspapers, billboards, posters, and magazines.

Since 1985, the government has aired TV programs and commercials for family planning (basically, "a small family is a happy family" message). Current plans call for this government-sponsored advertising program to receive annual funding upwards of Rp 37 million (U.S. $2.17 million). Specific contraceptive techniques will be promoted and the addresses of family health clinics will be announced.

At the same time, however, the government is very sensitive about commercial contraceptive advertising on radio and TV. Although the Ministry of Planning (the overseer of the Sathi program) supports the use of broadcast media and has a voice in the government's decision, final approval for advertising commercial products rests with the Ministry of Information.

II.9.1 Findings

Initial marketing plans for Sathi called for the use of television, cinema, radio, and newspaper advertising for launching the product nationwide. In light of government concern over possible public reactions to condom messages on broadcast media (TV in particular), however, the product's introduction was supported only by cinema commercials, in-store advertising, and brochures. The advertising program has also been severely constrained to date by a prohibition on the use of the word "condom" on any promotional material.

Approximately 250 cinema halls across the country are now exhibiting the Sathi ad; about 11,000 people are exposed to this ad per week in each theater. The cinema list will be expanded to upwards of 500 houses within the next year. Since it is unlikely that TV advertising for Sathi will be approved in the next year or two, the expanded cinema program should prove valuable in providing motivational messages.

A radio ad has been produced and will be aired immediately after it is approved by the Minister of Information (expected within the next few months).

The communication objective is to associate Sathi use with the spacing of children and the resulting benefits to the family. Consistent with this objective, the Sathi radio and cinema messages wisely promote male involvement in the spacing of children as an alternative way to express manhood. The ad strategy identifies the primary benefit as "maximizing enjoyment of your child" and the secondary benefit as "better upbringing of the child." The product attributes being highlighted are ease of use, safety, and reliability.

All point-of-sale material utilizes the Sathi "two bird" logo and, where space is available, includes the message "until you desire another child, rely on Sathi." Unfortunately, the advertising messages have not been customized to reflect the great difference in contraceptive knowledge that exists in the rural versus urban areas.

The program has also made effective use of brochures. To help pave the way for the introduction of Sathi, brochures describing the project were distributed to the Pakistani medical community. Highly informative brochures were also distributed to retail outlets and consumers. These brochures are part of a Sathi counter display and, as a result, are easy for retailers to make available. Because many urban and, in particular, rural people are uninformed about family planning, child spacing, and contraceptive methods, there is a need for the concrete information presented in the brochures.

No cross-product promotions for the customers have been implemented, but there are plans to include a small Sathi pamphlet within packages of Woodward Grippe Water in the coming months. The Grippe Water purchasers -- parents of infant children -- are a prime target for the Sathi message.

II.9.2 Conclusions/Lessons Learned

CSM projects are best served by communication plans that reflect cultural attitudes about family planning and that present benefits that go beyond the well-worn "small family is a happy family" platitude. In Pakistan the CSM program staff carefully studied male and female attitudes toward family size and concluded that the advertising must establish Sathi use as an act of male responsibility. Also, they were quick to recognize that simply saying "a small family is a happy family" would be rejected out-of-hand by the target groups. Through research and careful analysis, the team determined that a much more compelling

and believable promise is that family planning enables a father to better enjoy his children and that taking care of one's children is a responsible act of manhood.

When levels of family planning and contraceptive product knowledge vary greatly between urban and rural areas (or, for that matter, when knowledge or attitudes vary among any target subgroups), separate advertising and other promotional strategies must be considered for each group. In the case of Pakistan, rural people received the same messages as urbanites, even though less than 25 percent have knowledge about artificial contraceptive methods (versus about 70 percent of urban people).

A very effective way to increase consumer understanding of family planning and its benefits is to distribute brochures at retail outlets. This information source is beneficial not only for those shop patrons who may have heard a CSM commercial and wish to learn more, but it is also valuable for those people who missed the advertising and are curious about this new product on their retail shelves. The brochures can provide a good deal of specific information on a subject that many people find too embarrassing to discuss openly.

Recommendations:

- After reviewing the results of the market penetration/ user study recommended in section II.6.3, the project team should determine how best to modify the advertising program to reach urban and rural markets. In particular, plans should be developed to increase understanding of artificial family planning methods in rural areas.

- In light of the strategic value of the Sathi brochure program, Woodward should set up a system to ensure the availability of this brochure (and perhaps a follow-up brochure) at all retail outlets in the coming years.

- The project team should continue its efforts to implement promotional programs (e.g., the Grippe Water promotion) that encourage high-priority customers to try Sathi. Such promotions should be fielded at least twice a year.

- In light of the importance of radio advertising in providing critically important educational and motivational messages, the project team should aggressively pursue a change in government policy to allow radio advertising of Sathi.

- Should permission for radio or TV advertising of Sathi still not be granted in the coming months, the project team should be in a position to implement quickly a contingency program. For example, point-of-sale material could be modified to include the campaign's motivational message (i.e., plan your family so you can better enjoy and care for the current children).

II.10 Research and Evaluation

Research is potentially one of the most important elements of the Pakistan CSM program, yet it is probably the weakest component. Good research is necessary to define and specify the target market and the actual consumers. Given the low level of contraceptive prevalence in Pakistan and the limited knowledge and use of the condom, it is particularly important that marketing and advertising strategies be designed to motivate and educate the consumer. The marketing strategy is likely to change substantially depending on what research reveals about the current mix of Sathi customers.

Research is also crucial because senior members of the government who participate in the project's Advisory Board must be satisfied that the project is having a substantial impact and is not viewed negatively by important segments of the population. This advisory body has, for example, proscribed use of the word "condom" in any Sathi advertising and has urged large-scale, random sample surveys to test the appropriateness of proposed advertising campaigns. An early project member noted that "a strategy to respond to the board's request now needs to be carefully formulated and implemented as expeditiously as possible. The board's concerns about public reaction are legitimate. It is incumbent on CSM management to provide tangible evidence either in support of, or to mitigate, these concerns and to revise the advertising plan accordingly."

Although the project's resident advisor is authorized to assume a leadership role in clarifying the scope and objectives of additional and future research, he is not well positioned to do so. His professional expertise is in marketing and he lacks the knowledge necessary to design a research program to evaluate the impact of the Sathi program. It is important for the marketing of Sathi that a better understanding of the product's customers be obtained. At the same time, to justify the investments of the U.S. and Pakistani governments, more research should be undertaken to evaluate the program's overall impact on contraceptive prevalence and fertility.

A troublesome, but less important problem with ongoing research, concerns its timeliness. Apparently, research results

were not available in time to inform the design of the advertising or marketing campaign. Moreover, the lack of final reports and the lateness of preliminary tabulations caused problems in incorporating specific background factors to confirm or justify the program plans as presented to the Advisory Board. The Domestic Research Bureau will have to become better acquainted with alternative sources of demographic information in Pakistan and incorporate them into the design of its studies. In addition, a careful review of the Domestic Research Bureau's analytic methods needs to be undertaken. Current analytic techniques are extremely simple, and it is possible, if not likely, that confounding factors not analyzed by the Domestic Research Bureau are heavily influencing the results obtained.

II.11 Medical Aspects

The CSM program currently incorporates only the sale of condoms, but because of the possible introduction of oral contraceptives a preliminary assessment of the environment for marketing pills was also made. As noted earlier, the religious and cultural mindset in Pakistan severely inhibits the dissemination of information about contraceptives, and the word "condom" or its equivalent is carefully avoided in all communication media. Morever, very little knowledge exists about the condom, or contraceptives generally, and family planning training is not a part of the medical curriculum. Consequently, a high level of contraceptive ignorance exists among consumers (especially those in rural areas) and retailers (including grocery shops, dars, and hakims).

Oral contraceptives are freely available in drug stores without a prescription. The pills are dispensed like any other commodity -- without any precautionary advice to customers and, for that matter, no training of retailers or the medical community. Currently, The Pathfinder Fund is initiating family planning curriculum development for various categories of health personnel on behalf of Pakistan's Population Welfare Division.

It is to be hoped that with the gradual desensitization of the population to contraception through the marketing of condoms, bolder and more specific messages can be communicated about condoms in order to improve the knowledge base of retailers and consumers.

Recommendation:

- If oral contraceptives and/or IUDS become part of the CSM product mix, a strong training component should be included in the implementation strategy. Advice and assistance should be sought from Pathfinder and the

Family Planning Association of Pakistan, both of whom have had extensive field experience in family planning training.

II.12 Project Costs

The total budget for the CSM project, excluding commodity costs, amount to approximately U.S. $4.5 million per year over the four-year funding period.

Direct operating costs amount to Rp 80,313 million, of which

- 28 percent is allocated to advertising,
- 20 percent is allocated to packaging and printing,
- 12 percent is allocated to salaries and benefits, and
- 10 percent is allocated to the implementing agency's commission.

Indirect costs are covered by the GOP's contribution of U.S. $740,000 for personnel and overhead costs at NDFC and for the CSM cell in the Ministry of Planning and Development, Population Welfare Division. Additionally, the USAID Mission, through PSIMA, is investing $1.36 million to cover the cost of the resident advisor, special research projects, technical assistance, travel, and other items. Cumulative actual operating expenditures for the period December 1985 to June 1987 amounted to U.S. $904,000 -- 47 percent below budgeted expenditures.

Gross retail sales for the period January to June 1987 (the commencement of product sales) amounted to U.S. $262,000. The ratio of direct costs to gross sales is 3:1; this ratio is projected to improve to 1.5:1 by FY 88/89. This implies a positive move toward cost effectiveness.

Of more importance, from 4 percent to a maximum of 30 percent of gross sales is returned to the program and cumulated in a special GOP/A.I.D. fund, ostensibly to cover future project costs. Based on sales through June 1987, a minimum of Rp 185,541 (U.S. $10,554) has already been returned to the project (see below). Some project costs can, therefore, be recovered, but based on current levels, the program will not be able to achieve self-sufficiency or sustainability.

The program can, however, increase its chances of achieving a degree of self-sufficiency by introducing additional contraceptive products, as well as by increasing the minimum percentage return from 4 percent to 12 percent of gross sales. Further, the commission earned by the implementing agency is charged as a direct cost to the project. By contrast, all other

PROJECT EXPENDITURES AND RETURN
FOR THE PERIOD JANUARY 1987-JUNE 1987

Retailer Margin	Rp 2,087,336
Wholesaler Margin	Rp 463,853
Distribution Margin	Rp 695,779
Trade Incentive	Rp 927,705
Sales Promotion/Incentive	Rp 278,312
Return to Program	Rp 185,541
Total	Rp 4,638,526

Recommendation:

- Should self-sufficiency become a project priority, consideration should be given to incorporating part or all of the implementing agency's commission into the retail price of the product. This would obviously increase the cost to the consumer, and would have to be carefully tested before full national implementation.

II.13 Conclusion

II.13.1 Management/Organization

The major positive attributes of the Pakistan CSM program and its implementation are the following:

- The very high level of commitment and involvement by the Ministry of Planning and Development, which facilitates achievement of unity of purpose and program development.

- The organizational skills and commitment of the implementing agency, Woodward, which has enabled the program to achieve excellent product dispersal and visibility.

- The experience of supporting organizations, specifically NDFC (representing the GOP) and PSIMA.

- The initiative, patience, and perseverance of USAID/Islamabad in steadfastly promoting social marketing and orchestrating its development and progress.

In short, the program has created a management organization capable of responding to the nuances and vagaries of social marketing. There is a need, however, for the program to begin to tap private sector expertise to improve performance.

II.13.2 Marketing

In terms of sales to the trade, the Sathi program can be viewed as very successful to date. At the same time, however, since no tracking research has yet been fielded, it is impossible to evaluate the "quality" of those sales. Specifically, the project needs to know to what extent these sales are to new contraceptors or are merely sales to people who are substituting for the more expensive commercial brands.

Many aspects of the Sathi product launch were successful despite severe cultural and political constraints. The distribution and advertising programs are noteworthy in this context.

The "quality of sale" issue aside, the Sathi program has been effective in convincing key Pakistani government officials of social marketing's potential for providing not only family planning services but other health services as well.

The key challenges in the near future will be in assessing the strength of the program in bringing in new contraceptors, particularly those in the lower income groups. Also, the program must rethink its strategy for reaching rural versus urban target groups.

II.13.3 Research

Research has been limited in scope, weak in execution, behind schedule, and not widely disseminated. All these factors must be addressed if research is to help guide the marketing program and assist the government, A.I.D., and PSIMA in judging the project's impact.

II.13.4 Potential Customers

More attention must be paid to identifying the characteristics of potential customers. Although the program is focused on low-income consumers, the limited formal specification of the target group gives rise to considerable opportunity for confusion and conflict among key project actors, such as the Advisory Board, the Woodward management team, and the project sales force.

II.13.5 Impact

Although it is too soon to judge the demographic impact of the CSM project in Pakistan, it is clear that the project has

helped bring condoms out from under the counter and, thus, helped desensitize family planning in general and condoms in particular. Approximately 25 million condoms have been sold by Woodward and, although a large proportion remains with the trade, the product is apparently becoming increasingly popular.

To date, legal policy changes have not resulted from CSM activities in Pakistan. The CSM project itself, however, represents an important innovation in the delivery of contraceptive services. It is not unique in Pakistan's history, but the degree to which it has been supported by the current government is noteworthy. In addition, it seems likely that additional advertising, a crucial need of the program, will be permitted by the GOP shortly. If Sathi can be advertised on the radio, sales should increase considerably. The advertisements, if carefully done, should provide additional education and motivation, particularly to rural couples, who are very poorly informed about modern contraceptive techniques. The addition of radio advertising would be an important innovation brought about directly by the CSM project. Those changes are being discussed, so it is clear that CSM has added an important element to the current policy debate in Pakistan.

Annex A

PERSONS CONTACTED

Khan Ahmad Goroya	Director General (Programs), Ministry of Planning and Development
Dr. William H. Jansen	Population Officer, USAID/Islamabad
Agha Akhtar Ali	Marketing Director, PCS/NDFC
Frank R. Samaraweera	Resident Advisor, PSIMA
Dallas Voran	Acting Population Officer, USAID/ Islamabad
Brian Janjua	General Manager, M/S Woodward
Pervez Said	Manager, CSM Project, M/S Woodward
Riaz Haqqi	Product Manager, CSM Project, M/S Woodward
M.A. Baqai	Manager, Domestic Research Bureau
Tahir Khan	Managing Director, Interflow Advertising
Faisah Sherjan	Creative Director, Interflow Advertising
Dr. Reehana Ahmed	Medical Director, FPAP Model Clinic
Mrs. Zeba Zubair	Chairperson, NGO Coordinating Council
Ms. Bonnie Derr	Program Officer, PSI, Washington, D.C.

ANNEX B

DOCUMENTS CONSULTED

Advisory Board Minutes, CSM Project, Pakistan

M/S W. Woodward (Pak.), Ltd., Annual Marketing Plan, 1986-1987

U.S. Department of State (Pakistan), Background Notes

UNFPA Population Inventory, Pakistan, 1985-1986

Worldwide Report:	Population Projects funded by A.I.D., IPPF, and UNFPA
	Centrally Funded A.I.D. Population Assistance Program, FY 86
Quarterly Reports	SMC Project, Samaraweera, PSI
Sales Reports	SMC Project, W. Woodward
Organograms	SMC Project and W. Woodward

AFRICA

GHANA
NIGERIA

III. GHANA (Social Marketing Program)

Vincent Brown, Team Leader, Evaluator/Generalist
Carl Allen, Marketing Specialist
Stella Goings, Medical Analyst
Barbara Janowitz, Social Science Analyst

The Ghana Social Marketing Program (GSMP) is the private sector component of the Contraceptive Supplies family planning project, which also has a public sector component. The USAID/Accra Population Officer is the overall project manager. A Ghanaian pharmaceutical firm with a nation-wide distribution network, DANAFCO, is the implementing agency for the private sector component. TFG/SOMARC provides technical assistance and some funding. The project markets A.I.D.-supplied condoms, foam tablets, and oral contraceptives.

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ANNEXES

A: Persons Contacted
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GLOSSARY

DHS	Demographic and Health Survey
GOG	Government of Ghana
GSMP	Ghana Social Marketing Program
GNFPP	Ghana National Family Planning Program
MFEP	Ministry of Finance and Economic Planning
MOH	Ministry of Health
PIB	Prices and Incomes Board
PPAG	Planned Parenthood Association of Ghana

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The assessment team is indebted to a number of individuals and organizations for their advice and guidance, in particular the president and staff of DANAFCO/GSMP, Lintas International, and PharmaHealth, Inc., and the Population Officer of USAID/Accra.

The active support of the Ghanaian Ministry of Health and the initiative and encouragement of Dr. Mary Grant and Dr. Adamafio are also gratefully acknowledged.

The Medical Consultant's contribution to this assessment was considerably strengthened by the participation of Miss Victoria Assan and Mrs. Adelaide Arde Acquah of the MOH and of Prof. A.P. Asafo-Agyei (Ag. Medical Administrator), Komfo Anokye Teacher Hospital, Kumasi, Ghana.

EXECUTIVE SUMMARY

BACKGROUND

The rate of natural population increase in Ghana is over 3 percent. No recent national data on contraceptive prevalence are available. A World Fertility Survey (WFS) conducted in 1979-80, however, found that among women in union in the age group 15 to 49, 12.4 percent were using contraception but only 4.9 percent were using modern methods. A Demographic and Health Survey (DHS) scheduled for 1988 will update this information.

The CSM program in Ghana is the private sector component of a larger family planning project (Contraceptive Supplies), which also has a public sector component. The overall project has as its purpose to "increase the voluntary use of safe, effective and appropriate contraceptive methods by Ghanaian couples. This is to be accomplished by making an adequate supply of contraceptive and family planning services available on a continuing basis through the existing service delivery networks of the Ministry of Health (MOH) in the public sector and through the development of a contraceptive social marketing (CSM) program in the private sector."

The marketing objectives and strategies of the CSM project are broadly stated as overall program goals, distribution targets, and product use targets:

- Increase contraceptive prevalence in urban areas from 7 percent to 10 percent.
- Increase knowledge in urban areas of the program's three contraceptive methods (condoms, foam tablets, and oral contraceptives) and their current use.
- Increase acceptance of the concept of family planning.

It is too early to predict to what extent these goals will be achieved, but the project is off to a good start. (Distribution goals and product use targets are discussed below.)

MAJOR FINDINGS AND RECOMMENDATIONS

General

Ghana's CSM program is only in its second year of operation and, generally speaking, is doing well. The government fully supports the CSM program, and USAID/Accra is playing an

important role in helping coordinate this private sector undertaking within the public sector program.

The government's implementing agent is a private, Ghanaian company, DANAFCO, which has an established distribution network in all regions of the country and is continuing its expansion to major market towns. TFG/SOMARC (the A.I.D. centrally funded contractor), on request from USAID and DANAFCO, has supplied strong technical assistance and financial support for CSM activities carried out by DANAFCO and its subcontractors (PharmaHealth--training, and Lintas--advertising).

The project has had to operate in the face of a number of constraints:

- A ban was imposed on mass media advertising of contraceptives for nine months; this has only recently been lifted.
- Scheduled delivery of transport vehicles to DANAFCO was delayed and restrictions were placed on their use.
- Research and analysis of data needed for marketing purposes have been delayed.
- Government pricing of some contraceptive products has kept profit margins too low.
- Diversion of public sector commodities into the commercial marketplace has prevented DANAFCO from obtaining a large enough market share to make distribution profitable.

Management/Organizational Structure

The project's organizational structure is well designed and is adequate to carry out the project's objectives. The Ministry of Finance and Economic Planning (MFEP), which supervises the government's contract with DANAFCO and, largely, leaves DANAFCO free to carry out its marketing responsibilities under the contract, is satisfied with the contractual relationship. DANAFCO's two subcontractors have also been performing satisfactorily.

The overall project coordinator is the USAID/Accra Population Officer, and USAID controls are built into almost every stage of the CSM program. Although this facilitates USAID's day-to-day monitoring of operations, it also postpones the day when the government will be able to assume responsibility for supervising the public and private sector components of the project.

Recommendation:

- Steps should be taken by USAID to increase the capability of the government to assume responsibility for overall coordination of the public and private sector components of the program.

Target Groups

The target groups for the three products distributed by the CSM project are as follows:

- Panther condoms: urban men aged 20 to 55 who are sexually active and urban women aged 13 to 45 who want to practice contraception.

- Kamal vaginal foam tablets: urban men and women of reproductive age who do not need constant contraception.

- Norminest oral contraceptives: urban women aged 18 to 35 who do not have contraindications for oral contraceptives and are not currently using them.

Urban men and women were selected as potential customers because of existing distribution capabilities and retail outlets. The target groups appear to be appropriate given the political and social climate in Ghana.

Products

Panther condoms, Kamal foam tablets, and Norminest oral contraceptives are all readily available. The products, however, could benefit from more competitive packaging. The cost of more competitive packaging is important, but the potential effects on sales of higher costs should be tested. The final decision should be based on data, not just on judgment.

It should be stressed that from a correct usage/ medical point of view, it is unwise to continue to distribute oral contraceptives without providing information regarding use and contraindications. The decision to sell the pills unpackaged and without instructions was a stop-gap measure to meet a short-term need. Preparing the instructions will require substantial skill, pretesting, and revision because the instructions must be designed not only for the literate population (English and major dialects) but, more important, for the illiterate population.

Recommendation:

- The project should consider packaging condoms in three- or four-pack boxes (appropriately tested), upgrading foam tablet packaging, and packaging oral contraceptives (including use instructions and contraindications for the literate and illiterate populations).

Distribution

DANAFCO's distribution goals are as follows:

- Year 1 -- Establish depots or authorized dealers in all 10 regional capitals and in the 22 next largest towns.

- Year 2 and onward -- Complete direct distribution to the 157 towns with a population of 5,000 or more.

The expansion of direct distribution to the 10 regional capitals has been successfully completed and further expansion to the 22 large towns is on schedule. The plan for direct distribution to the 157 towns has yet to be developed, however. The training schedule for the new retailers is progressing in a highly professional manner, but the timing of the training sessions could be better coordinated with the appointment and supply of the local dealer.

In terms of management efficiency and the need to keep distribution costs down, a major limitation is that the five transport vehicles donated by A.I.D. for use in this project can be used only to transport CSM contraceptives and directly related materials. This means that establishing new retail outlets requiring the full line of DANAFCO products will be severely limited by lack of transport. DANAFCO points out that it is not profitable to use the A.I.D.-supplied vehicles for distributing contraceptives only.

Recommendations:

- Wherever possible, the training effort should follow the appointment/supply of a local dealer and not the other way around.

- USAID should continue to reexamine the current restrictions on the use of donated vehicles to see whether procedures for more efficient and productive use of the vehicles can be worked out in the near term.

Advertising and Promotion

The advertising plan for the project encompassed a well-considered, three-phase strategy geared to avoiding controversy and adverse public opinion: Phase I, generic advertising of the health benefits of family planning; Phase 2, generic advertising of the health benefits of family planning products; and Phase 3, announcement of CSM-brand products. Despite these precautions, advertising contraceptives was banned shortly after the project was launched, and it took nine months to get the ban lifted. The new campaign, which is just now starting, will not use TV advertising and will proceed cautiously on other fronts, principally radio and the press.

Recommendation:

- Although the government is solidly behind the project, project managers should proceed cautiously with advertising campaigns, submitting advertising copy for review, pretesting it, and the like.

Research

A Research and Evaluation unit has been set up within DANAFCO with monies from the TFG/SOMARC centrally funded budget. The unit is run by a highly qualified Ghanaian. Although the unit's mandate allows it to contract out research, most of the research is done within the unit because of the lack of qualified Ghanaian research entities to do marketing and other related research.

A review of the planned research agenda and the timetable for doing the research and analyzing the results raises questions as to whether DANAFCO has the ability to mobilize the financial and human resources needed to carry out the plan as designed.

Medical Aspects

The quality of information given to customers about contraception is generally poor. In the CSM context, the need for high-quality training of distributors is obvious and urgent. The CSM training program is producing a cadre of well-trained vendors who should be able to provide reliable and appropriate information about contraception and contraceptive products to customers. The number of these trained vendors is small, however, and the pace of training is slow. The training program is beginning to include a broader spectrum of personnel from the retail outlets, however.

Recommendation:

- The training program should continue to be expanded to include a broad spectrum of the staff of pharmacies and other retail outlets and to increase the number of trainees.

Project Costs

It is not possible to determine the full cost of the CSM program because it is an integral part of the larger overall Contraceptive Supplies project. However, information is available on product sales, on local costs under the DANAFCO/MFEP contract, and on TFG/SOMARC financial support. TFG/SOMARC estimates that if only in-country expenditures are considered, the cost per CYP is $6.33 (March 1987); that if both U.S. and in-country expenditures are considered, CYP costs rise to $20.23 (not including commodity costs). However, CYP costs are expected to decline markedly over the next year or two, when the start-up "investment"/training phase will have been completed and the project will move into a sustaining mode.

DANAFCO officials are unable to predict when the project will be able to sustain operations without outside assistance (apart from provision of free contraceptives). Given no major setbacks, they anticipate that the break-even point could be reached in about two years.

Recommendation:

- Given the difficulties in determining the full direct costs of CSM projects (not to mention indirect costs, e.g., cost of procurement of contraceptives), A.I.D. should select one or two CSM countries for an in-depth study of direct and indirect costs and develop a methodology for determining these costs that could be used for CSM projects in other countries and regions.

III. GHANA

III.1 Background

Ghana is situated on West Africa's Gulf of Guinea. Most of the population lives on the coast, in the northern areas near the Ivory Coast, and in the principal cities of Accra and Kumasi.

III.1.1 Economic and Demographic Context

Ghana's economy is mainly agricultural, but the country has a good industrial base compared with most other African countries. The industrial sector, however, is operating far below capacity due to depressed economic conditions and limitations on foreign exchange for imports. An agreement has been reached with the International Monetary Fund, and the currency (cedi) is being devalued to bring it into line with its real value. The economy is recovering but per capita income remains low (U.S. $350).

The population of Ghana is growing rapidly. The rate of natural increase is over 3 percent, and the estimated total fertility rate is 6.5. Recent national-level data on contraceptive prevalence are not available. A World Fertility Survey (WFS) was conducted in 1979-80 and a Demographic and Health Survey is scheduled for 1988. Among women in union in the age group 15-49 at the time of the WFS, 12.4 percent were using contraception but only 4.9 percent were using modern methods. Data from the WFS also indicate that at that time there was strong support for large families. Of the currently married, fertile-aged women living in rural, urban, and large urban centers, only 10, 12, and 16 percent, respectively, expressed a desire to have no more children. Only after as many as five children did the percentage of those wanting no more children exceed 20 percent.

The situation, however, may be changing. Reports from USAID/Accra and team interviews in the field indicate that many Ghanaians are now seeking family planning services. The most common reasons given are related to the difficult economic conditions--the problems parents are having feeding their children and their desire that their children get a good education. High abortion rates and concern about adolescent fertility are also indications that there is increasing awareness of the problem.

III.1.2 Family Planning Context

In "Guidelines for the Five-Year Development Plan (1975-1980)," the Government of Ghana (GOG) emphasized the view that a high birthrate was a constraint on the health of the people and that good health was one of the primary requirements for economic and social development. Basic government health services include family planning, and many organizations in the country are actively involved in promoting family planning objectives.

The Ministry of Health (MOH) is supportive of the CSM project in Ghana. It considers the dangers of complications from family planning to be so much lower than those from pregnancy that it is in favor of providing contraceptives through chemist outlets.[5] Although the MOH also provides contraceptives, its clinics are not very accessible, according to Dr. Joseph Adamafio, Deputy Director of Medical Services. He believes that the chemist outlets in the towns and cities are more convenient than are MOH clinics.

The CSM project and similar projects wishing to distribute contraceptives face a number of constraints. First, oral contraceptives are considered ethical drugs and can be dispensed only by prescription. To facilitate distribution through pharmacies and chemist outlets, the GOG has agreed to a CSM demonstration program whereby pharmacists and chemists/vendors who complete special training can dispense oral contraceptives without a prescription. The results of the initial program will determine whether the training will be expanded; such expansion would vastly increase access to oral contraceptives. As a precondition to approving the demonstration program, the GOG required that the project agree to conduct research to determine if dispensing oral contraceptives over the counter posed greater health risks to women than dispensing them by prescription.

Second, government objections to the CSM program's advertising campaign resulted in a ban on all mass media advertising of contraceptives for nine months. The ban has since been lifted, but concern over the possible reintroduction of the ban has led to a more cautious and conservative mass media advertising campaign (see section III.9).

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[5]Chemist outlets are retail shops that specialize in over-the-counter drugs. They are not owned/operated by a licensed pharmacist, but they often sell drugs that ordinarily require a prescription. The retailers in these outlets are often referred to as chemists, chemical sellers, and chemist/vendors.

