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THE POTENTIAL FOR A CONTRACEPTIVE
SOCIAL MARKETING PROJECT IN THAILAND

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INTRODUCTION AND BACKGROUND

During the period February 8-21, 1984 a team of three consultants from the International Contraceptive Social Marketing Project (ICSMP) examined the feasibility of expanding the supply of contraceptives through rural commercial outlets in Thailand. The team was composed of Dr. Robert Smith (The Futures Group), Mr. Terry Louis (PSI - Sri Lanka) and Mr. Robert Druckenmiller (Porter, Novelli and Associates). Upon arrival in Bangkok the team was given a scope of work which stated the following objectives:

1. Determine if adequate market potential exists to justify development of a subsidized commercial contraceptive scheme for Thailand.
2. Analyze the current and planned contraceptive supply distribution system through the public and private sectors; describe the gaps in the system and identify the number, location and types of commercial outlets appropriate to filling those gaps.
3. Develop program options for a commercial marketing of contraceptives scheme, including such factors as product configuration, brand development, advertising, distribution and pricing. This should include a discussion of program costs and revenues necessary to achieve eventual program self-sufficiency.
4. Identify and discuss the strengths and weaknesses of potential Contraceptive social marketing project implementing agencies.

After discussions with representatives of USAID and the Ministry of Public Health, it became apparent that the major issue centered on whether a social marketing project was really necessary given the following: 98 percent of ever-married women are aware of at least one modern method of contraception; 76 percent of ever-married women have used at least one method of contraception; and 59 percent of ever-married women are current users of contraceptives (1981 Contraceptive Prevalence Survey). Given this very high knowledge and prevalence rate, the question can fairly be stated as: Is there adequate justification for introducing a social marketing project into Thailand? This question is further compounded by the fact that the Population and Community Development Association (PDA) is already running a very successful community-based distribution program in 157 of the 620 districts in Thailand and this program, with few exceptions, is identical to a contraceptive social marketing program.

CURRENT CONTRACEPTIVE DISTRIBUTION - MOPH

The Ministry of Public Health (MOPH), through the Department of Health and its Family Health Division (FHD), is responsible for the provision of family planning services through government outlets. Personnel working for the FHD are responsible for health promotion and preventative and curative services, of which family planning is only one. In addition, the FHD has eight Maternal and

Child Health (MCH) hospitals directly under its supervision and is also responsible for commodity procurement and distribution information Education and Communication (IE&C), training, research and evaluation and planning.

The Family Health Division, which recognizes the rural and agricultural setting of Thailand, focuses its emphasis on delivering contraceptives and contraceptive services through the existing clinical infrastructure. The one significant feature of the government program is that it has added the "pull" factor at the rural level through its trained village health volunteers and village health communicators who are linked to the 5,300 health centers in the country.

The Health Department provides public health facilities at regional, provincial, district, subdistrict and village levels. There are nine regions with fourteen regional hospitals. There are 89 provincial hospitals with a chief provincial medical office (CPMO) taking responsibility for health care delivery in the province.

The provinces currently include a total of 620 districts. In these districts there are 356 hospitals that are channels for the delivery of family planning services of the government. The districts are divided into subdistricts that are outside municipal limits of the districts. There are 5,443 subdistricts with 5,270 health centers. Supporting the health centers are 1,242 midwifery centers that serve the 53,838 villages throughout the country.

The smallest health facility is the midwifery center which is staffed by one auxiliary midwife who is responsible for maternal and child health, family planning and minor medical care. Complementing the government staff at the village level are 41,600 village health communicators and 4,500 village health volunteers who have been trained and serve the community.

The supply of commodities for the family planning program is purchased centrally, on tender, through the Government Printing Office (GPO). After the products are purchased by GPO, they are warehoused in Bangkok for distribution to the warehouses at the CPMO and the eight MCH hospitals. From these warehouses the district health officers draw their supplies on a monthly basis coincidental with their monthly staff meetings. Similarly, the subdistrict health officers and the village health volunteers have a monthly meeting at the district health office where they also can draw the supplies they will need for the ensuing month.

While this system works fairly effectively, it was noted that in some districts not all brands of contraceptives (particularly oral pills) are regularly available, and that clients were being switched from one brand to another, depending upon availability of supply (e.g., in Chaing Mai Province, Eugynon, the most popular pill, was not currently available, although stocks were readily available at the Bangkok warehouse). It appears that the distribution system from Bangkok to the CPMO responds both to the requests for products and also to the need to reduce specific inventory to make space available for new shipments.

Discussion with MOPH officials, CPMO officials, district health officers and village health volunteers revealed that the village health worker concept is working well, but on a sporadic basis. Turnover among volunteers is high (30 -40 percent), and variation in policy and practice is also significant. For example, in some districts the village health volunteer distributes oral contraceptives after a new acceptor has had an initial visit at the district or subdistrict health center.

In these cases contraceptives are distributed free to those who cannot afford to pay, and a nominal donation is requested of those who are judged eligible to pay. In other districts, however, the village health volunteers are not permitted to distribute contraceptives, a decision which is made at the district health office. In the one case where this was actually observed, the district health officer stated that the village health volunteers were unable to maintain adequate records, so distribution through this channel had been stopped. According to MOPH estimates, fewer than 50 percent of village health volunteers have been trained to distribute pills, although the number actually doing so is not known.

It appears that from the district health center level up through the MOPH there is concern about the efficiency of using the village health volunteer to distribute contraceptives. One official commented that as long as it was government policy to use this channel, he was supportive, but felt the cost/benefit ratio was not favorable (i.e., it was very expensive to train and then retrain the volunteers). Additionally, it was very difficult to determine if the volunteers were actually performing the required functions or whether they simply became volunteers in order to obtain the per diem that is paid during the training period.

As with any system as large and complex as the village health volunteer network, logistics, management, organizational and motivational factors will vary considerably from province to province and from district to district. Nevertheless, in the districts where the system is adequately supported, it appears to work well, and in those where it is not supported, it appears to have little, if any, impact.

The consultant team found the following to be the major impediments to the successful implementation of the village health worker system for the delivery of family planning services:

1. The variety of available oral contraceptives is not uniform and the supply (in terms of continuity of brands) has varied over time and may continue to do so in the future.
2. The village health volunteer has a variety of responsibilities only one of which is family planning. Thus, the attention given to this area may be minimal. In fact, in conversations with village health workers, family planning was not mentioned as one of the areas of concern.
3. Control systems to ensure that the volunteers perform as required are almost nonexistent, and in any event would be prohibitively expensive to implement.
4. The expense of installing and maintaining the system over time is significant.
5. The incentives for the volunteer to continue in the system are very small, and continued high turnover can be anticipated in the future.
6. The autonomy of each administrative unit in the system is such that adequate nationwide coverage in family planning is problematic.

