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**From Deal to  
Delivery  
Lessons Learned from  
SOMARC III About  
Building Partnerships  
with the  
Commercial Sector**

**SOMARC III  
Special Study 10**

**The Futures Group  
International**

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**From Deal to Delivery Lessons Learned from SOMARC  
About Building Partnerships with the Commercial Sector**

**SOMARC III Special Study 10**

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## EXECUTIVE SUMMARY

It is the intention of USAID/Washington/Global to award in latter 1998 a new contract that will support expanded use of commercial opportunities for growing and sustaining contraceptive prevalence in countries around the world. The current moment is particularly opportune therefore, for analyzing experiences from the past 20 years and for developing "lessons learned" that can be used as guides in designing and implementing effective, innovative efforts in the future.

One of the most significant evolutionary changes in contraceptive social marketing (CSM) project implementation that has occurred during the past 15 years has been the establishment of partnerships with commercial sector entities to create enhanced markets—through targeted distribution, pricing, advertising and promotion—for contraceptive sales. During the approximately 10-year period between implementation of the earliest USAID-funded contraceptive marketing projects and the middle of Social Marketing for Change (SOMARC) I, several facts became clear:

- Increasing demand for contraceptive commodities in USAID client countries among both public sector and social marketing sector consumers was substantially increasing USAID's "bill" for contraceptive procurement
- The task of registering for sale USAID-provided ethical pharmaceutical/contraceptive products with ministerial pharmaceutical regulatory agencies was a cause of significant delays in social marketing project implementation
- In a growing number of developing countries, oral contraceptives were being sold as over-the-counter products—in practice if not in law—and were becoming more susceptible to consumer-oriented marketing techniques
- Commercial pharmaceutical companies were becoming increasingly aware, thanks at least in part to their experience in USAID-funded CSM projects that there was in many developing countries a mass-market potential for some of their contraceptive brands

The recognition of these facts led staff of SOMARC with relevant USAID/Office of Population program managers to consider implementing more direct partnerships with commercial entities in contraceptive marketing projects. Partnerships with commercial sector entities were sought to achieve several broad objectives: 1) to eliminate the need for USAID/Washington to purchase contraceptive commodities for use in social marketing projects by using brands already commercially available, 2) to reduce the time required for project development and initiation by using contraceptive brands already registered in the local markets, and 3) to increase the resources available for project marketing support activities through commercial partners' investments in their own product sales. These partnerships have been based on the premise that there is sufficient demand for contraceptives in many countries to make a lower-priced mass-market contraceptive brand commercially profitable and that both commercial entities and USAID-funded family planning projects have something to gain not only from increased use and/or sales of contraceptives but also from each other.

This study describes the process by which SOMARC was able to interest potential commercial partners in project participation in a variety of countries, the “deal” that was finally struck with each partner, and the degree to which the partnership succeeded or failed in making modern contraceptives more widely available and more affordable to middle- and lower-income consumers. Specifically, the study examines experience in creating and implementing partnerships with commercial sector entities in Brazil, Jamaica, Uganda, Jordan and Turkey. Each country presents its own market circumstances, its own opportunities and its own challenges. Analysis of each country experience, however, has allowed the development of a set of lessons learned that may serve to improve the efficiency and effectiveness of future collaboration.

Partnerships with commercial sector entities have proved “successful” in a variety of ways. The ways in which each commercial partnership contributed to achievement of the country’s family planning goals and the degree to which each partnership succeeded, however, have varied from marketplace to marketplace. Overall, partnerships with the commercial sector have contributed to USAID’s family planning service delivery objectives in the following areas:

- Reliance on commercially available contraceptive products in many social marketing programs has reduced USAID/Washington’s commodities cost by more than US\$47 million over the last 10 years.
- The availability and accessibility of modern contraceptive methods have been increased in many project countries.
- The range of contraceptive methods readily available to consumers has been increased in a number of project markets.
- Reliance on public sector resources for family planning products and services has been decreased in some markets.
- Project activities have encouraged some contraceptive manufacturers to begin to include in their strategies the marketing of contraceptive products positioned to reach lower-priced mass markets rather than higher-priced niche markets alone.

A number of lessons have been learned during the past 15 years that may shed light on the reasons for greater or lesser “success” from one commercial partnership to another or from one marketplace to another and that may be useful in improving and expanding the effectiveness of future commercial sector partnerships. Below, we group these lessons learned into 10 categories:

## **Lessons Learned**

### *What's in it for them?*

- There must be something in project participation that is of appreciable value/advantage to a commercial partner. Where such an advantage is not delivered or is not delivered to the extent desired, commercial partners either drop out of project activities or contribute little if anything beyond their "usual and customary" efforts.
- "What's in it" for commercial partners is often complex and a combination of factors far beyond simple increases in sales. Social marketers need to understand commercial agendas more thoroughly.

### *Importance of Brand to Commercial Partners*

- The importance to a pharmaceutical manufacturer of maintaining or gaining market share leadership for its brands cannot be overestimated. At the local or regional level, companies are often willing to sacrifice some part of their profit margin to maintain or grow market share.
- The overall commercial importance of market share makes brand-specific marketing critically important to contraceptive manufacturers and distributors.
- A contraceptive manufacturer whose brand(s) are already market share leaders in a given marketplace may be more likely to participate in program efforts to "grow the overall market" because their leading brands are most likely to capture the major share of that overall growth.

### *Advertising*

- Direct access to the consumer through mass media advertising is often a major selling point for commercial partners' interest in project participation.
- Generic or method-specific advertising usually implemented by USAID-funded contraceptive marketing projects has increased consumer interest in and demand for family planning services. In some countries, increased consumer demand has led to noticeable increase of supply of such services, especially by private practice physicians.
- Generic or method-specific advertising does not deliver increased brand share. Commercial pharmaceutical partners in social marketing projects are primarily interested in increased brand share for their products.
- The limitations of method-specific advertising in creating increased brand share for a selected product cause a special problem for projects that support contraceptive categories represented by multiple participating brands. Method-specific advertising of oral contraceptives, for example, in many country projects does not work to the brand advantage of any pill product because there are many brand choices for the consumer. On the other hand, method-specific advertising of injectable contraceptives, when only Depo-Provera exists in the marketplace, does function to some extent as brand-specific promotion.

- Physicians react negatively in almost every case to the advertising/promotion of pharmacies and pharmacists as sources of family planning information and guidance
- The cost of mass media advertising is so high in some markets that commercial partners believe they cannot afford to use it even if legal and regulatory constraints on their access to the media are lifted

#### Role of Corporate Head Offices

- Corporate head offices can and sometimes do exert their influence on local country representatives to participate in social marketing projects (e.g., Pharmacia & Upjohn)
- A manufacturer's previous experience with a CSM project is often communicated either formally or informally throughout its regional offices and does carry weight that can be either positive or negative in local country representatives' decision-making (e.g., Schering AG)
- Wyeth-Ayerst, from whom USAID buys 48 million cycles of oral contraceptives annually, is frequently the pharmaceutical manufacturer least likely to support and/or allow project participation by its local country representatives

#### Place of Contraceptives in the Pharmaceuticals Business

- Contraceptives do not "drive" the business of many pharmaceutical manufacturers/distributors—especially contraceptive brands that they are willing to sell at mass-market prices
- Product detailing practices, costs of detailing and promotion, and sales commission/bonus patterns do not naturally favor placement of marketing and sales emphasis on lower-profit/lower-turnover products
- Revenues from sales of contraceptives are seldom reported by retail pharmacists to exceed 3-5 percent of their total income
- In countries where access to cash and/or hard currency is problematic for importers and retailers low-demand products—as hormonal contraceptives for example, are often perceived to be in those countries—are not high-priority investments for the trade

#### Mass Market for Contraceptives and Consumer Marketing

- Commercial partnerships for contraceptive marketing will not replace the need for public sector and donor resources/effort in expanding overall demand for contraceptive services and for serving difficult-to-reach segments of the population
- Prices of project contraceptive products have often increased when project-supplied funds for marketing support activities have ended. Sales revenues must cover the costs of marketing support
- The degree to which commercial partnerships for contraceptive marketing have succeeded in creating sufficient "mass" markets for lower-priced contraceptives to sustain continuing, enhanced consumer advertising/promotion, product detailing, public relations activities, etc. beyond project funding periods needs to be further examined and documented

- The definition of success for a commercial partnership in contraceptive marketing as creation of a commercially sustainable mass market for lower-priced contraceptives may not sufficiently recognize the range of positive impacts on contraceptive availability and use made by such partnerships

#### Private Providers as Commercial Partners

- Family planning services delivery is not a big moneymaker for private practice physicians
- It is difficult to change the service delivery behavior of medical care providers “One shot” training of physicians and pharmacists does not effectively change provider behavior
- Private providers in many countries are distrustful of hormonal contraceptives, in general, and do not have current/correct knowledge of contraceptives
- Private providers often promote those contraceptive methods that they can themselves directly dispense and therefore profit from

#### Donor/Host Government Supervision and Support of Commercial Marketing Programs

- Host government and donor processes sometimes required for approval of project marketing elements can be time-consuming and limit the programmatic flexibility and responsiveness required for effective marketing
- Approval/non-approval decisions for project advertising or promotional materials made by host government and donor staff are sometimes based on the appeal of these materials to those officials rather than on research results that indicate their effectiveness for target consumers and the trade
- In some countries, donor-supported economic assistance whose aim is to increase government revenues through new or more complete systems of taxation works against the objectives of concurrent donor-supported health and family planning objectives by increasing the price of contraceptive products to the consumer
- Untargeted access to free public sector contraceptive products in a given marketplace can eliminate commercial partners’ interest in marketing a lower-priced product to a lower-income market segment

#### Legal/Regulatory/Policy Issues

- Limitations on the degree of success of a given commercial partnership are often caused by constraints—such as government price controls restrictions on pharmaceutical brand advertising and value-added taxes—in the legal/regulatory environment for pharmaceuticals
- Increased accessibility of contraceptives in the commercial sector does not often enjoy sufficient financial and/or policy leverage to facilitate change in the legal and regulatory environment that affects the pharmaceutical sector as a whole

*Uniqueness of Markets and Replication of Successes*

- Each commercial marketplace is different, and the goals/needs of potential commercial partners vary from market to market
- The processes of project assessment and marketing planning can be replicated from one marketplace to another but not the specifics of project implementation

## **I INTRODUCTION**

Since 1980, The Futures Group International (FUTURES) has worked in the design and implementation of contraceptive social marketing (CSM) projects funded by USAID/Washington/Office of Population. During this nearly 20-year period, the concept of social marketing and the realities of contraceptive marketing have evolved and expanded.

In the course of this time, a variety of project implementation mechanisms have been tried—some later rejected, some adapted, some improved. One of the most significant evolutionary changes in social marketing project implementation has been the establishment of partnerships with commercial sector entities to create enhanced markets—through targeted distribution, pricing, advertising and promotion—for contraceptive sales. These partnerships have been based on the premise: 1) that there is sufficient demand for contraceptives in many countries to make a lower-priced mass-market contraceptive brand commercially profitable, and 2) that both commercial entities and USAID-funded family planning projects have something to gain not only from increased use and/or sales of contraceptives but also from each other.

It is the intention of USAID/Washington/Global to award in latter 1998 a new contract that will support expanded use of commercial opportunities for growing and sustaining contraceptive prevalence in countries around the world. The current moment is particularly opportune, therefore, for analyzing experiences from the past 20 years and for developing “lessons learned” that can be used as guides in designing and implementing effective, innovative efforts in the future.

This study examines the experience of the Social Marketing for Change (SOMARC) project and FUTURES in creating and implementing partnerships with commercial sector entities in Brazil, Jamaica, Uganda, Jordan and Turkey. Each country presents its own market circumstances, its own opportunities and its own challenges. Analysis of each country experience, however, has allowed the development of a set of lessons learned that may serve to improve the efficiency and effectiveness of future collaboration.

## **II BACKGROUND**

In the early 1970s, USAID/Washington/Office of Population/Family Planning Services Division funded a contract to assess the potential of commercial distribution channels to help expand the availability and accessibility of modern contraceptive products. The original assessment included South Korea, Thailand, Jamaica, Panama, Venezuela, Iran, Tunisia and Turkey. In the mid-1970s, based on information gathered during the assessment, USAID/Washington/Office of Population contracted for implementation of “contraceptive retail sales” projects in Ghana, Nepal, Jamaica and Tunisia.