Third, a Prices and Incomes Board (PIB) reviews the prices to be set for new products entering the market.[6] For one of the CSM products, the PIB's cost-of-packaging allowance resulted in the price being set too low to make distribution profitable (see section III.8).

Fourth, although prices are set by the PIB, they are not monitored at retail outlets. CSM products, for example, sell at prices considerably above mandated prices, although below those of other contraceptive products. These higher prices make it difficult for the program to reach the targeted income groups (see section III.8). The retail prices charged reflect product availability, as well as the advertised prices. The MOH, which also sells its contraceptives at the PIB prices set for CSM products, is well aware of this problem and has endorsed the advertising of retail prices. The CSM project managers believe that instituting such a measure, when combined with improved distribution, will bring down prices and place CSM contraceptives well within the reach of the targeted income groups.

III.2 CSM Goals and Objectives

The CSM program is part of A.I.D.'s larger $10.8 million Contraceptive Supplies project.[3] The purpose of the latter is "to increase the voluntary use of safe, effective and appropriate contraceptive methods by Ghanaian couples ... by making an adequate supply of contraceptive and family planning services available on a continuing basis through the existing service delivery networks of the Ministry of Health ... and through the development of a contraceptive social marketing (CSM) program in the private sector."[4]

The objectives of the CSM portion of the project were identified in the project plan as follows:

- Develop a largely self-financing contraceptive

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[6]The PIB reviews prices, theoretically, for all consumer goods. Its greatest impact is on manufacturers, who can be monitored easily. The prices charged by retailers largely reflect a free market system.

[3]The $10.8 million is broken down as follows on the Project Data Sheet: USAID bilateral funds, $7,000,000; A.I.D. (centrally funded), $576,000 (TFG/SOMARC); Ghanaian government funds, $3,273,000.

[4]Project Paper, Ghana Contraceptives Supplies project (641-0109), approved February 23, 1985.

distribution network.

- Establish an effective management supply system that allows for significant expansion of the retail sales network and vastly improved consumer access to contraceptives.

- Prepare a cadre of trained retailers and marketing staff who can provide improved sales and service to consumers throughout the retail sales network.

- Increase consumer awareness of available contraceptive products as part of product advertising and promotional and marketing activities.

III.3 Management/Organizational Structure

The MOH is the implementing agency for the public sector component of the project, and DANAFCO (a Ghanaian firm), on behalf of the Ministry of Finance and Economic Planning (MFEP), is the implementing agency for the CSM component. The overall project manager is the USAID/Accra Population Officer, who is responsible for coordinating all USAID inputs and for monitoring the progress of both the MOH and the CSM programs. In addition, TFG/SOMARC, working with USAID/Accra, provides technical assistance and some funding to DANAFCO.

Three aspects of the CSM project are noteworthy:

1. The program is implemented directly by a Ghanaian firm; DANAFCO signed a contract with the MFEP on March 29, 1986.

2. Through a closely monitored national training program for pharmacists and chemists/vendors (see section III.7), the CSM program may lead to the legal sale of oral contraceptives in Ghana without a prescription.

3. The program incorporates joint funding from both bilateral and central A.I.D. monies.

DANAFCO has overall responsibility for the CSM program, but it subcontracted to a local advertising agency, Lintas Ghana Ltd, for advertising and promotion.[5] PharmaHealth Ltd., also

[5]After the first year, the follow-on contract was not signed with Lintas, and since April 1987 all advertising work has been on an individual-order basis.

under subcontract to DANAFCO, conducts training programs. Research activities are coordinated by a research unit within DANAFCO, and some research studies are subcontracted by DANAFCO to outside suppliers. (Figure III.1 depicts the organizational structure for the CSM program in Ghana.)

An Advertising Review Board, chaired by the MOH, approves all mass media advertising, including contraceptive advertising. Contraceptive advertising must also be approved, from a technical standpoint, by the government Pharmacy Board.

The organizational structure appears well designed and fully adequate to carry out the CSM project objectives. Discussions with the MFEP officer responsible for the DANAFCO contract indicate that the Ministry is satisfied with the contractor's performance and has no problems with the current arrangements. In the past, some difficulties have arisen when the involved parties did not adhere to the project's chain of command. A subcontractor, for example, was reported to have acted independently of the prime contractor. The project managers appear to be trying to resolve such difficulties.

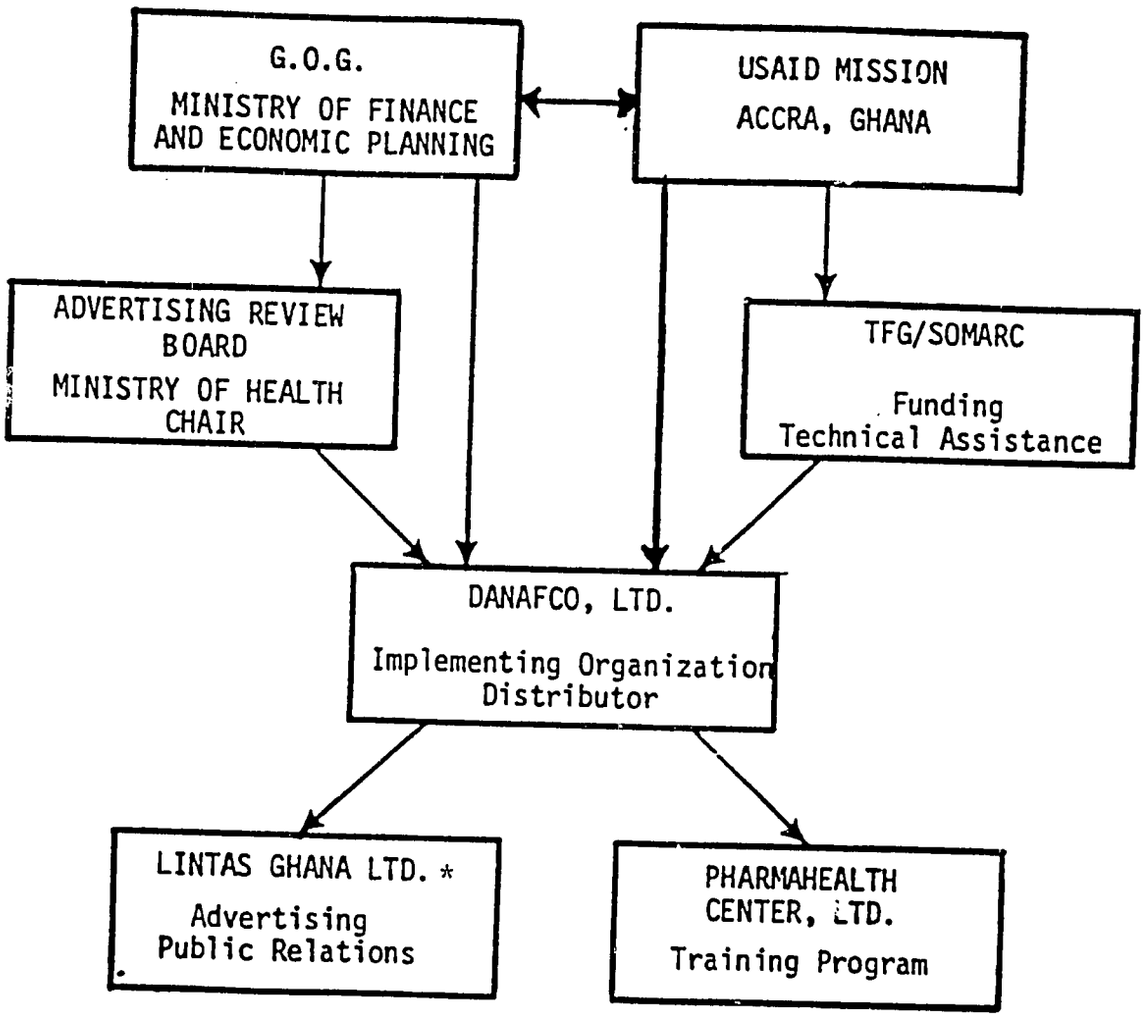
The overall project coordinator, as noted, is the USAID/Accra Population Officer, and USAID controls are built into almost every stage of the program. This facilitates USAID's day-to-day control of operations. From an institution-building point of view, however, it also postpones the day when Ghanaian personnel will develop the capability to assume major responsibility for supervising the public and private sector components of the program.

Given conditions in Ghana at the time the project agreement was signed, the Ghana National Family Planning Program (GNFPP) Secretariat or other entity was not able to assume a major role in the project. However, it might be useful to reconsider the advisability of involving an appropriate government entity and providing whatever training might be required. In this way, the government could begin to coordinate the public and private sector contraceptive marketing programs. At a meeting with the UNFPA representative and president of the Planned Parenthood Association of Ghana (PPAG), arranged for the assessment team by the USAID/Population Officer, there seemed to be considerable interest in helping the government gear up to assume coordination responsibilities.

Recommendation:

- Steps should be taken by USAID, in conjunction with the UNFPA, to increase the capability of the government to assume overall coordination of the public and private

FIGURE III.1: GHANA CSM PROGRAM ORGANIZATION



Source: The Futures Group, Washington, D.C.

*Lintas was the subcontractor for only the first year of the project. Since then, advertisements have been developed on an individual-order basis.

sector contraceptive marketing programs so that it could carry on should USAID not be available to provide this service.

III.4 Marketing Objectives and Strategies

The marketing objectives and strategies of the project are fairly broadly stated as overall program goals, distribution targets, and product use targets.

Overall Goals:

- Increase contraceptive prevalence in urban areas from 7 percent to 10 percent.
- Increase knowledge in urban areas of the program's three contraceptive methods (condoms, vaginal foaming tablets, and oral contraceptives) and their correct use.
- Increase acceptance of the concept of family planning.

Distribution Goals:

- Year 1. Reach the 10 regional capital towns of Ghana and 22 larger towns through the depots of authorized DANAFCO dealers. These areas represent 80 percent of the target population and 24 percent of the total national population.
- Year 2. Reach an additional 157 towns having populations of 5,000 or more through authorized DANAFCO dealers.

Product Use Targets:

- The longer term project goal is to achieve 30 percent product usage among the target population by 1989.

The marketing strategies for individual CSM brands are well defined and include statements reflecting

- brand positioning,
- competitive environment,
- pricing analysis, and
- advertising target and strategy.

Any of the individual elements of the marketing strategies may be questioned at this time, but experience and the research that is planned will assist the project in fine-tuning the strategies. (See section III.6.2 for recommendations regarding individual brands.)

III.5 Potential Customers

The target population for the CSM program is urban men and women of reproductive age who are not using an efficient method of contraception.

III.5.1 Product Target Groups

The targets for the three types of contraceptives distributed by the CSM program are described below.[6]

Condoms. The target group is urban males aged 20 to 55 who are sexually active and urban females aged 18 to 45 wanting to practice contraception. The primary potential customers are in the lower-middle and low socioeconomic groups (C2 and D classes) and have less than 10 years of formal schooling.[7]

Vaginal Foaming Tablets. The target group is urban men and women of reproductive age who do not need constant contraception and those who have not yet completed their family and, therefore, need a temporary contraceptive but have contraindications or choose not to use the more reliable hormonal contraceptives or the IUD. These potential customers include the lower-middle and low socioeconomic groups (C1, C2, and D).

Oral Contraceptives. The target group is urban women aged 18 to 35 who do not have contraindications for oral contraceptives and are not currently using them. If married, they should have had at least one child and be wanting to space childbearing. If unmarried, they should be wanting to postpone their first child or wait before having another. This target group includes all socioeconomic groups, literate and illiterate.

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[6]Briefing Paper: The Ghana Social Marketing Program, September 1987, The Futures Group/SOMARC.

[7]The C income class encompasses a fairly broad, middle range of wage earners, self-employed petty traders (e.g., market women), part-time farmers, and double-income families. For these reasons, it is useful to subdivide this group into C1 (upper middle) and C2 (lower middle) income subgroups.

The total population of urban women of reproductive age is approximately 842,000. The total urban population of males above age 15 is approximately 937,000.

III.5.2 Target Selection

Urban targeting was chosen because of the existing distribution capabilities and location of retail outlets. As for the age of the target population, the full range of reproductive years was chosen, except for the early teen years. Marketing contraceptives to teenagers is politically and socially unacceptable in Ghana. For medical reasons, the upper age limit for oral contraceptives was set at 35 years.

The target groups appear to be appropriate given the political and social climate, with the exception of the upper age limit for oral contraceptive users. Forty should be the upper age bound for oral contraceptive sales, except for women who smoke.

III.5.3 Target vs. Actual Customers

A DANAFCO study of the socioeconomic status of customers was carried out among 21 outlets--a subset of outlets covered in retail audits in Accra. This included 15 pharmacies and 6 chemist outlets. The study was originally planned as a consumer intercept study of buyers of contraceptives in pharmacies, but there were too few buyers to make this strategy possible. Consequently, this discussion is limited to the characteristics of buyers who frequent the type of outlets reached by the CSM program.

Ninety-four percent of those surveyed attended school, and of those, 17 percent had some university or advanced education; 7 percent had attended only primary school. Eighty-seven percent worked for pay and of those, 24 percent were working proprietors (largest group). Eighty-four percent owned a radio, 50 percent owned a TV, 48 percent had a refrigerator, and 28 percent owned an automobile. These retail outlets, thus, appear to be serving the A and B income groups, not the C and D income groups.[8]

It should, of course, be anticipated that customers at

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[8]The World Bank is conducting a survey of living standards in Ghana, which will be used by SOMARC in classifying customers by socioeconomic status group.

outlets in urban areas outside the capital city would be of lower socioeconomic status than customers in Accra; other cities probably comprise a higher proportion of lower income groups and have a higher proportion of chemist outlets/vendors. It is the chemist outlets/vendors that serve the lower socioeconomic status groups. In Accra it would seem that the DANAFCO outlets serve a high proportion of people of higher socioeconomic status than the intended target groups. Reaching the lower income groups will require innovative approaches to targeting distribution points that serve those groups.

The intercept survey also revealed that only 7 percent of those interviewed had come to the outlet to purchase contraceptives, but half said that they were using family planning. This percentage is undoubtedly much higher than for the overall population of Accra. (Information on age is not available; some customers may not have been of fertile age. Also, 27 percent of those surveyed were single, and some may not have been sexually active.)

The most frequently used products were reported to be condoms and vaginal foaming tablets, which together accounted for over half of all contraceptive use. What brands were generally purchased is not known.

Recommendation:

- The GSMP should explore other channels of distribution within Accra in order to reach the lower income groups.

III.6 Products

The CSM project currently markets three contraceptive products, all supplied by A.I.D.:

- Panther Condoms: sold in strips of four. Boxes of 25 strips of four condoms each are overlabeled with the Panther and project logos and serve as a storage/display unit for retail stores.[9]

- Kamal Vaginal Foaming Tablets (Conceptrol): sold in boxes of 12.

- Norminest Oral Contraceptives: currently sold by the single cycle in the original blister pack, unboxed. This approach was taken as a temporary measure to fill

[9]The Blue Panther Condom is known as just "Panther" in Ghana.

a commodity shortage in the marketplace. To date, sales of Norminest have been low.

The CSM program cannot choose the contraceptives it distributes. That decision is made by A.I.D.'s procurement staff and may change as cheaper alternatives become available. This makes it difficult to establish brand loyalty among customers.

The Panther product and packaging conform to the competitive environment. In fact, the two other most prevalent brands in the market, Sultan and Tahiti, are almost identical to Panther.

The Kamal foaming tablet faces unusual competition from Neo-Sampoon, a Japanese tablet packaged in units of 20 in an attractive, resealable aluminum tube. At a price per use roughly equal to that of Kamal, the compact tube is an attractive option to the bulky Kamal box containing 12 tablets.

The Norminest oral contraceptive, as currently sold in individual blister packs, has a major deficiency in that product use instructions are not included. Project managers realize this and plan to market a boxed, three-cycle product containing use instructions. Preparing the instructions will require substantial skill, pretesting, and revision because the instructions must be designed not only for the literate population (English and major dialects) but, more important, the illiterate population.[10]

Norminest is also associated with a higher-than-average incidence of breakthrough bleeding. This side effect may discourage continued use of the product.

An issue that confronts the entire oral contraceptive market in Ghana is the lack of product standardization. There exist, for example, a large number of competing brands of various colored pills, which consumers may find confusing. This problem is especially relevant to the CSM project--changes in A.I.D.'s source of supply may result in a new, different colored pill suddenly being distributed. Moreover, changes in the composition of the pill may cause side effects not previously experienced and lead to customer dissatisfaction.

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[10]Katre Abu, an anthropologist doing research in northern Ghana, believes that written materials will be useful for the illiterate because almost everyone has a literate friend or relative. This is very encouraging, but users may not feel free to go to literate friends on a sensitive subject like contraception.

Fortunately, the project has created a strong identity. The logo for the project is used prominently in all package designs and advertising. The continued use of these elements should help to reassure consumers and assist in marketing replacement or new products.

Recommendations:

- o With regard to the use instructions for the oral contraceptives, appropriate illustrations should be developed and the instructions should be pretested among illiterate women.

- o Despite the fact that Panther is well positioned in the marketplace, a test should be made of a three- or four-pack, boxed product, for the following reasons:

  - Anecdotal information suggests that consumers may prefer a boxed product. In addition, a pilot project in Nigeria indicated a directional preference of 2 to 1 for a boxed product versus the identical product unboxed. A sales test in a limited number of stores should be sufficient to identify consumer preferences.

  - Packaging would facilitate the enclosure of use instructions. This may become more important as consumers begin to want more information about preventing AIDS.

  - Approval from the PIB for a boxed condom may help to justify packaging costs for Kamal (see section III.8 for details).

- o The project has already considered smaller (four- or eight-pack), more attractive boxing for Kamal. New packaging should be introduced for Kamal to accomplish the following:

  - Establish a price-per-purchase advantage over Neo-Sampoon.

  - Deliver product benefit and use information. It is thought, for example, that customers perceive a product advantage for Kamal in that the tablet produces a less warm sensation during use than Neo-Sampoon. Also, each Kamal tablet is individually wrapped, which ensures product efficacy.

III.7 Distribution

The choice of DANAFCO as the product distributor was made for sound business reasons:

- The firm successfully distributes a line of pharmaceutical products nationwide and does not deal in any products that compete with the CSM products.

- The company successfully markets some of the most popular and widely available consumer products in Ghana, including the Paracetamol analgesic.

- DANAFCO already had in place a network of five branch depots providing good coverage to the southern portion of the country. Distribution to the northern regions was accomplished through established relationships with wholesalers who customarily collect goods from one of the DANAFCO depots.

Part of the agreed plan for DANAFCO's participation in the CSM program includes the phased expansion of direct distribution as follows:

Year 1--Establish depots or authorized dealers in all 10 regional capitals and the 22 next largest towns.

Year 2 and onward--Complete direct distribution to the 157 towns with a population of 5,000 or more.

The expansion of DANAFCO's distribution system was necessary to coordinate and reinforce the project's retail staff training program. In a significant concession, the government agreed to permit pharmacists and chemists to dispense oral contraceptives if they were trained in counseling customers and identifying medical contraindications. A comprehensive training schedule was planned with PharmaHealth, a subcontractor to DANAFCO.

It should be noted that in most instances the new authorized dealers appointed by DANAFCO are the major reputable pharmacies or chemist outlets in the area. To enable DANAFCO to carry out this much-expanded distribution task, five transport vehicles were made available by AID/MOH to supplement the DANAFCO fleet, albeit the delivery of the vehicles was later than scheduled.

The expansion of direct distribution to the 10 regional capitals has been successfully completed and further expansion to the 22 larger towns is proceeding according to schedule. The

plan for expansion to the 157 additional towns has yet to be developed. At this stage of the program, and with the considerable experience it has already gained, DANAFCO should reevaluate its plan for expanding to the 157 additional towns. In particular, it should focus on the number and size of transport vehicles needed to service those locations directly.

The training schedule for retailers is progressing in a professional manner, but it is not always coordinated with the expansion of direct distribution. As a result, there can be a time lag between the provision of training and product availability.

Finally, DANAFCO has been constrained by the fact that it can use the five vehicles donated to the project only to transport CSM products rather than its full line of products. This is a serious error for the following reasons:

- The appointment of an established distributor with a successful line of products presupposes economies in distribution and overhead costs and sales leverage with accounts.

- It should be apparent that upon completion of the logistic requirements of further direct distribution, full use of all vehicles will be required to approach the level of direct distribution originally planned.

This is not an easy problem to resolve, however. Under the bilateral agreement, the vehicles were granted to the government, which permits the private sector program to use public sector vehicles. To overcome this constraint, USAID has been exploring the possibility of DANAFCO's purchasing of the vehicles at the conclusion of the bilateral project.

Recommendations:

- The training effort should follow distribution to local dealers and not the other way around. The impact of the training program should be reinforced by immediate product availability through the local authorized dealer appointed by DANAFCO.

- All authorities within the CSM project should agree to remove immediately the constraint on the use of AID/MOH vehicles so that their use can become more cost effective.

III.8 Pricing

The prices of all CSM products, as noted earlier, are subject to approval by the PIB. The format for price calculations is clear and fair. It provides reimbursement to DANAFCO for direct costs (raw and packing materials and direct labor) and allowances for delivery, selling expenses, and overhead. The calculation also provides for a "return to project fund."

Although appropriate documentation of packaging costs was presumably supplied, the PIB disputed the claim for packaging costs for the Kamal foaming tablets and arbitrarily shifted a large portion of that direct expense to the "return to project fund" category, which resulted in an unsatisfactory margin position for DANAFCO.

For reasons discussed in section III.6, packaging modifications have been recommended for Kamal and Panther condoms. It is hoped that the additional submissions to the PIB regarding Kamal and Panther pricing will assist the project in convincing the PIB of the validity of the packaging expenses for Kamal.

Although the PIB approves the suggested retail prices for contraceptives, the actual retail prices are set by the marketplace (see Table III.1). It would appear that the CSM products set, more or less, a commodity-type pricing level for contraceptive products diverted from the private sector. Excessive middlemen and retail profits are presumably due to inconsistency in supply.

Contraceptive products diverted from both the MOH and the PPAG are found at retail outlets throughout the country. Although it can be argued that increased sales, no matter what their origin, increase contraceptive use, the presence of these products makes it difficult for DANAFCO to develop the broad base of business planned by the project. The MOH has agreed to charge the same retail prices for PPAG-distributed contraceptives as approved by the PIB for CSM products. This should help eliminate the financial incentive for diverting products from the public sector.

III.9 Advertising and Promotion

There exists in Ghana a full range of communications media:

- Television--approximately 250,000 sets; primarily a medium for reaching consumers in the A, B, and upper C income classes.

- Radio--offers the highest penetration across socioeconomic and urban/rural boundaries.

- Outdoor--high-quality, well-serviced reminder medium for product identification.

- Press--good range of widely circulated newspapers and special interest periodicals.

Advertising for contraceptives must be approved by Ghana's Pharmacy Board before airing. In addition, the project has created an advisory Advertising Review board comprising representatives from the Pharmacy Board, the Ministry of Information, the National Family Planning Program, DANAFCO, Lintas, and the MOH. The advisory board may make non-binding recommendations to the Pharmacy Board regarding the appropriateness of advertising content.

The advertising plan for the project is a well-considered strategy consisting of three phases. The plan is geared to avoiding controversy and adverse public opinion.

- Phase I: Generic advertising of family planning benefits from a health standpoint.

- Phase II: Generic advertising of family planning products, also from a health standpoint.

- Phase III: Announcement of CSM-brand product availability.

Despite this well-formulated plan, all contraceptive advertising, as noted above, was banned in Ghana shortly after the advertising campaign was launched because of government objections. The ban has since been ostensibly lifted and advertising will resume soon. Television advertising will not be used in the new campaign, however, because this medium is the most likely to provoke controversy. The campaign will focus instead on radio, outdoor, and press advertisements. The decision to proceed cautiously in advertising CSM products, especially on television, was well taken.

III.10 Research and Evaluation

III.10.1 Research Capacity

A Research and Evaluation unit has been set up within DANAFCO and is headed by Y. J. Owusu, who was formerly at the

Table III.1

PRICING STRUCTURE FOR CSM PRODUCTS
(in cedi)

Product	Ex-Warehouse	Wholesaler	Margin	Retail Price	Margin
Condoms:					
Panther					
Approved	210/100 units			250	16%
Observed	210/100 units	250	15%	500	50%
Sultan (public sector diverted)	100-150/100 units	200-250	25-50%	500	50-60%
Foaming Tablets:					
Kamal					
Approved	1,000/50 boxes			1,250	20%
Observed	1,000/50 boxes	1,200	17%	1,500	20%
Neo-Sampoon (Public Sector diverted)	---NOT KNOWN---			40-60/Tube	
Oral Contraceptives:					
Norminest					
Approved	16.67/cycle			20	16.7%
Observed	16.67/cycle	20	16.7%	30	33.3%
Feminol	6-10/cycle	20	50-70%	40-50	50-60%

Note: The PIB approval format does not recognize the wholesale trade and therefore, the wholesale selling price and wholesaler margin are not specified.

Ghanaian Central Bureau of Statistics. According to the USAID Population Office in Accra, consideration was given to working with existing research entities in Ghana, but no suitable organization could be found. Although the purpose of the project is not to build research skills in Ghana, it is unfortunate that no suitable research facility was available locally.

Originally, Mr. Owusu was to contract out much of the work and provide technical assistance and coordination. But because of difficulties in finding contractors, he has had to serve as research director. This change might have worked out reasonably well had he had sufficient staff. There is disagreement between Mr. Owusu and AID/SOMARC over the adequacy of the research budget. This problem must be resolved if the Research and Evaluation unit is to manage effectively the large number of studies it plans to undertake.

A related concern is the isolation of the research director. The staff of DANAFCO does not see the relevance of the research program to its task of expanding product distribution. Consequently, there is little communication between the research director and other DANAFCO staff. Although some of the research program is indeed not pertinent to DANAFCO's activities, much of it is, and the research director must find a way to make clear to DANAFCO the importance of the research program.[11]

Very little data analysis has been carried out by the Research and Evaluation unit. Because of difficulties with a data tape, for example, only a subset of questions on the Pre-Training Retail Outlet Survey was analyzed. Only frequency distributions from the SES intercept survey, discussed in section III.5.3, were done by the unit (the data analysis is to be done in Washington, D.C).

III.10.2 Research Strategy

The initial research priorities were (1) to obtain feedback on retailer training and trade promotions and (2) to establish systems for tracking the flow of products from the central warehouse and depots to retailers, and from retailers to

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[11]SOMARC has initiated discussions with the Ghana Institute of Management and Personnel Administration regarding moving the GSMP research unit there at the expiration of DANAFCO's research contract.

consumers.[12] Consumer research was to be limited to qualitative studies.

Because of the prohibitive costs of constructing an adequate sampling frame and the low contraceptive use in Ghana, which would have meant surveying large numbers of women to find sufficient numbers of users to obtain information on their characteristics, the research strategy has been to build on initial distribution and trade studies using the project's channels of distribution as the sampling frame for common intercept and communications-tracking research.

Aside from strictly market research, the research strategy is designed to obtain information on (1) the impact of the project on contraceptive use and use of specific methods and brands, (2) the impact of the training program on retailer knowledge of contraceptive technology and use of that information, and (3) whether there are any adverse health effects from distributing contraceptives through the commercial sector.

A tracking study will be carried out to assess the impact of the communications strategy and the impact of the program on contraceptive prevalence. Plans call for interviewing 1,600 people (800 men and 800 women, aged 15-50) in three locations.[13] The tracking study will be a joint project. Lintas is to carry out the field work under contract to DANAFCO and with the supervision of Mr. Owusu. According to SOMARC, the tracking study was added to the GSMP research agenda largely at the request of AID/Washington in order to obtain information on contraceptive prevalence. Unless contraceptive use increases by a very significant amount, however, the sample sizes involved will not be large enough to detect changes in contraceptive use at any reasonable level of confidence. Although SOMARC briefing materials indicate the survey instrument has been pretested, according to the research director the questionnaire is in draft form and will be finalized during a scheduled visit of a SOMARC consultant.

A retailer survey to determine the seller's knowledge of contraception and interaction with customers is also planned. Because it is often not the retailer but a clerk or other family member who serves the customer, the person who actually provides the service no matter what his or her status, will be interviewed. In the initial round of training being conducted by

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[12] R. Porter, GSMP Research: An Overview, TFG/SOMARC, September 25, 1985.

[13] Ibid.; conversation with Y. J. Owusu.

PharmaHealth, however, it is the manager who is being targeted. Information from the retailer survey will likely show the need for training clerks who are not proprietors. This survey will have to be delayed, however, to get the tracking study under way.