CURRENT CONTRACEPTIVE DISTRIBUTION - PDA

The Population and Community Development Association operates its community-based distribution system (hereafter referred to as the contraceptive social marketing project) under the Rural Population and Health Bureau. Under the director of the bureau are two operating divisions, one responsible for three branch offices (two in the north and one in the south) and one responsible for two branch offices (one for Bangkok and one for the northeast). Each branch office has between four and five people on the administrative staff plus a number of field officers (dependent upon the number of districts covered in each province). In total there are 24 field officers to whom report 157 field supervisors. These supervisors are responsible for approximately 10,200 village volunteers (one in every village in the districts served). The turnover rate for field supervisors is between 3 percent and 5 percent and for volunteers about 10 percent per annum.

Supervisors receive about U.S. \$70 per month, a 5 percent commission on sales and about U.S. \$18 per year for motorcycle maintenance. Life and accident insurance are also provided. Village volunteers receive compensation in the form of margins of ฿1 per cycle of oral contraceptives and ฿3 per 12 condoms. PDA currently has four brands of oral contraceptives that sell for ฿5, 7, 9 and 11. Current average monthly sales of oral contraceptives total 150,000. There is one brand of condom available through the village program that sells for ฿1 per piece with total monthly sales of approximately 12,000.

Contraceptive products sold through the PDA system are obtained free of charge from the MOPH and warehoused initially in Bangkok. In those circumstances where PDA cannot obtain the brands it needs from the MOPH, it purchases them either directly from the manufacturer (condoms) or through an international broker (orals). Distribution of commodities within the PDA system is similar to that of the government in that products are shipped from the central warehouse to the branch offices and from there to the field supervisors who in turn distribute to the volunteers. Once a month the supervisors submit a report on supplies needed (based on volunteer records) to the branch office. The branch office maintains approximately 2-3 months' supply. The striking difference between the PDA system and the government system, however, is in the controls established for distribution and the method of delivery of products to the volunteers. In terms of controls, each volunteer is supplied on a monthly basis at a replacement level dependent upon the number of contraceptives sold during the previous months. Records that were examined showed very careful reporting and control both of product and revenue. In addition, volunteers maintain adequate stocks of product beyond those required for just monthly distribution, although replacement of stock is based on actual sales. Also, and most importantly, the PDA system delivers the product directly to the volunteers on a monthly basis, rather than requiring them to physically pick up their own supplies, as in the MOPH system. Thus, contact is frequently made by the field supervisor with the volunteer at the volunteer's place of business. In addition, every 3 months the field officers visit the field supervisor and may, in turn, also visit some of the volunteers. This tight control of the distribution system has resulted in adequate stocks of products always being available plus frequent contact and assistance being provided to the village volunteer.

From discussions with PDA representatives, plus direct observations, the following appear to be the major issues either currently confronting the PDA and/or would be impediments to further expansion of the program.

1. PDA oral contraceptives are distributed without outer packaging. This allows the package to become dusty and detracts from product presentation. Additionally, in those areas where a village health volunteer and a PDA volunteer coexist, the distributed products are identical.
2. Products currently being supplied free of charge by the MOPH place PDA in a precarious long-term position of dependency upon the government's ability and willingness to continue this activity. Also, any contemplated expansion of the project must take into account the significant increase in contraceptive supplies that will be required and the attendant costs associated with product procurement.
3. PDA volunteers currently represent a variety of occupations. Nevertheless, the most effective volunteers, in terms of expanding the project, may well be those who are owners/operators of retail shops. Not only are these people more skilled in selling and managing merchandise, the environment surrounding a retail shop is more dynamic than that found either in a home setting or in one of the service industries.
4. Only about 15 percent of PDA overall effort (in terms of budget) is devoted to social marketing. This is, of course, partly due to the funding situation but also results from increasing attention being paid to additional activities in rural development that are now being undertaken by the organization since it cannot embark on geographic expansion of the family planning program.
5. The headquarters staff of PDA is composed of extremely capable people. Nevertheless, there appears to be a lack of trained marketing personnel in positions of authority. While this circumstance has probably not hindered PDA in the past, it is likely to be a constraint to further growth of the program over the long term.
6. The long-term personnel constraints confronting PDA represent a hidden, but potentially serious, constraint. For an organization that is only a decade old, it has acquired an extremely impressive staff which has made a significant contribution to family planning efforts in Thailand. The staff, however, is not paid at commercial rates nor is it provided with adequate retirement or other benefits as with government employees. Thus, over time, PDA may well lose management staff either to the private sector or government agencies with increasing regularity and face the recurrent and expensive problem of training new people to fill these vacancies.

PLANNED PARENTHOOD ASSOCIATION OF THAILAND PROGRAM

The Planned Parenthood Association of Thailand (PPAT) is one of four non-government organizations supporting and complementing the government's efforts to achieve the objective stated in the fifth Five-Year Economic and Social Development plan. The objective is to reduce the growth rate of the country to the level of 1.5 percent by 1986.

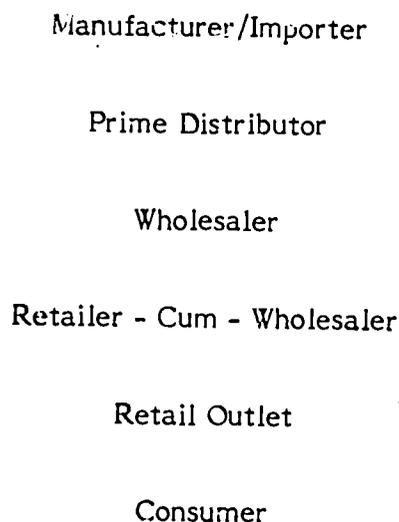
PPAT, with a staff of 70 and 10,000 volunteers, lays its stress more in information, education and communication activities. The single, sizable contraceptive delivery program is directed at low-income groups in urban areas using 800 volunteers to recruit contraceptive acceptors. This program which promotes the pill accounts for approximately 900,000 cycles per year. Apart from this, PPAT has four other projects; one in the south, one in the northern province and two others directed at a housing community and the refugees.

The program uses Eugynon, Microgynon and Noriday, all supplied by International Planned Parenthood Federation. The program also uses Durex, Tahiti and Viking condoms, but the distribution is relatively small when compared to oral contraceptives.

PPAT is quite active in its IE&C program having 360 three-minute presentations four times a day on four different TV stations. Fourteen radio broadcasting stations have regular weekly programs throughout the year. These are further supported by posters, handouts and leaflets distributed through the volunteer network.

PRIVATE-SECTOR MARKET

The private commercial network in Thailand is quite extensive and active within the free economic climate in the country. The traditional system of distribution for consumer goods, which is multilayered, functions efficiently. This means that at the farthest point from Bangkok, the goods pass through several layers of middlemen before reaching the end user. This multirouting is presented below:



In Thailand this traditional multilayered system is established and functions well. The wholesaler-retailer pipeline system is linked and originates from Bangkok. The system uses the pipeline because it is the simplest way to move products within the country.

Between 40 percent and 50 percent of all sales of consumer products are in the greater Bangkok metropolitan area, and the products move from there to the provinces. There is also a well-organized trade delivery system serving the outstations, and the distributing organizations use this to get their products to the outposts.

Trade margins on consumer items and pharmaceuticals, and oral contraceptives in particular, average 5 percent to the wholesaler and 15 percent to the retailer on the retail price.