USAID's objective for this new programmatic activity was twofold: 1) to use the resources and methods of private sector marketing and distribution to increase the availability and use of modern contraceptive methods among low-income consumers, and 2) to supplement and complement the efforts of public sector information, education and

communication (IEC)/distribution systems in expanding modern contraceptive use in project countries. To keep the retail price to the consumer low, USAID/Washington provided the contraceptive products free to each participating local distribution system. The margins and mark-ups allowed at each level of the distribution chain provided the financial incentive for the commercial sector's participation in these early CSM projects. Additionally, the USAID-funded budgets for advertising and promotion supported commercial interest.

By 1981, USAID-funded CSM projects had proven successful in expanding sales and use of modern contraceptive methods in the initially selected countries. This led USAID/Office of Population to execute a cooperative agreement with FUTURES to provide technical support for existing projects and to initiate CSM projects in additional countries such as Barbados, Costa Rica, the Dominican Republic and Mexico.

During the approximately 10-year period between implementation of the earliest USAID-funded contraceptive marketing projects and 1984, several facts became clear:

- Increasing demand for contraceptive commodities in USAID client countries among both public sector and social marketing sector consumers was substantially increasing USAID's "bill" for contraceptive procurement.
- The task of registering for sale USAID-provided ethical pharmaceutical/contraceptive products with ministerial pharmaceutical regulatory agencies was a cause of significant delays in social marketing project implementation.
- In a growing number of developing countries, oral contraceptives were being sold as over-the-counter products—in practice if not in law—and were becoming more susceptible to consumer-oriented marketing techniques.
- Commercial pharmaceutical companies were becoming increasingly aware thanks at least in part to their experience with USAID-funded CSM projects that there was in many developing countries a mass-market potential for some of their contraceptive brands.

Recognition of these facts led staff of FUTURES and relevant USAID/Office of Population program managers to consider implementing more direct partnerships with commercial entities in contraceptive marketing projects. Partnerships with commercial sector entities were sought to achieve several broad objectives: 1) to eliminate the need for USAID/Washington to purchase contraceptive commodities for use in social marketing projects by using brands already commercially available, 2) to reduce the time required for project development and initiation by using contraceptive brands already registered in the local markets, and 3) to increase the resources available for project marketing support activities through commercial partners' investments in their own product sales.

From 1985 onward, SOMARC/FUTURES began to negotiate agreements with local representatives of international contraceptive manufacturers and with local distributors, to market selected commercially available brands at prices affordable to lower-income consumers. This study describes the process by which SOMARC/FUTURES was able to interest commercial entities in project participation in a variety of countries, the "deal" that was struck with each partner, and the degree to which the partnership succeeded or failed in making modern contraceptives more widely available and more affordable to middle- and lower-income consumers. Finally, this study presents the overall "lessons learned" by SOMARC/FUTURES' through its work with commercial partners in the marketing, distribution and sales of modern contraceptives.

### III METHODOLOGY

This study is based on information gathered from personal interviews, review of project documents, analysis of survey data, and the author's experience in the field.

Individuals interviewed for this study include managers and technical staff of SOMARC/FUTURES/Washington, SOMARC regional technical officers, SOMARC country project managers, headquarters staff of pharmaceutical manufacturers, regional and local country managers of pharmaceutical manufacturers, staff of local distribution companies, and technical staff of other U.S. organizations interested in the role of the commercial sector in family planning services delivery.

Documents reviewed include Memoranda of Understanding between FUTURES and commercial sector partners, SOMARC staff and consultant trip reports, project progress reports, SOMARC Highlights, SOMARC Special Studies, relevant papers of the Options for Population Policy (OPTIONS) and POLICY projects, and SOMARC sales data reports. Demographic and Health Surveys (DHS) and relevant SOMARC market research reports were also consulted.

The author's experience in the field has included technical assistance in the design, implementation and evaluation of numerous CSM projects in Ghana, India, Indonesia, the Philippines, Brazil, Haiti, Jamaica, Egypt, Jordan, the Central Asian Republics, Russia and the Ukraine. This country-specific experience has involved collaboration and exchange with Ministry of Health officials, representatives of other government regulatory agencies, USAID mission staff in both technical and contractual areas, advertising and media representatives, staff of local distribution companies, country representatives of international contraceptive manufacturers, and representatives of other donor agencies and NGOs involved in CSM.

## IV COUNTRY EXPERIENCES

### A Brazil

Family Planning Environment The contraceptive prevalence rate (CPR) in Brazil is quite high. Seventy percent of all married women of reproductive age (MWRA) reported current use of a modern contraceptive method in the 1996 DHS. Of these, 20.7 percent were using an oral contraceptive, and 40.1 percent had received a tubal ligation. Only 4.4 percent reported use of condoms while the IUD and injectable contraceptives were reportedly used by fewer than 1.5 percent of MWRA.

Both public (43.1%) and private (54.1%) sectors are significant sources of contraceptive services for Brazilian women. As might be expected, supply methods such as oral contraceptives (90.5%) and condoms (77.1%) are provided largely through private sector channels. While injectables are a very small portion of the overall method mix, 94.3 percent of injectable users reported in the 1996 DHS that they purchased that method in the private sector. This is probably indicative of two factors in the Brazilian environment: 1) pharmacists are allowed to give injections to their clients, and 2) the public sector, except in USAID-supported Northeastern states, has not greatly invested in injectable contraceptive commodities. Almost 71 percent of all women who have received a tubal ligation have received this service in a public sector facility—almost certainly a result of lower cost to the consumer.

The three most striking features of the contraceptive environment in Brazil appear to be: 1) the overall high CPR, equal to that of almost any developed country, 2) the basis of high prevalence on what is almost exclusively a two-method program, and 3) the high incidence of tubal ligation.

Commercial Pharmaceutical Environment Brazil is a large country with a relatively high per capita GNP (approximately US\$3,000), consequently, many major pharmaceutical companies seek to establish themselves in the Brazilian marketplace. Schering AG, Organon, Wyeth-Ayerst, Pharmacia & Upjohn, and Johnson & Johnson/Ortho are among those companies marketing contraceptive products that currently do business in Brazil. A variety of oral contraceptives and condoms is available in the marketplace. During the past two years, several IUDs imported from Asia as well as the U.S.-made Copper T380A (CuT380A) have joined Organon's MultiLoad IUD in the Brazilian market. Schering's injectable has been marketed for some years.

Prices of pharmaceutical products are no longer controlled by the government and have risen in the years since controls were lifted. Competition among pharmaceutical companies is keen.

Distribution systems are well-established in Brazil. Local advertising and promotion agencies are sophisticated and are recognized around the world for their creativity. The costs of marketing are considered to be high compared to other countries in the region.

Primary Reason for Establishing a Commercial Sector Partnership USAID plans to end its funding of family planning programs in Brazil in the year 2000. In the interests of long-term family planning program sustainability, there is a desire to broaden the range of contraceptive methods readily available/acceptable to Brazilian women beyond oral contraceptives and tubal ligation before this funding cut-off date. Additionally, there is concern to ensure that contraceptive methods are available through commercial sector channels since government purchase of contraceptive commodities may diminish with the cut-off of USAID donor funds.

The Deal Depo-Provera was registered in Brazil for use as a contraceptive in January 1997. At that time Pharmacia & Upjohn's launch strategy was to position Depo-Provera as a niche product marketed to nursing mothers at a price of approximately R\$20/injection. There was no intention to try to capture mass-market sales for Depo-Provera.

SOMARC assessed the market potential for Depo-Provera differently. Staff members analyzed 1996 DHS data to ascertain a profile of current users of injectables; this profile was projected nationally to obtain the total number of current non-users of contraceptives with the same characteristics. Based on these calculations, SOMARC staff believed that injectable contraceptives in 1996 had captured only 7 percent of their potential market in Brazil. The potential convenience to the consumer of a three-month injectable in a market where oral (hormonal) contraceptives are already widely accepted was thought to strengthen the mass-market potential of Depo-Provera.

The quantitative picture of the potential mass market for Depo-Provera was used by SOMARC to "pitch" to Pharmacia & Upjohn/Brazil the commercial potential of a partnership with SOMARC in promoting and selling Depo-Provera to a broad-based market. SOMARC also used its analysis of pricing patterns for oral contraceptive brands in Brazil (60 percent of oral sales in Brazil occur at the R\$3-5/cycle price point) to "sell" to Pharmacia & Upjohn a mass-market price of approximately R\$10/injection for Depo-Provera's introduction. About 88 percent of all consumers in Brazil are considered to fall within the C and D socioeconomic classes.

In exchange for Pharmacia & Upjohn's agreement to promote and sell Depo-Provera to a broad-based market at a mass-market price, SOMARC offered a USAID-funded budget of US\$1 million for: 1) advertising the injectable contraceptive method, 2) public relations support for injectables, 3) detailing of pharmacists, and 4) training of providers in selected states in the Northeast.

The project pitch was made to Pharmacia & Upjohn staff in Brazil: the president (former Pharmacia manager in Brazil), the vice president (former Upjohn manager in Brazil) and the marketing manager. Negotiations took place over a period of four months; the pricing negotiation was considered especially difficult. By July 1997 a Memorandum of Understanding (MOU) between SOMARC/FUTURES and Pharmacia & Upjohn/Brazil had been drafted and was ready for signing.

At this moment in the process, Pharmacia & Upjohn hired a new marketing manager in Brazil—an OB/GYN who was opposed to Depo-Provera as a mass-market product. The new marketing manager used results of focus groups undertaken by Pharmacia & Upjohn with physicians (in which some physicians expressed negative opinions of Depo-Provera as a mass-market contraceptive) to bolster his rejection of the nearly completed MOU. It quickly became apparent to SOMARC that the president (former Pharmacia employee) was not going to stand against the opinion of the new marketing manager. Only the vice president (former Upjohn employee) remained in favor of the negotiated project agreement.

For support, SOMARC turned to Pharmacia & Upjohn's corporate-level staff—specifically its manager of donor sales (USAID/Washington is perhaps his largest client, with annual purchases of 9 million units of Depo-Provera). This corporate manager brought together in his office the Pharmacia & Upjohn manager for Latin America and the Depo-Provera product manager for the United States to discuss a corporate position for the product in the region. Depo-Provera is now a very successful mass-market product in the United States. In fact, it is currently Pharmacia & Upjohn's largest-selling product in the United States. The Depo-Provera marketing experience in the United States—almost certainly in conjunction with the importance of USAID as a customer—contributed to the decision at this corporate-level meeting to support the mass-market positioning of Depo-Provera. Due to the intervention of the corporate manager of donor sales, the decision by the Brazilian Pharmacia & Upjohn management team to annul its agreement with SOMARC was overturned, and the MOU between SOMARC/FUTURES and Pharmacia & Upjohn for a commercial partnership in Brazil was signed.

The Delivery Sales of Depo-Provera were launched in Brazil in October 1997. Pharmacia & Upjohn has invested heavily in detailing activities for all of its products in Brazil, a large sophisticated market. It provides monthly training for its medical representatives along with supporting materials for their use in marketing to the medical/pharmacy community. Depo-Provera has been included in this program. Pharmacia & Upjohn has also secured the endorsement of the Brazilian Association of Gynecologists for Depo-Provera, and SOMARC has begun to implement the partnership's public relations strategy. Sales of Depo-Provera—which were initially projected at 55,000 vials for the first six months after launch and 192,000 vials for the second year—reached 50,000 vials after only two months.

Management of the Pharmacia & Upjohn side of the partnership takes place within the company's normal marketing management structure. SOMARC manages its participation in the partnership through a consultant who travels to Brazil frequently from the United States to liaise with Pharmacia & Upjohn/Brazil, USAID/Brasilia and the local entities contracted for public relations and other marketing support. This consultant reports to SOMARC's Latin America Regional Manager in Washington.

Not surprisingly, because his decision to nullify the MOU was overturned, the Brazilian marketing manager has a negative attitude toward the partnership and is quick to criticize any delays or apparent difficulties in project implementation. For this and perhaps other

personality-related reasons local Pharmacia & Upjohn marketing management has not been as closely involved in collaborative project management with SOMARC as has occurred in other countries

The coolness between local marketing management and the project was compounded by USAID/Brasilia's unexpected concerns over approving product/method-specific mass media advertising. Shortly after product launch, a meeting of a wide variety of opinion leaders was convened to develop local support for Depo-Provera and other injectable contraceptives. No opposition to injectables was discovered, however, in the course of discussing planned project activities one activist group expressed alarm at the idea of using mass media to promote specific contraceptive methods to consumers. Fearing political repercussions, USAID/Brasilia declined to approve the project-proposed advertising, which had been promised as part of the partnership agreement with Pharmacia & Upjohn. When no mass media advertising appeared during the five months after product launch, local marketing management for Pharmacia & Upjohn used this delay as an excuse to telephone SOMARC/Washington and cancel its partnership agreement. In response, SOMARC/Washington was at last able to persuade USAID/Brasilia to approve advertising for the project and called again on the influence of corporate Pharmacia & Upjohn to revive the partnership agreement.