Finally, a panel study to assess the health risks of over-the-counter distribution of oral contraceptives is planned. This is the study required by the MOH as a precondition to approving the demonstration program for oral contraceptives (section III.7). The results will have implications for the expanded delivery of oral contraceptives. Although this study is scheduled to begin in January 1988, it may have to be delayed until Norminest is distributed at outlets similar to the PPAG or MOH clinics, probably maternity units, which has not yet occurred.

Several research projects have been completed or are ongoing, including retail audits, which provide information on the market share of CSM products. The socioeconomic status intercept study of customers at CSM retail outlets, discussed in section III.5, was also an addition to the research agenda and necessitated postponing other studies.

The studies planned by the unit often involve the use of long, complex questionnaires, and one study will use repeat measurements. Although plans call for analyzing the bulk of the data in Ghana (with the exception of the panel study), a plan must be developed to get the data analyzed and the report written in a timely manner.

The Research and Evaluation unit has prepared a list of questions to be considered for inclusion in the Westinghouse's Demographic and Health Survey (DHS) to be fielded in 1988. Because Norminest is probably the oral contraceptive most likely to be associated with breakthrough bleeding, it would be useful to obtain data from the survey on experiences with this problem, as well as other side effects and fears or concerns about contraceptives. Westinghouse has agreed to include the research unit's questions in the survey questionnaire.

Recommendations:

- A plan should be drawn up to enable DANAFCO's research unit to carry out some data analysis in a timely manner.

- The research unit should work with SOMARC and USAID/Accra to sort out budgetary problems so that the research director can begin to hire staff and carry out the research agenda.

- The research agenda should be carefully reviewed and emphasis placed on conducting fewer studies and establishing realistic timetables for their completion.

- Priority should be given to designing less complex studies to facilitate in-country analysis. This will require the cooperation of all concerned because the more difficult studies are being carried out at the request of other parties, e.g., the panel study (MOH) and the tracking study (AID/Washington).

III.11 Medical Aspects

III.11.1 Quality of Retailer Training

The content and presentation of materials in the training course for retailers appear to be appropriate, adequate, and effective. Training techniques include pre- and post-testing, role playing, problem solving, workshops, and didactic teaching.

Throughout the course stress is placed on the importance of screening and of referral to a physician or family planning clinic for women with contraindications to the requested contraceptive product. In the case of oral contraceptives, age (<19 or >35 years), pregnancy, breastfeeding, hypertension or cardiac disease, diabetes, cancer, and smoking history are all identified as reasons for referral. Participants are drilled on effective screening methods--how to ask the questions--and practice in role-playing exercises.

This training program is the first to address the information needs of the chemists/vendors and is the first to foster among them attitudes of professional identity and responsibility. They are told that they are a part of the health care delivery system and, thus, are entrusted with a social responsibility. Discussions with participants at Nkawkaw and training graduates in retail outlets suggest that this responsibility is being taken very seriously and is an important part of the training experience.

III.11.2 Quality of Consumer Information

The CSM products, as noted, are distributed without individual package inserts. Condoms are distributed in strips and written user instructions are not provided. Foaming tablets are being packaged in boxes that have brief user instructions (in English). Information about contraindications and potential

complications is not included, however. Oral contraceptives are sold in card form, and product information sheets (four per 100 cards) are included. The instructions are written in English, which many retailers and customers cannot read.

Verbal product information, careful screening of potential product users, and counseling were available in only 2 of the 19 retail outlets visited. Both were larger shops, and both vendors had participated in the CSM training program. These vendors were referring new oral contraceptive users, breast-feeding mothers, and individuals with histories of hypertension, jaundice, headaches, nervous disorders, varicose veins, and a wide range of other related contraindications to the PPAG clinics or to private clinics for evaluation. In no case was the referral to one of the government's public family planning clinics, and this was because those services were known to be limited. Additionally, these two retailers were prepared to offer appropriate information to Norminest users who might have missed a pill or who might have developed minor complications, such as nausea, breast engorgement, or breakthrough bleeding.

The obvious problem is that adequate product information was available in only 2 of 19 (10.5 percent) outlets visited. The outlets were in urban and periurban areas, and there is every reason to suspect that product information would be even less available in rural areas.

III.11.3 Correctness of Contraceptive Use and Customer Satisfaction

The time constraints of this CSM assessment made it difficult to collect even anecdotal information regarding contraceptive use. Ghanaians as a group, however, appear to be reluctant to discuss personal matters with strangers. Further, it can be considered insulting to discuss contraception with a Ghanaian woman in public, as a woman having sex in union is thought to have no need for contraception and such a discussion would imply that she is a "loose woman." Even women who want to discuss contraception would be reluctant to do so in public and express concern that they might be seen by other women and slandered in their communities.

The USAID Mission reports a somewhat different perspective. A recent seminar with Ghanaian market women showed that these women were not reluctant to discuss contraception.

Conversations with contacts in Ghana and with vendors suggested that even among contraceptive users, there is very little understanding of the biologic principles of reproduction

and, consequently, of either the way contraceptive products act or their correct use. It was repeatedly suggested that misconceptions about oral contraceptives are widespread and an obstacle to acceptance. Specific concerns were said to be that the contraceptive effects are permanent, that the pill increases bleeding, and that the pill shortens the menses and thus leads to a retention of evil or damaging body substances.

III.11.4 Conclusions and Recommendation

The CSM project is producing a cadre of well-trained vendors who should be able to transfer information about contraception and contraceptive products reliably and appropriately to customers. The numbers of these trained vendors is small, however, and the pace of training is slow. The program would benefit from an intensification of these efforts, and the program managers have taken some steps to broaden the spectrum of vendors to be trained.

Overall, however, information about family planning and family planning products is not readily available. In particular, the potential for distributing oral contraceptives to those with contraindications is significant. This potential is not just a result of the CSM program, because numerous other products are available, but it may be interpreted by local authorities as having resulted from the CSM effort.

Recommendation:

- The training program should continue to be expanded to include a broad spectrum of the staff of pharmacies and other retail outlets so that the numbers of vendors trained can be increased.

III.12 Project Costs

It is not possible to isolate the total direct and indirect costs of the CSM program from the costs of the overall Contraceptive Supplies project. Some data are available, however.

The MFEP has provided DANAFCO with some $300,000 in cedis, from PL-480 counterpart funds, and USAID has made available eight vehicles valued at about $175,000. In addition, as of November 30, 1988, the value of A.I.D. shipments of CSM

products was $785,309.[14] Product sales have totaled 10,540,000 cedis. TFG/SOMARC has kept very good records of its centrally funded expenditures on behalf of the CSM project in Ghana. Its in-country expenditures were $127,772, and expenditures in the United States were $280,457, for a total of $408,229 from February 1986 to March 1987.

Little is known about the indirect costs of buying the contraceptives and packing and shipping them. The real value to the CSM program of the vehicles on loan from A.I.D., which as noted can only be used to transport CSM products, is also unclear.

Project costs for 1986 (see Table III.2) illustrate clearly that the volume of sales will have to rise significantly before promotion, training, and distribution costs will be covered. DANAFCO officials are unable to predict when the project will be able to sustain operations without outside assistance (apart from provision of free contraceptives). However, they anticipate that, given no major setbacks, the break-even point could be reached in about two years. Given present conditions, they cannot foresee a time when increased sales would enable them to cover the cost of contraceptive products as well.

TFG/SOMARC has prepared a cost-effectiveness analysis based on project data through March 1987. If only in-country expenditures are considered, costs per CYP are $6.33. If both U.S. and in-country expenditures are considered, CYP costs rise to $20.23 (see Table III.3).

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[14]The quantities shipped, by product, are shown below.

Product	Quantity		
	1985	1986	1987
Condoms	4,002,000	2,004,000	0
Oral Contraceptives	0	500,400	799,200
Foam Tablets	0	3,009,600	0

Source: A.I.D., Science and Technology Division, Office of Population, Washington, D.C., November 1987.

Table III.2

PROJECT COSTS, 1986
(in cedis)

	Quarter 1 (Apr-Jun)	Quarter 2 (Jul-Sep)	Quarter 3 (Oct-Dec)
Promotion	2,065,928	2,070,753	758,984
Training	479,621	1,187,263	1,622,668
Distribution	648,098	897,654	810,256
Total	3,193,647	4,155,670	3,191,908
Amount received from sales	764,610	1,059,030	955,920
Return to project fund (15% of sales revenue)	116,512	161,376	145,664
Interest of MFEP funds	367,858	553,175	423,666

Note: These costs are paid out of MFEP funds, not SOMARC funds.
Source: The Futures Group/SOMARC, Briefing Paper: The Ghana Social Marketing Program, September 1987.

Recommendation:

- Given the difficulties in determining the full direct and indirect costs of CSM programs, A.I.D. should select one or two CSM countries for an in-depth study of direct and indirect costs as a basis for developing a methodology for determining costs that could be used in other countries as well.

III.13 Conclusion

Overall, the CSM project in Ghana is in very good shape. Although there have been some setbacks--for example, the ban on advertising contraceptives, the constraints placed on use of the donated vehicles, and the low price set for the Kamal foaming tablet--most problems have been resolved. The program is fully operational.

Table III.3

COST-EFFECTIVENESS ANALYSIS

Condoms		
Number sold (4/86-3/87)	1,832,000	
CYPs = 1,832,000/100	18,320	
Vaginal foam tablets		
Number sold (1/87-3/87)	185,952	
CYPs = 185,952/100	1,860	
Total CYPs (4/86-3/87)	20,180	
SOMARC expenditures (2/86-3/87)		
US and in-country	$408,229	
In-country only	$127,772	
SOMARC expenditures per CYP (2/86-3/87)		
Based on in-country SOMARC expenditures only	$127,772 / 20,180	= $6.33
Based on U.S. and in-country SOMARC expenditures	$408,229 / 20,180	= $20.23

Source: The Futures Group/SOMARC, Briefing Paper: Ghana Social Marketing Program, September 1987.

Although the training program for pharmacists and chemist shop owners is going very well--some 1,200 have been trained--much more needs to be done. Expansion and acceleration of the training program are needed so more retailers can be reached. In addition, although the owners have been trained, the salespersons waiting on customers may not have been informed about the effects of the various products and what to do about contraindications.

Diversion of contraceptives provided to the public sector to the open market is a concern, especially because it was reported that a number of clinics had no contraceptives. Donors supplying the contraceptives (UNFPA, USAID, PVOs, and religious groups) should work with the MOH/PPAG to monitor their distribution networks and to reduce the incentive to divert

products by charging the same prices in their clinics as are charged in the pharmacies and chemist shops.

DANAFCO and its subcontractors are capable of carrying out the CSM program. The research unit will require some bolstering, however, if it is to complete its research assignments in a timely fashion. Significant research on the characteristics of the market has already been carried out or is under way.

Finally, USAID should consider ways to develop within the government the managerial capability necessary to assume some of the responsibility for coordinating the contraceptive supply/distribution/training program.

ANNEX A

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ANNEX B

DOCUMENTS CONSULTED

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IV. NIGERIA (Private Sector Family Planning Project)

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In the CSM project for Nigeria, A.I.D.-donated contraceptive products are channeled through Family Planning International Assistance (FPIA), the project manager, to Sterling Products (Nigeria) Limited for distribution throughout its system of (largely urban) pharmaceutical outlets. Income generated from the sale of contraceptives is used to cover distribution costs, marketing, research, and training activities designed to increase the distribution of contraceptives. The project is currently looking into ways to expand the number, location, and kinds of outlets through which to sell contraceptives.

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GLOSSARY

FHI	Family Health Initiatives
FPIA	Family Planning International Assistance
GON	Government of Nigeria
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
PSI	Population Services International

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EXECUTIVE SUMMARY

The A.I.D.-funded Private Sector Family Planning Project (Nigeria-18) is managed by Family Planning International Assistance (FPIA), a nonprofit, family planning service delivery organization. The project, which has distributed 10 million condoms, 1 million vaginal foaming tablets, and 800,000 cycles of oral contraceptives, started in the summer of 1985 and began its sales program in November 1985.

CONTEXT

The population of Nigeria is increasing at an annual rate of 3.3 percent (natural increase). A World Fertility Survey (WFS) conducted in 1981-82 estimated that only about one-third of the population has any knowledge of family planning. About 6 percent of women in union aged 15 to 49 were using contraception at the time of the survey, but only 2.6 percent were using modern methods. The main obstacles to use of modern contraception appeared to be lack of widespread knowledge about and availability of family planning services.

The Nigerian government is highly supportive of family planning in general and sees an important role for the private sector in its efforts to reduce the birthrate. It is also acutely aware of the sensitivity among religious groups and decision makers about advertising contraceptives. Sterling Products (Nigeria) Limited (SPNL) sponsored the first family planning promotion on television in Nigeria. Also, in an effort to combat the AIDS disease, TV ads have been aired to alert the population to the problem and to the use of condoms to lower the risk. Over the coming months this may desensitize the audience and make way for stronger CSM messages. The government will proceed cautiously in this area, however.

PRINCIPAL CONCLUSIONS AND RECOMMENDATIONS

Organization and Management

The project's objective is to provide low-cost delivery of contraceptives using large-scale distributors, principally Sterling Products and private health and service delivery entities. Income generated from the sale of A.I.D.-supplied condoms, vaginal foaming tablets, oral contraceptives, and IUDs is used to cover distribution costs and marketing, research, and training activities designed to increase distribution of contraceptives.

The project got off to a very promising start in terms of contraceptives purchased by wholesalers and retailers the first year, when the Nigerian economy was strong, i.e., a seller's market. Sterling Products did an excellent job of distributing the contraceptive products to its 3,522 retail outlets throughout Nigeria. Sales amounted to almost 1.3 million naira in the first year (November 1985 - October 1986).[15]

In 1986, however, a severe economic downturn led the Nigerian government to sign a structural adjustment agreement with the International Monetary Fund to institute a number of economic reform measures that raised the cost of foreign exchange, increased domestic prices, and generally caused belt tightening among consumers. This led to a change from a seller's to a buyer's market. In this context, contraceptive sales (reorders/new orders) fell dramatically. Sales for 1986-87 are not expected to exceed N 500,000.

Beginning in spring 1987, Sterling undertook a series of measures (assisted by FPIA) to develop and tailor marketing and training programs to counteract the decline in demand and save the contraceptive product line.

Looking to the near future, as of fall 1988, the FPIA-Sterling project will be fully integrated into a new, US-funded ($67 million) integrated family planning project, entitled "Family Health Initiatives II" (FHI-II), which has four major components: private sector service delivery; public sector service delivery; information, education, and communication; and policy implementation.

Marketing Objectives and Strategies

Beyond listing the numbers of contraceptive products to be sold in a given period, the original project strategies involved only (1) limited advertising (including TV ads) to advise consumers that the products were now available and (2) employment of "nurse-detailers" to reach large businesses and government agencies. These strategies reflected the lack of concern about the competitive market that prevailed when the project was initiated. Since then, Sterling and FPIA have been

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[15]The exact dollar equivalent of 1.3 millon naira is difficult to calculate because over the past two years the value of the naira fell from N 0.85 = $1.00 to N 4.5 = $1.00, or by about 81 percent. The rate in the first year was $1.00 = 1.235, N = 1.07.

trying to adjust to the new market conditions.

Recommendations:

To meet the sales objectives of the program, project managers should undertake the following:

- o Identify the total market size and brand shares for each product category (condoms, vaginal foaming tablets, and pills).
- o Identify target audiences and develop consumer attitude and awareness profiles for each product category.
- o Fine-tune the marketing strategy for each product category, including
  - -- product
  - -- packaging
  - -- pricing (including trade margins and consumer shelf pricing)
  - -- distribution coverage
  - -- media plan
  - -- advertising messages
  - -- promotion plan.

Target Groups

FPIA is a family planning organization whose mandate is to provide family planning to all groups regardless of income. FPIA's long-term objective is to reach the entire urban market. The short-term target group, however, is middle and upper income consumers (2.5 million of Nigeria's total population of 95.2 million), who are both more likely to use contraceptives and to be customers at the retail outlets supplied by Sterling. The income generated from sales to these groups was to be used to expand the distribution network to outlets frequented by low-income consumers. No information is available regarding the actual purchasers of CSM products.

Recommendation:

- o Data should be collected and analyzed to determine the characteristics of the purchasers of CSM products.

Products

The first contraceptive products to be introduced were condoms (three brands--one the first year and two in the second year), followed by oral contraceptives, and finally, a vaginal foaming tablet. The products are sold in unboxed strips. Use instructions are not included, and most products do not include any brand identifiers.

Recommendation:

- Much more could be done with the CSM products through careful packaging. This is particularly important for oral contraceptives, which should be sold with use instructions that can be understood by both the literate and illiterate population.

Distribution

Sterling has a well-organized distribution system and successfully markets some of the most popular and widely available consumer products in Nigeria. To achieve maximum distribution, however, more attention needs to be directed toward educating CSM sales staff and retailers. Advertising is also necessary to stimulate a consumer "pull" effect, which is important in securing wide distribution in Nigeria.

Recommendation:

- The marketing/distribution plan should include the following components:

  -- Continued education in CSM products and sales techniques for Sterling's field and warehouse sales staff.

  -- Contacts with chemist shops and provision of product information and samples.

  -- An advertising and media plan that effectively addresses the target audience.

Price

The apparent price objective at the start of the program was to set retail prices as low as possible to maximize the consumer's access to the products. There is ample room, however, to make some price adjustments in order to cover the

cost of additional packaging, which would enhance the products' competitiveness.

Advertising and Promotion

Nigeria has a wide range of media services available: network and local television, many radio stations broadcasting in all major languages, many newspapers, a well-serviced national billboard network, and mobile cinema services. Radio is common in both urban and rural areas.

Currently, the project is running a re-introductory "blitz" campaign through spot advertising on television; the ads focus on the generic benefits of child spacing. Panther condoms and Petal foaming tablets are mentioned at the end of the spot ad. The ad does not refer to the overall CSM project nor identify the "sponsor" of the project. Only a sketchy plan exists for providing sustained advertising support following the campaign. Advertising plans depend largely on funds generated through product sales.

The promotion and product-sampling plans for increasing direct retail sales are not well formulated. Most activities in this regard seem to be aimed at opening new channels of distribution, such as in-house sales to factory workers. There is no overall plan, for example, for detailing to physicians who prescribe oral contraceptives.

Recommendations:

- Identify target audiences for each CSM product and for an umbrella family planning campaign. This will assist in the development of an advertising strategy for each element of the project.

- Create an umbrella identification for the project, such as a seal or logo. This will help to

  -- reassure the consumer of product quality in relation to the low price,

  -- legitimize oral contraceptives, which cannot be advertised by brand but which may feature a logo, and

  -- provide continuity of product image in the event that the source of A.I.D. supplies changes.

- Develop a product information and CSM program promotion aimed at physicians who prescribe oral contraceptives. Strictly speaking, a prescription is required for oral contraceptives, and it is believed that many consumers remain loyal to the brand first prescribed. The user base created by medical prescriptions is a necessary element in the success of oral contraceptives.

Research and Evaluation

Although research was not originally an important part of this project, the change in market conditions has made market-related research vital. Plans are under way to conduct market research using one or more Nigerian research organizations.

The follow-on FHI-II project will have a major research component, including baseline and follow-up surveys. These surveys will include questions to help assess the impact of the CSM project, including source of supply, price paid, and method and brand preferences. Given this situation, the outlook for adequate research and evaluation is promising. FPIA also plans to conduct research directly related to its private sector activities, which should complement the efforts noted above.

Medical Aspects

The CSM programs in Nigeria are producing a cadre of well-trained vendors and pharmacists who are providing adequate information about contraception and contraceptive products to customers. The number of these trained vendors and pharmacists is small, however, and those trained are located only in urban centers.

The potential for distributing oral contraceptives to those with contraindications is significant, and such distribution may occur as a result of the increased sales under CSM programs. This would undoubtedly have an adverse effect on CSM activities. This has been a concern of Sterling and FPIA for some time.

Recommendation:

- CSM program managers should aggressively pursue collaborative interaction and cooperation with the established medical and pharmaceutical communities to foster safe distribution practices.

Project Costs

It was not possible to determine overall project costs in the time available. Although the estimated cost of the contraceptives is listed in the project budget, actual product costs and administrative costs for purchasing, transport, insurance, handling, and the like are not easily available. The cost of centrally funded FPIA supervisory and administrative activities carried out by FPIA's regional office in Nairobi for this project were also not available. In addition, in 1987 there has been a significant increase in technical assistance, research, training, and advertising because of the change in market conditions.

Regarding sustainability, there are no estimates as to when this might be achieved. However, informal discussions indicate that if the drop in sales can be reversed, the CSM project could become self-sufficient (with free, A.I.D.-supplied contraceptives) over the next two or three years. Should there be an upswing in the overall Nigerian economy, full self-sufficiency (including commodities) might be achieved over time (5 years or so) using less expensive contraceptives, perhaps procured from Taiwan, South Korea, or Brazil.

Recommendation:

- A.I.D. should develop a system for estimating the total cost of private and public sector contraceptive distribution activities so that cost effectiveness, continuing costs, and sustainability can be assessed. This might involve in-depth studies in one or two countries that are receptive to the idea to develop the appropriate methodology.

IV. NIGERIA

IV.1 Background

IV.1.1 Demographic and Economic Context

Nigeria is the most populous country in Africa (about 95.2 million) and accounts for one-fourth of sub-Saharan Africa's people. Less than 25 percent of Nigerians live in urban areas, but more than 24 cities have populations of at least 100,000. The dominant ethnic groups are the Hausa-Fulani (in the north), the Yoruba (in the southwest), and the Ibo (in the east).

The population of Nigeria has been increasing rapidly. In fact, if the population continues to grow at the current rate, in about 50 years Nigeria's population will equal that of the current population of all of sub-Saharan Africa (454 million). The annual rate of natural increase is 3.3 percent, and the total fertility rate is 6.5. Infant mortality is also high: 105 deaths per 1,000 live births.[1]

The per capita income in Nigeria is U.S. $680. Nigeria's Government Household Survey (1983-84) reported that 61 percent of rural, and 31 percent of urban, households earned less than $300 per year. Recently, Nigeria has experienced a rapid economic reversal. Annual oil revenues were $25 billion in 1982 and now are only $5 billion. Unemployment is high. In October 1986, a series of restrictive economic measures were taken in line with a structural adustment agreement with the International Monetary Fund. Foreign exchange restrictions were imposed, and prices rose across the board. Nigeria's currency (naira) has been devalued by about 81 percent, and the devaluation has sharply increased the price of imported goods and goods fabricated with imported materials.[2] Per capita income is falling, and sales of foodstuffs and other items are down. School enrollments and use of medical facilities have also declined because Nigerians can no longer afford to pay for such services.

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[1]Demographic data from A.I.D., Subproject Paper, Family Health Initiative II (FHI-II) Nigeria (697-0462.20), Washington, D.C., July 1987 (based on World Bank projections).

[2]Over the past two years the value of the naira fell from N 0.85 = $1.00 to N 4.5 = $1.00, or by about 81 percent.

IV.1.2 Family Planning Context

As a consequence of the country's rapid population growth, the Government of Nigeria (GON) has rapidly become supportive of a strong national family planning program, not just for health reasons, but also because of the country's bleak economic and demographic prospects. The government has developed a national population policy and has singled out provision of "easily affordable, safe and culturally acceptable family planning services" as one of its most important strategies. The Fifth National Development Plan (1986-91) identifies family planning as a component of primary health care. The government is supportive of efforts to provide contraceptives through the private sector, but counsels the need for caution because of expected objections to private sector provision of contraceptives.

A World Fertility Survey conducted in 1981-82 found that the level of knowledge of family planning is low--about 33 percent. Among women in union aged 15 to 49, 5.7 percent used contraception but only 2.6 percent were using modern methods.[3] The main obstacles to use of modern contraception appeared to be lack of knowledge about and availability of family planning services.

The CSM program in Nigeria makes available condoms, vaginal foaming tablets, and oral contraceptives. Although oral contraceptives are considered an ethical drug that can be sold only by prescription, in practice they are often purchased without a prescription. Because they are an ethical drug, however, they can be advertised by brand only in trade journals; non-trade journal brand advertising of contraceptives is limited to condoms and vaginal foaming tablets. On the other hand, generic advertising of oral contraceptives is permitted.

The distribution of oral contraceptives by the CSM project is further limited by the requirement that they be provided only to licensed pharmacies.[4] The government, however, has shown its willingness to try new approaches, as evidenced by its support of an innovative program to train market women to be distributors of oral contraceptives. According to the Federal Ministry of Health, the delivery system might be expanded to make

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[3]The WFS data are the best available, but they may not be fully accurate given that statistics in Nigeria are not based on uniform data or data-gathering techniques.

[4]This requirement holds for many, but not all, states in the Nigerian federation.

oral contraceptives available at other outlets if distributors are given appropriate training in how to counsel women about oral contraceptives.

In 1986, family planning ads appeared on television for the first time. There were objections to the ads (e.g., some said that they were too explicit), and so the ads were withdrawn. Ads are now being submitted to statewide networks, which costs less and does not require the approval of Nigeria's Food and Drug Administration, a requirement imposed in the wake of the ad controversy. Concern about AIDS has prompted the government to advertise condoms, and this has eased the environment for advertising social marketing products.

Social marketing of contraceptive products must compete not only with commercial brands but also with products distributed by the public sector and by the Planned Parenthood Federation of Nigeria (PPFN). Although the public sector and PPFN contraceptives expand the availability of contraceptives, they make it more difficult for the CSM distributor to earn a profit and continue marketing contraceptives.

IV.2 CSM Goals and Objectives

The Private Sector Family Planning Project (Nigeria-18) has as its goal the low-cost delivery of contraceptives by private sector organizations as a means of increasing the availability, accessibility, and use of contraceptives. The project also has specific objectives for each funding period.

Within this overall goal, the project agreement with the FPIA (modification 2) for the period November 1, 1986 to February 29, 1988 established the following specific objectives:

- Distribute, through approximately 3,500 retail outlets, 12 million condoms, 6 million foaming tablets, and 1.5 million oral contraceptive cycles in all states of Nigeria. In addition, distribute 10,000 IUD pieces to institutions staffed by trained personnel.

- Train 580 nurses and 30 doctors in family planning counseling and service delivery, and train 580 educators in family planning information, education, and communication (IEC). Provide family planning information to 84,000 people and distribute 113,800 condoms, 106,400 foaming tablets, and 11,300 pill cycles to family planning clients.

- Manage the project in accordance with Sterling

Products' policies and procedures, GON regulations, and FPIA's terms and conditions.

IV.2.1 Progress in Meeting Objectives

According to the FPIA project agreement mentioned above, the project has successfully introduced family planning information and services into the health clinics of private companies in Lagos and chemist shops in 19 states of Nigeria. Nurses, doctors, and educators from 36 companies, private hospitals, and government agencies were trained and supplied with contraceptives. Personnel managers in 24 companies in Lagos attended seminars on the benefits of family planning and the role of family planning in industrial productivity.

Between November 1985 and May 1987, approximately 10 million condoms, 1 million foaming tablets, and almost 800,000 cycles of oral contraceptives were sold. These sales generated approximately N 1,493,213,[5] reached an estimated 254,000 clients, and provided 170,000 couple years of protection (CYPs).[6] Despite this excellent start, contraceptive sales have since dropped dramatically in the wake of the restrictions placed on the economy in the fall of 1986. What for many years had been a seller's market suddenly turned into a buyer's market.

Condom sales since November 1986 have averaged about 200,000 per month, which makes it unlikely that the objective of sales of 12 million condoms will be reached by February 1988. Sales of foaming tablets have fallen off even more severely, to less than 20,000 per month. Sales of oral contraceptives, which had averaged about 65,000 per month in the first year of operation (November 1985 to October 1986), fell to about 4,000 per month in 1987 and are not likely to meet the objective set out above. (See section IV.4 for a fuller discussion of the sales difficulties in 1987 and measures being taken to market these products more effectively.)

Sterling Products and FPIA have been working hard since early 1987 to reverse this downward trend. They initiated a

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[5]The dollar value was roughly $373,300 at N 4 = $1.00 in May 1987. However, pre-September 1986, N 1.493.213 equaled approximately the same in U.S. dollars. Post-September 1986, the naira was devalued by about 77 percent and has continued to decline.

[6]FPIA, Working Document, Sales Summary: Nigeria-18, New York, June 16, 1987.

retraining program for Sterling's sales staff and mounted a vigorous advertising campaign, including scheduled market research, using naira generated from contraceptive sales. FPIA, working closely with USAID/Lagos, has played a major role in motivating and advising Sterling management. The effort to strengthen Sterling's activities in these areas so that project objectives will be met is well advised (see section IV.9 for specific recommendations in this regard).

IV.2.2 Future Project Objectives

The Private Sector Family Planning project will become the private sector component of the new FHI-II subproject for Nigeria starting in spring 1988. The overall Nigerian subproject is designed to "enhance the quality of life of Nigerian citizens. To this end, the ... project is to increase the acceptability and availability of integrated family planning services in both the public and private sectors throughout Nigeria."[7] The overall subproject ($67 million) will seek the rapid expansion of family planning over the next five years through coordinated activities in four key functional areas:

- private sector service delivery,
- public sector service delivery,
- information, education, and communication, and
- policy implementation.