Typically, distributors have representatives to take orders, deliver to outlets at the retail and wholesale levels and, in the case of pharmaceuticals, promote the products through "detailing" to the medical practitioners.

The push-pull process is an essential component to any marketing operation that uses a pipeline system. Push is defined as the sale of the product to retailers or pharmacies. Pull is the process of stimulating the consumer through advertising and promotion to purchase the product. This system is well recognized by marketing organizations in Thailand and is well utilized.

The oral contraceptive private-sector market is estimated at a little over 3 million cycles a year with Schering taking 40 percent of the market share. Wyeth accounts for a little over 20 percent and the rest is shared between Organon, Ortho Labs, Searle and Syntex. There are 14 brands on sale in pharmacies throughout the country, and the pharmaceutical organizations cover the pharmacies with their sales representatives and the medical practitioners with their detailmen.

It is estimated that there are 10,000 medical practitioners in Thailand and of these only about 30 percent are detailed by the pharmaceutical organizations for the oral contraceptive pill.

Oral contraceptive private-sector pricing is competitive. The prices range from $\text{฿}23$ to $\text{฿}28$ for most brands except Exulton which is a 34-pill cycle of progesteron and sells at $\text{฿}35$. The retail outlets, depending on their turnover, have an elastic sales price.

Pharmaceutical outlets are mainly urban. Ninety percent of the outlets out of the approximately 1,750 grade "A" pharmacies in the country are in the main towns. In fact, Bangkok accounts for almost 700 outlets. This distribution network clearly indicates that the rural areas depend entirely on either the government delivery system or other alternate systems for their contraceptive supply. There does not seem to be any conflict either on supply or price between the commercial sector and alternate contraceptive delivery systems.

Condoms are sold in all pharmacies along with oral contraceptives but do not appear to have much consumer demand. There are several brands on sale but

four leading brands account for almost 80 percent of the market share. They are Durex, Kingtex, Oka and Rainbow. Each brand has over two product offerings, such as Kingtex "Parisian" and Kingtex "Longtime" or Rainbow "Superthin". Pricing ranges from Rainbow at \$6 for three to Durex Featherlite at \$16 for three. Except for Rainbow Regular, all other brands are offered at \$15 for a pack of three.

Advertising and promotion for condoms are quite small. Only Kingtex has, during past years, used media for promoting its brands. It is evident that condoms are not commercially promoted as a method of contraception, but rather are promoted for the prevention of venereal disease.

PRIVATE-SECTOR O.C. MARKET

<u>PRODUCT</u>	<u>MANUFACTURER</u>
1. Eugynon	Schering
2. Microgynon	Schering
3. Neogynon	Schering
4. Gynovalar	Schering
5. Auovalar	Schering
6. Ovulen	Searle
7. Ortho Novun	Ortho
8. Nordette	Syntex
9. Noridol	Syntex
10. Ovral	Wyeth
11. Trinordiol	Wyeth
12. Ovastat	Wyeth
13. Exulton	Organon
14. Lyndiol	Organon

(14 Brands and 6 Manufacturers)

CURRENT MARKETING AND PROMOTION OF CONTRACEPTIVES

A. INTRODUCTION

All the major family planning organizations in Thailand--public, private, and nonprofit--have sponsored promotion materials and activities. Their involvement covers the full promotion spectrum:

1. materials and training to support the vital interpersonal communication networks established by local volunteer programs;
2. mobile audio-visual programs to reach out into the rural areas;
3. direct mail to support the volunteer network and gain new acceptors;
4. incentive programs to encourage greater participation by acceptors;
5. merchandising to boost inquiries and sales at the retail level;
6. classroom education programs to improve understanding of tomorrow's parents; and
7. mass media advertising and editorial support to foster family planning practices and pull contraceptives through the distribution channels.

Since the inception of family planning promotion programs in the late 1960s, strategic thinking in promotion has changed. Initially the primary concern was in providing information and improving understanding of family planning and the alternative methods of contraception. Today, given the high public awareness of family planning and the different methods available, the strategy has shifted toward placing a greater emphasis on motivating selected audiences to participate in family planning practices. The concept of "two-child families" as the ideal will soon be an important item in a new MOPH promotion. Many organizations are now targeting their promotional efforts to reach men and convince them to have vasectomies... bringing the ratio of male sterilization more in line with female sterilization. (Currently the ratio is almost four female sterilizations to every one male sterilization--and the gap appears to be widening.)

Finally, while all forms of contraception are promoted, it appears that oral contraceptives and to a lesser extent injectables are the preferred methods, and are more heavily promoted through the interpersonal channels of communication, that is, the volunteers. Condoms, the only contraceptive method that can be promoted with a brand identification in the mass media, have not been aggressively promoted even by the commercial companies that seem to find the broadcast media censorship a handicap. (Total advertising for the leading commercial distributor of condoms, Kingtex, does not exceed 1 million baht or U.S. \$45,000.)

In the next section, the current family planning promotion, education, and information activities will be described for all the participating organizations.

This review will provide a better perspective of the role promotion has played in the success of current family planning programs, and help identify the role promotion could play in a comprehensive social marketing program.

B. CURRENT PROMOTION ACTIVITIES

1. Training and Materials Support for Staff and Volunteers Who Make Up the Interpersonal Family Planning Communication Network Principally in the Villages

Three organizations currently support a network of paid supervisors and volunteers who, as part of their duties, "educate" and "motivate" individuals in their geographic areas to practice family planning. The process of supporting this interpersonal network in their promotional activities involves the following:

- o Training--staff and volunteers in all the programs are given an initial training program of from one day (PDA) to three weeks (MOPH) and their own handbook to strengthen their understanding of family planning and clarify their responsibilities. Staff and volunteers are paid a per diem fee for attending these training sessions.
- o Teaching aids--FHD staff and all volunteers and staff of PDA receive flip charts, diagrams, and "models" to support them in their educational sessions.
- o Brochures--each of the major organizations makes brochures available on family planning, in general, and specific contraceptive methods.
- o Posters--approximately ten years ago the MOPH provided a supply of large four-color posters--one for each major form of birth control. About two years ago, MOPH provided five new versions that feature the two-child family and all six major contraceptives in one poster. These posters are now being replaced, or soon are to be replaced, with even newer versions. The PDA identifies each of its volunteers in the villages with a bright yellow sign and a PDA logo.
- o Wall books--wall books, combination newspapers and posters, are distributed every two months to supervisors and through supervisors to volunteers at PPAT (20,000 copies) and PDA (20,000 copies) for posting at the village sites. The wall books cover a variety of subjects in health and community development including family planning. PDA has continued to refine the content and format of its wall books to reflect the needs of the volunteer and the perceived needs of the village people as expressed through regular surveys conducted by PDA.
- o Technical magazines--magazines that provide greater detail on community development issues, including family planning, are also distributed regularly to staff and volunteers. PPAT sends a publication (20,000 copies) monthly to its network, and PDA sends copies (16-20,000) quarterly.