It is thought by SOMARC/Washington managers that Pharmacia & Upjohn/Brazil's unhappiness with the mass-market price of R\$10/injection was the true root cause of its attempt to cancel the partnership agreement. Marketing costs in Brazil are high, and inflation is a concern. It appears likely that to maintain the partnership there will have to be some compromise over the product price, at least to account for inflation. As one SOMARC manager said, "The negotiations never stop."

To maintain a solid partnership with Pharmacia & Upjohn, SOMARC management now recognizes that it will be necessary to 1) place method-specific advertising in the mass media as quickly as possible and 2) enhance the participation of Pharmacia & Upjohn management and staff in project activities.

## **B Jamaica**

Family Planning Environment Jamaica's national family planning program is long-established and was initiated from the early (1960s) service delivery and educational efforts of the Jamaica Family Planning Association, an affiliate of the International Planned Parenthood Federation (IPPF). Since those early days, the Government of Jamaica (GOJ), with substantial commodity and other assistance from USAID, has implemented under the aegis of the National Family Planning Board (NFPB) and the Ministry of Health (MOH) a nationwide family planning services delivery program. The full range of modern contraceptive methods is registered for use and available in Jamaica. Abortion, however, is not legally available except under limited circumstances.

The 1997 Contraceptive Prevalence Survey (CPS) indicates that 64.4 percent of all Jamaican women of reproductive age and currently in union use a modern method of contraception. This represents nearly a 10 percent increase since 1989, when the CPR was measured at 54.6 percent.

There is little variation in contraceptive use among the socioeconomic classes in Jamaica. Slightly more than 62 percent of the "low" and "medium" segments of the economy currently report using a contraceptive method, while 68 percent of the "high" segment currently contracept. Contraceptive prevalence rates among the urban and rural areas are also similar.

Approximately 32 percent of all Jamaican women in union using a modern family planning method choose to use the oral contraceptive. Almost 17 percent rely on condoms, 12 percent have received a tubal ligation, and about 11 percent use an injectable. IUD use is almost non-existent (1%).

Despite the relatively widespread reported use of contraceptives, the results of the 1997 CPS indicate that of all births during the previous five years, only 36 percent were planned. Forty-two percent of births were considered to have been "mistimed" and 18 percent were "unwanted."

Increasingly, women are procuring their supplies of oral contraceptives and condoms from the private sector, specifically from pharmacies. In 1997, retail pharmacies were reported as the source of oral contraceptives for almost 59 percent of pill users and 54 percent of condom users. Public sector health centers are the source of 35.5 percent of oral contraceptives and 18 percent of condoms. Public sector health centers also provide approximately 84 percent of all injectable contraceptives. Private practice physicians and/or private clinics are the reported source for less than 10 percent of any modern contraceptive method.

Commercial Pharmaceutical Environment There is a strong private sector tradition in Jamaica. In fact, the commercial sector there, in both formal and informal manifestations, has been quite active for many decades. No significant governmental/regulatory constraints on currency exchange, importation of products or establishment of businesses exist. However, during the last 10 years there has been a steady decrease in the value of the Jamaican dollar—to the extent that the purchasing power of the middle class has been gravely eroded. Whereas the rate of exchange in the early 1980s was about J\$1.75 to US\$1, the rate is now approximately J\$35 to US\$1. Prices of all products, whether durable goods or consumables, reflect this economic reality and have risen markedly.

A number of international pharmaceutical manufacturers are represented in Jamaica. Among those manufacturers whose product lines include contraceptives are Gedeon Richter (oral contraceptives), Pharmacia & Upjohn (injectable contraceptive), Wyeth-Ayerst (oral contraceptives) and Schering AG (oral and injectable contraceptives and the IUD). Finishing Enterprise's CuT380A IUD is also present in the market. As in other

countries, medical representatives are used to promote each company's line of products to physicians and other members of the medical community. Condoms are imported and sold as over-the-counter products by a number of different commercial firms.

The distribution infrastructure in Jamaica is relatively strong. National distributors, regional wholesalers and independent small truckers/salesmen serve retail outlets throughout the country. Volume discounts, bonus goods and other promotions to the trade, and availability of credit terms appear to play a considerable role in sales, especially to small- to medium-sized retailers.

National television and national and local radio are leading media for advertising. The popularity of talk radio throughout the country makes radio an especially effective medium. Newspapers and magazines are also published.

Primary Reason for Establishing a Commercial Sector Partnership Management of the CSM project in Jamaica resided in the NFPB, a statutory body of the GOJ, from the project's inception in 1973. USAID/Kingston staff and technical assistance consultants had long felt, however, that marketing decisions regarding price, advertising and promotion were not made within the context of this governmental agency in a manner sufficiently responsive to market conditions to allow for real project sustainability and success. Additionally, USAID/Kingston began to encourage the NFPB to withdraw itself from the management and implementation of family planning services delivery projects, in general, in order to concentrate its efforts and resources on strategic planning and advocacy for the national family planning program as a whole.

By 1991, USAID/Kingston was making plans to phase out its contribution of contraceptive commodities to the GOJ, including those donated for sale in the CSM program. This commodity phase-out decision helped finally to precipitate the NFPB's withdrawal from management of the contraceptive marketing program. Since sales of the project's oral contraceptive and condom products represented a significant share of the commercial sector's contraceptive market, however, USAID/Kingston sought a way to continue the commercial availability of these products beyond NFPB involvement.

The Deal Grace Kennedy, a major Jamaican corporation working in the manufacture, processing, exportation and distribution of a wide range of goods and products, was the agency through which the CSM project's oral contraceptive (Perle) and condom (Panther) were promoted and distributed from 1973 forward. From the beginning, Grace Kennedy's participation in the project was based on the personal commitment of the corporation's chairman, Mr. Carlton Alexander, to return some service to his country. However, the very low retail prices of the contraceptive products, which were set and maintained over many years by the NFPB, along with the difficulties of trying to coordinate responses to the marketplace with a governmental body, kept enthusiasm for the project lower than optimum among mid-level corporate managers with implementation responsibility. Despite these drawbacks, Grace Kennedy never abandoned its distribution of Perle and Panther, indeed a sense of "ownership" of the

brands—a historical as well as emotional link with these products—developed over time at Grace Kennedy

By 1993, the time at which USAID and the NFPB agreed that the NFPB would withdraw from management and implementation of the CSM project, Perle and Panther dominated their respective product categories in the commercial marketplace (Annual sales of Perle had reached 600 000 cycles by 1993, annual sales of Panther had reached 2,675,000 units by that same year) The exceptionally low retail price of both products (Perle at J\$8/cycle and Panther at J\$8 05/box of three) and the fact that USAID-funded brand-specific advertising for both had been aired off and on for over 15 years were the primary reasons for Perle and Panther's dominance of the market in terms of units sold

While SOMARC staff had provided short-term technical assistance to the NFPB social marketing effort over a period of several years, SOMARC became directly involved in contraceptive marketing in Jamaica in 1985, when, under the AIDSTECH Project, it designed and implemented a condom distribution and sales campaign in collaboration with local consumer goods distribution companies Because of SOMARC's familiarity with the Jamaican market and its involvement in local contraceptive sales, USAID/Kingston asked SOMARC staff to negotiate the transfer of Perle and Panther sales to the commercial sector and to provide long-term technical assistance and marketing support to the newly constituted USAID-funded social marketing project

SOMARC used several key points to sell to Grace Kennedy management the notion that the company should pay the NFPB for the rights to market (including commercial procurement of the products) and sell Perle and Panther after the NFPB's withdrawal from the project These key selling points included the following

- The project's demonstration in past years' performance of the existence of a broad-based mass market for oral contraceptives and condoms in the commercial marketplace
- The dominant market position in regard to number of units sold of each of the two CSM brands within their respective product categories
- The future ability of Grace Kennedy to bring product prices more nearly into line with commercial realities

Of these selling points the dominance of their respective categories by both Perle and Panther and the ability to raise prices once NFPB control ended were quite compelling Grace Kennedy's long-term historical/emotional commitment to providing affordable contraceptives for lower-income consumers also facilitated SOMARC's "pitch "

After nearly two months of rather gentle negotiations with the manager of MediGrace, the pharmaceuticals division of the corporation, Grace Kennedy agreed to pay US\$100,000 per brand to the NFPB for total rights to Perle and Panther (SOMARC identified the sum of US\$100,000/brand as a fair price based on its calculation of the "net

present value” to the NFPB of sales generated by these brands. The calculation was made by taking Perle and Panther sales over the previous five years, eliminating the highest and lowest years’ sales, and obtaining a three-year average for sales from the remainder. The revenue that Grace Kennedy would have returned to the NFPB for product sales at the level of this three-year average was identified as the net present value of the brands.)

In return, SOMARC pledged to work on behalf of Grace Kennedy in identifying an advantageous source of products to be sold under the Perle and Panther names since USAID-provided supplies would no longer be available to Grace Kennedy. SOMARC also agreed to continue to provide USAID-funded marketing support for relevant contraceptive methods and to work for over-the-counter regulatory status for oral contraceptives, a shift already being discussed within the MOH. (While sales of Perle occurred under the aegis of the NFPB, the MOH allowed it to be purchased and advertised as an over-the-counter product. This exception for Perle was considered by everyone in the marketplace as especially important to Perle’s sales success. While virtually all oral contraceptives are in practice sold without prescription in Jamaica, advertising ethical pharmaceuticals to consumers is still proscribed.)

Since contraceptive marketing supported by USAID funds was now to be undertaken with a commercial partner, USAID/ Kingston and USAID/Washington wished to ensure that all contraceptive manufacturers, especially U.S. manufacturers, were given equal opportunity to participate. While Grace Kennedy did not relish having to share the project’s support for its products with competitive brands, Grace Kennedy management accepted this condition because of the marketing advantage it perceived it would have with the preeminent position of its about-to-be-acquired Perle and Panther brands.

Responding to USAID’s desire that all contraceptive manufacturers/representatives who wished to participate be allowed to join in the contraceptive marketing project, SOMARC presented a deal for participation to local representatives/offices of Schering AG, Wyeth-Ayerst, Pharmacia & Upjohn, and Gedeon Richter.

Three primary selling points were used to interest these contraceptive manufacturers in participating in a commercial partnership whose goal was to ensure the continuing commercial availability of contraceptives affordable to lower- and middle-income consumers. First, to accommodate the commercial interests of a variety of brands, SOMARC developed as a key strategy for “selling” project partnership a project-inclusive logo, Personal Choice, which would be available for use on product packaging and other promotional materials by all participating companies. This logo representing all participating contraceptive products could and would be advertised to consumers in the mass media through use of USAID-provided project funds. Jamaican law prohibits brand-specific advertising of ethical pharmaceutical products; consequently, this umbrella logo approach provided them with an avenue for reaching consumers with advertising related to their products to which they had not previously had access. Second, project partnership was presented as a means for competing on more level ground with Perle and Panther brands for their large market share. Third, data of

previous Perle and Panther sales clearly indicated the existence of a large market for lower-priced contraceptive products that was of sufficient size to be commercially interesting in the Jamaican context

To make the deal with each of these potential new partners, SOMARC relied considerably on the influence of each company's corporate management. In the case of Pharmacia & Upjohn, the corporate manager for donor sales in the United States accompanied SOMARC staff to Jamaica to make the partnership presentation to the local Pharmacia & Upjohn staff. Schering AG had previous experience working with SOMARC in the region. In fact, Schering's very positive partnership experience with SOMARC and the IPPF affiliate in the Dominican Republic was well known by Schering AG regional staff, and they were eager to have their Jamaican representatives join the project partnership.

In the meantime, SOMARC had identified Gedeon Richter as a likely source of a low-cost oral contraceptive (Regevidon) for Grace Kennedy to market as PerleLD (Perle LowDose). To negotiate the lowest possible price of Gedeon Richter's product for Grace Kennedy, SOMARC staff met with the Jamaican distributor of Gedeon Richter products as well as with Gedeon Richter's international office in New Jersey. The familiarity with and acceptance of the proposed sales price in the New Jersey office is thought by SOMARC staff to have provided the "comfort level" in the Jamaican office necessary to finalize the agreement.