By the end of this project (1992), it is expected that there will be a broad political and social constituency for family planning policies and programs. Family planning information and services are expected to be widely available at reasonable cost through both the private and public sectors. The role of the private sector will be to develop, refine, and implement large-scale, private sector initiatives in family planning that provide services through a variety of commercial, workplace, and community outlets and through private maternity homes and medical facilities. As a result, it is estimated that by 1992 approximately 70 percent of the expected 2.5 million family planning users in Nigeria will be served by the private sector (1.7 million) and 30 percent by the public sector (800,000). That will be a reversal of the current ratio, in

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[7]A.I.D., Subproject Paper, Family Health Initiatives II-Nigeria, Washington, D.C., July 1987. The subproject (698-0452.20) is for the period 1987-92.

which 70 percent of users are served by the public sector and 30 percent by the private sector.

The integration of the private sector service delivery project into the FHI-II subproject is a good step. The overall coordination planned for the project should make the total effort more effective.

IV.3 Management/Organizational Structure

The Nigerian project has been in operation for about two years, and at present it is in the process of adjusting to the economic downturn in Nigeria. The change in the economic environment has had a major impact on the project's management and organizational priorities.

IV.3.1 Findings

Conceptually, the FPIA-managed CSM project in Nigeria was unique. Apart from a small first-year, up-front U.S. investment of $47,000 and the donation of U.S.-supplied contraceptives, the project was structured so that the sale of contraceptive commodities would generate sufficient income to cover the costs of CSM training, research, and marketing (advertising and promotion). The income generated would provide an important element of self-financing.

The project's management structure is shown in Figure IV.1. The implementing agency, Sterling Products, receives 19.7 percent of the sales proceeds to cover overhead and profit. The remaining 80.3 percent is returned to the project for broader contraceptive social marketing activities--not necessarily all with Sterling.

Figure IV.1: CSM PROJECT MANAGEMENT STRUCTURE

```
USAID/Lagos--------FPIA (Nairobi Regional Office)
                    |
Sterling Products (Nigeria) Limited (SPNL)
 (Sales/Distribution/Training Organization)
                    |
-------------------------------------------------------------
|                   |                                       |
LINTAS              19 States-Wholesalers &                 Private Firms
(Advertising)       Retailers (3,522 outlets)               & Govt. Agencies
```

Sterling's organizational structure for the CSM project is shown in Figure IV.2. The chart identifies the key positions concerned with distributing, marketing, and selling contraceptives. A training section reports directly to the project coordinator. The percentages shown indicate the amount of time Sterling employees are to devote to making the contraceptive product line salable.

Sterling has an excellent distribution network that reaches 3,522 retail outlets. Capitalizing on the seller's market that existed during the first year of the project, it persuaded its retailers and wholesalers to purchase substantial quantities of condoms, foaming tablets, and oral contraceptives--in part as a quid pro quo for the privilege of purchasing other Sterling products in short supply.

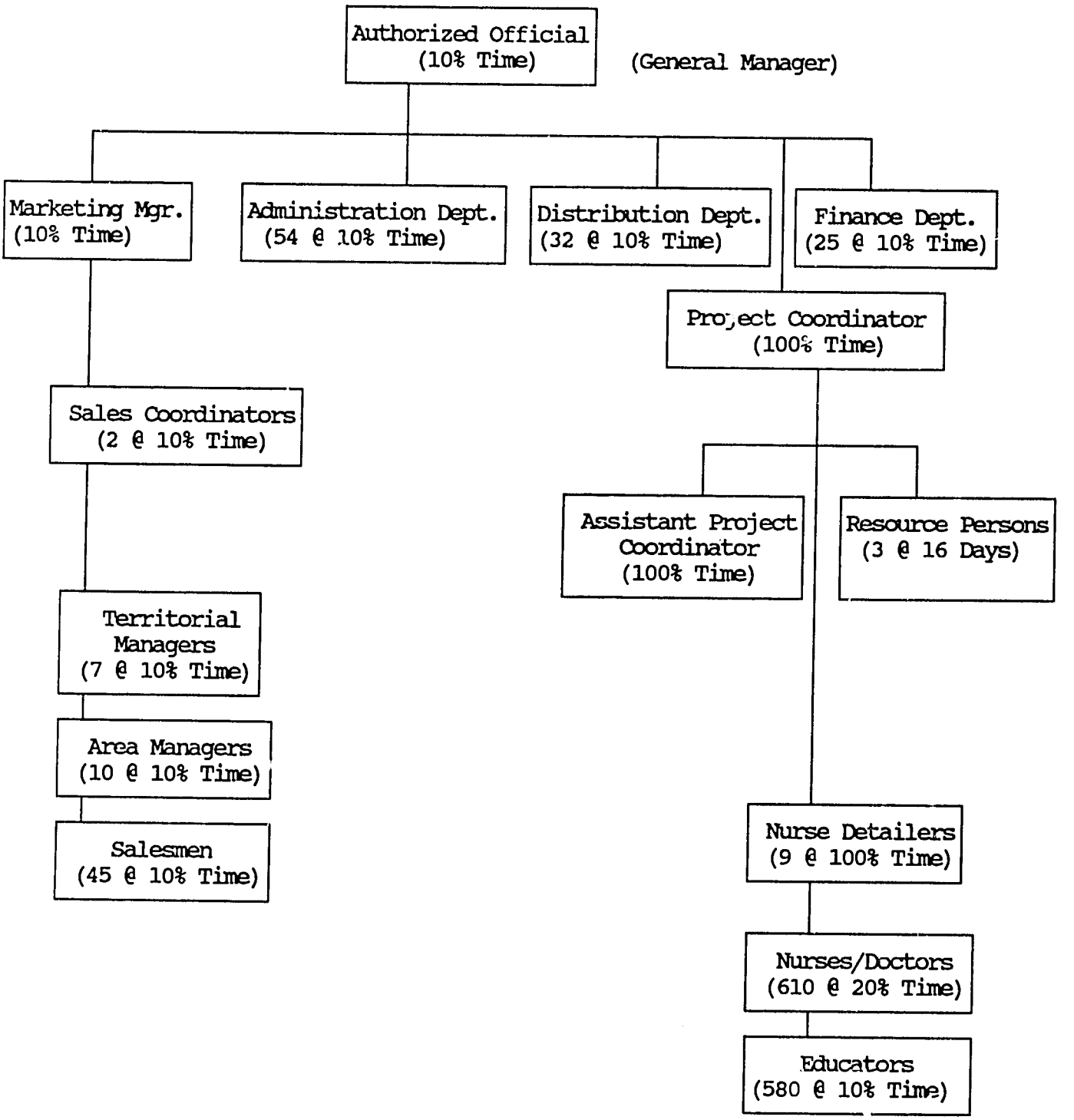
Although Sterling had an effective distribution network, it had not had to compete actively for its share of the market for more than 10 years. In the new economic situation that followed Nigeria's agreement with the IMF, however, Sterling experienced substantial problems. Sales of its old, established product lines began to fall off, not to mention the new contraceptive product line added under the CSM project.

By 1987, the project's income was insufficient to support planned CSM activities. A high proportion of the income that was received had to be reprogrammed for market research and advertising and promotion of the contraceptive product line. Technical assistance from FPIA staff based in Nairobi increased significantly, as well as the use of outside consultants.

Product sales are the clear priority for the project, so the use of the income generated to achieve sales objectives was to be expected. First priority was given to covering the expenses of a major marketing campaign for CSM contraceptives. Advertising was oriented to reaching upper income (A and B income groups) consumers, the main body of contraceptive purchasers and those most likely to patronize the outlets supplied by Sterling, rather than the lower income C and D groups (see discussion of target groups in section IV.5).

Once this project is phased into the FHI-II project in 1988, FPIA will focus essentially on differentiating and separating the training/service delivery work from the sales work. This approach is designed to strengthen the project's distinctive elements. Specifically, in the first year of activity under FHI-II, spending is not expected to equal income to be generated, in part because the costs of nonproduct sales items and training will be paid by FPIA and be budgeted separately from contraceptive product sales. The expected excess funds generated from sales over expenses will be held in a

Figure IV.2: STERLING PRODUCTS, CSM ORGANIZATIONAL STRUCTURE



Source: FPIA, Project Description and Budget, Nigeria-18 (modification 2).

Note: Percentages indicate amount of time company officials will devote to marketing the contraceptive product line.

special account and programmed in the second year, thus enabling planners to prepare their programs based on funds already in the bank, while not impinging on private sector sales-oriented activities.

IV.3.2 Conclusions

The measures taken by FPIA and USAID, working jointly with Sterling, should eventually reverse some of the decline in sales. From a management standpoint, significant managerial help has been supplied through FPIA in 1987. It is too early, however, to predict the ultimate effect of the measures being taken, especially since the belt tightening in the Nigerian economy is still in process.

The transition to the larger FHI-II project will begin in early 1988. The new organizational structure will ensure improved coordination between public and private sector activities. A full-time resident director for private sector activities will be hired by FPIA and stationed in Lagos, along with Nigerian professional support staff.

The proposed organizational arrangements for the Nigerian project were worked out carefully among the government, USAID, and the major contractors. The measures taken will provide the resources necessary to develop a broad-based private sector contraceptive marketing program that is complementary to and supportive of the other activities under the FHI-II project (public sector service delivery, IEC, and policy implementation).

The Nigerian project has made an important contribution to CSM thinking by designing a program that required very little dollar outlay up front because most of the cost of marketing, research, and training activities was covered by income generated from sales. The Nigerian model would appear to have only limited applicability to other African countries, however, because many would not have either the seller's market that existed initially in Nigeria or a pool of already convinced contraceptive buyers large enough to generate the income needed to finance the social marketing program.

As noted above, FPIA, working with the Nigerian government and USAID, has responded very well to the changed economic situation and its implications for the CSM product line. FPIA has worked out a number of organizational changes that delineate more clearly the straight marketing functions and training/services aspects of the program.

Given the project's income-generation needs, the cutback in the 1986-87 budget, and the priorities understandably given to protecting and reinforcing the contraceptive product line, however, it would appear that the "outreach" activities (family planning information, education, and communication) will not grow as planned. Additional help in this area is not planned until the project is integrated into FHI-II.

Recommendation:

- USAID and FPIA should consider what measures might be taken prior to the initiation of the FHI-II project to bolster the social marketing activities designed by FPIA to broaden the private sector resources mobilized for contraceptive delivery (e.g., W.C. Clark [food], taxi, and market women associations) and avoid any loss of the momentum already generated in this area.

IV.4 Marketing Objective and Strategies

The marketing objective of the Sterling distribution component of the program, as noted, was broadly defined in the FPIA agreement in terms of physical product movement: distribute 12 million condoms, 6 million foaming tablets, 1.5 million oral contraceptive cycles, and 10,000 IUDs. It was assumed that the widespread availability of high-quality, low-cost contraceptive products would attract low-income (C and D classes) customers in addition to upper income customers (A and B classes).

The following strategies were adopted to achieve the above objectives:

- Integrate the CSM products into the Sterling distribution network.
- Sponsor media advertising, to include radio, television, and print advertising.
- Employ "nurse-detailers" at each branch depot (12 depots nationwide) to establish new distribution outlets through factories and other companies, provide training to factory health practitioners, and provide (on a fee basis) family planning information sessions to groups of workers.
- Make use of promotional materials, such as bumper stickers and free product samples.

This broad definition of marketing objectives and strategies was typical among consumer product marketers in the seller's market that prevailed in Nigeria through the years of economic prosperity. The leaner, more competitive environment that prevails now, however, requires that more attention be paid to establishing firm marketing objectives and developing appropriate strategies. FPIA has indicated that it was moving in this direction, but no evidence to that effect was available in the field.

Recommendations:

To meet the volume objectives established for the program, the project should undertake the following.

- Identify the total market size and brand shares to be achieved for each product category (condoms, vaginal foaming tablets, and oral contraceptives).

- Identify target audiences and develop consumer attitude and awareness profiles for each product category.

- Fine-tune the marketing strategy for each product category, including an examination of all elements of the marketing mix:

  - product
  - packaging
  - pricing (including trade margins and consumer pricing)
  - distribution coverage
  - media plan
  - advertising copy
  - promotional plan.

  (Each of these marketing elements is discussed in the sections that follow.)

IV.5 Potential Customers

IV.5.1 Target Groups

FPIA is a family planning organization and considers its mandate to be to provide family planning services to all groups regardless of income. Its first objective, then, is to provide family planning to men and women in urban areas to help them space their children or prevent pregnancies.

Whereas FPIA's long-term objective for the CSM project

is to reach the entire urban market, its short-term strategy appears to be to concentrate on consumers in the A and B income groups.[8] Because the project requires that, except for commodity costs, all costs must be covered by income generated from the project, it is necessary to generate income in order to finance activities needed to expand the distribution of the product. The A and B income groups are both more likely to use contraceptives and to be clients of the retail outlets supplied by Sterling. The strategy is to target these groups, generate income from sales to them, and use the resultant income to expand the distribution network to reach outlets frequented by low-income consumers. The short-term target group, then, comprises the middle and upper income groups, covering 2.5 million of Nigeria's total population of 95.2 million.

IV.5.2 Appropriateness of Target

The current target customers in this project are very different from those of other social marketing programs, which usually target the lower income groups.[9] To determine if the target is appropriate, it is necessary to examine the decision to base expansion of the program on revenues generated. Other CSM programs generally envision a longer "investment phase," during

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[8]FPIA points out that it did not target A and B groups rather than the full spectrum of income groups. Once the project was under way, however, it found that purchasers were coming from the A and B groups, but this was not the result of specific targeting. Based upon on-site observations (e.g., a television ad shown for the team), the A-B group orientation is nevertheless there and reflects Sterling's natural emphasis on servicing the most readily available customers.

[9]FPIA points out that this statement highlights the "essential philosophical disagreement between FPIA and CSM advocates." FPIA considers this project a "contraceptive marketing project," not a "contraceptive social marketing (CSM) project." It is designed to service all income groups and is not focused on the C and D income groups, as is the case with most CSM projects. (Letter of December 8, 1987, to John McWilliam, ISTI, from Cornelia O'Connor, Deputy Chief Operating Officer, FPIA, transmitting FPIA comments on an early draft of this report.) The team agrees with the decision to separate the products sales function from the training/services function. Once this is done, however, and separate financing made available for the training/service function, there would not seem to be much difference between this arrangement and those aspects of CSM projects called "social marketing."

which expenditures are made on advertising and distribution, the payback from which is not expected to generate sufficient income to cover most costs for several years. The investment phase in the Nigerian project was only one year.

Given the decline in Sterling's sales, it was necessary to focus on middle and higher income consumers to generate sales. If the market had remained buoyant, the target would not have been narrowed to the A and B income groups. The Sterling decision to focus on the A and B consumer income groups would appear to be appropriate given the constraint that expenditures can only be financed from income generated.

IV.5.3 Actual versus Target Customers

There are no data on the actual purchasers of the CSM commodities. No surveys have been conducted to date to determine the characteristics of buyers. FPIA is planning to support market research (see section IV.10), and this research will provide data on characteristics of consumers.

Recommendation:

- The financial constraints under which the program is operating may have forced Sterling to emphasize sales to the A and B income groups. Nevertheless, every effort should be made to expand the distribution system to reach the lower income groups. This may mean reconsideration of the decision not to put additional money into the project at this stage. Additional funds will become available as the project is integrated into the FHI-II project.

IV.6 Products

The Nigeria CSM project sells products donated by A.I.D. The first products to be introduced were condoms (three brands--one brand the first year and two more the second year), followed by oral contraceptives, and finally, a vaginal foaming tablet.

No reliable estimates exist regarding the sizes of the markets for the product categories or competitive market shares. Competing brands are imported by the private sector and some products donated for family planning activities by the international community are diverted to the private sector and offered for sale at the retail level.

Each product category is discussed below. The project also sells professional products, such as IUD kits, to medical practitioners. This aspect of the project, however, was not part of the assessment.

IV.6.1 Condoms

The CSM project originally intended to market three brands of condoms: a low-, medium-, and high-priced brand. The products were identified by brand name on the individual unit of use but were otherwise not packaged. Only the low-priced entry (Blue Panther) was to receive advertising support. The products are, in fact, identical except for the brand name or logo. All of the CSM brands are sold, unboxed, in strips of four units. (Many consumer products, e.g., analgesics, are sold in unboxed strips in Nigeria.)

The major private sector brands are Durex, an established brand whose name is generic for "condom," and Fulex, a more recent import, which is usually sold for less than Durex. Both brands are attractively boxed, contain three units per box, and are sold to customers at two to three times the price of the CSM products.

One public sector (non-A.I.D.-donated) condom, Sultan, is sometimes diverted to the private sector. This brand is identical to the CSM products and is sold unboxed in strips of four for about the same price as Blue Panther.

The project has no information about customers' brand preferences or their perceptions of comparative product attributes. However, the original marketing objective of providing high-quality, affordable condoms to C and D customers may be met with the Blue Panther product, provided customers like the product, can really afford it, and can be persuaded to use condoms. A proposed printed display box (see section IV.9) should assist in this effort.

The soundness of the marketing strategy for the medium- and high-priced brands is less clear. Apart from the price advantage, it is not apparent why a Durex or Fulex customer would switch to Coin (medium-priced brand) or Majestic (high-priced brand).

IV.6.2 Oral Contraceptives

The CSM project markets one brand of oral contraceptive (Noriday), which is supplied by A.I.D. The product is sold at a very significant retail price advantage versus the competition.

The pills are sold in single-cycle blister packs (no outer packaging or use instructions).

A large number of competing brands of oral contraceptives are found in retail outlets, and at widely varying prices. All of these products are boxed, and most contain some type of use instructions.

One problem experienced by the project, and which is out of its control, is the periodic change in the product supplied by A.I.D. This is a special problem when there is a change in product attributes, such as the color of the pill.

Although the norm for packaging pills in Nigeria is a conventional cardboard outer package with a paper insert, use of a less expensive option, such as an envelope with the product designation printed on one side and use instructions on the other, might well be satisfactory.

IV.6.3 Foaming Tablets

The CSM product supplied by A.I.D. is Conceptrol. It has a flower for a logo, is called "Petal," and is sold, unpackaged, in strips of four tablets. The private sector sells a competing product, Neo-Sampoon, which is attractively packaged in a metal tube and costs less per use than the CSM product.

Although consumer product preferences are not known, the CSM product may be perceived as producing a less warm sensation in use. It may also be more efficacious because the tablets are individually wrapped and therefore remain fresh until used. The Neo-Sampoon package contains 20 unwrapped tablets, which lose efficacy as the container is repeatedly opened and closed.

This product's share of the market is thought to be small. A point in its favor, however, is that it, along with condoms, can be advertised, and the tandem advertising approach should strengthen the overall CSM project image and provide benefits for those CSM products that cannot be advertised (oral contraceptives and other ethical products).

Recommendations:

- Given the project's need to generate revenue to pay for advertising, promotion, and other activities, a serious entry to compete with the Durex and Fulex condoms should be considered in order to achieve maximum market share.

- An outer package should be used for the oral contraceptive product so that use instructions can be provided and product identity can be maintained even when the product is changed by A.I.D. For example, the pills could be labeled as "N.F.P. (Nigerian Family Planning) Oral Contraceptives" and a minor notation could indicate the actual product (e.g., Noriday or Norquest).

- Packaging should also be explored for the foaming tablets to establish brand identity and to convey product attributes and use instructions.

IV.7 Distribution

The choice of Sterling Products as the distributor for the CSM project was based on sound business reasons:

- Sterling was already assisting with the delivery of USAID contraceptive products to distribution points within the public sector.

- The firm has a well-organized distribution system and successfully markets some of the most popular and widely available consumer products in Nigeria (e.g., Cafenol analgesics and Andrews Salts).

- The firm was willing and able to expand its product line to include contraceptives and had no competing brands.

- The firm had the capacity to transport and distribute the products without any additional investment in transport vehicles.

The A.I.D.-FPIA agreement with Sterling includes reimbursement of its warehousing, transport, and other direct expenses in the amount of 19.7 percent of the total ex-warehouse sales value. The remaining sales revenues are held in a fund to pay for advertising and promotion costs and for other FPIA CSM family planning activities. Advertising and promotional budgets are approved in advance by Sterling and FPIA.

The distribution system includes 12 branch warehouses located in six sales areas, which achieves national distribution. Each warehouse employs at least one sales representative and each area is supervised by an area manager. Through this system, Sterling services 550 direct wholesale accounts and some 3,500 retail pharmacy outlets. It is not known what portion of total

pharmacy outlets this coverage represents, but the system appears to provide excellent coverage of licensed pharmacists and wholesalers.

It is not known what portion of over-the-counter drugs are sold through chemists shops (not licensed to dispense ethical drugs), although there appear to be considerably more of these outlets than pharmacies. Sterling does not sell directly to an appreciable number of these outlets because the average sale to these, mostly small, outlets is insufficient to cover the cost of reaching them. Typically, the chemist will purchase over-the-counter items from a wholesaler on a cash-and-carry basis. Thus, the chemist is guided by a "consumer pull" approach; i.e., he stocks what his customers are buying or requesting. In the case of heavily consumed, well-known brands, such as the Cafenol analgesic and Andrews Salts, distribution is assured.

To some extent, the distributor or wholesaler can encourage distribution of new products by tying the purchase of the new product to that of an established brand, a practice known as conditional selling. This is a widely practiced sales technique in Nigeria and was used by Sterling in selling the initial inventories of CSM products. The practice was effective in filling the trade pipeline but has since been discontinued in light of the buyer's market that now prevails.

Recommendation:

- To stimulate "consumer pull," which will be necessary for the successful distribution of the CSM products and subsequent sales to consumers, a more detailed and consumer-oriented marketing plan is required. The plan should include the following elements:

  -- Education in CSM products and selling techniques for Sterling's field and warehouse sales staff.

  -- Promotion to chemists, for example, provide product information, samples, and distribution information.

  -- An advertising strategy that effectively addresses the target audience (see details provided in section IV.9).

IV.8 Pricing

The apparent price objective at the start of the project was to set retail prices as low as possible to maximize

the consumer's access to the products. The original sales estimates and corresponding financial projections indicated that the retail prices set, which were very favorable to the consumer, would provide a more than adequate advertising and promotional fund. In fact, the retail prices established for the CSM condom brands were likely responsible for an overall decline in condom prices.

The original retail prices did not allow retailers to earn their usual profit margin on the CSM products. Thus, in April 1987, suggested retail prices were increased to bring the CSM product margin into line with the competition. The wholesale price and, therefore, revenue to the project were not changed. The pricing structure for CSM and competitive brands is shown in Table IV.1.

Table IV.1

PRICING STRUCTURE FOR CONTRACEPTIVE PRODUCTS, NIGERIA (in naira)

Brand	Wholesale Price	Suggested Retail	Observed Retail Price
CSM Condoms			
Panther	12.5/100	1/4	1-2/4
Coin	15/100	1.2/4	N.A.
Majestic	18/100	1.5/4	N.A.
Other Condoms			
Durex			2-3.5/3
Fulex			1.5-2.5/3
CSM Pills			
Noriday	75/100	1.5/cycle	1.5-2.5/cycle
Other Pills			
Microgynon			6-8/cycle
Noridol			7-8
Nordette			6-6.5
Anovlar			7.5-18.5
CSM Foam Tabs			
Petal	12.5/100	1/4	1/4
Other Foam Tabs			
Neo-Sampoon			2-3.5/20

Note: N 4.5 equaled U.S. $1.00 at the time this report was prepared.
Source: Store check during field visit.

The retail price for the Blue Panther condom appears to be justified. It provides good value for a good product to be sold without packaging. There does not appear, however, to be sufficient spread in retail pricing to justify both medium- and high-priced condoms. A boxed condom product might be justified, however.

The price advantage the CSM oral contraceptive enjoys versus the competition is very commendable. However, the price could be increased slightly to cover the cost of an outer package and use instructions. This would maintain the product's financial viability and still offer the consumer an excellent value.

The consumer price per unit for the Petal foaming tablet is already at a disadvantage relative to the competition. Sales should be tracked and consumer preferences measured to determine whether this is a problem. In section IV.6, testing of packaging for this product was recommended to enhance the product image and provide use instructions. Pricing should be adjusted to cover the cost of packaging. To repeat, this is an important item in the product line because it can be advertised and thereby contribute to overall communications about family planning methods.

Recommendations:

- o A boxed condom product should be tested against Durex, the apparent market leader. A box of four CSM condoms might be sold, for example, for the same price as a box of three Durex condoms. FPIA concurs that a decision in this regard should be based on market research.

- o At a minimum, focus-group testing should be completed before launching the boxed condom, to determine

  - product preference vs. Durex
  - color preference (colors or neutral)
  - brand name preference
  - packaging preference.

- o Consideration (including appropriate research and testing) should be given to raising the retail price of the oral contraceptive to cover the addition of an outer package and use information.

- o Consideration (including appropriate research and testing) should also be given to raising the price of the Petal foaming tablet to cover the cost of packaging and use information. A retail price of N 1.5 for a box of eight tablets might be competitive.

IV.9 Advertising and Promotion

Nigeria has a wide range of media services available: network and local television, radio stations broadcasting in all major languages, many newspapers, a well-serviced national billboard network, and mobile cinema services. Radio is prevalent in rural and urban areas; television, which has achieved only limited penetration, is considered important in reaching community and opinion leaders.

The initial radio and television campaign for the CSM products stressed a generic family planning benefit and included a brief mention of the condom and foaming tablet brands. The appearance of the television ad during a network news broadcast led to the cancellation of all contraceptive advertising. Now the Food and Drug Administration (FDA) must approve all advertising for contraceptive products. In practice, approval from this body is most relevant for TV network advertising; local stations do not insist on approval by the FDA for spot ads. Over-the-counter brands, as noted, may be advertised but only generic ads may be run for ethical drugs, such as oral contraceptives.

Currently, the project is running an eight-week re-introductory blitz campaign through spot advertising on television; the ads focus on the generic benefits of child spacing. Panther condoms and Petal foaming tablets are mentioned at the end of the spot ad. The ad does not refer to the overall CSM project nor identify the "sponsor" of the project. Only a sketchy plan exists for providing sustained advertising support following the "blitz" campaign. Advertising plans depend largely on funds generated through product sales.

The promotion and product-sampling plans for increasing direct retail sales are not well formulated. Most activities in this regard seem to be aimed at opening new channels of distribution, such as in-house sales to factory workers. There is no overall plan, for example, for detailing to physicians who prescribe oral contraceptives. Specific activities to stimulate sales were recommended in section IV.7, and additional recommendations are made below.

Recommendations:

The following recommendations are made with regard to advertising.

- Identify target audiences for each CSM product, condoms, foaming tablets, and oral contraceptives, as well as for an umbrella family planning campaign. This

will assist in the development of a marketing strategy for each element of the project.

- Create an umbrella identification for the project, such as a seal or logo. This will:

  -- help to reassure the consumer of product quality in relation to the low price,

  -- help to build brand recognition for the oral contraceptive, which cannot be advertised by brand but which may feature on-package advertising logos, and

  -- provide continuity of product image in the event that the source of A.I.D.'s supply changes.

- Conduct, at a minimum, focus-group testing of advertisements among the identified target audiences.

- Develop an investment-level advertising program using targeted, tested advertising copy. In the competitive Nigerian environment of today, such an investment plan is a prerequisite to successful product launch.

- Develop a CSM promotional campaign aimed at physicians who prescribe oral contraceptives. Strictly speaking, a prescription is required for oral contraceptives, and it is believed that many consumers remain loyal to the first brand prescribed. Although some brand switching and unprescribed dispensing undoubtedly occur, the user base created by medical prescription is a necessary element in the success of oral contraceptives.

IV.10 Research and Evaluation

Given the seller's market that prevailed at the time the CSM project was initiated, FPIA decided that a market research survey was not needed to design an advertising strategy for a ready market. Advertising was only necessary to alert the public to the availability of the product, and only a family planning message was required. Although the products were not to be packaged, whereas the competitors' products were packaged, no research was done to test whether the lack of packaging would deter customers from purchasing the products. A study conducted by Population Services International (PSI), however, showed a slight consumer preference for a packaged product with fewer

condoms over an unpackaged product with more condoms.[10] Finally, although the CSM products were priced considerably below commercial brands, no research was done to determine the importance of price in the consumer's decision to purchase contraceptives.

The situation has changed considerably since the project was started. Sales to distributors were initially brisk but have since declined dramatically. Whether consumer sales have also plummeted or never were very high is unknown. Demand for the CSM products appears to be weak, although it is also likely that the distributors have not gotten the product out to the sales outlets. FPIA now recognizes the need for (1) market research to determine how best to increase demand and (2) retail audits to determine whether there are problems in getting the product out to the sales outlets. FPIA also commissioned a consultant to review the research program and to make suggestions as to what strategies should be followed in improving the program.