- o Evaluation and follow-up--family planning activities of the staff and volunteers are monitored principally through reports they are required to file on the distribution of contraceptives and number of new acceptors they recruit. Those volunteers in PDA or FHD who do not meet expectations (i.e., bring in too few acceptors) are shifted to "motivators", and play a lesser role. As motivators they are expected to continue to encourage family planning practices in their area and help facilitate family planning education activities such as special visits by FHD audiovisual vans or vasectomy drives.

PDA supervisors and FHD health officers and workers are expected to attend periodic training, for example, on providing injections through the community health centers.

Observations in the field

Visits with volunteers at the village level, and staff members at the sub-district, district and providence level, both in central Thailand (100 km north of Bangkok) and just outside Chaing Mai revealed the following:

- o FHD staff has an inventory of all the education materials; some sampling of the poster materials is usually visible at the volunteer level;
- o however, few handout materials, for example, brochures and technical publications, appear to be displayed at the volunteer level; and
- o most posters and wall books were very old, for example, FHD's 10-year-old-posters and PDA's wall books in the old formats.

2. Mobile Units

The FHD and PDA operate mobile vans that take audiovisual programs to the rural villages. FHD has 150 audiovisual vans and PDA has 3 that are used principally to support their vasectomy programs. The FHD audiovisual presentation integrates family planning information with an entertainment program. Following the audiovisual presentation printed materials are distributed.

Approximately 150 vans, visiting a different village each day, five days a week and 50 weeks a year could theoretically reach almost every village in Thailand. In visiting the field, however, we found little awareness of the mobile vans and suspect they play a small role in the ongoing promotion program . . . although they may play a very important supporting role in promoting events in the village such as the vasectomy drives.

3. Direct Mail

The use of direct mail has been experimented with both as a promotional tool and as a means for gaining new acceptors. The FHD uses direct mail to reach village headmen each year and provide them with a calendar and other family planning materials for posting and distribution.

Direct mail also offers a possible means of gaining new male acceptors-- for example, users of condoms. Direct mail offers two unique advantages:

- a. anonymity--shy acceptors can be users of contraceptives without having to go to a local store or village volunteer and identifying themselves.
- b. reach--in rural areas where it may be impractical to support a network of volunteers, the mailmen can act as distributors.

At least two organizations have experimented with direct mail to promote condoms. Kingtex used newspaper ads and found the response to be far more than expected. It reported receiving many requests from all over the countryside. Unfortunately, in pricing the promotion Kingtex had neglected to include a request for inquirers to include return postage. This would undoubtedly have reduced the favorable results somewhat, although by cutting out the retail markup (which direct mail allows you to do) the cost of postage could possibly have been covered.

PDA also experimented with direct mail as a means of promoting the use of condoms, but cited the costs of packaging for mailing and the unreliability of Thailand's mail service as two reasons for not continuing to use direct mail in this way.

4. Incentives

Incentives have been used in two ways to promote family planning in Thailand. PDA frequently offers prizes to winners in vasectomy raffles, drawing from a list of those individuals who sign up on a particular day to have a vasectomy; and PDA has offered incentives to first-time users of condoms, for example, offering free initial supplies, key chains, etc.

There have been no known incentive programs aimed at sustaining ongoing family planning practices.

5. Retail Merchandising

PDA produces point-of-purchase merchandising materials such as counter cards, display racks, promotion calendars, shelf-talkers (flagging the products on display), decals, and signs. However, there is little evidence in the retail stores and pharmacies visited of any of these point-of-purchase materials being used. While retailers are always reluctant to carry point-of-purchase merchandise which they feel clutters their display area, one volunteer retailer requested a small counter-top display which she thought would be very helpful in merchandising PDA products. A former manager of advertising for Kingtex recommended new packaging be explored that, like some of the current hair shampoos, would allow distributors of

birth control products to hang their products more visibly with accompanying promotion messages, and take them out of the crowded display cases.

6. Classroom Education Programs

Very little appears to have been invested in promoting the education of the next generation of parents who are now in school. The PPAT has taken a lead in education through youth counseling programs and promoting sex education in secondary school. PPAT is now in the third year of a five-year program to educate trainers, and in turn use these trainers to reach all the teachers in Thailand and strengthen their sex education skills. Limited funds have kept the scope of this project modest and do not allow for the production and printing of classroom education materials.

6. Mass Media

The growth of mass media in Thailand is revolutionizing marketing and promotion strategies. Although media was once available only on a regional basis, television's channel 7 will soon cover 90 percent of the country, and the Thai Rath newspaper already covers the country. The growth in national mass media has led to an increasingly homogeneous market of 50 million people who are sharing similar wants, ambitions, lifestyles, and purchasing behavior.

Some of the most dramatic changes are occurring in the rural areas where, for example, the growth in TV households has tripled in the last three years and the number of up-country people who watched TV "yesterday" was more than double the number in Bangkok (6.2 million versus 2.8 million). The number of TV households in Thailand now appears to be close to 40 percent.

Today the following mass media are available for promotion in Thailand:

<u>Medium</u>	<u>Number of Outlets</u>
Television	9
Radio	251
Newspapers	258
Magazines	31.5
Theaters	252

MEDIA BEHAVIOR	BANGKOK		UP-COUNTRY			
			Urban	Rural		
	Male	Female	Male	Female	Male	Female
	%	%	%	%	%	%
Watched TV yesterday	1342 m*	1543 m*	735 m*	816 m*	3003 m*	3210 m*
Listened to radio yesterday	67	57	71	66	57	58
Read any newspaper yesterday	75	52	64	51	25	15
Read monthly magazine past month	63	64	49	48	27	25
Visited cinema past fortnight	24	19	38	36	17	15

*People.

Source: Research and Data Resource (RDR): 1983 Media Monitor.

The family planning programs have not been able to fully capitalize on the rapidly growing importance of mass media for several reasons:

- o birth control pills, as a prescription drug, cannot be advertised on the mass media and in all likelihood will not be granted an exemption in the near future;
- o censorship practices by the owners of TV and radio media have limited the type of message that can be produced for condoms---in the perspective of some commercial distributors taking away the most promising communication strategies;
- o brand-name advertising by nonprofit organizations such as PDA would jeopardize their standing with donor groups and the MOPH;
- o rapidly escalating costs make paid mass media unaffordable on a sustaining basis; unless advertising proves commercially feasible and can be used to support some form of self-sufficiency, it will not play a major role. The MOPH has been in and out of mass media programs, but unable to sustain a significant campaign for more than three months a year which is of marginal value in a social marketing program designed to change well-established behavior patterns; and
- o mass media is still a problem in some regions of Thailand where customs and languages require the production of regional messages, and mass media is physically unavailable.

All the family planning organizations, however, have used mass media to support their family planning programs--most often with an educational/information strategy. PPAT has, perhaps, sustained the most constant presence in the mass media, sponsoring:

- o a 3-5 minute slide-talk series called "Window of Life", televised each day on four TV stations reaching principally the northeastern and southern regions. This program covers a variety of health-related subjects and offers scripts of the programs in booklet form for ฿ 25 or about U.S. \$1.00 to interested viewers;
- o 30-minute radio programs broadcast each week through stations in the central, northeastern and southern regions.