Interestingly, it was only Wyeth-Ayerst that declined participation as a project partner in Jamaica. Historically, Wyeth-Ayerst has been the most reluctant among all contraceptive manufacturers to collaborate as a partner in USAID-supported contraceptive marketing programs. Fear of product liability suits was the reason given by Wyeth's corporate managers in earlier days of social marketing. Lack of interest in the Jamaican market was given as the reason for non-participation in this instance. The fact remains, however, that USAID is a major customer for Wyeth's oral contraceptives, yet this relationship appears to have had little positive impact on Wyeth's interest in participating as a partner in USAID-supported contraceptive marketing projects.

The final partnership agreement between SOMARC and participating pharmaceutical companies included the following elements:

- Grace Kennedy (Perle oral contraceptive and Panther condom), Pharmacia & Upjohn (Depo-Provera) and Schering AG (Mimigynon oral contraceptive) each agreed to make their project-designated contraceptive brand(s) available to retailers at a price that would allow for an affordable price to consumers. Gedeon Richter (Regevidon oral contraceptive) agreed to make its product available to Grace Kennedy for repackaging as Perle LD at a designated low price.
- Grace Kennedy, Pharmacia & Upjohn and Schering AG agreed to detail and promote their project-designated brands to the medical community, pharmacies and other retail outlets (for condoms).

- Grace Kennedy, Pharmacia & Upjohn and Schering AG agreed to incorporate into their project-designated brand packaging and promotional materials the Personal Choice logo
- Each relevant company agreed to provide free to the NFPB a quantity equal to 5 percent of the total number of cycles sold of its project-designated oral contraceptive. These cycles will be distributed to users as free samples through outreach efforts affiliated with the NFPB
- SOMARC agreed to provide a USAID-funded annual budget of US\$250,000 for advertising and promotion of Personal Choice contraceptive methods, technical assistance in marketing, provider training, and market research
- SOMARC agreed to work to achieve over-the-counter status in Jamaica for oral contraceptives

Memoranda of Understanding were completed and signed between each commercial firm and FUTURES by December 1994

The Delivery Management of the commercial sector's side of the Jamaican partnership takes place within each company's usual marketing management structure. SOMARC manages its participation in the partnership through the activities of a Jamaican resident advisor and her project assistant. The resident advisor liaises with the staff and managers of the commercial partners, USAID/Kingston and local entities hired to provide marketing support to the project. She reports to the Regional Director in SOMARC's Latin America Regional Office. Formal liaison between SOMARC and its commercial partners occurs at regularly scheduled quarterly meetings, while informal liaison between SOMARC's local advisor and commercial partners occurs on a day-to-day basis as required. While each partner shares its brand-specific sales data with SOMARC, SOMARC shares only total sales/contraceptive method with the group as a whole. This protects the proprietary interests of each firm from its competitors.

Implementation of the partnership agreement began with Grace Kennedy's need to procure an oral contraceptive product and a condom product to replace those previously provided by USAID. The most advantageous price that Grace Kennedy could obtain for a low-dose oral contraceptive was from Gedeon Richter for its Regevidon. This product was consequently purchased then repackaged by Grace Kennedy under the brand name PerleLD. Perle had previously been USAID-provided Norminest (a Syntex product with a different formulation than Regevidon), which is no longer commercially available. GOJ pharmaceutical regulators required a change in the brand name (hence PerleLD) because of the change in formulation.

The need for price increases, which had been pent up for many years under the NFPB's control of the project, was suddenly addressed. Grace Kennedy immediately moved up the price of PerleLD by 35 percent. Sales dropped an unanticipated amount—from 600,000 cycles of Perle/year in 1993 to 341,000 cycles of PerleLD/year in 1995 to

270,000 cycles of PerleLD/year in 1997 Grace Kennedy has consistently raised its PerleLD prices by 15-20 percent annually since that time

It is now believed by SOMARC staff that Grace Kennedy, in its original negotiations, considerably underestimated the following costs

- cost of packaging, which is high in Jamaica,
- cost of actively detailing its product to physicians (Perle was such an established brand that Grace Kennedy had not actively detailed it in many years, switching the brand's formulation from that of Norminest to that of Regevidon required detailing),
- cost of "selling doctors and consumers on a new oral contraceptive product formulation at a new price even though the product is under a familiar name

Schering AG has responded to the changes in Grace Kennedy's marketing of PerleLD by pricing its project-designated oral contraceptive Minigynon at a lower point than PerleLD In fact Schering AG has aggressively sought to take the market share previously held by Perle Schering's local representative has invested considerably in advertising and promoting Minigynon to the trade and uses phrases such as "look for the Personal Choice pill in the green and white box" to gain near brand-specific references to its product in the campaign Corporately, Schering AG has invested in hiring two promoters who visit schools, factories and healthcare providers to talk about family planning and oral contraceptives The work of these promoters is in addition to the work of the usual staff of medical representatives working for Schering AG in Jamaica

Personal Choice oral contraceptive prices in 1997 were as follows

- Minigynon @ J\$40/cycle
- PerleLD @ J\$45/cycle

Non-project oral contraceptives average approximately J\$120-150/cycle

While sales of PerleLD have still not regained the 600,000 cycles/year achieved in 1993, the combined sales for the low-priced Personal Choice brands exceeded 700,000 cycles in 1997 PerleLD remains the market leader with a 32 percent share of the overall oral contraceptive market (includes public and private sectors)

In general SOMARC management has been disappointed in the lack of investment made by its commercial partners in promoting Personal Choice brands—Schering AG being an exception While Grace Kennedy initially made considerable investments in expanding its condom sales, it now contemplates investing no more money in condom advertising, and sales have plateaued Grace Kennedy also has consistently moved the price of PerleLD upward to the outer limits of C and D class consumer affordability Pharmacia & Upjohn's participation in the partnership has been "quite staid" In fact, Depo-Provera appears to be low among Pharmacia & Upjohn's Jamaican priorities for promotion While commercial sales of Depo-Provera have increased by over 100 percent during the period 1995 to 1997, they remain small compared to sales of the product to the public

sector Gedeon Richter did agree in 1996 to provide Grace Kennedy with its Regevidon product already packaged (including the project's logo), which lowered Grace Kennedy's costs of sales, however it does not provide any marketing support to Grace Kennedy for the product (Manufacturers of pharmaceutical products often provide their distributor representatives with some type of marketing support—such as detailing brochures, posters, promotional items and the like—for their brands )

Perhaps to a great extent the reluctance of commercial partners to invest in product promotion for oral contraceptives is due to the unexpected difficulties in achieving a change in regulation regarding the status of this method Because the MOH has not yet completed the process necessary to regulate oral contraceptives as over-the-counter drugs, brand-specific advertising to consumers is still proscribed Manufacturers and their representatives appear unwilling to invest in method-specific promotion that may benefit their competitors as much as themselves

Additionally, the low price at which Gedeon Richter sells Regevidon to Grace Kennedy does not allow for much profitability from which to take funds for investment in marketing support for the brand

SOMARC's response to what its management sees as less than optimum effort to promote project products has been threefold

- SOMARC's resident advisor devotes special emphasis to providing "push" to commercial partners to increase their marketing support for project products SOMARC staff, in effect provide the marketing leadership for its commercial partners in developing and implementing promotional and other marketing strategies for their project-designated products
- SOMARC is encouraging Gedeon Richter to price and market its own Regevidon product to take the place of PerleLD with C and D consumers SOMARC also plans marketing support for introduction of another product (emergency contraception) by Gedeon Richter The company is quite excited about the sales potential of this product which will have no immediate competitor in the Jamaican market
- SOMARC has established and funds cash-incentive programs to reward sales performance of employees of its commercial partners Commercial sector sales representatives are generally incentivized on the basis of the dollar value of their sales Because the project promotes low-priced products, the potential for reward under the normal commercial system is diminished The SOMARC-funded incentives are designed to "level the playing field" for project products and are paid to sales representatives if they meet and/or exceed agreed-upon targets (numbers of units sold) Interestingly, these cash incentives are now made to sales "teams" within each company rather than to individual sales representatives This has transpired because certain individuals so frequently won the cash reward that other sales representatives became demoralized The concept of a team reward seeks to increase the interest in project product sales of a maximum number of sales representatives

Now, in 1998, SOMARC staff in Jamaica believe that the most important response to commercial partners' lower-than-desired levels of product promotion is to facilitate completion of the process within the GOJ for making oral contraceptives an over-the-counter drug. The process appears to be stalled due primarily to administrative "back-up." Consequently, SOMARC is considering hiring an attorney to draft the legal notice that must be published by the GOJ in order to complete this process.

## **C Uganda**

Family Planning Environment There is not a strong tradition of contraceptive use in Uganda. The CPR among MWRA for modern methods was only 7.8 percent (about 255,000 women) in 1995. The addition of 7 percent of MWRA (about 228,000 women) who reported in 1995 that they used a traditional contraceptive method brings the total CPR in 1995 to only 14.8 percent. The 1995 CPR of 7.8 percent for modern methods does, however, represent an increase of 312 percent over the 1989 CPR for modern methods, which was 2.5 percent. Concurrently, the total fertility rate (TFR) fell from 7.3 children per woman in 1989 to 6.8 children per woman in 1995.

Among MWRA, 3 percent (about 98,000 women) currently use oral contraceptives, and 3 percent use injectables. These two methods account for approximately 77 percent of all use of modern methods in Uganda.

Overall health status of the approximately 20.4 million Ugandans is not good. Average life expectancy has fallen over the last decade, largely due to AIDS. As much as 50 percent of the population in some parts of the country has an active sexually transmitted infection (STI) at any given time. In fact, the high prevalence of HIV/AIDS and other STIs is considered Uganda's most urgent public health concern. Surveillance studies from 1996 suggest, however, that the rate of new HIV infection is falling—perhaps by as much as 50 percent over the period of three years. This decline is primarily attributed to behavior change in 1) limiting the number of sexual partners and 2) increasing condom use.

Commercial Pharmaceutical Environment Currently, no international pharmaceutical companies have offices in Uganda. International pharmaceutical manufacturers do, however, contract for product sales with local importers/distributors. Smith Kline Beecham, Janssen, and Sterling Health are three manufacturers known to have their pharmaceutical products imported into Uganda. Kampala Pharmaceutical Industries (KPI) is the only large company that manufactures pharmaceutical products in Uganda, and its product line is limited to basic pharmaceuticals. No company currently manufactures any type of contraceptive.

Few importers/distributors bring contraceptive products into the country. A single individual, for example, is reported to import Rough Rider condoms—probably from Nairobi. Some contraceptive brands that appear from time to time in the commercial marketplace are products that have been diverted from public sector or NGO stores. One private sector pharmacy that functions as both a wholesale and retail outlet has registered

Depo-Provera for sale in the commercial sector This pharmacy has succeeded in gaining the distribution rights for Pharmacia & Upjohn products in the Ugandan market

A wide variety of condom brands are currently available in the commercial marketplace, with prices ranging from 200 Ush (US\$0 17) per package of three for social marketing project products such as Protector to 3,000 Ush (US\$2 60) for several Durex brands such as Select and Featherlite Oral and injectable contraceptive products are also commercially available but their prices can vary greatly from outlet to outlet Depo-Provera, for example, is priced from 500 Ush (US\$0 44)/vial to over 5,000 Ush (US\$4 35)/vial Microgynon, an oral contraceptive manufactured by Schering AG and distributed through the Family Planning Association of Uganda, has been widely sold but has recently disappeared from the market

A history of years of authoritarian rule and civil war has created a mentality of scarcity in Uganda This pervasive mindset underlies the suppliers market that exists in Uganda even though the national economy has been improving during the last several years

In a marketplace of real or perceived scarcity, product distribution systems are usually quite limited In Uganda, for example, a trader in Kampala purchases a quantity of imported or locally produced goods opens his warehouse or store, perhaps places an announcement in the newspaper of the arrival of his products, and waits for other traders and shopkeepers from Kampala and other parts of the country to come to him to purchase his newly acquired products until his supply is exhausted So-called distribution companies in Uganda, therefore, are accustomed to operating in a market environment where whatever limited supply of goods available can be sold quickly for cash and where long-term investment in creating a sustainable distribution/supply system is not required in order to do business

The weaknesses inherent in Uganda's supply-driven distribution system include the following