The preliminary plan for the market research calls for focusing on buyers of contraceptives at retail outlets served by Sterling. As discussed above, these are generally consumers in the A and B income groups. These are also to be the initial targets of the market research program. A two-part survey (one part will be a 50 percent consumer-intercept study and the other a 50 percent door-to-door sample) is planned in five urban areas: Lagos, Ibadan, Jos, Port Harcourt, and Kano. The survey, which is intended as a pilot for a wider based survey, should provide information on the population reached through retail outlets, consumers' attitudes and preferences for family planning, consumers' preferences for packaging, and acceptable price levels. Persons in any income category will be interviewed. These data should help in developing a marketing strategy to target the A and B consumer income groups. The second aspect of the research is to conduct sample surveys. These would provide data on program impact over time. The research is to be carried out by a Nigerian research organization and will result in increasing the capacity of that organization to conduct research on contraceptive use.

To determine how widely distributed the product is, retail audits will also be conducted. These data should be helpful in determining how consumers make product choices. Reorders could also be considered valid measures of consumer demand--as valid as point-of-sale data--since vendors do not

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[10]The PSI survey was conducted in Nigeria by the University of Lagos under the sponsorship of the Population Crisis Committee.

reorder products that do not sell. Under FHI-II, efforts will be made to collect data on sales at point of purchase; such data more accurately reflect consumer use than do sales to distributors.

Finally, baseline and follow-up surveys are planned to determine the effects of the entire FHI-II project. These surveys will include questions to help assess the impact of the CSM project, including source of supply, price paid, and method or brand preference. These surveys will be carried out under the direction of the North Carolina Population Center.

IV.11 Medical Aspects

IV.11.1 Distributor Training

Sterling's training materials were examined and are adequate; however, very few vendors have been trained with them. In the short time available for field visits, no Sterling-trained retailers were identified among the vendors visited, and thus further evaluation of the Sterling program was not undertaken.

In contrast, under a Columbia University project, market women in Ibadan are attaining and retaining a high level of expertise in family planning methods and counseling techniques. The content and presentation of materials in their training course appeared to be appropriate, adequate, and effective. Training techniques included testing, role playing, and didactic teaching; continuing supervision is provided by the University College Nursing Staff.

Throughout the Columbia training course, carried on outside the FPIA project, emphasis was placed on the importance of screening and of referral to a physician or family planning clinic for women with contraindications to the requested contraceptive product. For oral contraceptives, for example, age (<19 or >35 years), pregnancy, breastfeeding, hypertension or cardiac disease, diabetes, cancer, and smoking history were identified as reasons for referral. Participants were drilled on effective screening methods (how to ask the questions) and practiced in role-playing exercises. So far, however, sales of contraceptives have not been large.

In Lagos, licensed pharmacists dispensing oral contraceptives and other contraceptive products demonstrated a high level of product knowledge and concern regarding appropriate screening and continued medical supervision of women buying contraceptive products. This, however, does not restrict a woman's ability to purchase products widely and without

prescription from untrained personnel in chemist shops. Product information, counseling, and screening were uniformly not available in chemist shops in Lagos and Ibadan.

IV.11.2 Product Information

Contraceptive products are widely available on the commericial market and are predominantly higher priced, brand name items. Oral contraceptives, in attractive boxes, invariably contain package inserts with user instructions and contraindications printed in English. Vendors in the pharmacies visited provided supplemental verbal information, which was accurate. Vendors in chemist shops, as noted, were not knowledgeable about the products (many could not pronounce the product name but could recognize the product by comparing the used box brought in by the customer or allowing the customer to indicate the desired product). These vendors offered no information to customers.

IV.11.3 Correctness of Contraceptive Use and Consumer Satisfaction

The time constraints of this assessment made it difficult to collect even anecdotal information regarding contraceptive use. Conversations with contacts in Nigeria and with vendors, however, suggest that among contraceptive users there is a growing awareness of the biologic principle of reproduction and, consequently, of the way contraceptive products work. This is augmented by the inclusion of family life (biology) in the curriculum of secondary schools.

On the other hand, it was repeatedly suggested to the assessment team that among the lower socioeconomic groups and in rural areas misconceptions about oral contraceptives were widespread and, therefore, an obstacle to acceptance.

IV.11.4 Conclusions

The CSM training programs in Nigeria (by Sterling and others) are producing a cadre of well-trained vendors who are providing adequate information about contraception and contraceptive products to customers. The number of these trained vendors and pharmacists is small, and those trained are located only in urban centers. These urban centers seem to provide a major component of the country's health services, however, even for those living in rural areas. This is due, in part, to the fact that rural Nigerians freely visit their cities and urban

dwellers retain their roots in their villages and return to their traditional homes frequently.

The potential for distribution of oral contraceptives to those with contraindications is significant, and such mistakes may occur as a result of the CSM programs. This would undoubtedly trigger a reaction among the medical/pharmaceutical professions that would affect CSM activities.

Recommendation:

- The CSM program staff should aggressively pursue collaborative interaction and cooperation with the established medical and pharmaceutical communities.

IV.12 Project Costs

It was not possible in the time available to determine the overall direct and indirect costs of the project. Although the estimated cost of the contraceptives is listed in the project budget, actual product costs and administrative costs for purchasing, transport, insurance, handling, and the like are not easily available. In Nigeria, private sector firms (in this case Sterling) are reluctant to let outsiders review their accounts. The cost of centrally funded FPIA supervisory and administrative activities carried out by FPIA's regional office in Nairobi for this project were also not available.

The substantial changes in staffing and operational emphasis that have been made recently affect cost projections. When the assessment team was in Lagos, the budget then in force was being modified.

The FPIA Project Description and Budget for the CSM project contains detailed workplans and budgets. Budgets are well done and provide an excellent overview of the work planned during the funding period covered. The original Nigeria-18 budget, as amended, which covered the funding period July 1, 1985-October 31, 1986, obligated N 36,490 ($45,069) from FPIA (A.I.D.) sources and provided N 555,534 ($684,610) of commodities.[11] Income generated from product sales amounted to N 1,322,712. Modification 2, which covers the period November 1, 1986-February 29, 1988, projected zero dollars from FPIA and a

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[11]Modification 1 to the Project Description and Budget was a five-month, no-cost extension from May 31 to October 31, 1986.

donated commodity value of $1,371,375.[12] The project budget of N 1,773,400 was to be financed entirely from income generated from sales of contraceptives. This budget is currently in the process of being revised substantially downward because income generated in the first seven months of the second year (November 1, 1986-May 31, 1987) was only N 170,501. (Table IV.2 provides a summary of sales data, from the beginning of the project until May 1987.)

The revised budget is for N 1.4 million, of which N 900,000 is expected to come from income generation and will emphasize contraceptive marketing activities. Private sector outreach and broader social marketing activities are expected to be substantially reduced from earlier plans.

Beginning in April 1988, the project will begin to be phased into the FHI-II project. The budget for the integrated project totals $67 million for the period 1987-92. The budget earmarks $10 million for FPIA contract costs and $17 million for contraceptives for the private and public sectors. The private sector is projected to use two-thirds of the contraceptives available through the project.

Project support will be reinforced significantly with the addition of a full-time expatriate advisor with private sector experience and three senior Nigerian assistants. Income generated from sales of contraceptives will continue to be a major source of income for project activities. However, the first year of activity under the new project will be supported by direct FPIA funding; the income generated will be placed in a special project account and then programed into the second year. This will enable planners to prepare their programs based on

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[12]Quantities and expenditures for contraceptives by type, year shipped, and amount are shown below:

Type	1985 Qty. (000)	1985 Cost (000)	1986 Qty. (000)	1986 Cost (000)	1987 Qty. (000)	1987 Cost (000)	Total Cost (000)
Condoms	8,682	$363	14,178	$591	0		$ 954
OCs	0		0		0		
Foaming tablets	340	25	432.6	41	0		66
		$388		$632			$1,020

Source: A.I.D., Bureau for Science and Technology, Office of Population, "Quantity and Value of Shipments," Washington, D.C., November 1987.

funds already in the bank, rather than having to depend on the vagaries of current monthly sales for income, as was the case in the 1986-87 operational year. This decision on the part of FPIA was well taken.

Regarding sustainability, there are no calculations or firm estimates as to when this might be achieved. However, informal discussions would indicate that if the drop in sales of contraceptives can be reversed and the previous sales targets reached, the private sector portion of the project could become self-sufficient in the next two or three years if A.I D.continues to donate the contraceptives. Full sustainability is not likely to be achieved in less than five years, and then only if there is a strong upturn in the Nigerian economy.

Given Nigeria's current economic difficulties, it is not likely in the foreseeable future that imports of contraceptives could be made self-supporting at a price that would make them accessible to most Nigerian men and women. Preliminary exploration in this regard would indicate that contraceptives from Brazil, Taiwan, and South Korea are far cheaper than equivalent products produced in the United States.

Recommendations:

- A.I.D. should consider providing funds for the social marketing/outreach activities beginning in early 1988 without waiting for the completion of the phase-in period to the new project.

- A.I.D. should develop a system for estimating the total cost of private and public sector contraceptive distribution activities so that the cost effectiveness and sustainability of the project can be estimated.

IV.13 Conclusion

The Nigeria CSM project, after an excellent first year of contraceptive sales, was faced with a major falling off of sales due, in large part, to a Nigeria-IMF agreement that led to a major restructuring of the economy. As a result of that agreement, import prices rose by over 400 percent, the consumer's disposable income was reduced significantly, and the economy changed from a seller's market to a buyer's market.

From the outset, one of the attractive features of the project was the low U.S. contribution required for start-up, investment, and market development costs. Those costs were to be met from income generated by sales of A.I.D.-supplied

Table IV.2

SALES SUMMARY
(as of June 16, 1987)

Month	Condoms Units	Condoms Naira	Pills Cycles	Pills Naira	Foaming Tablets Units	Foaming Tablets Naira	Income
1985							
Nov	1,499,300	131,188.75	121,800	81,606.00			212,794.75
Dec	929,300	81,313.75	91,300	61,171.00			142,484.75
1986							
Jan	1,220,800	106,820.00	125,100	83,817.00			190,637.00
Feb	555,200	48,580.00	69,200	46,364.00			94,944.00
Mar	499,700	43,723.75	55,700	37,319.00			81,042.75
Apr	254,600	22,277.50	32,800	21,976.00			44,253.50
May	470,700	41,186.25	53,800	36,046.00			77,232.55
Jun	552,300	48,326.25	57,800	38,726.00	128,200	11,441.50	98,493.75
Jul	430,100	37,633.00	32,200	19,320.00	207,500	18,156.00	75,109.00
Aug	184,700	16,161.00	22,800	13,680.00	112,000	9,800.00	39,641.00
Sept	1,245,500	108,981.00	63,600	38,160.00	302,200	26,443.00	173,584.00
Oct	572,100	50,058.75	42,800	25,680.00	191,500	16,756.25	92,495.00
Sub-total	8,414,300	736,250.00	768,900	503,865.00	941,400	82,597.75	1,322,712.05
1986							
Nov	313,200	28,980.00	6,900	4,140.00	30,200	2,642.00	35,762.00
Dec	123,400	10,797.50	600	360.00	23,100	2,021.25	13,178.75
1987							
Jan	160,900	14,061.25	2,700	1,160.00	15,400	1,347.50	16,568.75
Feb	212,300		3,100	1,860.00	22,200	1,391.25	21,827.50
Mar	301,000		5,100		19,800		31,130.70
Apr	223,000		1,300		10,200		24,867.50
May	74,600		9,200		1,200		27,166.00[a]
Jun							
Jul							
Aug							
Sept							
Oct							
Sub-total	1,408,400	53,838.75	28,900	7,520.00	122,100	7,402.00	170,501.20[a]
Total	9,822,700	790,088.75	7,800	511,385.00	1,063,500	89,999.75	1,493,213.25[a]

Source: FPIA (New York)
[a]Includes sale of 190 copper-T IUDs, 5 IUD kits, and 650 pairs of surgical gloves.

contraceptives. This objective was partially achieved in the first year, when contraceptive sales grossed over a million naira. Since November 1986, however, when the Nigeria-IMF agreement went into effect, income generation has fallen to less than N 500,000 against an original budget of N 1.7 million for the period November 1986 through October 1987.

Although management and technical assistance from FPIA was modest in the first year, of necessity it has been sharply increased since early 1987. FPIA and Sterling have agreed to use the limited income-generated funds on hand to expand the demand for Sterling's contraceptive product line, which, if successful, will generate additional funds.

The shortfall in income generation will cause serious cutbacks in those aspects of the program designed to provide training and expand further the market for contraceptive products. The priority given to preserving the contraceptive product line is understandable, but project planners should seek other ways of funding the planned increase in "outreach/market expansion" activities without having to wait for the integration of the existing project into the FHI-II project in 1988.

Given the short time the project has been under way and the unique circumstances surrounding its development and implementation (huge country, seller's market, pent-up demand, radically changed economic situation), the Nigeria project may not be a good model for other African states. Nevertheless, the project has been good for Nigeria, and it has the full support of the Nigerian government.

Pending a turnaround in the project's income-generation capabilities, emphasis should be given to finding the funds required to maintain and encourage those additional social marketing activities that will expand the outreach and training efforts needed to broaden the contraceptive marketing base.

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ANNEX B

DOCUMENTS CONSULTED

"A.I.D.'s Experience with Contraceptive Social Marketing: A Synthesis of Project Evaluation Findings," A.I.D. Evaluation Special Study No. 40, Washington, D.C., Agency for International Development, 1986.

"Family Health Initiatives II - Nigeria," subproject paper 698-0462.20 (Lagos, A.I.D. Affairs Officer).

"Health Policy Declaration," Federal Republic of Nigeria, 1986.

LATIN AMERICA/CARIBBEAN

DOMINICAN REPUBLIC
MEXICO

V. DOMINICAN REPUBLIC (Microgynon Program)

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The CSM project in the Dominican Republic began in 1985 and is being implemented by PROFAMILIA, the country's IPPF affiliate, with technical assistance from SOMARC. Within the project's first initiative--the Microgynon program--the CSM project introduced a ground-breaking approach to working with the private sector. In the Microgynon program, PROFAMILIA purchases oral contraceptives (Microgynon) from Schering Germany (through IPPF volume purchases), sells them at less than the import price to Schering Dominicana, and then provides advertising/promotion for the product. Schering distributes the product to a majority of the country's pharmacies for 3.9 pesos, originally one-half and now one-third of the market average. SOMARC provides core support for the CSM project and technical assistance in market research. The Microgynon program was the focus of this evaluation.

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ANNEXES

A: Persons Contacted
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GLOSSARY

CIEM	Center for Marketing Research (private consulting group)
CONAPOFA	National Council for Population and the Family, unit within SESPAS (see below)
IDSS	Dominican Social Security Institute
IEPD	Institute for Population and Development Studies, unit within PROFAMILIA
JSA	John Short and Associates, subcontractor on SOMARC contract and major SOMARC representative in Dominican Republic
KAP	Knowledge, attitudes, and practice of contraception
PROFAMILIA	Family planning association of Dominican Republic, IPPF affiliate
SESPAS	Secretariat of State for Public Health and Social Assistance

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We also appreciate the time and information provide by Ms. Magaly Caram, Executive Director of PROFAMILIA Mr. Santiago Plata, Director of the SOMARC project, and the staff of both PROFAMILIA and USAID/Santo Domingo's Health and Population Office.

EXECUTIVE SUMMARY

BACKGROUND

The Dominican Republic is facing one of the most difficult economic periods in its history. The country is heavily in debt and short of foreign exchange, underemployment and unemployment are widespread, and inflation ravages the budgets of families accustomed to many years of currency stability.

The Dominican Republic supports voluntary family planning as a means to achieve a decline in population growth rates. In 1968, a national family planning program was established under the leadership of the National Council for Population and the Family (CONAPOFA), a semiautonomous institution associated with the Secretariat of State for Public Health and Social Assistance (SESPAS).

Prevalence rates in the Dominican Republic are high: One of every two women of reproductive age in union in 1986 was using contraception, as opposed to 32 percent in 1975. During this interval, the only contraceptive method to have increased in prevalence has been female sterilization, which rose from 36 to 68 percent. The promotion of oral contraceptives and other effective modern contraceptives is regarded as an important way to offer young Dominican women the opportunity to space childbearing and an alternative to early sterilization.

THE PROJECT

PROFAMILIA and Schering Dominicana have an agreement whereby Schering distributes Microgynon, an oral contraceptive, to a majority of the country's pharmacies and PROFAMILIA provides publicity for the product. Schering agreed, in late 1985, to keep the price at 3.9 Dominican pesos, which was approximately one-half (now approximately one-third) the market average.

SOMARC provides support to a CSM unit within PROFAMILIA that is the major support for the PROFAMILIA advertising campaign for Microgynon, thus enabling PROFAMILIA to keep its part of the contract with Schering. The CSM unit also provides funding for a full-time CSM manager, who is expected to develop other CSM initiatives, along the lines of traditional programs, for which A.I.D. provides total commodity support. Initially, SOMARC also had a resident advisor in country to help recruit and train the PROFAMILIA CSM manager. The CSM office is supported through a subcontract between John Short and Associates (JSA) and

PROFAMILIA. In-country research activities are supported through subcontracts between PROFAMILIA and other local institutions.

The immediate marketing objective of the CSM project is to provide a safe, affordable contraceptive to women in the C and D socioeconomic classes. Young women were especially targeted by the project in response to concerns by family planners that large numbers of women in their twenties were choosing sterilization. In the long term, the project plans to diversify its product line to include condoms and, perhaps, other brands of oral contraceptives.

FINDINGS

Within the SOMARC agreement, JSA plays a role that The Futures Group plays in other countries. The Futures Group, however, enters into project management activities (e.g., clearing contracts and strategies) the way it would in other projects, which leaves the Dominican Republic with two cooperating agencies carrying out activities that one could complete. In addition, the use of contracts for numerous locally funded activities is cumbersome.

The CSM project within PROFAMILIA is institutionally separate from the A.I.D.-funded CBD project. The interplay between the two projects is seen in the field but not at an institutional planning level.

Monthly sales of Microgynon increased from approximately 1,100 cycles a month in 1985, when the price was at market level, to between 2,500 and 3,000 in early 1986, when consumers could take advantage of the low price and Microgynon sellers could take advantage of the effects of a successful television advertising campaign. In 1987, sales were averaging between 13,000 and 15,000 cycles a month.

After one year of operation (1986-87), a SOMARC intercept survey of 252 Microgynon users revealed that 49 percent of the users were from class D neighborhoods, 35 percent from class C, and 16 percent from class B. Thirty-four percent of the users were new acceptors of any method.

The distribution system works very well. The cost of distribution is completely paid for by the consumer, although A.I.D. covers the PROFAMILIA and SOMARC costs of training for pharmacists, advertising, and research. Microgynon is distributed the same way as are all other Schering oral contraceptives, and the system has withstood a large and rather unexpected increase in sales.

The marketing strategy includes training sessions for 1,800 sales clerks. These sessions are aimed at informing the clerks about contraceptives and teaching them how to inform and motivate potential customers in a responsible way. Participants are recruited individually by a detailer. Between April and September 1987, some 600 clerks from 350 pharmacies were trained.

Two important aspects of the pricing structure for Microgynon are that (1) the price covers the cost of the commodity, packaging, and distribution and (2) previous or current users of public sector and PROFAMILIA CBD products (approximately 13 percent of the intercept survey) reported switching to Microgynon from a heavily subsidized oral contraceptive that PROFAMILIA distributes through its CBD program.

The first Microgynon television commercial, which featured a popular Dominican singer (Vickiana), was taken off the air after two months.* It had not been pretested, it was clearly controversial, and church and other opinion leaders were disturbed by it. Yet everyone who reports on the success of the Microgynon program gives most of the credit to Vickiana and the commercial. Training of pharmacy clerks and detailing to physicians are also important components of the promotional campaign.

The research strategy being implemented by SOMARC for the CSM project is impressive for its comprehensiveness, logic, and step-by-step development. It is a research and evaluation strategy worthy of emulation by marketers anywhere, but one whose costs exceed by a wide margin whatever revenues the CSM project could ever hope to generate. A considerable amount of this research, however, is conducted to enable A.I.D. to assess the success of the CSM approach.

Various local institutions have participated in the research in the past, and the project managers now recognize that project research should be consolidated and placed in the hands of the most capable local firms. Still, the research component of the project is a matter for concern. Findings from the first Microgynon intercept survey, for example, have not clarified the project managers' decisions regarding whether to add a new oral contraceptive to the product line.

If the Microgynon initiative is deemed costly, as it probably would be considering that A.I.D. usually measures a

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*The commercial was used prior to A.I.D. funding of the CSM project.

project's cost effectiveness based only on in-country costs, it is not the fault of the model (e.g., working with a pharmaceutical firm). Instead, the issue is the high level of financial support that has been given to the CSM project to address in-country CSM project needs.

CONCLUSION AND PRINCIPAL RECOMMENDATIONS

This first attempt at bringing a pharmaceutical firm into a CSM project is to be applauded. As A.I.D. cooperating agencies and local family planning organizations develop more experience working with private drug firms, A.I.D.'s population program should benefit. Similar approaches may be tried in other countries (e.g., Peru, Ecuador). Such arrangements with the private sector should be investigated whenever possible.*

Recommendations for the project in the Dominican Republic concern the role of the CSM program within PROFAMILIA, the project's training and research components, project costs, and project decision making.

- CSM in PROFAMILIA: It is imperative that sales and cost recovery of contraceptive marketing within both the CSM and CBD projects of PROFAMILIA be considered in tandem. CSM managers must know what effect the CBD project may have on the CSM program, and perhaps more important, whether the CBD project can take on a stronger cost-recovery component. This would be a decision of PROFAMILIA.

- Training: The recruitment effort for the training sessions is impressive, but the training sessions themselves could impart the necessary skills more effectively. In particular, the sessions should include more participatory training techniques and ensure that trainees understand how oral contraceptives work, possible side effects and their management, and how to introduce potential users to the product. Follow-up sessions should also be held to determine if the training has been absorbed.

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*SOMARC staff report that special IPPF world prices are not necessary to involve locally based pharmaceutical firms, and thus it is not necessary that this approach include local private voluntary organizations.

- Research: The research and evaluation strategy should be simplified to minimize cost. Program managers must be clear from the outset whether (and how) they expect a piece of research to assist in making operational decisions or to document the progress of the CSM programs. A.I.D. should decide what is considered appropriate project documentation.

- Project Costs: Future CSM projects should investigate what level of support is needed to support project initiatives.

- Project Decision Making: PROFAMILIA, SOMARC, AID/Washington, USAID/Santo Domingo and, if appropriate, Schering Dominicana should meet periodically to discuss project progress and major decisions. When contraceptives are being provided by a private supplier to CSM programs that are being primarily supported by A.I.D., A.I.D. and/or an A.I.D. cooperating agency should be part of the agreement, or have some formal contact with the supplier.

V. DOMINICAN REPUBLIC

V.1 Background

V.1.1 Economic Context

In recent decades the Dominican Republic was able to attain relatively high rates of economic growth. Beginning in the mid-1970s, however, the national economy went into a sharp decline as the shocks of oil price increases began to be felt. The ensuing international recession further exacerbated the country's economic situation. The coup de grace came in the form of the collapse of sugar, the main foreign exchange earner, on the international sugar market. Currently, the Dominican Republic is in one of the most difficult economic periods in its history. The country is heavily in debt and short of foreign exchange, underemployment and unemployment are widespread, and inflation ravages the budgets of families not accustomed to living in a never-ending inflationary spiral after many years of currency stability. In 1987 the inflation rate may have topped 40 percent. Were it not for substantial emigration, mainly to the United States, and the large flow of foreign remittances associated with it, the picture would be even darker. Still, in real terms, the purchasing power of most Dominicans continues to decline as salary adjustments fail to keep up with price increases.

V.1.2 Family Planning Context

The Government of the Dominican Republic supports voluntary family planning as a means to achieve a decline in population growth rates. In 1968, a national family planning program was established under the leadership of the National Council for Population and the Family (CONAPOFA), a semiautonomous institution associated with the Secretariat of State for Public Health and Social Assistance (SESPAS). The program provides oral contraceptives, condoms, and IUDs through rural and urban health centers belonging to SESPAS, the Dominican Social Security Institute (IDSS), the Armed Forces, and the National Police. NORPLANT implants are available on a test basis through four health centers. Voluntary sterilizations are carried out through a network of private hospitals, and the demand for sterilization is high. Nearly 7 out of every 10 Dominican women in union who are of reproductive age and are using contraception are sterilized. This is one of the highest sterilization rates in the world.

PROFAMILIA (the Dominican association for family welfare), the leading nonprofit, private family planning association and an affiliate of IPPF, is the other important provider of family planning services, education, and supplies in the country. In conjunction with Schering Dominicana, PROFAMILIA manages the SOMARC-supported contraceptive social marketing project. PROFAMILIA'S overall urban and rural network of community-based distributors and promoters provides oral contraceptives, foams, and condoms. In addition, with the support of clinics and private physicians, it helps satisfy some of the demand for IUD insertions and surgical sterilizations.

Prevalence rates in the Dominican Republic are high; one of every two women of reproductive age in union in 1986 was using contraception, as opposed to 32 percent in 1975. The increasing trend in contraceptive use has resulted in a rapid decline in the total fertility rate--from 4.7 children per woman in 1973-74 to 3.8 in 1986. During this interval, the only contraceptive method to have shown an increase in prevalence has been female sterilization, which has risen from 36 to 68 percent. Such a marked increase in the percentage of women relying on sterilization and the declining use of other contraceptives are a cause of concern; it is believed that far too many women are failing to space their families and are availing themselves of surgical sterilization while still at a young age (in their twenties). The promotion of oral contraceptives and other effective modern contraceptives is regarded as an important way to offer young Dominican women both an opportunity to space childbearing and an alternative to early sterilization.

V.2 CSM Goals and Objectives

V.2.1 Project Objectives

The initial plan for the Dominican CSM project was to have PROFAMILIA purchase and oral contraceptive, Microgynon, from the Schering Company in Germany as part of an economy-of-scale purchase by the IPPF. PROFAMILIA would then sell it to Schering Dominicana, the company's local affiliate, for much less than from Germany.[13] The primary motivation for the project was to generate income for PROFAMILIA.

As the project developed, however, PROFAMILIA and Schering Dominicana combined forces to provide C- and D-class consumers (middle-income and upper low-income groups) with a low-

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[13]This process is similar to the one used successfully by PROFAMILIA Colombia.

cost, low hormonal dosage oral contraceptive. To this end, Schering Dominicana agreed to offer Microgynon to pharmacies for half the market price, and PROFAMILIA, with assistance from the SOMARC project, contracted to provide publicity, retailer training, and medical detailing.

V.2.2 Findings

The objective of the program is clearly being met. After one year of operation (1986-87), a SOMARC survey of 252 Microgynon users revealed the following:

- 49 percent of the users were from class-D neighborhoods, 35 percent from class C, and 16 percent from class B.
- 34 percent of the users were new acceptors of any method; the remainder switched from other methods, but lapsed use of the other methods was not measured.[14]

Monthly sales of Microgynon increased from approximately 1,100 cycles a month in 1985, when the price was at market level, to between 13,000 and 15,000 cycles in 1987. Once consumers could take advantage of the low price and Microgynon sellers could take advantage of the effects of a television advertising campaign, sales increased to the current level.

Data about the income-generation results or potential of the Microgynon project were not available. Purchasing agreements between IPPF and Schering Germany and between PROFAMILIA and Schering Dominicana are not public knowledge.

V.3 Management/Organizational Structure

V.3.1 Project Structure

PROFAMILIA, Schering Dominicana, and both the SOMARC prime contractor, The Futures Group, and a subcontractor, John Short and Associates (JSA), make up the institutional base for the CSM initiative in the Dominican Republic. Schering distributes Microgynon to a majority of the country's pharmacies and agreed in mid-1986 to keep the price at 3.9 Dominican pesos, originally one-half and now approximately one-third of the market average.

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[14] E. Green, Contraceptive Social Marketing of Microgynon in the Dominican Republic--Progress of the Campaign, Washington, D.C., SOMARC/The Futures Group, 1987.