PDA has also been a user of mass media, but schedules its TV exposure to coincide with special family planning events such as vasectomy drives on the King's birthday. Mass media messages are scheduled about one month in advance of the event to build awareness and understanding for the value of vasectomies. As the event approaches, the PDA mass media messages take on the immediacy of the event,

announcing location, time, incentives, etc. Bus posters and outdoor signs are widely used in areas near the location at which the vasectomies will be performed. During the week prior to the event, a one-hour TV special is scheduled which features many popular entertainers.

As mentioned in the beginning of the promotion section, FPA is undertaking a mass media campaign to promote:

1. two-child families
2. vasectomies

With 1.6M Baht in UN funds (about U.S. \$73,000) FHD developed an advertising program in 1983 aimed at rural populations. Prototype radio spots and posters were pretested during July and August, using small groups recruited from the hill tribes, northern (non-hill tribes) rural areas, and southern rural areas. Separate research groups were conducted for men and women. Groups in the south were not shown vasectomy material but only two-child family material because their Muslim heritage is thought to make a campaign for vasectomy impractical. The sample radio spots featured dialogue between husbands and wives, older and younger men, etc. There are eight different approaches to vasectomy posters, but three basic treatments provide a lot of information on vasectomies; another features one dialogue much like the radio; and a third popular poster emphasizes the fact that vasectomies are free. All the materials on vasectomies address the barriers which research has shown are of concern to men, that is:

- o loss of strength
- o loss of sexuality and sexual desire/enjoyment
- o pain and complications in the surgery

Three different approaches to posters on the two-child family theme took two different directions. One poster addressed the advantages or benefits that accrue to two-children families, principally the ability to provide a good education for children. A second direction addressed the disadvantages of having three children. This was thought to be difficult to do in areas such as food or clothing so instead the posters show how inconvenient it is to go on a picnic with three children (only two can be carried) or to travel on a motor scooter (two can fit comfortably but it is difficult to fit three). Radio spots for the UN sponsored campaign were scheduled during the months of October, November and December, 1983. Approximately 16 stations carried messages on vasectomies; 15 stations carried messages on small families. The posters have yet to be printed although MOPH plans to print 25,000 copies of eight posters for distribution in 1984.

A second FHD campaign, funded with 1.3M Baht from USAID (U.S. \$59,000) is directed at urban and semi-urban populations and is

focused on vasectomies, although a secondary objective will be to continue to emphasize the value of a two-child family.

One roughly produced 30-second TV spot, three posters, and three brochures have just been pretested with small groups. The TV spot features a real doctor (not an actor) with his wife and two children. He has just had a vasectomy. FHD also hopes to feature other real people in this TV spot and other materials, for example, an office worker, laborer, farmer and average family man. One interesting insight was gained through the TV pretest. Men (and women) do not want to hear that they will enjoy sex even more after a vasectomy because it implies that the operation may have an abnormal effect on them.

Of the three prototype brochures tested, one was a lift of the TV message. A second provided more information on the vasectomy itself; and a third was produced in a cartoon style similar to the third poster--and also rejected during the pretest. A headline that was well liked in the pretest and featured on one of the brochures, was, "I'm one of 3,000 men who have already had a vasectomy."

A third campaign on IUDs is now in the early planning stages; with funds of about U.S. \$30,000 (USAID), FHD will produce posters and radio materials.

McCann Erickson Limited, the third-largest advertising agency in Thailand, produced, pretested, and placed (in the case of radio) all the materials funded by the UN and USAID grants.

During 1984 FHD plans to continue scheduling about 5,000 hours in radio programming, using a combination of popular folk song programs FHD produces, dramas produced by the radio stations, and local programs produced by FHD field people in the regions. Each program runs for almost 30 minutes and carries several one-minute family planning messages. The messages are on delaying pregnancy, spacing, sterilization, pregnancy care, early childhood care, and two-child families.

In addition to this regular programming FHD will award (through a competitive bidding process) a contract to a Thailand advertising agency to purchase about U.S. \$50,000 in TV time and U.S. \$27,000 in radio time to support the new campaigns just developed.

There seems to be a pattern going back to the mid-50s, of investing well in the development of good original materials, but of having far fewer funds to implement a meaningful, longer-term paid media campaign. Without the resources to do both--develop and implement a campaign--it appears that considerable time and money could be wasted. Furthermore, the contractual process of bidding on production and media placement separately, and having to do so each year, prevents the continuity and longer-term perspective needed to sustain an effective mass media approach.

Finally, under the subject of mass media promotion, commercial distributors of condoms have continued to use mass media advertising

in support of their retail sales programs--although limiting themselves primarily to the print media. Kingtex won a creative award for a TV message that apparently was carried for some time then banned because it was considered by the censors to be too provocative. None of the major distributors of condoms spends more than 1M Baht or U.S. \$50,000 on mass media advertising.

MARKET POTENTIAL

Although the various family planning delivery systems currently operating in Thailand have done an impressive job in making products widely available, there remains an unserved target market that appears large enough to warrant an expansion of social marketing activities in the country. This fact was also noted in Dr. John Farley's report dated 6/23/81. The following page shows an update of Farley's market estimates based on the 1981 Contraceptive Prevalance Survey.

RECOMMENDATIONS

Having looked at the four main contraceptive delivery systems, namely, the government, Planned Parenthood Association, the private sector and PDA, it is evident that each of them has an identified market segment which it serves. The government uses the clinical delivery system offering "health care" and family planning through its network and supporting it with the volunteer worker and communicator. PPAT confines itself mainly to urban areas and concentrates on information, education and communication activities. The private sector, in its traditional way, delivers contraceptives through pharmacies and private medical practitioners mainly in the urban sector. PDA concentrates at the grassroot level, distributing through its 10,200 volunteers in 157 districts and managing the delivery through supervisors, backed by the divisional staff in five branch offices and the central office in Bangkok.

From the distribution point it is noted that the weakest area that needs support is the rural market segment. It is poorly covered and even where the delivery system exists, except for PDA's volunteer community-based deliveries, the rest is sporadic and lacks supervision and continuity. The country is mainly rural with 80% of the people living in rural settings. The positive step then would be to develop a delivery system that can provide contraceptives to those who desire to protect themselves, conveniently, on a regular basis and at affordable prices.

The prevalence survey and current contraceptive activity points to the oral contraceptive pill as the most widely used contraceptive method. In fact, the survey records 54 percent for the oral contraceptive pill as a current use of a method. The condom is reported at only 7 percent. With this evidence it is logical that efforts should primarily be focused in marketing the oral contraceptive pill. Distribution and advertising are two functions that are central to the success of any marketing operation. In the

permitted climate the marketing challenge is to use the available channels of distribution that can reach the target market and stimulate the medium of promotion to achieve maximum market penetration and communication speed.