- It does not respond well to existing or potential consumer demand
- It is not useful for stimulation of demand for products
- It does not consistently and efficiently serve areas outside the major commercial center (A majority of Ugandans live in smaller towns and villages that are not directly served by the Kampala-based distribution infrastructure )

While the commercial sector and its distribution system have strengthened during the 1990s with the end of civil unrest, the market remains immature and unstable Despite some increased competition among distributors of consumer products importers/distributors remain reluctant to invest their limited financial resources in growing the market for any product category or brand

Primary Reason for Establishing a Commercial Sector Partnership Faced with public health problems of crisis proportions, USAID/Kampala wished to use all channels possible to ensure the availability and accessibility of needed contraceptive/AIDS-

prevention products Although the commercial sector infrastructure in Uganda appears weak in comparison to markets in Latin America and Asia, for example, it is still better able to deliver goods efficiently than is the public sector While USAID supports health and family planning service delivery in the Ugandan public sector, the commercial distribution system has demonstrated its ability to operate to some degree during times even of civil war

To compensate for the general weakness of the economy and the limited ability of many consumers to pay for the goods and services that they need, USAID chose to create within the commercial sector a donor-subsidized system for the promotion and distribution of contraceptive/AIDS-prevention products

The Deal The limitations of the economy and of the market infrastructure, as well as the public health urgencies created by a high TFR and high rates of HIV/STI infection, defined the framework for "the deal" in Uganda Consequently, the commercial sector partnership here is significantly different from that in many other SOMARC countries A significant difference is that the purpose of the deal in Uganda was not near-term project sustainability or cost recovery but rather an immediate consistent availability of selected contraceptive products in the widest possible range of outlets throughout the country

Under the market conditions described above, USAID/Kampala and SOMARC management agreed in 1991 on the following terms for a potential commercial sector partnership for contraceptive marketing

- Contraceptive products would be provided by USAID through SOMARC free to the distributor
- SOMARC would contract with the distributor for specifically agreed upon costs of distribution and sales of the project's products (including some transportation expenses fuel inventory management expenses and reporting)
- SOMARC would provide promotional and advertising support for project products
- The commercial partner would consistently include project products in its distribution and sales system (including payment from the distribution fee of usual and customary sales bonuses and reimbursement of sales representatives travel expenses) throughout the country
- The commercial partner would sell the products to the trade at a wholesale price that would allow for an agreed-upon retail price

SOMARC began the search for a commercial sector partner with the broadest-based and most effectively managed distribution system In 1991, only one pharmaceutical distribution company, Armtrades Ltd, proactively reached areas outside Kampala with its system The promise of a consistent supply of international quality product at no cost, marketing support with a budget of approximately US\$100,000/year, and payment by SOMARC of a distribution fee were enough to persuade Armtrades to sign a contract to distribute project contraceptives, even though the market for such products in Uganda and the agreed-upon retail price (and, therefore, the potential for profit) were relatively small

The Delivery Sales of Protector condoms were launched in 1991 and of Pilplan oral contraceptives in 1993. The existence of a contract between Armtrades and SOMARC/FUTURES gave SOMARC, at least theoretically, considerable leverage over Armtrades' implementation of the deal. However, the absence at that time of a locally stationed SOMARC manager—who could supervise and prod implementation activities on a daily basis—weakened the effectiveness that a contract relationship might have provided.

By 1994, it was clear that the implementation of this original partnership agreement was not sufficient for the aggressive expansion of product distribution and sales that AIDS and fertility rates required. While sales of Protector condoms reached 4,000,000 units in 1994, Armtrades' unwillingness and inability to service non-pharmacy outlets—especially important to target consumers' easy access to Protector condoms—were apparent. Virtually all of the 1,500 points of sale reached by Armtrades with project products were pharmacies, drug shops or clinics. Additionally, experience with Armtrades led SOMARC staff to recognize that the needs and opportunities for up-country distribution were considerably more complex than originally assessed. Specifically, many retailers outside Kampala preferred to come to Kampala for their supplies. Although this journey to the capital required their time and some travel expense, these up-country traders believed that they could get a better price in Kampala for the products they wanted to buy. They did not apparently place sufficient value on the convenience and efficiency of distribution directly to their shops to pay a slightly higher price for goods so delivered. Their continuing practice of traveling to Kampala from time to time to purchase products meant that consistent product availability for up-country consumers did not improve to the extent desired by project planners.

SOMARC's subsequent response to this initial partnership experience in Uganda was based on its recognition of the following three needs:

- to ensure as quickly as possible the regular supply of contraceptives at all levels of the market in both urban and rural areas,
- to demonstrate to retailers that consistent product availability generates consumer demand (sales) and regular product turnover, and
- to demonstrate to importers/distributors the profitability of supplying demand consistently.

To meet these needs in the marketplace, SOMARC management implemented a three-pronged strategy. First, SOMARC ended its partnership agreement with Armtrades and in 1995 negotiated a distribution agreement with Twiga Chemical Industries, Ltd. Twiga was selected as the project's new commercial partner because of its consumer product distribution experience and the expectation that its consumer product orientation would benefit especially Protector condom availability and sales. In less than a year, however, Twiga discontinued its consumer product business. In 1996, SOMARC selected an additional commercial partner, KPI. Second, SOMARC created a project-subsidized and project-managed supplementary distribution system to serve trading centers, rural areas and non-traditional retail outlets. Third, SOMARC developed a network of local and

international NGOs that purchase and distribute project products to their constituencies. This NGO network reaches special target consumers and more remote rural areas.

The New Deal As project product sales had grown over time, SOMARC management realized that there was an opportunity to modify the initial deal made with its commercial partner. In 1995, annual sales of Protector condoms and New Pilplan oral contraceptives reached 6,000,000 units and 272,000 cycles, respectively. This level of consumer demand allowed SOMARC 1) to require Twiga to pay for the contraceptive products received from USAID and 2) to drop reimbursement to the distributor of any sales/distribution costs. KPI, the project's newest distributor, purchased its project products from Twiga.

By April 1997, however, KPI became the project's sole commercial partner. A new deal was negotiated between SOMARC/FUTURES and the CEO of KPI's parent company (Dembe Group), and a contract was signed in the second half of 1996. KPI was selected as the commercial partner because the project had introduced Injectaplan (an injectable contraceptive product) to its product line earlier in 1996. Government of Uganda (GOU) pharmaceutical regulators required the project to use a pharmaceutical distributor for distribution and sales of this new product. KPI also offered improved re-packaging and inventory management conditions for project products in general.

SOMARC, in turn, indicated to its new partner an intention to commit approximately US \$200,000 per year to demand-creation efforts. This intention is not, however, included in the distribution contract.

The New Delivery By September 1994, SOMARC management, with concurrence from USAID/Kampala, had placed a full-time expatriate country manager in its Uganda office. The SOMARC country manager took immediate responsibility and authority for management of the contract with the project's new commercial partner and for management of the newly created project-funded distribution system.

As implementation of the distribution contract with the third commercial partner got underway, however, the potential for fraud and corruption in the Ugandan commercial environment became increasingly apparent. Unbeknownst to SOMARC staff negotiating the new deal, KPI's parent company (Dembe Group) was simultaneously moving to sell off KPI to another company. When this sell-off of KPI was complete, parent company management who had signed the contract with SOMARC/FUTURES began to charge KPI a "transfer fee" for releasing project contraceptives to it for distribution. This introduction of an unintended middleman to the distribution chain inflated the costs of product sales to KPI, the distribution company. Since the retail price of project products was set in the contract agreement, these increased costs of sales diminished KPI's profits from the partnership and therefore its interest in actively promoting and distributing the products. It was only when the SOMARC country manager admonished KPI management for their flagging enthusiasm that she was able to draw out the story of the previously unknown company spin-off and the subsequently instituted "transfer fee." In 1997 SOMARC succeeded in eliminating the parent company intermediary from its

contract relationship and contracted directly with KPI, the newly created distribution firm

In the meantime during early 1995, SOMARC began implementation of the second prong of its new strategy—creation of a project-subsidized and -managed supplementary distribution system. The basis of the project's distribution system is van and truck distribution/sales carried out by two-person sales and promotion teams. These teams take project products up-country on a regular two-week sales cycle. They serve trading centers, rural areas and non-traditional outlets—segments of the distribution chain most neglected by established commercial distribution companies.

Soon thereafter SOMARC created a complementary distribution system for operation in Kampala where there are a large number of potential outlets, especially for condoms in urban slums and suburbs. The project's distribution system in Kampala, consequently, is based on motorcycle sales and promotion teams that visit small shops, kiosks, clubs and bars. Protector condoms are the focus of the sales and promotion efforts of these motorcycle teams. A truck sales team is used to service general goods outlets, smaller drug shops and clinics in Kampala that are not reached by the commercial distribution partner.

The success of SOMARC's strategic response to inadequacies in the original commercial partnership with Armtrades is easily seen in the breadth of current project product distribution. Annual sales of Protector condoms reached 10,000,000 units in 1996, in 1997, over 13,000 outlets carried project products compared to the 1,500 outlets achieved by Armtrades.

In the short run SOMARC staff fear that discontinuation of the project's supplementary distribution system would not lead to similar aggressive selling on the part of the commercial sector distribution chain. Availability and sales of critical project products might therefore drop. In the long run donor funds necessary for continuation of the project's marketing support may diminish and the consequent need for increased project sustainability grows.

The strategic question now facing SOMARC management is how or when to move from its subsidized re-enforcement of the commercial partnership to greater reliance on a more completely commercial partnership. The appropriate strategic response to this development is not yet clear.

## **D Jordan**

Family Planning Environment In the last five years profound change has occurred in the enabling environment for family planning and reproductive health services in Jordan. As recently as the early 1990s, family planning needed to be couched in terms of "family health" and "birth spacing." By 1995, however, family planning had become politically and culturally acceptable. The watershed event, in 1996, was the approval of the National Population Strategy by the Government of Jordan (GOJ) Cabinet. In that same

year, the MOH and USAID/Amman were able to forge a strategic objective in their bilateral agreement for "increased practice of family planning, with an emphasis on modern methods"

According to the 1997 Jordan Population and Family Health Survey (JPFHS), the age-specific fertility rate has decreased from 5.5 in 1988-1990 to 4.4 in 1995-1997. In 1997, approximately 38 percent of Jordanian MWRA were using a modern method of contraception. Sixty-one percent of these contraceptors were using the IUD and 17 percent an oral contraceptive. Six percent of contraceptors reported that they were using condoms, and 11 percent reported that they had received a tubal ligation. Fewer than 2 percent were using an injectable contraceptive.

The private sector (private hospitals/clinics, private practice physicians, pharmacies and NGOs) is the source of contraceptive services, according to the 1997 JPFHS, for 72 percent of all modern method contraceptors. Pharmacies supply 52 percent of oral contraceptive users, and NGO clinics provide approximately 41 percent of all IUD insertions. Private practice physicians account for an additional 26 percent of IUD insertions.

Commercial Pharmaceutical Environment Jordan's geographic position in the Middle East and its relative lack of natural resources have led to the development over many decades of a strong tradition in trade. Regulations regarding currency exchange, import/export and product registration do not appear to constrain business unduly.

A number of international pharmaceutical manufacturers, including at least five manufacturers of contraceptives (Schering AG, Pharmacia & Upjohn, Wyeth-Ayerst, Searle and Organon), are represented in Jordan. Seven agents for these international manufacturers distribute contraceptive products nationwide.

A domestic pharmaceutical manufacturing sector is growing, and pharmaceuticals have become a leading export. At least one of these local manufacturers (Arab Center for Pharmaceuticals and Chemicals) produces a contraceptive product, the spermicide Senocin.

The contraceptive market in Jordan is small (approximately US\$400,000 annually) compared to other categories of pharmaceutical products. Jordanian representatives of contraceptive manufacturers estimate that contraceptive sales represent approximately 2-8 percent of total pharmaceutical sales in the country.

Prices of pharmaceutical products are controlled by the MOH (IUDs are considered to be devices, and their prices are not controlled). Upon registration of a pharmaceutical product for sale in Jordan, the agent/importer/distributor shows proof of the landed price of the product. A margin of 15% + 4% for the agent/importer and a margin of 20% + 6% for the retailer are added to the landed price. This total becomes the MOH-approved retail price of the registered product. These margins must cover all marketing costs (detailing, promotion, bonuses to the trade, etc.) as well as desired profit.