SOMARC provides support to a CSM unit within PROFAMILIA that handles the PROFAMILIA publicity campaign for Microgynon, thus enabling PROFAMILIA to keep its side of the contract with Schering. For the entire CSM project, SOMARC provides technical assistance in program coordination and management and funding for a full-time CSM manager, who is expected to develop other CSM initiatives, along the lines of traditional programs wherein A.I.D. provides total commodity support. Initially, SOMARC also had a resident advisor in country to help recruit and train the CSM manager. Additionally, the CSM office is supported through a subcontract between JSA and PROFAMILIA. Other in-country activities (e.g., research) are supported through subcontracts between PROFAMILIA and other local institutions.[15]

V.3.2 Findings

The plan for a resident advisor and a CSM unit within PROFAMILIA dates back to the A.I.D. request for proposal (RFP) for a social marketing contractor. The organizational structure, however, has some serious inherent problems:

- SOMARC helps PROFAMILIA meet its contract deliverables with Schering Dominicana (publicity), but it is not a party to the PROFAMILIA/Schering contract. A.I.D. is not in communication with Schering Dominicana or Schering Germany concerning the PROFAMILIA initiative. This contractual imbalance fosters a considerable amount of conversation, and at times agreement, between pairs of institutions but tends to leave decisions about program direction up in the air for extended periods of time. Also, it is apparent that PROFAMILIA and Schering need a liaison.

- PROFAMILIA appears to prefer working with A.I.D rather than the private sector and separates CSM activities from other activities within the association. The latest draft marketing plan for the CSM unit within PROFAMILIA (supported by SOMARC) suggests that developing plans for a traditional, A.I.D.-donated-commodities CSM project has consumed a considerable amount of time and that the CSM components of other PROFAMILIA initiatives (CBD, medical detailing) are not being considered.[16]

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[15]These local institutions are contractors to PROFAMILIA, which is a contractor to JSA, which in turn is a contractor to the Futures Group, Inc. (SOMARC), which is a contractor to A.I.D.

[16]SOMARC staff report that the CSM project director has since become involved in price structuring for NORPLANT and the new IUD and in strategies for cost recovery from non-CSM programs within PROFAMILIA.

- Within the SOMARC agreement, JSA plays a role that the Futures Group plays in other countries. The Futures Group, however, enters into project management activities (e.g., clearing contracts and strategies), the way it would in other projects, which leaves the Dominican Republic with two cooperating agencies for activities that one could complete. In addition, the use of contracts for numerous locally funded activities is very cumbersome.

Recommendations:

- A.I.D. and/or an A.I.D. cooperating agency should be part of the agreement, or have some formal contract, with a private supplier of contraceptives when A.I.D. is supporting a large portion of the initiative.

- All actors, including representatives from cooperating agencies and USAID/Santo Domingo, should discuss and delegate major programmatic decisions (e.g., introduction of new products, price changes).

- Given that the Schering model is a new approach for A.I.D. that is expected to be replicated in other countries, USAID/Santo Domingo and/or A.I.D. representatives in Washington should consider meeting with Schering officials occasionally to discuss the merits and progress of this new collaboration.

V.4 Marketing Objective and Strategies

V.4.1 Context

The immediate marketing objective of the CSM project is to provide a safe, affordable contraceptive to women in C and D socioeconomic classes. Young women were especially targeted by the project in response to concerns by family planners about the number of women in their twenties who are choosing sterilization. In the long term, the project plans to diversify its product line to include condoms and, perhaps, others brands of oral contraceptives.

The strategy for achieving the marketing objective was as follows:

- Find a pharmaceutical firm willing to cut its price on oral contraceptives on the assumption that its sales volume would increase.

- Convince the firm (Schering) to undertake advertising (beyond medical detailing) of an ethical product.

- Prepare a publicity campaign.

- Have Schering distribute its product through its existing distribution system.

Perhaps more than in any other CSM initiative, this approach requires that all parties benefit sufficiently from the arrangement so as to continue to participate.

V.4.2 Findings

To date, the marketing strategy has worked and the marketing objective has been achieved. The process required time, patience, and luck, however. The idea for having a CSM program dates back to 1979. PROFAMILIA first asked Wyeth and Syntex, the market leaders in the Dominican Republic, whether a buy-back agreement interested them. It did not; Schering was the third choice. Arranging the contract between PROFAMILIA and Schering took five years of discussions and research. Special components not found in other CSM programs that had to be agreed upon include the following:

- Schering would be selling Microgynon (a brand sold at market price) below market price.

- Special packaging had to be used to identify the product as subsidized.

- Distribution and sales of the product were to be handled by the Schering system, which usually received a higher per-unit distribution price.

PROFAMILIA, Schering, and the pharmacies involved are pleased with the results. Sales are much better than expected, and a consumer intercept survey, cited above, indicates the target market is being reached.

According to SOMARC, the institutions involved with the CSM project have never come to an agreement on a detailed marketing plan. A draft marketing plan is currently being reviewed. Major marketing questions being considered at this time include the following:

- Should the price of Microgynon be raised to keep up with inflation and the rest of the market?

- Should the project begin to market A.I.D.-donated condoms?

- Should a lower cost oral contraceptive be added to the product line?

PROFAMILIA and Schering have not agreed on a price increase for Microgynon nor on how the revenue from the price increase would be distributed. Condoms for the project would have to be donated by A.I.D. (see section V.6.2); discussions have been started with private distributors to get CSM condoms into pharmacies. Complicating the decision is the fact that a large shipment of condoms has arrived in the country for a public sector program, and plans for a nationwide program to combat AIDS and other sexually transmitted diseases are under way.

The decision whether to add a new oral contraceptive to the product line is not strictly a marketing issue.[17] Also at issue is the fact that PROFAMILIA has much more confidence in working with A.I.D. than with private pharmaceutical firms.[18] Perhaps the only long-term strategy that is clear at this time is a well-planned publicity campaign (see section V.9).

V.5 Potential Customers

The target group for the CSM project is young women who are not currently using a reliable contraceptive method and who wish to space or postpone the birth of their children. The recently completed consumer intercept study indicates that the intended target group, in general, is being served. The survey found that Microgynon users are mostly young, low-parity women of lower-middle socioeconomic status, primarily from the C and D income categories. These are precisely the women the program wants to reach. Increased use of oral contraceptives among these women may permit them to delay the time at which they seek sterilization; this delay is a top priority of PROFAMILIA.

The publicity and promotional efforts associated with the social marketing of microgynon have led to a considerable

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[17]The CSM program brought in a shipment of Norminest late in 1986 to avoid ne import duties, which went into effect in 1987. The pills were to be used if the CSM project managers decided to add a new oral contraceptive to the product line. SOMARC decided later to move the pills to Ghana.

[18]PROFAMILIA has been receiving A.I.D. assistance for approximately 20 years.

increase in the demand for oral contraceptives in the Dominican Republic. As noted earlier, the intercept study found that 34 percent of Microgynon users were first-time users, but that a great deal of product substitution was also going on. Eighty percent of those who had used another method were previous users of another brand of oral contraceptive and 10 percent of IUDs. Overall, 54 percent of Microgynon users had used another oral contraceptive previously, and about 10 percent had been using less effective methods (condom, rhythm, and vaginal methods). The survey results suggest that may of the so-called "switchers" were in fact women who had not used any method for some time before starting to take Microgynon. If this assessment is accurate, the number of "new" users may in fact be higher than indicated by the results of the survey. A more detailed analysis of the pattern of oral contraceptive sales by brand, conducted by SOMARC, concluded that for each five Microgynon users three new users of oral contraceptives were gained in the commercial sector.

The combined efforts of PROFAMILIA and Schering Dominicana have been effective in expanding the market for oral contraceptives, in general, and for Microgynon, in particular. Television advertising and other promotional efforts (see section V.9) succeeded in bringing to the attention of young women the availability of a low-dose oral contraceptive at a low price.

Over the past several years, the national economy has deteriorated severely and average income levels have declined drastically. In addition, under the impact of inflationary pressures, prices have been on the rise. As a result, most brands of oral contraceptives distributed in the commercial sector are now selling at prices well beyond the reach of most contracepting women of classes C and D. Under these circumstances the issue of product substitution must be evaluated in a somewhat different light.

More of the target groups might be reached by distributing Microgynon through other existing outlets. One possibility would be to make Microgynon accessible through PROFAMILIA's CBD promoters for the same price charged in pharmacies. Both the CBD and the CSM program have certain common cost-recovery attributes, and they may overlap somewhat in the type of clientele they serve.

Recommendations:

- Given the success of the project thus far, the project should be continued.

- It would also be useful to explore the desirability of

expanding the distribution of Microgynon through other outlets.

V.6 Product

V.6.1 Context

A variety of oral contraceptives are available in the Dominican Republic. Schering sells Trilquilar, Neogynon, Eugynon, and through the CSM project, Microgynon. Wyeth sells Trinordiol, Nordette, Novral and Loval. Syntex Norinyl and Noriday (diverted from the public sector program) are also available. In all, six pill formulations are available commercially. There are also numerous commercial condoms available in pharmacies.

The public sector program provided Noriday for 10 years but now provides Feminol, Lo-Feminol, and Orveret instead. The PROFAMILIA CBD program has switched to Lo-Feminol. The two programs are totally dependent on A.I.D.-donated commodities. PROFAMILIA also received a shipment of Norminest in late 1986 for use in the CSM program. At an early stage of the project it was thought that a two-tiered price system would be used by the CSM program and the Norminest shipment was obtained early to avoid new import taxes. As indicated above, however, the program decided not to distribute the Norminest in the Dominican Republic.

V.6.2 Findings/Conclusions

Continuity: The crucial issue for Dominican contraceptive users is continuity. Recent changes in the brand of products offered by the public sector and PROFAMILIA's CBD program indicate that changing brands causes problems for customers. Programs that rely on A.I.D.-donated products, for example, cannot ensure continuity of a brand. Although it is important to use a brand name to establish product identity, using pharmaceutical names (as opposed to testing and using CSM names) appears to be appropriate.

Microgynon Model: Expanding a contraceptive line through agreements similar to those between PROFAMILIA and Schering, and PROFAMILIA and SOMARC, is clearly preferable to a program in which A.I.D. donates the commodities, but it is not an easy program to implement. PROFAMILIA has experience working with Schering now, but it has not indicated an interest in entering into similar private sector agreements. Some commodities, such as the condom, are not available in the market

and a private sector agreement for anything more than distribution is probably out of the question. In such cases, A.I.D.-donated commodities will be necessary.

Image: Microgynon has a good product image among the medical community and users. In focus groups, users indicate the product is gentle and safe, although comparisons are often made with other contraceptive methods (condoms and IUDs) rather than with other oral contraceptives. From the advertisements (discussed below) users know about, and apparently believe, they want Microgynon because it was advertised by a famous singer.

Access: Schering covers close to all pharmacies in the country, and the price of Microgynon is clearly within the price range of C- and D-class consumers.[19]

Source of Product: The advantages of working with the private sector as opposed to requiring A.I.D.-donated commodities are that the costs of the product and distribution are covered in the price and that the brand will not change due to A.I.D. procurement procedures. An advantage of the IPPF/PROFAMILIA transfer (discussed below) is that the CSM product is not as affected by increases in importation costs as are private sector products.

Registration: Microgynon was registered as a health product and as a brand before the PROFAMILIA/Schering agreement was in place. This was especially helpful because health registration in the Dominican Republic can be extremely time consuming. If the condom or other products are to be added to the line, the registrations should be done in PROFAMILIA's name.

Line Expansion: As mentioned above, introducing the condom and a new oral contraceptive to the product line is under consideration. However, the public sector is likely to be giving away a large number of condoms as part of an anti-AIDS campaign. The CSM project is also considering taking on a publicity and educational role in the campaign rather than adding a new product to its line at this time. A study is under way to investigate the potential market for a CSM condom. The CSM project is also contemplating adding NORPLANT to its product line. This would be done through a system of medical detailing, initiated under the Microgynon project. PROFAMILIA has the valuable license from Leyras to market NORPLANT in the Dominican Republic.

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[19]Few A- and B-class consumers were found to be purchasing Microgynon in the recent intercept survey. It is likely that most of these consumers were using the product before the price was reduced.

Recommendations:

- The Microgynon model allows for continuity and access to products not achievable by CSM projects using donated commodities and untested distribution systems. However, program managers must make sure that the agreement between PROFAMILIA and Schering continues to ensure that low-cost products are provided to Schering Dominicana and that the low prices are passed on to Dominican users.

- The program managers should be very cautious before deciding to add new product lines. Such caution is warranted by market uncertainties. In the case of the condom, the Dominican market may have an overabundance of supply. As for the IUD, more research is needed to determine if the low appeal of this method can be overcome by educational and promotional activities.

V.7 Distribution

The distribution system for Microgynon begins in Berlin. Schering A.G. packages Microgynon especially for the PROFAMILIA/Schering Dominicana program and sells the commodity to the IPPF, based in London, at an economy-of-scale price. IPPF then "sells" (ultimately donates) the product to PROFAMILIA, its affiliate in the Dominican Republic. PROFAMILIA pays for transport, insurance, and import fees and sells the contraceptives to Schering Dominicana; Schering then distributes the Microgynon at a low price to pharmacies nationwide.

V.7.1 Findings

The distribution arrangement outlined above works very well. The consumer intercept survey, store checks, and focus groups indicate that the customer targets (young, new users) are being reached, though stores are not always stocked. The costs of the system are completely borne by the consumer, although A.I.D. covers the major portion of PROFAMILIA and SOMARC costs of pharmacist training, publicity and research.

Microgynon is distributed largely in the same way as are all other Schering oral contraceptives. The system has withstood a rather unexpected sales volume, and there are no indications that this low-cost product is treated any differently from Schering's more expensive products, which are expected to bring in a larger margin per unit. Pharmacists tend to place new orders as they receive a delivery. The product is moving quickly, but it is too early to discern whether there are any

problems with warehousing or store maintenance procedures. The Schering packaging, however, is designed to protect the pills for five years under extreme climactic situations.

The only in-country difference between the distribution system used for Microgynon and that for other Schering products is that PROFAMILIA trains the pharmacy clerks (described below) and does the detailing to physicians. Schering representatives normally visit physicians, but the company's policy is to promote only the newest brand in a line. Triquilar is the oral contraceptive currently being detailed; thus, PROFAMILIA had to take up the task of detailing Microgynon.

The fit among the distribution, training, and publicity components appears to be good, but it is difficult to judge this with a young project that is experiencing such good sales anyway. PROFAMILIA's training and detailing efforts are related to conflict-of-interest concerns that could arise if A.I.D. funds were used to teach clerks or physicians about Microgynon specifically. Publicity is discussed in more detail in section V.9, but it should be noted here that basic distribution/publicity procedures are covered (e.g., the product is in the stores when publicity occurs).

V.7.2 Conclusion

This project is not only using a private sector distribution system, but one that has experience distributing oral contraceptives nationwide. Accordingly, the results have been excellent. Nevertheless, the project should be observed carefully as it matures, especially if sales should decline or level off for an extended period.

Recommendation:

- The preliminary recommendation is that this distribution system be replicated in other CSM projects.

V.8 Pricing

V.8.1 Findings

As noted earlier the price of Microgynon to the consumer covers the cost of the product and distribution (see Table V.1 for prices and margins). The price to the consumer is set in the contract between PROFAMILIA and Schering Dominicana.

Market prices have increased by approximately 55 percent since the project began, mostly to cover the increase in import costs caused by devaluation of the peso and inflation. The average price of other oral contraceptives is about 12 pesos.

Table V.1

PRICING STRUCTURE FOR MICROGYNON, 1987
(in Dominican pesos)

	Price/ Cycle	Margin	Margin as % of Price
Schering A.G. to PROFAMILIA*	.88		
PROFAMILIA (import, insurance, & transport)--estimate	.42		
Total cost to PROFAMILIA	1.30		
		1.20	48%
PROFAMILIA to Schering Dom.	2.50		
		.50	17%
Schering to pharmacies	3.00		
		.90	23%
Pharmacies to consumer	3.90		

*PROFAMILIA actually purchases the commodities from Schering Germany at an IPPF price. At least the initial shipment of Microgynon was purchased with IPPF grant money.

The television advertisement for Microgynon announces that the price to the consumer is 3.9 pesos; thus, the set price is what is paid. Pharmacists report that when women request Microgynon, they tend to ask for Vickiana's pill (woman in ad) or the 3.9 peso pill. This universal awareness of price led Schering to pull a higher-priced Microgynon (8.5 pesos a cycle without the PROFAMILIA name on the package from the market.

Two important aspects of the pricing structure for Microgynon are that (1) the price covers the cost of the commodity, packaging, and distribution and (2) previous or current users of public sector and PROFAMILIA CBD products (approximately 30 percent of the intercept survey) reported they preferred purchasing Microgynon to receiving free or heavily subsidized commodities.

V.8.2 Conclusions

The organizational structure of the CSM project substantially affects its ability to use price to cover costs (e.g., publicity, market research) of the Microgynon project. The CSM project, as set up in the SOMARC (JSA) subcontract with PROFAMILIA, created its own office and staff within PROFAMILIA, and the presumption has been that the project will expand beyond the Microgynon project. After the first advertising campaign, PROFAMILIA could not afford to meet the Schering advertising requirements in the PROFAMILIA/Schering contract and, thus, SOMARC's assistance was crucial to the success of the program.

When SOMARC took over the financing of the publicity for the Microgynon project, Microgynon became another activity of the SOMARC-supported CSM project. PROFAMILIA's revenue from the Microgynon project is not necessarily allocated to the publicity campaign. Thus, SOMARC is technically still helping PROFAMILIA meet its contractual responsibility with Schering, although some PROFAMILIA donations for publicity continue to occur. With a large, funded CSM project, PROFAMILIA rationally decided to use the Microgynon revenue elsewhere.

Again, because CSM is separated from other programs within PROFAMILIA, the interplay between CSM and PROFAMILIA's CBD projects is seen in the field but not at an institutional planning level. The CBD program is 10 years old and has gone from distributing commodities free to charging 10 centavos for a cycle of oral contraceptives, to 25 centavos, to 50 centavos. Changing prices has not affected usership, though changing brands a year ago did. If women receiving free pills through the government or 50-centavo pills through the CBD program are willing and able to pay 3.9 pesos for Microgynon, it would make sense to study the effect of price changes in the CBD program before considering adding another, lower cost pill to the commercial line. Visits by the assessment team to CBD posts and pharmacies in the same neighborhoods suggest the need for CSM decision makers to become more aware of the interaction between the two programs.

V.9 Advertising and Promotion

All types of mass media (e.g., television, radio, newspapers) are readily available and easily accessible in the Dominican Republic. The Microgynon project soon learned that censorship tends to come from opinion leaders within the community, not as a result of legal procedures.

The following television commercial for Microgynon aired for two months in 1986:

> A man enters a bedroom with nothing on but a towel. He embraces Vickiana, a glamorous Dominican singer, who is wearing a wraparound nightdress with lace. Vickiana looks into the camera, shows the audience a pill and explains it is her daily secret for enjoying love. Vickiana then tells viewers the pill costs 3.9 pesos a cycle and identifies the pill as Microgynon. The camera cuts to a physician, who assures viewers that most women can use the product and that they should check with their doctor.[20]

Opinion leaders, including the church, were disturbed and the commercial was taken off the air. It had not been pretested and was clearly controversial. Yet, everyone who reports on the success of the Microgynon project gives most of the credit to Vickiana and commercial. Consumers walk into pharmacies and ask for Vickiana's pill, even CBD promoters who do not have a television set know about the commercial, and fully 80 percent of those questioned in the intercept survey had seen or heard about the commercial.

Now that the magic of the publicity campaign is in place, the CSM project has turned to fine-tuning its new messages by pretesting them with potential users and opinion leaders, using family planning materials that have Vickiana's picture on them, and concentrating on training pharmacy clerks and completing detailing visits to physicians. A second television commercial did a good job of referring to Vickiana's commercial.

All the publicity and market research for publicity are done in country. Much of the publicity work is completed in the PROFAMILIA communications department, and the talent available is excellent.

A strict schedule for television and radio publicity is contained in the PROFAMILIA/Schering contract. Although the schedule is not always met, the incentive to complete deliverables is probably stronger than it would have been had the schedule been in the PROFAMILIA/SOMARC agreement.

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[20]PROFAMILIA paid for this first commercial and continues to pay for the sectior of all subsequent commercials where Microgynon is mentioned specifically in order to avoid conflict-of-interest in the use of A.I.D. funds.

V.10 Research and Evaluation

V.10.1 Findings

The research approach proposed and being implemented by SOMARC for the Microgynon project is impressive for its comprehensiveness, logic, and step-by-step development. It is a research and evaluation strategy worthy of emulation by marketers anywhere, but one whose costs exceed by a wide margin whatever revenues the CSM project could ever hope to generate. The profit margins for Microgynon and the Dominican contraceptive market are too small to ever compensate for the costs of promotion, research, and evaluation.

As in other SOMARC projects, the research program includes the use of focus groups to learn about contraceptive perceptions and behaviors and to test the promotional and advertising materials. An innovative feature of the research plan was the development of an empirically based scheme for characterizing the socioeconomic status of consumers.

Following an initial period of promotion and sales, consumer intercept studies were scheduled at regular intervals to develop consumer profiles. (The first to be completed has been referred to above.) Sales trends are to be assessed through retail store audits and the continued evaluation of existing marketing data. The impact of the training and promotions offered to pharmacists and physicians is to be studied with opinion surveys and the use of mystery shopper techniques. A panel study will measure recall and changes in contraceptive behavior of those in a 1984 baseline study, along with attitudes on IEC and brand advertising. Finally, consideration is being given to evaluating the overall impact of the project through a nationally representative survey of contraceptive knowledge, attitudes, and practice (KAP). The results of this survey would be compared with those of earlier fertility and prevalence surveys, whose results would serve as benchmark data.

The intended relationship between market research and evaluation and operational decisions within the Microgynon and the entire CSM project is not clear. For example, once PROFAMILIA aired a successful, though controversial, TV commercial without pretesting, why were all subsequent commercials pretested? To avoid controversy? Certainly the advertiser was capable of designing an effective ad. No pre-testing of effects on different income groups was done, and the intercept survey completed later answered the targeting questions anyway. As another example, the intercept survey was designed to assess whether the target group of users was being reached and to help the CSM program decide whether to add another oral

contraceptive to the product line. When survey results indicated that the target market was being met, the decision to reprogram a shipment of CSM oral contraceptives (Norminest), which would have been used for the second tier of a two-tiered pricing system, took several months. Finally, the objectives of the panel study and opinion survey neither address operational decisions to be made within the CSM project nor clearly explain what aspect of the CSM approach is being evaluated.

V.10.2 Conclusion

Although the technical merit of the research and evaluation plan is beyond dispute, specific elements of the plan can be improved, something the technical advisors to the project recognize themselves. Major differences, for example, are apparent in the technical sophistication of the various local firms the CSM project is using to conduct some of its research activities. In terms of research designs, there are flaws, equally recognized by the SOMARC advisors, that in time and with some experience can be corrected. Some of the issues involved are indeed difficult to address, and the project has been resourceful in trying to cope with the problem. Two specific problems are the methodology used to select the sample of users interviewed in the intercept study and some of the premises used to evaluate the validity of the socioeconomic indicators of consumer status. These problems are common to most research endeavors, but nevertheless must be resolved.[21]

The main objection to the research and evaluation plan is that it is far too sophisticated and costly for the marketing situation at hand. Clearly, many of the research initiatives are of interest to CSM managers and donors, but they are not necessary to the successful implementation of the project nor to the reasonable documentation of program results. A nationally representative KAP survey to assess the effects of the project, for example, can hardly be justified. It is very likely that many of the results achieved so far could have been achieved with a much simpler approach. A good example is provided by the Vickiana commercial and associated materials. That commercial was successful even beyond the wildest expectations, yet it was not pretested before it was broadcast.

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[21]It should be noted that the use of various market research firms at the initial stages of this project was done in answer to a SOMARC mandate to spread business among local firms and to encourage technology transfer.

Recommendations:

- The research and evaluation strategy should be simplified to minimize cost. The overall CSM strategy should be consistent with the national context in which it is being implemented and in accordance with realistic expectations regarding the revenues that can be generated through the sale of items with a very reduced margin of profit. If sight is lost of this consideration, any hope for the eventual self-sufficiency of the program will also be lost.

- A.I.D. should make sure that CSM questions are adequately addressed in program-wide KAP studies for the Dominican Republic.

- "Technology transfer" of market research techniques should be of low enough priority in future CSM programs so as not to interfere with CSM project objectives.

V.11 Medical Aspects

The CSM project's oral contraceptive has been well known in the international medical community for approximately 15 years. Microgynon has a 3.78 mg hormonal content per cycle with .15 mg levonorgestrel and .03 mg estrogen per pill.

The latest draft of the CSM marketing strategy (September 1987) states that 1,800 sales clerks will attend orientation meetings in 1987. These meetings are aimed at informing pharmacy sales clerks about contraceptives, especially Microgynon, and teaching them how to inform and motivate potential customers in a responsible manner.

The team observed two training sessions for sales clerks held in Santo Domingo in October 1987. The sessions attended were representative of the entire training program. Participants are recruited individually by a detailer. Approximately 20 clerks attend each session, held from 8:00-11:00 p.m. at the Santo Domingo Headquarters of the Dominican Medical Association. Each participant receives a training manual. The program consists of (1) an ice-breaking session, (2) an introduction to PROFAMILIA and its CSM program, (3) a review of male and female anatomy and physiology as they relate to reproduction, and (4) an introduction to contraceptives, especially oral contraceptives. The session ends with participants filling out an evaluation questionnaire and a short biographical data form. Following a short refreshment break, participants are given a free ride home.

Between April and September 1987, 27 training sessions were held and 498 participants from 253 pharmacies located in Santo Domingo attended the sessions. In Santiago, La Vega, San Francisco, and Puerto Plata, 208 sales clerks from 98 pharmacies attended a session. Training sessions have not been held elsewhere.

A focus group session with users of Microgynon from average income neighborhoods (class C) was organized so the team could observe the potential customers of the sales clerks being trained. Topics covered and responses included the following:

how client decided on method used	couple decided
how the product is used	knew when to do if a day was missed
previous contraceptives used	those using other methods had condoms break, pain and bleeding from IUDs, and said foams were too messy
side effects experienced	generally positive responses
publicity	" "
availability of product	" "
price	" "

Most members of the group were highly satisfied with Microgynon because of the low price, minimal side effects (some weight gain and dizziness), availability in pharmacies, and the protection the product provides in preventing pregnancy.
Recommendations:

Some suggestions for improving the quality of the training sessions follow:

- Use appropriate audiovisual material to review the menstrual cycle.
- Reduce the amount of time spent discussing anatomic features of the reproductive systems.
- Include more participatory training techniques, such as role playing.

- Focus session on ensuring that participants will leave with an understanding of
  - -- what a combined oral contraceptive pill is,
  - -- why the hormone composition of a pill makes a difference,
  - -- proper use of pill and management of common side effects,
  - -- expiration dates and storage information,
  - -- how to counteract common misconceptions about the pill held by customers and how to refer customers to appropriate facilities when necessary, and
  - -- how to introduce the potential pill user to the CSM product (e.g., lower price does not mean lower quality).
- Hold follow-up sessions to ascertain how much of the training has been absorbed.

V.12 Project Costs

From A.I.D.'s standpoint, the fact that Schering is providing the contraceptive and the distribution system for it, is an unqualified plus in terms of project costs. Local project costs for A.I.D. total approximately $185,000 per year[22] (mostly to PROFAMILIA) plus whatever administrative costs are incurred by SOMARC in managing contract activities with PROFAMILIA.

V.12.1 Findings

Cost effectiveness is affected by the project organization created by the SOMARC contribution and management within PROFAMILIA. Assuming that monthly sales of Microgynon

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[22]This is the 1987-88 figure for support to the Microgynon project in the September 1987 draft market strategy paper. An estimate of PROFAMILIA's contribution to the advertising campaign has been subtracted from the overall in-country costs. The local costs to A.I.D. denoted in this strategy total approximately $185,000 a year for the Microgynon portion of the project.

average 11,000 cycles a month,[23] or 132,000 cycles a year, one CYP costs A.I.D. approximately $17 in in-country costs. It is likely that a careful review (see section V.10) would indicate that mandatory assistance in advertising, training, and research to the Microgynon initiative would require a smaller budget. Also, if A.I.D. is supporting this initiative, it should have a formal say in the use of the project's sales proceeds. As soon as sales revenues are added to the project, the cost per CYP is lowered.

This initiative of Schering, PROFAMILIA, and SOMARC teaches a lot about the potential for sustainability in a CSM program. Clearly, the existing product and distribution system save A.I.D. money up front and throughout the life of the project. What is also important to note, however, is that Schering may not have entered into this arrangement unless economic forces had affected its ability to sell Microgynon at the market price. In 1985, Schering was selling approximately 1,100 cycles of Microgynon a month at the market price without advertising the product. Triquilar was the newest Schering oral contraceptive in the country, and company policy prohibits promoting other oral contraceptives (e.g., Microgynon) during detailing visits to physicians. International Monetary Fund indexes for the cost of importing goods into the Dominican Republic in 1985 suggest that the average importer's costs increased by 200 percent. Schering had a product that was low on its priority list for sales, that it was not advertising or promoting, and that was becoming increasingly costly to import. Without PROFAMILIA/SOMARC assistance, Schering could probably not have lowered the price and most certainly would not have advertised the product. From a purely economic standpoint, then, PROFAMILIA's offer of a low retail price and free publicity was a no-lose situation for Schering.