Examining the channels of distribution that can meet our objectives, we feel that PDA has the organizational structure and experience to expand its area of activity, from its 157 rural districts to the rest of the country on a phased program. The program should be spread out over a period of time. We feel that a phased four-year program will permit PDA to identify, train and organize appropriate distributors in each village and set up the system to supervise, ensure regular supply and promote the oral contraceptive pill at the rural level. Assessing the organization, and its past performance, it is possible to expect it to expand the program at a level of adding 120 districts each in the first three years. Looking at the current sales through the PDA system in the 157 districts, it can be expected that between 500,000 and 600,000 cycles of oral contraceptives can be delivered in total through this program monthly in the 620 districts of Thailand (approximately 420,000 new acceptors) over a four-year period. Importantly, the system provides the mechanism to monitor the acceptor at the village level and this is unique.

It should be noted that representatives of the MOPH have stated that it is highly unlikely that contraceptives will be exempted from the prescription requirement in the foreseeable future or will brand-specific media advertising be permitted. In the following section we have attempted to outline the basic issues that must be considered in an expanded PDA program.

A. EXPANSION OF DISTRIBUTION

In assessing the delivery system of providing contraceptives to the rural market, it is important that there should be a systematic utilization of community personnel and resources through careful identification, selection, training, distribution, motivation and supervision. The activities undertaken in this step should include recruitment of the district supervisor who has a knowledge of the area and who is acceptable within the community. The distributor should be selected taking into consideration the location and the business activity he or she carries out in the village. Care should also be given to the individual's standing in the community. The village distributor should have leadership qualities, be trustworthy, have a working career and reside in the village. The team strongly recommends that PDA recruit shopkeepers or grocers with the stated qualifications since they will best fit the role of "contraceptive social marketer".

Once the distributor is identified it is important to initiate a well-designed training program that will expose the selected candidate to knowledge of the basic human reproductive system, methods of family planning and their misconceptions, simple screening checklists, contradictions, side effects, recordkeeping and motivation for family planning services.

Supervision for such a program is critical to its success. Supervision activities should ensure at least a once-a-month visit to the distributor to resupply stock, collect income from the distributor, assemble records and help the distributor with any questions or difficulties that may have arisen during the previous month. A second level of supervision should be a field visit, made every three to four months, by central field operation staff. These visits should be objective and designed to improve activities at the village level. An additional level of supervision recommended is the administrative coordination with the district health officer.

The timing for the expansion of the PDA program should be staggered to move to areas immediately outside their areas of existing operation and in areas where the government volunteer distribution is weak. The strength and weakness of the government program is easily ascertained through its central evaluation unit which records monthly performance of Government and non-governmental organizations on a district basis. It is possible to expand the program by adding approximately 120 districts a year in the first three years, and such a target should be set and the program should work toward achieving this target.

B. PRODUCT CONFIGURATION

1. Packaging

The team recommends that all products distributed through the PDA network be over-packed. Packaging the products will not only present a better product appeal to the consumer, but more importantly it will differentiate the PDA products from those supplied through the government's village health volunteer and will justify the higher price that must be charged through the PDA volunteer. A more complete discussion of this topic is included in the section that deals with promotional issues.

2. New Products

The team recommends that PDA investigate the addition of a variety of products to its existing product line. While there are certainly a number of products that would comfortably "fit" with the distribution system and offer additional revenue sources, we feel that early on PDA should specifically look at further expansion of oral rehydration salts and injectable contraceptives. Injectable contraceptives could easily be sold on a per vial basis by the PDA volunteer directly to the consumer who would then take them to the local midwife or other trained personnel for administration of the dosage. By using the PDA system we estimate the consumer could be saved up to one-half of the cost currently being paid. Conceivably the village volunteer could be trained to actually administer the injection, but the team is not qualified to make a judgment on the practicality or merits of doing this.

In the area of oral rehydration therapy, and other primary health care products, the team recommends that the Royal Thai Government

(RTG) and PDA request through USAID that a representative from the PRITECH project of Management Sciences for Health visit Thailand to assess the feasibility of including primary health care products in the PDA distribution system.

C. PRICING

Pricing of contraceptive products in a social marketing project is a difficult issue since little, if anything, is known about price/demand elasticity. However, since a project on this subject is about to be undertaken in Thailand, the team recommends that final decision on retail price be deferred until after this study is completed. In the meantime we suggest that the current retailing prices be maintained, or only slightly increased to help defray the cost of packaging.

D. PROMOTIONAL ISSUES

Why mass media?

There are three reasons why the use of mass media should be considered in the development of a comprehensive social marketing program in Thailand:

1. TV, radio and print media are expanding very rapidly in Thailand, reaching more and more people in all areas and becoming increasingly national in scope. Mass media is fast becoming an efficient means for reaching all socioeconomic levels, and a good method to promote favorable national family planning lifestyles.
2. Mass media has never been used to aggressively promote family planning practice on a sustained basis. PPAT has sustained an ongoing information and education program, but with a limited "call to action" or motivational emphasis. The FHD has invested in well-researched persuasive mass media messages, with a specific call to action (vasectomies), but has lacked either the resources or longer-term procurement process required to sustain the paid media portion of a campaign. PDA's campaign has been short-term by design, focusing more on special events.
3. Mass media is a powerful tool with a long, successful record in "pulling" consumer products through the distribution pipeline. Considerable investment has been made in developing a good distribution system to "push" the products. Mass media can provide the consumer "pull" needed to make the system work even more efficiently.

Restraints in using mass media to support a social marketing program:

1. Mass media advertising on prescription items, for example, birth control pills and injectables, cannot be brand specific, but must be generic.

2. Mass media advertising, particularly in the broadcast media, cannot be too provocative.
3. A mass media campaign will be successful only if there is a very visible tie-in at the retail and volunteer level; for example, the product and corporate logo are very visible and adequate inventory exists.
4. At this stage of development in family planning, with high awareness, good knowledge of the contraceptive methods, and a relatively high acceptor level, the challenge of a media campaign is greatest of all. Just how much a paid media campaign can add to the program is hard to predict.

Promotion Recommendations in the Use of Mass Media

1. Test the value of paid media by selecting one test market and one control market and running a six-month campaign. The test market must have:
 - a. adequate supply of contraceptives
 - b. PDA distribution comparable to the country as a whole
 - c. a demographic profile representative of Thailand
 - d. mass media that can be isolated with a minimum of waste

In both the test and control markets it must be possible to monitor: total sales and inventories of contraceptives (commercial, PDA and other), all sterilizations, competitive advertising and editorial coverage in the mass media, other competitive promotion activities, and competitive pricing activities. This will require considerable cooperation from commercial manufacturers and distributors that might be expected to gain from a successful social marketing program.

2. Produce advertising materials that are aimed at specific audiences, that is, young women and young men who want to delay having children, or space them, and couples who already have two children. Targeted messages will enable audiences to identify more readily with the message; and by aiming messages at many different audiences, the overall impression will be that everyone can (should) play a role in family planning.
3. Offer alternative methods where possible, for example, oral contraceptives or injectables; this will allow the marketer to make the investment in expensive advertising work harder (i.e., for more than one product) and tell consumers that they have a choice.
4. Build confidence/credibility through real-life testimonies. Pretesting research would suggest that the strongest creative approaches are those that reassure consumers that the proposed

methods work. Using real people who have had vasectomies, using authorities/celebrities who are practicing family planning, and using themes such as "I'm one of 3,000 men who have had . . ." all seem to be directionally most effective. Cartoons and illustrations do not appear to be as promising.