Price controls keep prices to consumers low, however, when the allowed percentages are applied to landed prices the resulting margins are often considered by the trade to be inadequate. Prices for many brands of oral contraceptives available in the Jordanian market were reportedly set by the MOH as many as six years ago. Margins have been eroded by inflation and rising costs during this time. Consequently, some products (such as the progestin-only oral contraceptive Femulen) have been dropped from the Jordanian market. In other cases, importers/distributors are unable or unwilling to provide effective levels of promotion for their brands because margins received do not adequately cover those costs.

Physicians report that there has been a decline in the quantity of both the promotional materials given to them by manufacturers' representatives and the number of conferences/seminars sponsored by manufacturers over the last two years. Physicians attribute this decline to economic constraints.

Primary Reason for Establishing a Commercial Sector Partnership When the SOMARC-assisted Jordan Birth Spacing Project (JBSP) was initiated in 1993, family planning services delivery in Jordan was largely dependent on two methods—oral contraceptives and IUDs. Available formulations of oral contraceptives did not include any progestin-only pill, no injectable contraceptive was registered for use in the country, and no affordable CuT380A-type IUD was available in the marketplace. (All USAID-funded physician training was based on use of the CuT380A IUD.)

At the same time, awareness was growing among program planners that considerable unmet need for family planning existed throughout the country. Experience in other countries had already demonstrated that expansion of contraceptive prevalence rates and fulfillment of unmet need require a broad range of contraceptive choices available for couples who want to space births or limit family size. Additionally, a national campaign to encourage longer-term breastfeeding was being launched, and no progestin-only contraceptive appropriate for nursing mothers was available in the Jordanian marketplace.

While GOJ attitudes toward family planning and contraceptive services delivery were beginning to move toward a more positive and more active role for the MOH in 1993, long-term consistent government support for these services was still not assured. It appeared, therefore, that the private/commercial sector represented the best possibility at that time for broadening the range of contraceptive methods and making them consistently available to most Jordanian consumers.

The Deal In order to broaden the range of modern contraceptive methods available in Jordan, SOMARC/FUTURES made special efforts to contact manufacturers/distributors of contraceptives not then available in the country. Searle/ADATCO, which had previously marketed a progestin-only oral contraceptive but had withdrawn it from the market. Pharmacia & Upjohn/G.M. Khoury, which was initiating the process of registering Depo-Provera in Jordan, the newly appointed representative in Jordan for unregistered Norplant, and Finishing Enterprises, the U.S. manufacturer of the CuT380A

IUD To help ensure the constant availability of existing brands of modern contraceptives, SOMARC staff also approached Wyeth-Ayerst/Arab Company for Medical and Agricultural Products (oral contraceptives), Organon/Mohammed Sabbagh (oral contraceptives and IUD), and Schering AG (oral contraceptives and IUD) to discuss their possible project participation

In 1993, SOMARC/FUTURES presented three key benefits of project participation to each potential project partner 1) substantial "outside" (USAID) funding for marketing/product support activities over a period of three to five years, 2) mass media advertising as an integral part of the marketing support plan, and 3) the potential additional sales revenue for each participating company as a result of project-funded marketing activities

Unlike Jamaica, Indonesia and some other CSM project countries, a key benefit to potential commercial partners of project participation was *not* the prospect of gaining favor with the government In fact, the GOJ was perceived in 1993 by most potential partners as being so uncommitted, perhaps even opposed, to family planning services delivery that a number of potential partners required SOMARC/FUTURES to obtain a letter from the MOH indicating that it approved of the project as part of its bilateral agreement with USAID and did not object to the commercial firms' participation before the companies would consider "the deal "

An additional significant benefit of project participation existed for two of the potential commercial partners USAID/Amman was so interested in ensuring the availability of progestin-only contraceptive methods in Jordan and as part of project activities that they agreed to use wherever appropriate the influence of USAID in 1) encouraging the MOH to move expeditiously and favorably in registering Depo-Provera for use as a contraceptive, and 2) increasing the price of Femulen (Searle's previously withdrawn progestin-only oral contraceptive) to a level that would allow Searle to reintroduce the product to the Jordanian market

Since Finishing Enterprises U S manufacturer of the CuT380A IUD, did not have a commercial distributor for its product in Jordan SOMARC/FUTURES also had to pitch to appropriate commercial firms the benefits of representing this product as well as of participating in the project Fortunately G M Khoury, the distributor representing Pharmacia & Upjohn in Jordan, was interested in expanding the product line that its medical representatives could detail to OB/GYNs and expressed a desire to import a high-quality, lower-priced IUD Khoury's interest was based on the firm's projections of potential sales of an IUD significantly less expensive than the NovaT (Schering AG) and the MultiLoad (Organon) SOMARC/FUTURES put G M Khoury management in contact with management of Finishing Enterprises and facilitated negotiations between the two firms Finishing Enterprises agreed to sell its CuT380A device to Khoury at a price that, in turn, would allow Khoury to sell the IUD to Jordanian physicians at a price considerably lower than that of the NovaT or MultiLoad

In order to participate in the JBSP, each potential commercial partner was asked to agree to do the following

- ensure the consistent availability of project-designated contraceptive brands in pharmacies throughout the country,
- apply a project-provided logo sticker to the outer packaging of its project-designated brand(s),
- include a project-provided “low-literacy” instruction sheet in all project-designated oral contraceptive packages,
- put agreed-upon levels of promotional emphasis on project-designated brands in detailing and sales activities,
- distribute, on request, project-provided promotional and educational materials to pharmacies and physicians’ offices and ensure their continuing presence in such outlets,
- participate/contribute as agreed upon, from time to time in project public relations and training activities,
- provide monthly brand sales data at the end of each quarter, and
- assist in the development of project marketing plans

(Low product price was not included in the list of conditions for project participation because the prices of pharmaceutical products in Jordan are controlled by the MOH Existing prices of potential project brands were already set at a low or affordable level )

As its part of the social marketing project deal SOMARC/FUTURES promised the following

- coordination and management of project marketing activities,
- implementation of public relations activities that would create and/or strengthen support among government officials, physicians and the public for family planning and use of modern contraceptive methods,
- development of a project logo that could be used to advertise and promote project institutional partners as well as their contraceptive products
- an annual USAID-funded budget for mass media advertising and promotional support of project products,
- short-term technical training for pharmacists and pharmacy assistants to support product sales
- implementation of activities among physicians to provide information about contraceptives especially the injectable contraceptive, and
- implementation of regular marketing research whose results would be shared with project partners

Among the potential commercial partners approached Organon/Mohammed Sabbagh immediately declined project participation This decision arose from the firm’s disappointment with the results of its participation in an earlier USAID-funded contraceptive marketing project in Jordan Schering AG however, was quickly inclined to participate due at least in part to previous corporate experience with USAID-funded contraceptive marketing projects in other countries The considerable potential for USAID/project-provided support for its registration and introduction of Depo-Provera to

the Jordanian market was influential in the decision of G M Khoury to become a project partner Searle/ADATCO made its project participation—reintroduction of its Femulen-brand progestin-only oral contraceptive to the Jordanian market—conditional on the MOH granting a higher/more viable price for that product

Interestingly, the female owner of the Arab Company for Medical and Agricultural Products, Jordanian distributor for Wyeth-Ayerst products, was immediately eager to participate in the social marketing project due in large part to her long-standing commitment to women's health and other women's issues In fact, she was the one company representative who spoke of project participation in terms of doing good for the country as well as in terms of expanding product sales The Arab Company found it difficult and time-consuming, however, to obtain the permission of Wyeth-Ayerst to include its oral contraceptive brand Nordette in the Jordanian social marketing project

The newly appointed representative for Norplant indicated interest in participating in the social marketing project but delayed its signing of the project agreement until such time as project registration was completed While registration was expected within the ensuing 12 months, Norplant was not in fact registered for use in Jordan until 1996

The Delivery Management of the commercial sector's side of the Jordanian partnership takes place within each company's usual marketing management structure SOMARC manages its participation in the partnership through the activities of a Jordanian marketing manager and his project assistant The marketing manager liaises with the staff and managers of the commercial partners, USAID/Amman the MOH and local entities hired to provide marketing support to the project He reports to a SOMARC technical officer based in the Africa Regional Office

Delivery of "the deal" has perhaps been more problematic in Jordan than in many other social marketing countries A variety of events delayed implementation of promised marketing support activities for project-designated products

- SOMARC's initially selected country marketing manager did not perform satisfactorily and had to be replaced after only six months in place The process of recruiting and hiring a new manager proved time-consuming The need to replace the local manager colored USAID/Amman's perception of overall project management capability and caused USAID staff to require rather lengthy approval processes for each proposed element in the marketing process
- Due to perceived cultural sensitivity to family planning and contraceptive use and due to MOH sensitivity to this private sector project's funds coming from the bilateral agreement USAID/Amman required JBSP management to obtain MOH approval of the proposed annual marketing plan Changes in relevant MOH personnel had occurred since the time of project design, consequently, the concept and value of private sector participation in family planning services delivery had to be "resold" to the MOH

- The MOH/Directorate of Pharmaceuticals and Drug Control initially refused permission for the participating commercial partners to place project logo stickers on the outer packages/boxes of the designated contraceptive brands
- Both the MOH and USAID/Amman were reluctant to allow mention by name and brand connection of participating commercial companies in project public relations or advertising messages for fear of appearing to promote those companies and their products over any others
- The Pan-Arab contraceptive method advertising campaign that had been developed and produced for use by CSM projects throughout the region was judged inappropriate for use in Jordan by USAID/Amman and presented to a specially convened review committee for comment. In order to obtain USAID and MOH approval for method-specific mass media spots, three existing Pan-Arab ads were selected to be rewritten and redubbed by Jordanian actors
- Approval by USAID/Amman of translations of family planning-related IEC materials from English into Arabic proved unexpectedly difficult since a generally accepted Arabic vocabulary for many important medical and technical terms did not appear to exist (Except in Syria medical school education in the Middle East is conducted in English)
- All project press releases and IEC/public relations pieces for use by local newspapers had to be approved by both USAID and the U S Information Service
- Approval by project commercial partners and USAID/Amman of the content and appearance of the “low-literacy” oral contraceptive instruction sheet to be placed in each project-designated pill package required more time than anticipated. Inclusion of the insert in product outer packaging also required special permission from the MOH/Directorate of Pharmaceuticals and Drug Control

Final approval of the JBSP marketing plan was received from USAID/Amman and the MOH in 1995. Project activities were officially launched in the fall of 1995 when Prince Firas participated in a project ribbon cutting and public relations media event. Contraceptive products with project logo stickers affixed to outer packs were delivered to pharmacy shelves throughout the country at the same time. Project-sponsored method-specific television advertising was first aired in September 1996.

Delays in project implementation—especially in the appearance of the promised television advertising—were not well received by the project’s commercial partners. It became increasingly apparent that the promise of mass media advertising—unavailable to commercial partners for their pharmaceutical products outside the project—had been a major factor in their assessment of the value of project participation.

Initial absence of the mass media advertising (airing of which had become identified in the minds of partner company managers with project “launch”) appeared to temper the willingness of partners to invest their personnel and other resources in promotion of project products beyond their “usual and customary” level of effort.

Participating commercial firms did, however, fulfill the most important condition of project partnership by making project-designated products consistently available in

pharmacies and to physicians throughout the country. The project, therefore, fulfilled the requirements of USAID/Amman/Office of Population and Family Health's Intermediate Results 3.3, "Increased Availability & Affordability of FP Products in the Private Sector", and 3.1, "Improved Knowledge of Contraceptives."

Even when the project-sponsored method-specific mass media advertising began to appear, commercial partners continued to place little or no more promotional/marketing emphasis on project-designated brands than usual. Pharmacia & Upjohn, for example, perhaps surprised by physician resistance to Depo-Provera, did not undertake a particularly strong program of introductory and provider training activities for this product, which has required considerable initial support in most other countries.

SOMARC sought to bolster the promotional efforts of its commercial partners through short-term use of project staff and local-hire consultants in calling on private practice physicians to introduce the JBSP and its designated contraceptive brands. Project introductory meetings and public relations dinners for practicing physicians were used as opportunities to introduce and discuss the injectable contraceptive. The project budget did not allow for long-term or regular continuation of these efforts. A part-time project staff member does, however, continue to spot check pharmacies throughout the country to ensure the availability and visibility of project-designated products and project-provided promotional materials.

Additionally, SOMARC project staff in conjunction with selected, specially trained consultants (Jordanian physicians and pharmaceutical medical representatives) provided contraceptive technology/quality customer service seminars for more than 1,000 pharmacists and pharmacy assistants throughout the country. These half-day sessions were received with such interest by pharmacists that those who originally declined to attend a seminar later called the project office and asked to be included. While turnover among pharmacy assistants in Jordan is high, it is estimated that every pharmacy in Jordan has at least one person on staff who has attended one of these project seminars.