V.12.2 Conclusions

If the Microgynon initiative is deemed costly, as it probably would be given that most observers measure a program's cost effectiveness based only on in-country costs, it is not the fault of the model (e.g., working with a pharmaceutical firm). Rather, more support may have been given to the PROFAMILIA project than was necessary strictly from the standpoint of the CSM objective in the Dominican Republic.

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[23]Sales for November 1987 reached 20,000 cycles.

Recommendation:

- o Future CSM projects should investigate what level of support is actually necessary to keep an agreement in place.

V.13 Conclusion

The economic realities of the Dominican Republic will demand that external assistance continue for the foreseeable future if existing family planning services are to continue. The Microgynon CSM project constitutes an interesting and novel approach to mininizing the costs of family planning programs by bringing together the private pharmaceutical sector and an aggressive and inventive family planning association. The CSM oral contraceptive is an affordable family planning alternative for Dominican women of limited means, who, under the present circumstances, would be hard-pressed to purchase contraceptives at commercial prices. In time, if the Dominican economy improves and if the price of Microgynon is adjusted, the CSM project could begin to contribute an increasing share of the costs incurred by PROFAMILIA to fund this and, perhaps, other programs. The CSM program may eventually also reach many of the women now relying on the even cheaper contraceptives provided in the CBD program.

This first attempt at bringing a pharmaceutical firm into a CSM project is to be applauded. As A.I.D. cooperating agencies and local family planning organizations develop more experience with private drug firms, A.I.D.'s population program should benefit. Similar approaches may be tried in other countries (e.g., Peru and Ecuador). Such an arrangement with the private sector should be investigated whenever possible.[24]

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[24]SOMARC staff report that special IPPF world prices are not necessary to involve locally based pharmaceutical firms, and thus it is not necessary that this approach include local private voluntary organizations.

ANNEX A

PERSONS CONTACTED

Asesores Asociados, S.A.
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Center for Marketing Research
- Leovigildo Baez, President
- Pablo Tactuk, Research Associate

Orientacion Mercadologica, S.A.
- Aldo Conde, Director

PROFAMILIA
- Magaly Caram de Alvarez, Executive Director

CSM Project
- Jorge Yordan, Director of CSM Project
- Teresa Virginia Gomez, CSM Training Coordinator
- Juan Munoz, CSM Medical Promoter
- Jose Merejo, Recruiter

Other
- Rodolfo Coiscou, Director of Education and Training
- R. Perez Jimenez, Director of CBD Project
- Rosa Rita Alvarez, Director of Communications
- Nelson Ramirez, Director of Institute for Population and Development Studies

Schering Dominicana, S.A.
- Gerd Keller, General Manager
- Diego Degaudenzi, Marketing Manager

SOMARC
- Santiago Plata, SOMARC Director
- Ted Green, Country Manager

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- Peter Croes, Director

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- Lisa Early, Deputy for Health and Population
- Manuel Ortega, Population Coordinator
- Maria Castillo, Population Assistant
- Ted Beasley, Economic Officer

ANNEX B

DOCUMENT CONSULTED

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VI. MEXICO (PROTEKTOR Project)

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In May 1986 the CSM project in Mexico was launched under an agreement between the Secretariat of Health (SSA) and the National Company of Popular Staple Products (CONASUPO). The project sells and promotes PROTEKTOR condoms, at one-third the market price, through CONASUPO-administered stores nationwide, a new channel for the distribution of contraceptives. SSA houses and administers the project, and its distribution arm, DISCONSA, provides the distribution system. A.I.D. provides the commodities through Family Planning International Assistance (FPIA) and, through the SOMARC project, technical assistance in social marketing.

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ANNEXES

A: Persons Contacted
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GLOSSARY

AAO	A.I.D. Affairs Officer
CONASUPO	National Company of Popular Staple Products, system of 17,000 grocery stores owned, franchised, or administered by the government; also the government's primary mechanism for farm price support
Consultores	Consultores en Comunicacion Social, advertising agency
DIPLAF	Civil agency within SSA used for contracting with private agencies
DISCONSA	Distribuidora CONASUPO; government-owned, nationwide distributor for CONASUPO stores
DGPF	Direccion General de Planificacion Familiar [General Directorate for Family Planning] in Secretariat of Health
ECCO	Estudios Continuos en Comunicacion
IMS	International Market Survey
IMSS	Instituto Mexicano de Seguro Social [Social Security Administration]
ISSSTE	Instituto Mexicano de Seguridad Social para los Trabajadores al Servicio del Estado [Social Security Administration for Government Employees]
PAZPU	Urban community development program within CONASUPO system
PROFAM	Previous CSM project in Mexico
PROTEKTOR	Brand name of CSM condom in Mexico
SSA	Secretaria de Salud [Secretariat of Health]

ACKNOWLEDGMENTS

The assessment could not have been completed without considerable assistance from those involved with the program being observed. The team would especially like to thank Ms. Patricia Dillon, the Latin American Coordinator for the SOMARC project, Mr. Salvador Ruiz de Chavez, Director of the PROTEKTOR project within the Mexican Secretariat of Health, and Mr. Ruiz's staff for facilitating our program of work. We are very grateful for their time and insights.

We also thank the staff of CONASUPO, DISCONSA, and the A.I.D. Affairs Office in Mexico City for sharing information and experience on the Mexican CSM initiative.

EXECUTIVE SUMMARY

BACKGROUND

The Government of Mexico continues to demonstrate a strong commitment to family planning, and contraceptive prevalence rates reflect this support: In 1986, 54 percent of fertile-aged women in union used contraceptives. Over 80 percent of current users rely on modern contraceptive methods, in particular, female sterilization and oral contraceptives. The effect of Mexico's continuing economic crisis on the poorest sectors of society has been severe, and the success of many ongoing social programs, family planning included, is likely to continue to depend on foreign assistance.

The government seems to be willing to initiate policy reform to remove legal barriers to the distribution or use of most types of contraceptives. A regulatory change, for example, made possible the advertising of specific contraceptive brands (though not methods). The CSM project took advantage of this for marketing the PROTEKTOR condom, as did PROFAM, the earlier A.I.D.-funded CSM project in the country.

The PROTEKTOR condom competes with over 40 other brands of condoms. All condoms are imported, but testing, lubricating, and/or packaging may occur in Mexico. The market leader is the PROFAM condom, now being distributed privately. PROFAM has approximately 35 percent of the national market, GELT PACK is second with 11 percent of the market, and PROTEKTOR ties for third place with Buena Suerte at 8 percent of the market.

FINDINGS

One important program objective has already been achieved: The government-administered National Company of Popular Staple Products grocery stores (CONASUPO) have, for the first time, become channels for selling contraceptives. In recent months, PROTEKTOR's availability in CONASUPOs, the project's use of mass media advertising, and presumably, the affordable price have made PROTEKTOR the third most popular condom on the Mexican market.

Information is not yet available from research in the field to determine to what extent the project's demographic objectives are being met. The most favorable estimates indicate that the project may have achieved half its target of providing 1 percent (70,000 CYP) of national prevalence per year, although recent Nielsen survey results indicate sales were actually much

lower. Recent sales figures indicate, however, that the target of 1 percent of prevalence is not out of reach for year two or three of the project.

The potential customers selected for the first phase of the CSM project were urban men and women under 25 years of age who belonged to consumer classes C and D. The socioeconomic status and demographic characteristics of the actual customers will be measured in a follow-up to the initial project baseline survey. The instrument for the follow-up is being finalized.

A conflict not being addressed by the project is that sales of condoms, especially to young couples, are not likely to succeed in areas where knowledge of family planning methods is low and where women are the predominant CONASUPO shoppers.

The CONASUPO system has problems that directly affect the CSM project. Generally, the system suffers from the following:

- Slow supply and resupply throughout the chain of distribution.
- Slow implementation of price changes.
- Inability to guarantee that stocks that arrive first in warehouses will be distributed first.
- Automatic resupply to stores that may be unable to sell product.

The price of the PROTEKTOR condom, which was set by the General Directorate for Family Planning (DGFP), was set lower than the market price and has not kept up with inflation. Project marketing costs (e.g., advertising, trade incentives, project management) are not covered. What price the C and D class markets could bear is not known. Once information is available on what income groups purchase PROTEKTOR and other condoms in Mexico, and on what prices are acceptable to C and D class consumers, the CSM project will have a stronger basis for making pricing decisions, which clearly are important for the project's long-term viability.

If the CSM project can indeed be credited with increasing sales of condoms of all brands over the past year as SSA purports, the project's advertising deserves the credit. The product presentation, name, and posters were pretested to ensure positive results. Focus-group research was used for most of this work and findings were acted on whenever possible. Although the radio commercials used to launch the project during the World Cup

Soccer games were not pretested, it is likely that this radio campaign was the most effective part of the advertising campaign because of the wide distribution of the message.

Training has focused on people who are not in direct contact with customers but who must understand and support the program to ensure its viability. Both DGPF/SSA and CONASUPO expect that those trained will share their information with others, but no mechanism for information-sharing was observed. Considerable attention is being given to integrating government medical personnel already working in areas covered by the CONASUPO system into project training and monitoring activities.

The CSM project has demonstrated that income generation is possible, yet costs to A.I.D. in the form of commodities and technical assistance provided through A.I.D. cooperating agencies will continue. Plans are under way to distribute PROTEKTOR condoms through private sector channels and to expand the CSM project's product line. Evaluating this investment by A.I.D. will require an assessment of whether the project is meeting its objective and whether Mexico really requires such a program. When A.I.D. discontinued financial support for PROFAM's CSM project in Mexico, the project did not collapse. Instead, it seems to have begun selling to the country's A and B class consumers.

CONCLUSION

Care should be taken when designing the new SOMARC subcontract (between The Futures Group and the Mexican Foundation for Health), particularly with regard to (1) payments that meet the needs of a country experiencing extensive inflation, (2) the plan for the project to become technically self-sufficient by the end of the contract period, and (3) a phase-down of financial support over a two-year period whereby project-generated income can be used to cover more of the costs.

Recommendations:

Three major program recommendations follow from this assessment.

- <u>Objectives:</u> Project objectives should be clearly defined and unattainable objectives should not be set. If, for example, more sparsely populated, rural areas are not accessible through the CSM approach, the project should concentrate on cities. If awareness-building for barrier methods is determined to be a primary objective, generic advertising should be considered.

- Training: Whether the CSM project or another SSA program continues working with rural CONASUPOs, the focus should be on designing and implementing an effective training program for salespeople. Depending on how effective SSA medical personnel prove to be as trainers and/or project monitors, the project must decide whether to proceed with the program in hard-to-reach rural areas.

- Research: Efforts are needed to collect and use appropriate information to make crucial program decisions concerning price, products, and distribution systems, and to measure program success. Particular attention should be given to involving locally based researchers in assisting the project address operational questions. For A.I.D., it is not enough to know what a CSM program can do (e.g., sell to low-income populations); it must be clear that the existing free market system could not do as well with less or no outside involvement.

VI. MEXICO

VI.1 Background

VI.1.1 Political-Cultural

The political environment for family planning activities in Mexico is very favorable. Since 1973, when the Mexican government in a well-publicized about-face decided to try to curb population growth, a deliberate and aggressive course to lower fertility has been pursued, and with striking results. Between 1970 and 1986, the birthrate declined from 44 to 27 per thousand and the total fertility rate was nearly halved, from 6.5 to 3.4 children per woman. The contraceptive prevalence rate has risen accordingly. In 1986, 54 percent of fertile-aged women in union were contraceptive users. Over 80 percent of current users rely on modern contraceptive methods, in particular female sterilization and oral contraceptives.

Such dramatic results could not have come about in the absence of a strong commitment on the part of the Mexican government. This commitment, under the aegis of the Partido Revolucionario Institucional, the governing party in Mexico over the past six decades, has been in evidence through three administrations. The party's new presidential candidate has already been announced and will continue to support the national family planning effort. The forthcoming administrative change, however, will in all likelihood result in some temporary disruptions in official family planning activities, since, as is customary in Mexico, the upper and middle echelons of the governmental bureaucracy will be replaced by a new administrative team fielded by the incoming president. Many experienced hands will be lost, but the effectiveness of the newcomers will gradually increase as they acquire in-job proficiency. If past changes in administration are any indication, these transitional disruptions should have only a temporary impact on program effectiveness.

Mexico's family planning accomplishments have been achieved despite several obstacles that interfere with the effectiveness of the programs. One of the most intractable problems has been reaching the more difficult to serve population groups, particularly in rural areas. These difficulties, to an extent, are related to the rough topography of much of Mexico as well as to the country's socioeconomic and cultural diversity (in terms of indigenous cultures, including indigenous languages). An overly centralized management of the nation's affairs has also played a role, although major attempts have been made to decentralize to the regional level the decision-making process

associated with the provision of social services. By most standards, however, the Mexican authorities have succeeded in creating a public opinion environment favorable to family planning as an important national goal.

VI.1.2 Family Planning Context

The CSM project in Mexico is but a very minor program within the national family planning effort. It serves less than 1 percent of current contraceptive users. In Mexico, both the public and private sectors are involved in the delivery of family planning services and supplies; the public sector served 58 percent of the need in 1986. At the apex of the system is the Secretaria de Salud [Secretariat of Health] (SSA), which, through the Direccion General de Planificacion Familiar [General Directorate for Family Planning] (DGPF), helps coordinate all official programs, channels international assistance, and oversees some of the activities of the voluntary agencies and the private sector. The coordinating activities of the DGPF include linking activities of different branches within the SSA ministry as well as those of other official entities.

Other major actors within the public sector are the two social security agencies, Instituto Mexicano de Seguro Social (IMSS) and the Instituto de Seguridad Social para los Trabajadores al Servicio del Estado (ISSSTE). The contraceptive needs of the country are also served by an extensive network of private and voluntary family planning organizations, some of which receive international assistance. Mexico is also the recipient of major contributions from foreign bilateral and multilateral sources. The private sector is active in the commercialization of selected contraceptive supplies.

VI.1.3 Legislative

There are some legislative constraints to family planning activities in Mexico, but none is insurmountable or particularly damaging. The government seems to be willing to modify or broaden the interpretation of any existing regulation that may interfere with the distribution or use of most contraceptive products. A regulatory change, for example, made possible the advertising of specific contraceptive brands (though not methods). The CSM project took advantage of this when marketing PROTEKTOR condoms, as did PROFAM, an earlier CSM

project in the country.[25] Oral contraceptives, technically, are distributed only under medical supervision but are in fact freely dispensed in pharmacies. In the event the PROTEKTOR program were to add an oral contraceptive to its offerings, the director of the DGPF has indicated the government's willingness to modify existing regulations to permit over-the-counter sales of oral contraceptives. The flexibility of the government in these regards is unquestionable.

This same flexibility, however, could be used to interfere with the activities of an ongoing program in the future. A proposed change in administrative format for the CSM project, which would place it under the Mexican Foundation for Health, could, if implemented, jeopardize government support. A somewhat similar situation led to the discontinuation of A.I.D. support for the PROFAM project, although that project was able to survive by raising its prices.

VI.1.4 Economic Context

The economic situation in Mexico continues to be delicate, a major devaluation of the currency having just occurred. Several years of negative or just barely positive rates of economic growth have contributed to a substantial reduction in real wages. High rates of inflation (currently at approximately 120 percent per year) and unfavorable exchange rates continue to affect living conditions adversely. The severe deterioration in economic conditions has affected the Mexican middle classes to an extent seldom seen in Latin America, and the effect of the economic crisis on the poorest sectors of Mexican society has been severe. In both instances, levels of disposable income have decreased. Although the government has been able to amass considerable amounts of hard currency reserves, it is obligated to service a large foreign debt. The future success of many ongoing social programs, family planning included, is likely to continue to depend on foreign assistance. In such an economic context, even the middle classes stand to benefit from a CSM project providing contraceptive supplies at a subsidized price. This is an important consideration when targeting the users of the program as well as when evaluating cost-recovery considerations.

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[25]The PROFAM project began with USAID support and now operates on a commercial basis exclusively (see sections VI 3.3 and VI.12.2).

VI.2 CSM Goals and Objectives

VI.2.1 Project Objectives

As a project of the SSA's General Directorate for Family Planning, the PROTEKTOR program, which was launched in May 1986, was designed to meet DGPF's institutional goal of furthering the delivery of family planning services nationwide. Within this general rubric the project has a multitude of objectives, including the following:

- Open up a new channel for the delivery of family planning services (CONASUPO--grocery stores).
- Achieve an estimated couple year of protection (CYP) equal to 1 percent of national prevalence every year of the program (approximately 70,000 CYP).
- Offer contraceptives at a price affordable to the C and D income groups.
- Improve the image of the condom as a method of family planning.
- Encourage more participation by men in family planning.
- Introduce young couples to effective methods of family planning.
- Implement a project that can become self-financing.

SSA is particularly interested in the possibilities for intergovernmental cooperation created by the project. SSA also sees this project as providing an excellent opportunity to identify and work to reduce regulatory barriers to the provision of family planning information and commodities.

VI.2.2 Findings

One important program objective has already been achieved: The government-administered grocery stores, the CONASUPOs, have become outlets for selling contraceptives. A large number of the 17,000 CONASUPO stores nationwide have received and are selling condoms. In recent months, PROTEKTOR's availability in CONASUPOs, the project's use of mass media, and presumably, the affordable price have made PROTEKTOR the third most popular condom on the Mexican market.

The project has not been in operation long enough, nor is the information available, to determine whether and how other objectives are being met. The most favorable estimates indicate that the project may have achieved half its CYP target in the first year, though 1987 Nielsen survey results indicate sales were actually much lower (see section VI.7.2). Recent sales figures suggest, however, that the "1 percent of prevalence" target is not out of reach for year two or three of the project. In March 1987, results of a cost-recovery analysis based on current price levels and very optimistic distribution and sales estimates projected that the PROTEKTOR program could be self-financing in 1990 if only local costs were considered.

VI.2.3 Conclusions

Clearly, it is difficult to meet a series of objectives at one time, especially when those objectives can conflict. For example, greater coverage may have been achieved if PROTEKTOR had been distributed through pharmacies, yet distribution through pharmacies would have taken longer to arrange, may not have benefited from national advertising time on radio, and may have raised the price to consumers in order to cover the cost of packaging, retailer training, and all distributor margins.

Addressing the objectives that involve the characteristics of users (C and D income groups, young people, men) and attitudes toward condoms requires research. The socioeconomic status and demographic characteristics of customers will be measured in a follow-up to the initial project baseline study. The instrument for the follow-up survey is being finalized.

A conflict not being addressed by the project is that sales of condoms, especially to young people, are not likely to succeed in areas where knowledge of family planning methods is low and where women are the predominant CONASUPO shoppers. Field visits indicate that in rural areas and urban community development projects (PAZPU) within the CONASUPO system, a more well-rounded, health-oriented approach to family planning will likely be required.

Recommendations:

As the CSM project begins its second year, priorities should be established and progress in meeting them monitored carefully.

- Areas within the CONASUPO system that are physically or psychologically hard to reach with the CSM approach

should be dropped from the project's scope. (Other A.I.D. cooperating agencies may want to undertake activities in such areas.) If awareness-building is determined to be a primary objective, consider generic advertising.

- The spirit of the objectives set for this project must be addressed. For example, knowing whether PROTEKTOR is purchased by C- and D-class consumers or by young people is useful, but the point in setting the objective was, presumably, that the existing condom market was not reaching those groups. The entire market (CSM plus the existing commercial sellers) must be evaluated to determine whether a CSM project continues to be necessary.

VI.3 Management/Organizational Structure

VI.3.1 Project Organization

A three-person staff, working within the DGPF, administers and coordinates the PROTEKTOR project. The SOMARC project supports this staff through a civil agency called DIPLAF, which enables the SSA to receive financial support from private institutions. DGPF coordinates the following institutions and organizational inputs.

CONASUPO: For the past 50 years this organization and its antecedents have provided Mexican farmers with guaranteed price supports and Mexican consumers with low, stabilized prices for basic consumer goods. Approximately 17,000 stores are affiliated with the CONASUPO system nationwide, of which about 3,000 are owned directly by CONASUPO or franchised; the rest are financed through community development programs. CONASUPO and SSA have an agreement to sell PROTEKTOR condoms through the CONASUPO system and to use the earnings to help support educational and promotional activities.

DISCONSA: Distribuidora CONASUPO (DISCONSA), a for-profit company, is the sole distributor for CONASUPO stores nationwide and as such is responsible for the distribution of PROTEKTOR throughout the CONASUPO system. DISCONSA is also responsible for product packaging.

DGPF/DIPLAF: Beyond day-to-day project management responsibilities, DGPF/DIPLAF plan new marketing strategies, supervise market and evaluation research, contract for publicity, coordinate inputs of SSA personnel, and take the lead when government approvals are required.

A.I.D. provides the condoms (through FPIA) and technical assistance in developing and evaluating marketing strategies, program evaluation, and advertising through the centrally funded SOMARC (The Futures Group) project.

VI.3.2 Findings

DGPF receives a considerable amount of technical assistance from the SOMARC project. In fact, all contracts with Mexican advertising and market research organizations are implemented by SOMARC. As a partner in these contracts, SOMARC has a substantial monitoring role. The institutional objective of DGPF, SOMARC, and the A.I.D. Affairs Officer/Mexico City is that DGPF evolve into a more technically self-sufficient group.

CONASUPO and DISCONSA, especially DISCONSA, are basically implementors and have only minimal involvement in project direction. Since SSA-CONASUPO cooperation was a major institutional impetus for the CSM project, little background investigation was completed on the CONASUPO system prior to launching the project. As a result, it came as a surprise to DGPF that DISCONSA did not have an efficient distribution system outside the major cities and that franchise stores and both urban (PAZPU) and rural community stores were actually the basis for community development initiatives in which community committees, and not CONASUPO, decided what to stock.

CONASUPO has begun distributing oral rehydration therapy (ORT) salts and nutritional information under a UNICEF project that works directly with CONASUPO. Field visits indicate that store penetration and availability of informational material are the same for the ORT salts and the PROTEKTOR condom in urban community projects and rural areas (neither product has made it to the rural areas). UNICEF, however, has begun a community lecture series conducted by UNICEF medical representatives. CONASUPO personnel and, apparently, the communities like this approach.

Two critical changes in project organization are expected to take place in the next few months:

1. The new SOMARC subcontract for 1988-89 will be signed not with DIPLAF (DGPF) but with the Mexican Foundation for Health, a nonprofit organization supported by various local private and international groups.

2. Project managers with DGPF plan to commence marketing condoms through private (non-CONASUPO) grocery stores and pharmacies.

The new contracting arrangement is meant to ensure project viability during the upcoming change in government. Political positions at the DGPF level could change as the new six-year government comes into power in 1988. At least for the coming year, project personnel will still be situated within DGPF and can be expected to have access to administrative and technical support provided by SSA.

Little background investigation has been completed to date regarding expanding the PROTEKTOR project beyond the CONASUPO system. The expansion of distribution channels will require a private distributor for the first time. Plans under consideration include coupling the program with a private pharmaceutical firm or merely purchasing the services of one of the major distributors of ethical products in Mexico.

VI.3.3 Conclusions/Recommendations

Perhaps a pilot initiative by a more community-development-oriented A.I.D. cooperating agency (e.g., CEDPA or Pathfinder) could parallel the community initiatives planned by UNICEF, CONASUPO, and the staff of PAZPU to test the dissemination of family planning messages and a variety of products in the community context. Also, the PROTEKTOR staff should stay abreast of the development of the UNICEF/CONASUPO initiatives.

The CSM project will likely be safer in the coming year if housed outside the government. However, very careful reconsideration of project direction will be required if the new government does not accept the project within the SSA structure or does not allow the project to retain the legal and administrative advantages it gleans from being a government initiative. Legal constraints to the Mexican Foundation for Health's working with private pharmaceutical firms should be investigated as well.

The decision to move the project should be reviewed as more information on the new government becomes available. Mexico has already had the PROFAM experience, wherein a CSM project lost government and A.I.D. support, and whether one judges PROFAM as successful or not, the country clearly does not need a PROFAM-II.

VI.4 Marketing Objectives and Strategies

The program objectives identified above include elements that show concern for institutional relationships and program costs, but the marketing goals, outlined below, are clearer:

- Increase knowledge and acceptance of condoms as a method of family planning for C- and D-class consumers between 18 and 24 years old.

- Increase contraceptive prevalence by 1 percent.

- Expand the entire condom market.

No information is available at this time by which to determine the age or socioeconomic classes of PROTEKTOR customers. It is assumed that use of the CONASUPO channel will ensure that some are C- and D-class consumers. Nielsen and International Marketing Survey (IMS)[26] data indicate that the condom market did continue to expand in 1987. However, how much of that growth is attributable to concern over AIDS or whether the increase is in fact significant in comparison with market trends cannot be determined. Nevertheless, it is generally believed that the publicity campaign for PROTEKTOR did encourage sales (see section VI.9). SSA program managers have calculated that close to half of the 36 percent increase in the condom market between 1985 and 1986 can be attributed to the PROTEKTOR project.[27] An upcoming survey will address this issue.

Future marketing objectives for the project include the following:

- Expand the distribution channel for the PROTEKTOR condom to include private grocery stores (e.g., Aurera, Gigante) and pharmacies.

- Launch CSM projects for foaming tablets and oral contraceptives for C- and D-class consumers.

- Begin to collaborate with private pharmaceutical houses to implement CSM projects.

As noted above, plans to expand the distribution of the PROTEKTOR condom are under discussion. The project is waiting to hear whether Parke Davis will act as the distributor in the private sector.

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[26]IMS data are not available on use of condoms in Mexico, but trends in other barrier methods (e.g., foams) can be tracked and compared with growth in the condom market.

[27]Urbina Fuentes, Presentation to Secretary of Health on SSA/CONASUPO PROTEKTOR Program, August 4,1987.

The overall oral contraceptive market seems to be leveling off, and the market for foaming tablets is very small; thus neither can be considered potential growth markets. A possible drawback to the future expansion of the CSM contraceptive line is that the Mexican contraceptive market is already well served by many providers of contraceptives and, with the exception of condoms, at relatively low cost. Thus, the project should be very sure of its program and marketing objectives if the product line is to be expanded.

The project's plan to collaborate with private sector pharmaceutical distributors already in the market is well advised. PLAFAM, the oral contraceptive procured by the Mexican government for all its family planning programs, could also be an alternative to A.I.D.-donated commodities.

VI.5 Potential Customers

The target customers selected for the first phase of the CSM project were urban men and women under 25 years of age who belonged to consumer classes C and D. Very little is known about the specific socioeconomic characteristics and attitudinal traits of these consumers because a detailed study has yet to be completed. A consumer intercept study currently in progress should provide some answers, although some flaws in the design of the survey instrument may limit the applicability of the findings (see section VI.10.1).

VI.5.1 Selection Criteria

Several important considerations were weighed in selecting the potential customers for the PROTEKTOR condom. First, among younger people contraceptive prevalence rates are lower than among older adults. Second, condoms are an appropriate contraceptive for young people, who generally are involved in sex infrequently and are less likely to be in a stable sexual union. Project designers rationalized that condoms could be regarded as a first step toward the acquisition of contraceptive habits. Although men, traditionally, have been the main purchasers of condoms in Mexico, it was assumed that by selling condoms in the CONASUPO chain, women, the primary users of those stores, would be more likely to start purchasing the product.

All in all, the above rationale appears sound. It is somewhat unrealistic, however, to expect women to become regular purchasers of condoms, particularly when condoms are regarded in Mexico as an inconvenient family planning method and are often associated with illicit and casual sexual liaisons. Prevalence

associated with illicit and casual sexual liaisons. Prevalence figures (by method) in several Mexican surveys suggest that the condom is a method shunned by most Mexican couples, who prefer to rely on highly effective methods, such as sterilization and oral contraception.

VI.5.2 Target Customers vs. Actual Customers

It is very difficult to determine whether the target customers are the actual purchasers of PROTEKTOR condoms. Only anecdotal information on purchasers could be gleaned during visits to a number of CONASUPO stores in Mexico City and in urban areas in the state of Hidalgo. In urban areas, there is some question as to the type of customer who is purchasing the PROTEKTOR condom. The opinion of several store and warehouse managers, corroborated in many instances by team members, was that a majority of patrons of the major urban CONASUPO stores are drawn from classes other than C and D, mainly class B. Store workers interviewed in major stores reported purchases by both men and women, although the views expressed were sometimes contradictory. The same was true for reports of the age of purchasers; some store workers reported sales to younger consumers, others to older ones. In poorer urban areas, where PAZPU operates, the project can assume that customers come from the C and D classes, but store checks indicate that older (over 35) males are purchasing condoms. It is doubtful that young people, especially women, would buy condoms from the PAZPU stores, which tend to be very community oriented. Even anecdotal information is unavailable for rural areas.