5. Provide a "call to action" that leads consumers to seek a corporate solution instead of a specific brand; build a strong corporate identity. Because advertisers are prevented from promoting prescription items in the mass media, one possible solution is to promote the benefits of specific methods of contraception, for example, pills or injectables. Consumers can then be told to look for a corporate sign or logo "for help in planning your family" . . . to be accompanied by a corporate theme such as "XYZ Company, the first name in family planning". This strategy requires a very strong corporate identity on all products and a good corporate merchandising tie-in at the retail level. In cases where brand identification is permitted (e.g., condoms), more emphasis can be placed on promoting the benefits of the corporate product line.

6. Introduce campaign at substantial media level; sustain campaign throughout test period at a level affordable on a national basis. Use all media--TV, radio, outdoor/transit, newspapers, cinema and magazines--to introduce the campaign with, for example: three spots per day on the local TV station; eight spots per day on three of the strongest local radio stations; sponsorship of a strong radio program aimed at young adults; one 2 column by 14 centimeter newspaper ad per week in the largest circulating newspapers; messages in 10 cinemas (30-second spots) ten outdoor billboards; 100 bus signs, and 100 outdoor posters (placed by volunteers) at about 60 percent of the introductory level. The campaign introductory period should be a minimum of 8 weeks, then at 40-50 percent of the introductory level ongoing.

Total advertising costs for the test market production and media are estimated to be U.S. \$90,000. A national advertising program built on the results of the test market would cost approximately U.S. \$300,000.

7. Support paid advertising program with mass media public relations activities. Begin campaign with a joint press conference that involves all the major constituents in the family planning community. Establish a corporate spokesperson media tour to place news and feature story interviews in all the major broadcast and print media. Issue press releases on the progress being made. Provide feature stories to magazines, daily and weekly newspapers, and other publications. Profile celebrities in these feature stories who are participating in the family planning social marketing program as users of the services or products, or as staff and "volunteers".

8. Periodically schedule the mass media programs, advertising and public relations, in "flights" that focus on different family planning areas and are tied to consumer incentive programs. Over the period of a six month test or a year-long campaign, the mass media messages are scheduled as a mixture of those aimed at women and men, along with a generic message or two on the corporation or sponsoring organization. Periodically, however, the sponsoring organization will want to group the messages aimed at one audience, say women, and schedule four weeks of messages aimed almost entirely at women, some of which include incentives offering premiums (to be discussed further in a later section of the recommendations). A similar four-week promotion "flight" might also be planned to reach men and encourage vasectomies. During these special promotion periods, additional mass media public relations activities, such as PDA's hour-long TV variety show, should be scheduled.

Promotion recommendations for direct mail

In addition to maintaining direct mail programs designed to keep staff, volunteers, and the trade informed and motivated, we recommend that direct mail continue to be tested as a means for distributing condoms directly to consumers. Two approaches appear to be worth testing:

1. Small space newspaper/direct response advertising

To keep mailing costs down, a minimum multiple order of say six or nine condoms could be tested, and premiums offered along with the order, for example, a cigarette lighter at a very low (wholesale) cost. Small space newspaper ads (two columns by ten centimeters) can be scheduled in a variety of daily and weekly newspapers along with a coupon. The most effective newspapers (based on costs per inquiry) can provide the basis for future direct response programs. To further reduce mailing costs, but maintain competitive prices for the products, those who respond can be asked to include the stamps or equivalent amount required to cover return postage.

2. "Condom of the month" club

A concept that PDA has described but not tested is the idea of signing up men's "clubs" to receive a monthly supply of a specified number of condoms. Each month the supply would be mailed automatically, and the club would be billed accordingly. The mailing would be discontinued only at the request of participating clubs.

Retail merchandising and packaging recommendations

Good retail merchandising and product packaging are vitally needed to provide the critical tie-in to the mass media advertising and incentive programs. Posters and wall books are familiar formats that can be used widely in the villages, and should be used to support a social marketing program. In retail and pharmacy stores, particularly in the larger towns and urban areas, wall space is at a premium and posters are less likely to be used. For these outlets we recommend a counterdisplay that is approximately 40 centimeter high and 30 centimeter wide. It should be designed to stand by itself and be made of clear plastic in such a way that the contents (a single sheet of paper) can be easily changed. The message in these counterdisplays can be changed to support special promotions, introduce new products, and provide fresh messages for consumers. These counterdisplays are small enough to be acceptable to retailers. They can help tie-in the mass media advertising at the retail level and trigger impulse consumer purchasing.

All the packaging of contraceptive products should be reviewed and if necessary modified to reflect:

1. a corporate visual look--so the packaging reinforces the concept of a line of products--although appealing separately to each category of user;
2. a corporate theme drawn from the advertising to reinforce the advertising and corporate positioning; and
3. a strong, easily identifiable corporate logo on each package.

Since oral contraceptives are not now packaged by PDA, these recommendations can be considered immediately for the PDA's entire line of birth control pills. New packaging for other products, such as condoms, would have to be phased in according to current inventories.

New incentive programs

All the incentives used in current family planning programs in Thailand are designed to stimulate initial trial of such birth control methods as condoms, or increase participation in male sterilization programs. Additional incentives should be explored that are designed to sustain good birth control practices, for example, the regular use of birth control pills. These incentive programs can take several forms, for example:

1. Premiums can be offered, such as colorful posters of Thailand scenery or Thailand celebrities with a very low key family planning message, to reinforce good family planning practices. These posters could be offered to women who purchase a minimum of six straight cycles of birth control pills, or a set number of injectables, or to men who purchase a minimum number of condoms.

2. Self-liquidating premiums, such as practical household items, for example, bowls, towels, lighters, could be offered at very low prices in exchange for a minimum number of purchases; the cost of this type of incentive program can be covered in the price charged to consumers.

Training

One aspect of training deserves additional attention and emphasis in an aggressive social marketing program. Staff should be required, with each visit to village volunteers and retail distributors in town and urban areas, to:

1. make sure all the products are adequately inventoried, displayed in the right places to be seen by desired customers, and properly displayed visually . . . side-by-side as a product line where appropriate, easily seen and read, next to the best-selling brands, dusted, cleaned, rotated by expiration dates, etc.
2. make sure all the most current posters, wall books, and counter-cards are on display in good locations. This aspect of training under the current programs appears to have received too little emphasis and should be strengthened.

Evaluation

Evaluation related to promotion will be reviewed under three headings: "formative", which relates to research conducted to aid in the development of promotion materials; "process", which refers to the information gathered to measure how well the promotion programs are being implemented; and "outcome" or "impact", which measures the effect promotion materials and activities have on helping to achieve the desired marketing objectives.