The strict interpretation of brand-specific advertising that the project has been required to follow has also diminished the enthusiasm of the commercial partners for project commitments. Distributors expected project marketing support activities to have a direct impact on sales of their project-designated brands. Method-specific or generic, oral contraceptive advertising and promotion has not had a brand-specific impact. While the overall commercial market for oral contraceptives grew during the first two years of JBSP-sponsored oral contraceptive marketing activities, sales of project-designated brands remained relatively constant. Growth in the overall oral contraceptive market during that time can be accounted for by the introduction of new pill brands such as Schering's Gynera and Organon's Marvelon. (These brands were introduced to the Jordanian market with higher prices than project brands and, therefore, with greater revenue/profit potential for the trade. Manufacturers and distributors have invested considerably more promotional support in these brands than in the lower-priced project-designated brands.)

Local management of Schering AG, in fact, grew so disillusioned by the perceived lack of impact on Microgynon sales created by the project's method-specific advertising (in a project that included multiple brands of oral contraceptives) that they withdrew from project participation in 1997. Particularly dissatisfying to Schering AG managers was the fact that the project's method-specific advertising for the injectable contraceptive benefited Pharmacia & Upjohn's Depo-Provera as if it were brand-specific since Depo-Provera is the only injectable contraceptive brand currently available in Jordan.

The project's advertising did, however, generate considerable interest in the selected contraceptive methods among targeted women. Physicians participating in focus groups conducted as part of a USAID-funded private sector family planning service delivery assessment consistently said that with the advent of the television advertising their clients much more frequently brought up the topic of family planning during office visits and asked for specific contraceptive methods or more information about methods.

The second phase of project-funded advertising promoted consumers' use of private sector outlets (pharmacies and physicians) as sources of contraceptive products and services. While a 'tag line' on every spot stated that the consumer should see her physician for contraceptive information and prescription, physicians reacted negatively to the portrayal of a pharmacist talking to a female customer about contraceptive choices in one of the spots. Physicians' desire to maintain their position as the only "legitimate" source of medical information or services has led them in a number of countries to oppose project advertising that promotes pharmacies/pharmacists as sources of contraceptive information.

A further set-back to sales of project-designated brands occurred when extremely low-priced CuT380A IUDs (source unknown at this time) began to appear through informal or black market sales. Many private practice physicians from throughout Jordan report that they have been called on by individuals selling this IUD "from the trunks of vehicles." G M Khoury cannot compete with the JD1 or 2/unit price of the black market product, and its sales of the legitimately imported CuT380A have declined so drastically in the face of such price competition that Khoury has not made an order for additional product from Finishing Enterprises in more than a year.

Local project staff have attempted to retrieve samples of the black market IUD so that USAID/Washington commodities logistics staff can trace their source(s). So far, physicians have been reluctant to admit that they have purchased any of these products and claim not to have samples of the product to give to project staff when asked.

In the meantime Organon/Mohammed Sabbagh has introduced the Marvelon brand oral contraceptive into the Jordanian market. The prospect of receiving marketing support for this newly introduced product through the social marketing project's USAID-funded budget has become attractive to Organon's Jordanian representatives and they have asked to participate in the new phase of project implementation, which will begin in 1999. The objectives and design of USAID/Amman's next phase of private sector activities, however, are not yet known.

## E Turkey

Family Planning Environment Only 34.5 percent of MWRA in Turkey were using a modern method of contraceptive in 1993 according to the DHS that year. An additional 28.1 percent of MWRA, however, were using a less-effective, traditional method for birth spacing or limiting family size. In fact, withdrawal was the method of choice for 42 percent of all MWRA using any type of contraception. IUDs, on the other hand, the most widely used modern contraceptive method, accounted for only 30 percent of all MWRA contraceptors.

During the five-year period 1988 to 1993, use of modern contraceptive methods by MWRA increased by only 3.5 percentage points—from 31 percent of MWRA in 1988 to 34.5 percent of MWRA in 1993. At the same time, use of IUDs increased from 14 percent to 18.8 percent among MWRA, and use of oral contraceptives declined from 6.2 percent to 4.9 percent of MWRA. In 1993, almost 7 percent of MWRA reported using condoms as their contraceptive method.

Among MWRA, almost 62 percent have at some time used some modern method of contraception. More than 30 percent have ever used either the IUD or oral contraceptive, while 24 percent have ever used a condom as their contraceptive method. Of the current non-users interviewed in 1993 who expressed an intention to use a contraceptive method in the future, slightly more than 50 percent intended to use the IUD. Among currently married non-users in 1993, however, 46 percent did not intend to use any contraceptive method in the future.

Primary reasons for non-use among those who do not intend to use a method in the future as reported in the 1993 DHS, are: 1) 51 percent of women aged 15-29 want children now; 2) 18.5 percent of women aged 15-29 and 35 percent of women aged 30-49 believe that contraceptive use makes it difficult to become pregnant later; and 3) 35 percent of women 30-49 believe they are menopausal or have had a hysterectomy. Access, price, and general health/side effect concerns were each reported as constraints by fewer than 3 percent of women interviewed.

At the time of the 1993 survey, respondents reported that 13 of every 100 pregnancies ended in induced abortions, and eight ended in spontaneous abortions.

Private Sector Pharmaceutical and Healthcare Environment There is currently a very active commercial pharmaceuticals and consumer goods market operating in Turkey. Distribution of both pharmaceutical and consumer products is quite sophisticated, and products are available on the shelves of a variety of outlet types throughout the country.

Within the contraceptive category, at least five international manufacturers are now represented in Turkey—Schering AG, Wyeth-Ayerst, Organon, Pharmacia & Upjohn, and Gedeon Richter. Approximately 12 brands of oral contraceptives are available in the commercial market as well two injectable contraceptives and several IUD brands. A

variety of condom products are also sold. Among oral contraceptive brands, there is a range of retail prices—some of which are considered affordable to lower-income consumers.

In 1993, the public sector (government hospitals and health centers) was providing almost 55 percent of users with their modern contraceptive methods, according to the DHS. Retail pharmacies accounted for more than half of the modern contraceptive services delivery provided by the private sector. 70 percent of all oral contraceptive users obtained their pills in a private pharmacy. While private practice physicians provided services to only 15 percent of MWRA contraceptors, they did account for almost 25 percent of all IUD insertions. NGOs in Turkey are not a significant provider of family planning services (less than 1 percent for any modern method).

According to the Ministry of Health's recent "Health Services Utilization Survey in Turkey," most healthcare consumers choose public sector service outlets such as health centers and Maternal/Child Health (MCH) centers because of their inexpensiveness, the easy transport available to these outlets, and the absence of alternative outlets. The primary reason given for choosing a university hospital or private physician for healthcare services is "trust" toward the provider. Insurance status, however, is found to account for the majority of decisions regarding hospital-based service delivery.

There is almost no difference between urban and rural healthcare consumers in their use of public and private sector outlets for service delivery. 69 percent use public sector healthcare outlets, 31 percent use private sector sources.

While clients receive on average twice as much examination time from private physicians (20.1 minutes) as they do from public health centers (10.3 minutes) according to the MOH health services utilization survey, 100 percent of public health center clients perceive that their examination time is sufficient. Only 63.2 percent of the private physician clients, however, perceive that the 20-minute examination given them is sufficient. Clients of other public sector outlets, such as health centers (different from public health centers) and MCH centers, are not so satisfied (approximately 44 percent).

Clients of private practice physicians are most likely to be satisfied with the information that they receive from the doctor. Clients of SSK institutions (Turkish social security agency) are generally the least satisfied with the information given them by the attending physician, according to the survey cited above.

Healthcare consumers from the fourth, fifth, sixth, and seventh income deciles have approximately two to three physician contacts annually, as reported by the MOH services survey. Of the healthcare consumers visiting physicians, 21.8 percent come from the lower third of the population according to per capita income, 31.1 percent come from the middle third, and 47.1 percent come from the upper third. SOMARC/FUTURES research indicates that 50 percent of C socioeconomic class women have visited a private physician in the last six months.

Private practice OB/GYNs in Turkey provide antenatal care to many women who then choose to have their babies delivered in public sector facilities. This consumer practice is largely due to the lower cost of deliveries in the public sector. About 40 percent of the client load of private practice OB/GYN physicians is estimated to come from provision of antenatal care.

Private practice physicians are chosen by many women for provision of abortion services. Approximately 8 percent of private OB/GYN physicians' client load is estimated to come from delivery of abortion services.

The Turkish Medical Association (TMA), the syndicate of private practice physicians, sets *minimum* prices to be charged for all services offered by physicians in the private sector. "Many" physicians according to market sources charge less than the sanctioned minimums but cannot promote their prices since they violate syndicate regulation.

Primary Reason for Establishing a Commercial Sector Partnership—Part I In 1988, a Turkey Advisory Committee was established by USAID/Washington/Office of Population/Family Planning Services Delivery to look at opportunities for expanding and improving family planning services delivery in Turkey, a high-priority country for the Office. SOMARC/FUTURES was asked to collaborate with the Advisory Committee in assessing the availability and accessibility of a range of contraceptive methods in the Turkey setting.

The SOMARC assessment revealed that a variety of oral contraceptive brands were commercially available at that time. Higher-dose pill brands, however, were the market leaders. The predominance of higher-dose pills in the marketplace was thought to be the primary reason for the relatively high rate of oral contraceptive discontinuation (due to real and perceived side effects) among Turkish women. The reason for the predominance of higher-dose oral contraceptives in the Turkish market was strongly linked to Government of Turkey (GOT) pricing policies. Pharmaceutical prices were set according to the amount of "active ingredient" in each product. That is, the more active ingredient present in the product, the higher the price allowed by the government agency that controlled pharmaceuticals. In the case of oral contraceptives, newer, lower-dose formulations were granted a lower price than the older, higher-dose formulations. Pharmaceutical manufacturers, therefore, did nothing to lessen sales of their older, higher-dose, higher-priced products and little to introduce and promote their newer, lower-dose, lower-priced formulations.

SOMARC staff consequently identified the need for further introduction and promotion of lower-dose oral contraceptives to replace the higher-dose formulations present in the Turkish marketplace as a primary priority for improving family planning services available in Turkey and for increasing over time—through improved oral contraceptive continuation rates—the CPR among MWRA.

In 1988, there was no USAID mission in Turkey, all U.S. donor activities had to be channeled through the U.S. Embassy in Ankara. Embassy officials felt that they had

neither the staff nor time to oversee the project-related work of a variety of USAID-funded cooperating agencies. All USAID family planning assistance was, therefore, to be delivered under the aegis of the Turkish Family Health and Planning Foundation (TFHPF)

The TFHPF, however, did not itself have a product distribution system or a marketing management system capable of achieving the nationwide distribution/sales necessary to make a significant change in the overall availability of low-dose oral contraceptives (Social marketing experience worldwide has further shown that the financial time and personnel costs of establishing such a system are large.) Furthermore, manufacturers of low-dose oral contraceptives were already represented in the commercial marketplace in Turkey. SOMARC staff recommended, therefore, that the TFHPF look for commercial partners with existing low-dose oral contraceptive products and with capability in the distribution of pharmaceutical products nationwide.

The Deal—Part I Because of the size of the market in Turkey and the relative prosperity of its economy, many international pharmaceutical manufacturers were represented there. Wyeth-Ayerst, Schering AG and Organon each marketed a line of oral contraceptive brands in the Turkish marketplace.

The oral contraceptive market, however, was deteriorating in Turkey in 1988. Consumer dissatisfaction with side effects was leading to greatly diminished sales of higher-dose brands while the low prices assigned to lower-dose oral contraceptives prevented manufacturers' promotion of these newer formulations. Manufacturers were faced with the possible loss of the Turkish market for oral contraceptives.

The "hook" that SOMARC/FUTURES used to pull potential commercial partners into project participation was the opportunity that the project offered of USAID-funded marketing support for promotion of low-dose oral contraceptives both to physicians/pharmacists and to consumers. Manufacturers did not feel they could afford, under the low prices assigned by the GOT/MOH authorities to low-dose oral contraceptive formulations, the kind of promotion necessary to replace the declining sales of high-dose pills with low-dose pills in the marketplace. Recognizing the marketing advantages of lower-dose pills, manufacturers eagerly sought a mechanism for rebuilding the oral contraceptive market in Turkey.