VI.5.3 Impact of the Product

It was obvious during field visits that sales are not brisk. Urban stores, at best, report a moderate pace for sales. In the rural area visited sales were nil (the condoms had been distributed there at the initiative of the local management of the CONASUPO system, not as part of the original marketing plan); the condoms had even been returned to the local warehouse. Part of the reason for this poor performance was an almost total lack of publicity associated with distribution of condoms to the rural stores, although lack of motivation to use condoms in all likelihood accounts for most of the low demand.

To what extent product substitution is taking place is an open question, but undoubtedly it is occurring. The price of the PROTEKTOR condom is much lower than that of all commercial brands, and sales of PROTEKTOR have been strongly promoted by a relatively well-orchestrated publicity campaign, at least in

selected urban areas. The key issue is not the degree of substitution, but rather what effect the PROTEKTOR project has on demand and prices in the rest of the condom market.

Several indications suggest that the PROTEKTOR project may be having a halo effect greater than any negative effect related to possible substitution. First, the PROTEKTOR campaign has introduced to the mass media the open promotion of specific contraceptive brands. Second, the long-term consequences of the project will support important objectives of CONASUPO. Aside from ensuring the distribution of essential goods in difficult-to-serve communities and providing a stable market for many small producers, CONASUPO tries to intervene in the marketplace to regularize price. This is accomplished by selling selected goods (up to 5,000 items) at prices that include only a reasonable markup, thereby helping to reduce excessive margins in commercial outlets and, presumably, making many goods accessible to low-income purchasers. Thus, theoretically, the PROTEKTOR project may help contribute to an increase in contraceptive prevalence. In the highly inflationary Mexican economy, this may be more than a trivial externality given the continuous price increases that occur.

VI.6 The Product

VI.6.1 Contraceptive Markets

Markets for condoms, oral contraceptives, foaming tablets, and injectables exist in Mexico. Prices are not unreasonable, but publicity is almost completely limited to detail visits to physicians to introduce the products.

PROTEKTOR competes with some 40 other brands of condoms. All condoms are imported, though testing, lubricating, and packaging may occur in country. According to a 1987 Nielsen survey, the market leader is the PROFAM condom, the product of the earlier A.I.D.-funded CSM project. PROFAM has approximately 25 percent of the national market, GELT PACK has 11 percent, and PROTEKTOR ties for third place with Buena Suerte with 8 percent of the market.

Four or five brands of foaming tablets are on the market. Three brands (PROFAM, Norform, and LoroPhyx) share the top sales positions. Norform and Lorophyx are being considered as possible products by the CSM project.

The Mexican consumer can buy any kind of oral contraceptive (from tri-phasals to Norestisterals). Wyeth and Schering products lead the market. Mexico also has PLAFAM, a

government-regulated and procured public sector product currently being provided by Schering. The PROTEKTOR project staff hope to market an existing brand of oral contraceptive instead of using an A.I.D.-donated product.

Sales of injectables are higher in Mexico than in any other country in Latin America. One-month and three-month products are available, and the public sector buys one of the brands for its programs.

VI.6.2 Findings/Conclusions

VI.6.2.1 Product Line. Tentative plans are under way to expand the CSM product line. Mexico, however, does not need new contraceptives but rather more publicity for what already exists in the market and, possibly, some subsidy to make them more accessible. Thus, the CSM project should concentrate on achieving very specific social objectives in expanding its product line.

VI.6.2.2 Product Image. The image of PROTEKTOR is neutral. Publicity has improved sales and name recognition (see section VI.9). Given that many men and women do not like using condoms in general, no negative stereotypes appear to be attached to this brand in particular. This is important given its channel of distribution. CONASUPOs sell both regular products and CONASUPO brands. Many of the CONASUPO brands (e.g., laundry soap, beans) have a low-quality image. Since PROTEKTOR is distributed only in CONASUPOs, it could have lost credibility with shoppers as well, but that does not appear to have happened.

VI.6.2.3 Product Accessibility. Accessibility of the PROTEKTOR condom is fair. Condoms seem to have made it to CONASUPO outlets in major cities and selected rural areas, and a substantial pipeline exists in CONASUPO warehouses. As the CSM project moves into private sector retail outlets, distribution should improve considerably.

Product display is fair in large, urban stores, but it is minimal in stores in poor areas. It is likely that in many communities PROTEKTOR is an under-the-counter product. One price increase has been instituted since the project began, though percentage price increases in the rest of the market have been greater. The effect of this change was clearly not negative in terms of sales, but the project does not know who is buying PROTEKTOR or how many retailers had PROTEKTOR before and after the price change.

VI.6.2.4 Source. The source of the PROTEKTOR condoms (A.I.D./FPIA) is very reliable. Given the strong name recognition of the product to date and the fact that outside packaging of the product is done in country (handled by DISCONSA), the project could continue to import and sell condoms even if A.I.D. support should no longer be available.

VI.6.2.5 Registration. Registering nonethical products is not difficult in Mexico. The project, however, will have to register with its own secretariat (SSA) any ethical products it plans to market, and all brand-name products require the approval of two secretariats. No difficulties are anticipated in this regard.

VI.6.2.6 Non-Family-Planning Products. The CSM project has no immediate plans to diversify into non-family-planning products, and this is clearly appropriate considering its role within DGPF/SSA. As noted above, however, CONASUPO has initiated an ORT salts and nutritional information program in cooperation with UNICEF. Coordinating these initiatives and the CSM project within CONASUPO could be very useful, especially in rural areas and urban-based PAZPU community development areas, where knowledge and use of family planning may be low and where messages about the health benefits of family planning may be appropriate.

Recommendations:

- SOMARC should continue its efforts to collaborate with the Mexican commercial sector to secure alternative (non-A.I.D.) sources of supply for the project.

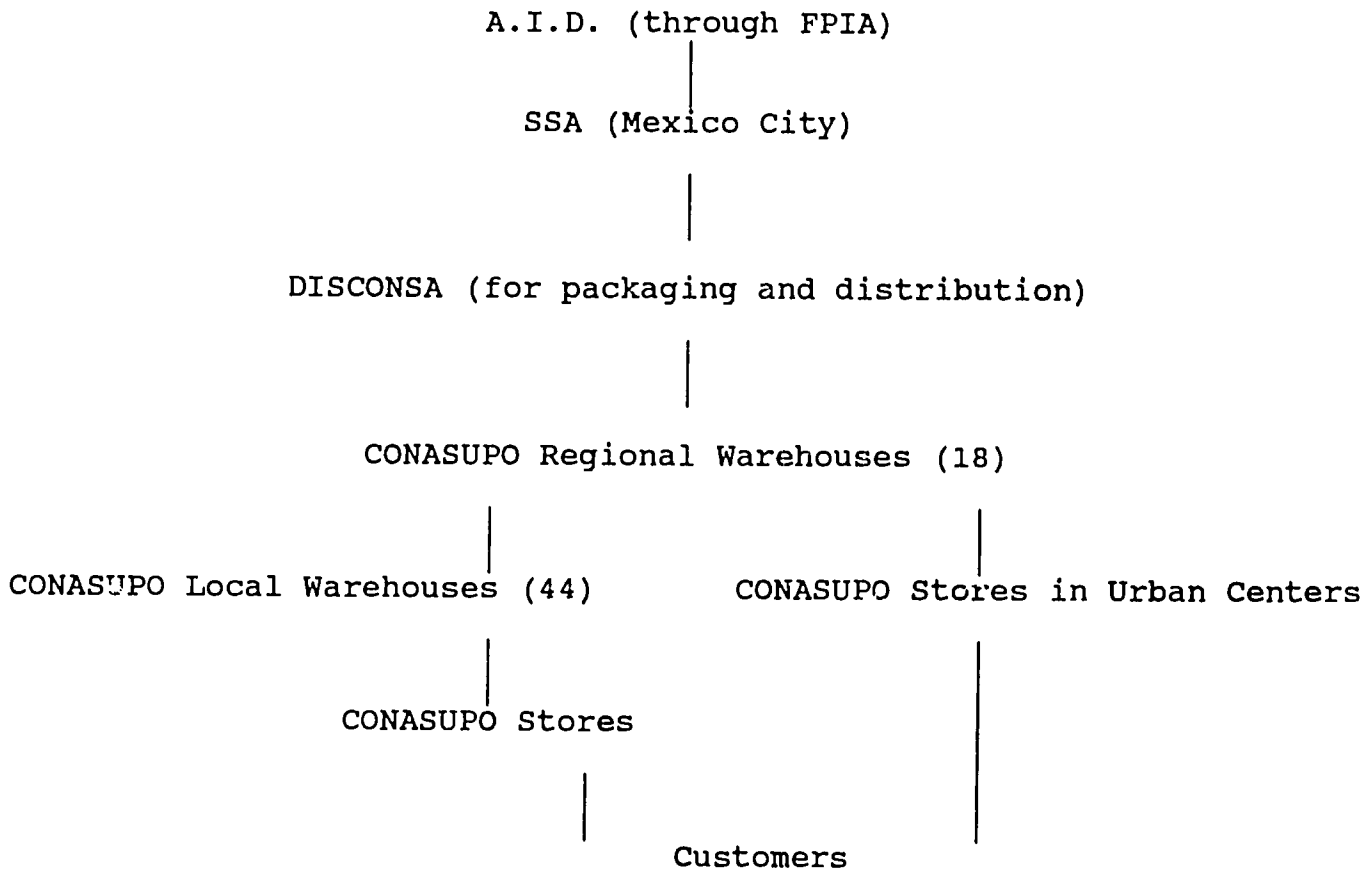
- The project should expand the product line, but this expansion should occur with products already in the market and not with A.I.D.-donated commodities. For oral contraceptives, advertising alone may be as effective as expanding the product line.

- An A.I.D. cooperating agency with experience in community-based family planning programs should be called on to assist CONASUPO with a specialized program for providing family planning in rural and urban community development areas.

VI.7 Distribution

VI.7.1 Distribution Network

The distribution system for the CSM project is as follows:



CONASUPO is a large and varied national system. It owns, franchises, or invests in some 17,000 stores nationwide. Although the actual number of affiliates often changes, the general breakdown of its structure is as follows:

Urban:	700	owned by CONASUPO
	2,300	franchise
	2,000	PAZPU (community and CONASUPO-supported
Rural:	12,000	franchise and community

The urban CONASUPO-owned stores account for approximately 70 percent of CONASUPO's sales volume. The system handles 5,000-6,000 products. CONASUPO receives government

subsidies, but its distribution arm, DISCONSA, is run as a for-profit company but enjoys exclusive distribution rights for the CONASUPO system.

VI.7.2 Findings

VI.7.2.1 Distribution Targets. Between June 1986 and June 1987, the distribution of condoms within the CONASUPO system was to be completed using the following three-phased plan:

Phase	Units Distributed
I	1,800,000
II	2,142,000
III	828,000
Total	4,770,000

Sales estimates indicate that approximately 837,000 units were sold during the first year. Although sales targets do not exist for the CSM project, the distribution target would have covered about .05 percent of prevalence (one-half the project's annual prevalence target of 70,000 CYP). If the sales estimates are accurate, approximately one-tenth of the prevalence target was met.

VI.7.2.2 The System. The CONASUPO system has problems that affect the CSM project. Generally, the system suffers from the following:

- Slow supply and resupply throughout the chain of distribution.
- Slow implementation of price changes.
- Inability to guarantee that supplies received first in warehouses will be distributed first.
- Automatic resupply of stores that may be unable to sell products.

VI.7.2.3. Product Availability. If all CONASUPO stores had the PROTEKTOR condom in stock, one could be assured that C-, D-, and even E-class customers had access to quality, low-priced condoms in their communities. As may be expected, however, the distribution problems cited above affect small rural and low-income stores. On the other hand, the large-volume, urban stores are well stocked. As the CSM project expands to pharmacies, product accessibility will increase considerably.

VI.7.2.4 Inventory. The DISCONSA system has no clear methodology for managing its inventory or reports on where products are in the distribution chain. An attempt has been made to have local SSA health personnel join in checking store inventories, but that program has not yet reached a level of implementation that would be of use in inventory management. The CSM project continues to spot check, to encourage DISCONSA to track the product, and to attempt to use SSA health personnel to check stores. As might be expected, since the product is not well tracked, neither are changes in price. When the price of PROTEKTOR was increased, for example, the retailer margin was increased (see section VI.8), but news of the price change did not reach all the stores in the distribution chain.

Recommendations:

As the CSM project begins working with pharmacies, many of its distribution problems will be solved. As long as the project continues to work with CONASUPO, however, closer supervision of CONASUPO's distribution efforts will be required. The CSM project should maintain closer contact with local warehouses and, specifically, small stores. Inventory and sales controls should be instituted and training in those controls provided for retailers.

VI.8 Pricing

VI.8.1 Pricing Structure

Given the government distribution system and the financial support the CSM project receives for training, advertising, trade promotion, market research, and project management, the project can set a price for the product that includes only the costs of packaging and value-added taxes. The final price to the consumer was set below market price. The pricing structure for a pack of three condoms is shown in Table VI.1.

The 119 pesos per 3-pack charged by DISCONSA covers the cost of packaging, which is currently minimal but will increase as new condoms are packaged. The remainder of the money is put into a project fund, managed jointly by DGPF and CONASUPO, that is used to help offset advertising and promotional costs of the project. In August 1987, SSA/DGPF announced that the fund contained 162 million pesos (about U.S. $100,000). Aside from the fact that any fund jointly managed by two government agencies is bound to be cumbersome, rampant inflation substantially decreases the value of the money collected before it can be used for program activities.

Table VI.I
CSM PRICE MARGINS
BEFORE AND AFTER JULY 1987
(pesos)

	5/86-6/87	7/87-Present
Import price (A.I.D. donated)	0	0
SSA price to DISCONSA	0	0
DISCONSA price to stores	119.00	119.00
Store margin	24.50	220.00
SUBTOTAL	143.50	339.00
Value-added tax (15%)	21.50	51.00
Price to consumer (3-pack)	165.00	390.00

NOTE: One U.S. dollar equaled 1,550 pesos in October 1987.
SOURCE: Presentation by Salvador Ruiz de Chavez, October 1987.

The price change outlined in Table VI.1 demonstrates that no attempt was made to use part of the price increase to improve the project's cost recovery. The increase went only to retailers and through taxes to the Mexican government. In fact, as the price of packaging increases, which is expected to occur soon, the project loses revenue. As mentioned earlier, even the retailer may not be gaining from the price change in that store clerks indicate that the price of PROTEKTOR has not been increased in all CONASUPO stores.

VI.8.2 Conclusions/Recommendations

The CSM project should concentrate on price setting, margin setting, and possibly price differentiation.

The price of the PROTEKTOR condom was set by the DGPF. The price was set lower than the market price, and it has not been increased to keep pace with inflation. The project's marketing costs (e.g., advertising, trade incentives, project management) are not recovered. What price the C- and D-class markets could bear has not been determined, but there are tentative plans for testing the price elasticity of demand.

Margin setting should include an increase in the return to project revenues (now the advertising and promotional fund). In the first year of the project, it appears that only half of the initial sales target was met. Under the best sales estimates, local project costs are not expected to be recouped,

but the present pricing structure for PROTEKTOR provides for an increase in the return to project revenues.

Although price differentiation is normally a delicate undertaking, CONASUPO officials report that it is very common for the same products to be priced higher outside the CONASUPO system. As the CSM project begins distribution in pharmacies and private grocery stores, a higher price is contemplated to help cover the increased distribution costs that will be incurred.

Once information is available on what income groups purchase PROTEKTOR and other condoms in Mexico and on what prices are acceptable to C- and D-class customers, the CSM project will have a stronger basis for pricing decisions, which are clearly important for the project's long-term viability.

VI.9 Advertising and Promotion

If the PROTEKTOR project can be credited with increasing sales of condoms of all brands (by approximately 36 percent overall in 1986), the project's advertising campaign deserves the credit. Strong SSA support helped the project reintroduce mass media advertising for brands of contraceptives (though the methods are not mentioned).[28]

Product presentations, the PROTEKTOR name, and posters were pretested to ensure positive results. Focus-group research was used for most of this work, and findings were acted on whenever possible.[29] Radio commercials used for launching the project during the World Soccer Cup games and sales of PROTEKTOR were not pretested. The copy for the radio spots was well thought out, however, and because most local stations around the country bought into the capital's coverage of the soccer games, it is likely that the radio campaign was the most effective part of the advertising campaign.

Not being able to use the word "condom" probably did not affect the PROTEKTOR campaign, because the advertising uses a

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[28]The PROFAM project had used mass media advertising earlier.

[29]An ironic twist in these focus-group investigations may have occurred as the brand name for the condom was being tested. Focus-group results indicated preferences for three brand names, all of which began with the letters "PRO"; no other sample name began with these letters. The best-selling condom in the country is called PROFAM, a name chosen at random in 1979 for the first CSM program in Mexico.

logo that clearly represents the method. The same will not be true for foaming tablets or oral contraceptives, and thus the lifting of this legal constraint is very important.

The CSM project has increased its level of experience in advertising since the project began. Learning that all radio stations will not choose to air an ad and that the product must be in a store before advertising begins were important lessons. Both CSM project staff and DISCONSA staff believe giving program participants a free carton of PROTEKTOR condoms (containing 20 packs of 3 units each) is a useful trade promotion (see section VI.11.1).

A survey currently in the field should help the project learn more about the acceptability of its advertising campaign and whether the target market finds it acceptable enough to buy the product. The impact of the campaign will be measured through sales.

One concern is that PROTEKTOR is advertised as being better that other methods of family planning (e.g., condoms have no side effects). It is hoped that this approach will not backfire as new methods are added to the CSM line.

VI.10 Research and Evaluation

The research and evaluation strategy of the PROTEKTOR CSM project, a typical SOMARC approach, is comprehensive. It incorporates studies specifically commissioned to evaluate consumer preferences, attitudes, and characteristics, as well as the use of marketing instruments to track trends in sales and changes in market shares. The strategy seems to be adequate for Mexico, a country that has a well-developed infrastructure for marketing and publicity. In general, the marketing and publicity aspects of the project are considerably more adequate than the monitoring of sales, although even in the former areas there is room for improvement.

Part of the problem with the monitoring of sales is that PROTEKTOR condoms are only distributed through the CONASUPO stores; thus, many of the more conventional commercial systems for monitoring sales cannot be used. CONASUPO keeps a daily record of its inventories in warehouses, but similar records are not maintained for each of the retail outlets. As a result, it has proven far more difficult to keep track of sales than of distribution to retail outlets. An only partially successful approach to overcoming this limitation has been to utilize the results of an ongoing market audit routinely conducted by the Nielsen firm for the CONASUPO chain. The retail audit keeps

track of a large number of goods distributed by the chain (CONASUPO carries over 5,000 items in its largest stores). There are several problems with this audit, aside from the large number of items it covers. In particular, until very recently it provided only results at the regional level (the latest results were for the Mexico City metropolitan area and "the rest of the country"). Some steps are being taken to improve the reporting, but how effective the new methodology will be remains to be established.

The project has used the services of a highly competent firm to conduct a baseline study against which to evaluate changes in awareness, attitudes, and use of contraceptives. This same firm will conduct the follow-up studies. Consumer intercept studies, one of which is already in the field, in conjunction with the tracking studies will prove very useful to the project managers. The first of the intercept studies will not be as useful as it could have been because of flaws in its design. The questionnaire does not provide for clear answers, and the crucial question of how PROTEKTOR user characteristics compare with those of other brands is not addressed. These shortcomings could have been avoided had some of the expertise in developing fertility and family planning surveys that is available in Mexico been tapped, even while preserving the integrity of the essentially marketing purpose of the study. This could have been accomplished through the use of selected consultants in marketing firms, for example.

Research results appear to be used only partially in management decision making. This may be due, at least in part, to the recency of the project. It was evident, however, that research results are often used to rationalize past decisions and to "prove" that the project is performing well. Many questions will be answerable once additional data become available. The main problem detected, to recapitulate, is the project's inability to determine sales levels and trends.[30]

Recommendations:

- The top research priority of the project should be to determine how to measure sales flow within the CONASUPO system accurately before the marketing efforts are extended to pharmacies and other retail outlets.

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[30]SOMARC staff note that if allowed by DGPF and DISCONSA they could provide the necessary assistance to improve DISCONSA's sales tracking.

- The project should consider the routine monitoring of even a small number of retail outlets strategically located in selected cities. This system would not be representative of all CONASUPO urban outlets and would involve certain costs, but it could provide some sorely needed information to the project's managers.

- The best research approach may be to work with a limited number of marketing and research firms rather than with a large number of firms. In Mexico the need for institutional development is not as pressing as in other, far less developed countries. The process of competitive bidding by itself should substantially narrow the field of research firms with the capability to conduct the studies.

VI.11 Medical Aspects

VI.11.1 Findings

The PROTEKTOR product is introduced to distributors (supermarkets, franchises, and PAZPU stores) through training sessions offered by SSA and DISCONSA officials. DGPF is beginning to tap regional, state, and jurisdictional SSA physicians and health representatives for use as trainers, as well. Potential customers learn through the promotional campaign that PROTEKTOR is safe, easy to use, and lubricated; that it has no side effects and prevents pregnancy; and that it is hygienic and inexpensive, needs no prescription, and is easily accessible at the local CONASUPO store. PROTEKTOR is the only condom on the market that is packaged with an informational insert.

No information is available as to whether PROTEKTOR condoms are being used properly. Use issues will become more important if the project begins to sell foam tablets and oral contraceptives.

Training has focused on people who are not in direct contact with clients but who must understand and support the program to ensure its viability. In July 1986, training sessions were held in six regions of the country. These sessions were attended by 557 store managers, 7 store administrators, and 65 training coordinators. The sessions lasted from two to four hours (an agenda appears as Table VI.2). Participants were able to ask any questions they had concerning the program, the product, and the product's promotion and sale. Trainers included state-level SSA personnel and national and state-level CONASUPO employees.

Table VI.2

TRAINING COURSE FOR
CONASUPO STORE MANAGERS AND TRAINING COORDINATORS

Points in Agenda	Time
SSA CONASUPO agreement and population problem in Mexico	30 minutes
Health and family planning	10
Contraception	30
Discussion of condoms; cooperation of CONASUPO sales force in marketing PROTEKTOR solicited	20
Handling and marketing of PROTEKTOR	10
Question-and answer session	10
Other	10
	120 minutes

Each participant in the training course received a free shelf box of PROTEKTOR condoms (20 boxes of three) and a primer describing the product in considerable detail. Participants were also shown examples of the posters, stickers, and other promotional materials used in the campaign.

Both DGPF/SSA and CONASUPO expect that those trained will share the information with others. No mechanism for passing this information on was evident, however. (Although one cannot generalize from a few examples, a site visit to the rural area of Pachuca indicated that the information store clerks had about PROTEKTOR seemed to come more from the publicity than the training course.)

Considerable attention is being given to integrating government medical personnel already working in areas covered by the CONASUPO system into project training and monitoring activities. Ongoing and planned training activities are as follows:

State medical representatives: DGPF introduced the PROTEKTOR program to state SSA family planning representatives. They were told about the product, the program, and CONASUPO. The DGPF hopes that, along with their other responsibilities, these state representatives can collaborate with CONASUPO personnel in their areas to train sales clerks. This system was not observed during field visits.

Medical supervisors in Mexico City: Approximately 50 DGPF officials make regular visits to each state to observe progress in the entire DGPF/SSA family planning program. These 50 officials were given a lecture on the PROTEKTOR program with the expectation that they could monitor PROTEKTOR sales during their visits to other states. It was also expected that this cadre of medical officials could help train store clerks at the state level. As yet no plans for training sessions (e.g., place, trainers, agenda, materials) by state or federal medical personnel are evident.

Government physicians: Between 200 to 300 local government family planning physicians are available nationwide. They are responsible for supervising all family planning activities in their jurisdiction. How these physicians have or will participate in training sales clerks or other store personnel has not been documented. Many of these physicians reside in rural areas not reached by the PROTEKTOR program.

VI.11.2 Conclusion

If coordinated properly, the use of government medical personnel for training and monitoring could be a low-cost complement to the project. These initiatives will require (1) extensive training, (2) continued support from units of SSA besides DGPF, and (3) a clear understanding on the part of the project team as to what can be expected of medical personnel in terms of nonmedical components of project monitoring (e.g., sales and inventory). The project may benefit from a pilot project to test these initiatives.

Recommendation:

- o Whether the CSM project or another SSA program continues working with rural CONASUPOs, the project should concentrate on designing and implementing an effective training program for salespeople. The UNICEF training initiatives being implemented should be considered when developing such a program. Depending on how effective SSA medical personnel prove to be as trainers and/or project monitors, the project must decide whether to proceed with the program in hard-to-reach rural areas.

VI.12 Project Costs

VI.12.1 Cost Components

Although costs must eventually be compared with program effectiveness, a first step toward evaluating whether a project should be initiated or continued is to understand its costs. As currently configured, the project costs include the following elements:

SOMARC subcontract: Between $550,000 and $600,000 per year for project administration, sales monitoring, promotion, advertising, trade incentives, research, and direct costs. (The total cost to A.I.D. may be as much as twice that amount considering technical assistance, monitoring, and program management activities provided by SOMARC outside the DIPLAF-Futures Group subcontract.)

A.I.D.-donated commodities: Seven million condoms in PROTEKTOR foil at approximately 2 cents a unit. (This cost to A.I.D. does not include the cost of A.I.D. and other government personnel who administer the commodities program, nor does it include the services of FPIA, which channels the commodities to SSA.)

SSA personnel support: The SOMARC subcontract covers personnel and administrative support for the DGPF staff directly involved with the PROTEKTOR project, but SSA contributes the time of SSA medical staff at various levels. Although the marginal costs to SSA of this donation is probably close to zero, creating a cadre of medical professionals outside the SSA system to assist with training and monitoring would have been extremely costly to A.I.D. had SSA not provided them for free.

CONASUPO and DISCONSA support: The marginal cost to CONASUPO (which distributes 5,000 to 6,000 products nationwide) of adding the PROTEKTOR product to its offerings is next to nil. Any replication of this nationwide distribution system in the private sector, however, would force an increase in prices to cover commercial margins, and the CSM project would likely continue to require A.I.D. support.

Project revenue generated from sales is jointly administered by CONASUPO and SSA through an advertising and promotional fund. As noted above, in August 1987, SSA/DGPF announced that the fund contained 162 million pesos (a little over U.S. $100,000).

VI.12.2 Findings/Conclusions

The PROTEKTOR project has demonstrated that income generation is possible. If the project reaches a CYP target that represents 1 percent of national contraceptive prevalence and local project costs and revenue continue to hold the U.S. dollar value estimated in the March 1987 marketing plan--$563,000 and $286,000 respectively--the PROTEKTOR project could reach a cost per CYP of $4.00.[31] (Actual start-up costs per CYP were about $8.00 if only local costs incurred by SOMARC are considered.) While local costs do not become self-financing under this scenario, approximately half of them could be over the next year.

Costs to A.I.D. in the form of commodities and technical assistance provided through A.I.D. cooperating agencies will continue. Plans for new channels of distribution and new product introductions suggest that costs to A.I.D. are likely to increase as the project expands. Evaluating this investment by A.I.D. will require an assessment of (1) whether the project meets an unmet demand for family planning for those who cannot afford market prices or do not find public services accessible and (2) whether generic advertising could be useful in generating acceptance of temporary methods of family planning. When A.I.D. discontinued financial support for the PROFAM CSM project, the project did not fold, but rather began selling its product at higher prices.

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[31]This figure was calculated as follows: (563,016-286,077 = 276,939)/67,700 CYP = 4.09. SSA assumes 100 condoms = one CYP. If one assumes condoms are 90 percent effective, the estimated cost per CYP would have been approximately $4.60 if the initial annual target of 70,000 CYP was met.

For A.I.D., it is not enough to know what a CSM program can do (e.g., sell to low-income populations). It must be clear that the existing free market system could not do as well with less or no outside involvement.

Recommendation:

- The project should attempt to gain information about the price elasticity of demand from C- and D-class consumers.

- A.I.D. should also carefully calculate expected costs and program income before beginning the next SOMARC subcontract. Project costs and income to date should be considered. The budget should show what activities within the project will be supported by project revenue. Breaking out "private" costs (e.g., margins, advertising) from "social" costs (e.g., impact research, retailer training) and attempting to cover "private" costs may be the most realistic approach.

VI.13 Conclusion

Care should be taken when designing the new SOMARC subcontract (between The Futures Group and the Mexican Foundation for Health), particularly in regard to (1) payments that meet the needs of a country experiencing extensive inflation, (2) the plan for the project to become technically self-sufficient by the end of the contract period, and (3) a phase-down of financial support over a two-year period whereby project-generated income can be used to cover more of the costs.

ANNEX A

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ANNEX B

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