Formative

Considerable pretesting has been done in the development of promotion materials designed to convince men to have vasectomies. Based on this investment, new materials can be developed with the confidence that they will reflect the sensitivities of this target audience. If additional investments are to be made in refining the development of new materials they should be made in the areas of female contraceptives and condoms. The evaluation techniques used should be similar to those followed in the development of the current MOPH vasectomy campaign, that is, the development of rough concepts, small qualitative sessions with the target audience, refinements in the concepts, and final production. Given the sensitive positioning of the materials to be developed on contraceptives, we recommend gaining clearance from the media censors before pretesting.

Process measurements

The following kinds of process measurements should be employed in monitoring a social marketing program, particularly in the advertising test market:

- o competitive promotion expenditures and pricing
- o number of sales visits by category of distributor/retailer
- o number of participants in incentive programs
- o direct mail inquiries per ad
- o inventory by product line
- o competitive product and packaging changes

These measurements should be obtainable through the normal management information systems either in place now or easily established.

Outcome or process measurements

While the key outcome measurement will be sales, both by the social marketing organization and all other distributors of contraceptives, other outcome measurements can help to assess the impact of promotion, such as:

- o recall of mass media advertising and themes
- o awareness of sponsoring corporation and logo
- o reported sources of information for those purchasing contraceptives (through volunteers and retailers)

The initial cost of providing these measures in the test market through a survey of the general public* is estimated to be U.S. \$7,500. To provide such information annually on a national basis, through participation in an omnibus survey, would be approximately U.S. \$2,500 (four basic questions on the advertising).

E. ORGANIZATIONAL ISSUES

1. Marketing Capability

The team recommends that PDA hire a full-time senior marketing expert to assist in developing the expanded social marketing project. While we do not consider this to be a requirement for success, we do feel that such a person will be able to make a significant contribution to the work of PDA.

2. Personnel Continuity

The team recommends that PDA structure itself to provide either for a higher salary to key employees and/or improved retirement benefits to ensure they can retain middle and senior management staff. While the team members are not well versed in the financial structure of PDA or its relationships with the various donor agencies, we suggest that organizational continuity may be threatened unless PDA itself can be either treated as a donor agency and/or can undertake long-term projects that provide a higher revenue stream than is currently being experienced.

* 200 urban and rural interviews.

3. Commodity Supplies

By the end of the fourth year of a PDA nationwide project, it is estimated that the annual oral contraceptive requirement will exceed 8 million cycles. Two issues are of paramount importance here: (1) PDA must be assured of continued supplies from the RTG or donor agencies at this level both during and beyond the expansion period, and (2) PDA must be assured of continuity in the formulations (brands) of contraceptives supplied in the appropriate ratio to sales.

Given the size of this program and considering the changes that can occur over time in the budget process, political priorities and attitudes of donor agencies, the team recommends that a mechanism be set up whereby PDA can be protected from the possibility of a supply disruption or cessation. For example, PDA could be given an interest free loan for a period of, say, 10 years, the terms or conditions of which would allow it to retain the interest earned and use it for commodity purchases, if required. In the event that PDA was not required to purchase commodities, the interest earned could be retained and form the basis of an "endowment" to help provide both for organizational continuity and/or new project development.

4. Organizational Structure

The team recommends that the nationwide social marketing project be operated as a separate entity from PDA. Conceptually it could take the form of a wholly owned subsidiary. We believe it is important that this activity be separated for the following reasons:

- a. Accounting for revenues and expenses will be simplified.
- b. A separate organization should have greater vitality and will more willingly experiment with new approaches.
- c. The distribution system will be more easily identified and controlled, thus making it a marketable resource for new products.
- d. In all likelihood the project will not be self-sufficient and therefore should not be burdened with this PDA objective.
- e. It will be able to advertise brand-specific products and pay taxes (if required) without affecting PDA's overall status.

F. PROJECT BUDGET

The following represents the probable costs of expanding the PDA program over a four-year period, exclusive of commodities. The operating assumption is that approximately 120 districts will be added each year. All figures are in U.S. dollars.

	YEAR 1	YEAR 2	YEAR 3	YEAR 4
Add Two Branch Offices	91,000	106,000	111,000	117,000
Salaries of Field Officers	54,000	108,000	162,000	210,000
Salaries of Supervisors	101,000	202,000	303,000	404,000
Operating Costs for District Distribution	450,000	450,000	450,000	450,000
Central Administrative Staff Support	180,000	189,000	198,000	208,000
Central Administrative Overhead Costs	120,000	126,000	132,000	139,000
Packaging Costs	71,000	210,000	297,000	402,000
Misc. (Monitoring, Etc.)	50,000	52,000	54,000	56,000
Point-of-Purchase Promotion	80,000	40,000	40,000	40,000
Media Test	90,000	--	--	--
Inflation @ 5%	--	60,000	77,000	91,000
	<u>\$1,287,000</u>	<u>\$1,543,000</u>	<u>\$1,824,000</u>	<u>\$ 2,117,000</u>

NOTE: This does not include nationwide advertising using mass media which is estimated at a minimum of \$300,000 per year. However, mediamedia advertising should only be undertaken after the media test is completed and if the test shows that the media costs can be covered by increased sales.

The oral contraceptives required for the expanded PDA program and the revenues are shown below.

	YEAR 1	YEAR 2	YEAR 3	YEAR 4
Total contraceptive requirement (including current activities)	2,820,000	4,200,000	5,940,000	8,040,000
New contraceptives required beyond current program	720,000	1,800,000	3,240,000	4,040,000
Revenues generated by expanded products only (not including current revenues)	\$ 167,000	\$ 417,000	\$ 750,000	\$ 1,115,000
Net cost of new program (not including media test)	\$1,030,000	\$1,126,000	\$1,074,000	\$ 939,000
Cost per couple year of protection of expanded program exclusive of commodities	\$ 17.16	\$ 7.51	\$ 3.98	\$ 2.65

As can be seen from the above calculations, the cost per couple year of protection would be extremely low, and compares favorably to other contraceptive social marketing programs throughout the world. However, the program cannot realistically expect to recover its costs, although the following observations are given as possibilities for increasing PDA revenues.

1. Increasing sales of oral contraceptives by approximately 100 percent over the estimates given in the budget would make the program self-sufficient. Since we anticipate that PDA will have to achieve a 30 percent market share among the primary target market to meet the budget as given, it is unlikely that it will be able to double that share in the foreseeable future. Nevertheless, any increase in sales will, of course, increase revenue to the project.
2. Increase the price of contraceptives at the retail level to improve PDA margins. The program could be self-sustaining if the retail price were increased by approximately $\text{P}4.3$ per cycle which would mean their least-expensive brand would sell for almost $\text{P}10$ and their most expensive product would sell for $\text{P}16$ pricing schedule, thus partially offsetting the anticipated increase in revenues.
3. Introduce new noncontraceptive products into the distribution system which have high margins. Such products as toothpaste, soap, etc., could be incorporated easily into the village distribution scheme and may well generate adequate income to allow the program to recover most, if not all, of its costs.
4. Significantly reduce the cost of distribution thereby balancing income with expenditures. By the end of Year 4, the operating costs for district distribution can be lowered significantly since the majority of these costs are for initial training of the village distributors. The rest of the costs are comparatively fixed, so it is unlikely that simple expense reduction will be sufficient to allow the project to recover its costs.