The deal that SOMARC staff offered to potential commercial partners included the following basic elements:

- a project-supported logo to represent the overall category of lower-dose oral contraceptives that could be used on the outer packaging of participating manufacturers' low-dose brands,
- a USAID-funded budget for mass media advertising that would feature the low-dose logo and would promote the advantages and benefits of lower-dose oral contraceptives and

- a consumer brochure promoting the benefits and advantages of lower-dose oral contraceptive use in quantities sufficient for mass distribution through pharmacies

In return, potential partners were asked to do the following

- withdraw all marketing and promotional support from higher-dose oral contraceptive brands so that their sales would end in Turkey over time,
- provide training to appropriate medical representatives on the low-dose oral contraceptive,
- place detailing emphasis on the low-dose oral contraceptive,
- place the project's logo for low-dose pills on the outer packs of their low-dose brands,
- participate in seminars for physicians on the advantages and benefits of low-dose oral contraceptives,
- distribute project-provided consumer brochures to pharmacies throughout Turkey, and
- return a small percentage of sales revenues to a project fund for future promotion of low-dose oral contraceptives

Convincing manufacturers to "exchange" sales of higher-priced, higher-dose oral contraceptives for sales of lower-priced, lower-dose oral contraceptives was not difficult due to the significantly falling sales of higher-dose pills in the Turkish market

SOMARC staff presented the deal outlined above to the local offices of Wyeth-Ayerst, Schering AG and Organon (These companies were chosen because of their position as market leaders) Each office made its decision through the process required by its respective corporation Both Schering AG and Wyeth's local offices had to request the approval of their headquarters office Schering AG, seeking aggressively to strengthen the position in Turkey of its oral contraceptive category, responded quickly and indicated its desire to accept the project deal Wyeth-Ayerst, after some time required to move through its corporate approval process, also agreed to participate as a project partner Organon's country manager however, had the authority at the local level to make his project decision Perhaps because of this responsibility, the Organon manager required considerably more information, explanation and negotiation to come to a positive decision than did the managers of the other two companies

The Delivery—Part I The project-related activities of the participating commercial partners were managed through their established marketing and management infrastructures

SOMARC's delivery of its part of the project deal and its liaison with the project's commercial partners were managed through 1) the efforts of a TFHPF staff member who also coordinated the in-country activities of many other donor-funded projects, and 2) the short-term technical assistance provided by SOMARC/Washington staff who came periodically to Turkey The TFHPF staff member who in effect worked part-time for the CSM project was so overburdened with management responsibilities for other projects that SOMARC staff came to feel—at least in the early stages of project

implementation—that progress occurred only when a SOMARC staff member was in the country

By 1991, however, the logo representing low-dose oral contraceptives, the consumer brochure and the mass media advertising campaign had been developed. Commercial partners' medical representatives had been trained in representing low-dose oral contraceptive products, and commercial partners' support for their higher-dose brands had stopped. Project launch occurred with the initial airing of the mass media campaign. Within three months of project launch, the oral contraceptive market in Turkey had grown by 120 percent—most of the growth occurring among lower-dose brands.

SOMARC staff and staff of the project's commercial partners continued to promote to providers and consumers the benefits and advantages of use of low-dose oral contraceptives through the mass media advertising campaign, medical detailing, public relations events, and seminars for providers. USAID-funded support for the introduction and promotion of low-dose oral contraceptives in the commercial marketplace ended, as planned in 1994. Once SOMARC—the low-dose oral contraceptive marketing effort's central coordinating force—withdrawed, however, collaboration among the competitive manufacturers to grow the overall market diminished.

Primary Reason for Establishing a Commercial Sector Partnership—Part II In 1989 USAID/Washington, U.S. Embassy staff in Ankara and SOMARC/FUTURES staff decided to use the commercial sector to expand further the range of contraceptive methods effectively available to potential family planning consumers. A 1989/1990 assessment by SOMARC/FUTURES indicated that condom sales offered the biggest opportunity for contraceptive-related social marketing at that time. There was already a consumer market for condoms in Turkey, but constraints on sales existed. Condoms were available only in pharmacies, they were not merchandized visibly, there was no local brand, and a considerable negative image was attached to the purchase of condoms. These barriers to increased sales, however, could all be resolved or at least diminished through changes in distribution strategies and addition of marketing support activities—allowed for over-the-counter consumer products like condoms. The untapped potential for condom sales appeared to be significant.

The Deal—Part II During 1990, SOMARC staff identified and interviewed virtually all pharmaceutical and consumer product distributors operating nationally in Turkey. On the basis of the information gathered, Eczacıbaşı was selected as the project-preferred distribution leader because of its size, effective distribution reach, and reputation as a market leader.

SOMARC offered to its potential project partner considerable data supporting the existence of a large untapped, profitable market for affordable condoms in Turkey, as well as: 1) a USAID-provided budget for a significant mass media advertising campaign for the project's condom product, 2) a USAID-provided budget for promotional and public relations activities to support product sales—a total advertising and promotional budget of approximately US\$1 million over two years, and 3) the social/cultural “protection” of

the TFHPF as a project sponsor. In return, SOMARC asked that its partner 1) select and import a quality condom product, 2) package the product under its own brand, 3) distribute and promote the product through its existing distribution/sales network to pharmacy and non-pharmacy outlets, 4) market the product at an agreed-upon, affordable price, and 5) return a stated percentage of sales to the TFHPF (return-to-project fund)

Considerable negotiations between SOMARC/FUTURES staff and management of Eczacıbaşı were required to convince the distribution company to participate in the social marketing project as a commercial partner. Eczacıbaşı managers' primary concern was not the potential for profit in project participation but rather the perceived risk of tarnishing the company's valuable image and standing with the pharmaceutical trade by carrying and promoting its own brand of condom, a product generally associated at that time with a lower-quality market. To overcome this objection to the proposed deal, SOMARC staff worked closely with Eczacıbaşı to develop a product positioning strategy that allayed their concerns. While it is sold in non-pharmacy as well as pharmacy outlets, the OK condom is packaged, for example, in a high-quality blue and silver box that is designed to appear very "pharmaceutical" in nature. Quality and "professionalism" were stressed in all the supporting promotional activities for the brand.

SOMARC/FUTURES staff negotiated with Eczacıbaşı management that the retail price of the project's OK brand condom would fall within the lower third of prices for condoms in the Turkish marketplace at that time. Within the framework of the agreed-upon retail price, Eczacıbaşı and its distribution network applied the usual and customary mark-ups and margins for the OK product.

From the beginning of the project partnership, SOMARC and Eczacıbaşı worked toward the stated goals of project "graduation" and product "self-sufficiency."

The Delivery—Part II Eczacıbaşı managed its marketing of the OK condom brand through its usual and customary management infrastructure. SOMARC/FUTURES liaised with Eczacıbaşı and local advertising subcontractors through Washington-based staff members who maintained long-distance communication and traveled periodically to Turkey. The TFHPF was not involved in the day-to-day management of the Part II project largely because Eczacıbaşı management did not need to work through the NGO for direct access to consumers. The TFHPF, however, played a crucial role in securing permission from the GOT/ Turkish Radio and Television Bureau for the proposed mass media advertising for the OK condom. In fact, advertising for the OK condom was the first brand-specific advertising for a condom product aired on Turkish television.

Eczacıbaşı launched distribution and sales of OK condoms in June 1991. Brand-specific mass media advertising of the OK condom was launched simultaneously. Within the first year of the project partnership, Eczacıbaşı was distributing OK to more than half of all outlets in Turkey that sold condoms. By 1992, Eczacıbaşı distributed OK condoms in both pharmacies and supermarkets and covered approximately 70 percent of these condom sales outlets. There was no noticeable adverse reaction from the retail trade—as

Eczacıbaşı had feared—to the active promotion and distribution of the project condom product

Sales revenues from the project's product quickly became commercially interesting to the company. In fact, product sales outperformed all expectations. 4.5 million condoms were sold in 1991 and 5.9 million in 1992. At the end of 1991, the retail price of OK was raised by Eczacıbaşı but remained only slightly more expensive than the low-priced market leader. By the completion of two and a half years of project product sales, Eczacıbaşı had increased OK's retail price five times over its initial price to keep pace with inflation and the rising costs of sales, however, OK's price remained in its position midway between the most and least expensive competing condom brands in the Turkish marketplace.

In 1992, Eczacıbaşı, with no USAID-funded support, began to import and market a "premium" OK condom product called OK Extra. This product was priced to reach an "elite" segment of the Turkish market.

As OK brand condom sales progressed, Eczacıbaşı management considered the addition of a possible project-related oral contraceptive to its product line. It was decided by company managers, however, that the existing market for oral contraceptives in Turkey was already too competitive to allow for the profitable introduction by Eczacıbaşı of a new oral contraceptive product.

After only two and a half years, Eczacıbaşı profit from OK sales was sufficient to "graduate" the project from USAID-funded marketing support. Eczacıbaşı marketing/management commitment to the product was also sufficient to warrant withdrawal of project technical support. A formal "Memorandum of Understanding for Graduation of the OK Condom Social Marketing Project in Turkey" was drawn up between SOMARC, the TFHPF and Eczacıbaşı. In this agreement, Eczacıbaşı promised to 1) "maintain maximum levels of distribution and continue to attempt to expand distribution wherever possible", and 2) continue to contribute 10 percent of the cost of goods to a TFHPF return-to-project fund intended to support future social marketing activities.

Sales of OK condoms not only continue, but the OK condom brand is also the present market leader. By 1995, an estimated 85 percent of all retail outlets in Turkey that sold condoms stocked OK. In-store displays, peer counseling at colleges and universities, and television advertising are marketing activities that the firm now feels comfortable undertaking for its condom products.

Primary Reason for Establishing a Commercial Sector Partnership—Part III Resource limitations and a growing population of healthcare consumers has caused the GOT/MOH to recognize during the period since 1993 the need to 1) segment the healthcare market among public and private sector delivery channels, and 2) move increasing numbers of healthcare consumers who can afford to pay into the private sector for service delivery.

In family planning, the private sector already plays a major role in delivery of temporary or short-term contraceptive methods—primarily through sales of oral contraceptives in retail pharmacies and of condoms in retail pharmacies and other consumer product outlets. U.S. Embassy staff and the MOH, therefore, wished to test a strategy for increasing private practice physicians' participation in the delivery of family planning services particularly in the provision of longer-term contraceptive methods. The success of social marketing in Parts I and II led Embassy and MOH staff to request SOMARC/FUTURES to design a social marketing project that would 1) motivate private practice physicians to take a more proactive role in providing family planning services, particularly longer-term methods, to healthcare consumers, and 2) increase consumer demand for such services from private sector providers.

The Deal—Part III The basic premise of the Part III services marketing project was that the creation of a "branded" network of private physicians—advertised to consumers for quality family planning services available at affordable prices—would increase client flow and therefore profits to participating providers. This premise became the key selling point SOMARC staff used to influence physicians to join the project network. Increased profits due to increased family planning service delivery would also, it was expected, lead providers to promote and proactively provide such services to their clientele.

Each private practice physician who wished to participate as part of the project network of providers was asked to agree to do the following:

- attend a 2 1/2-day, project-sponsored training session,
- charge agreed-upon fees for family planning-related services (fees approximately equal to the minimum fees set by the Turkey Medical Association,
- display a project-provided price list for family planning services and project promotional materials in their waiting rooms, and
- display the project's network logo sign at their practice sites.

In return, SOMARC offered participating practitioners the following benefits:

- a USAID-funded budget for marketing the network and its logo to target consumers including use of mass media,
- a public relations and neighborhood outreach campaign to support the concept of the network among target consumers
- promotional/IEC materials for distribution to clients, and
- a 2 1/2 day training session covering such topics as contraceptive technology, counseling/quality-of-care techniques and effective business practices.

The Delivery—Part III SOMARC/FUTURES' delivery of its part of the Part III deal is managed through the efforts of a full-time local project manager and his assistant, who report to SOMARC's technical advisor for long-term methods in the Washington office. Each participating private provider, or commercial partner, deals directly and individually with SOMARC's in-country manager. Each partner's project-related activities take place as an integral part of his/her private practice of medicine.

To identify private practice OB/GYN physicians who might be potential commercial partners for the project, SOMARC staff visited individual physicians and polyclinic owners in C and D socioeconomic class neighborhoods. Initially, these visits were “cold calls” in which staff introduced themselves and the objectives of the future project to physicians with whom they had had no previous contact. As the project was implemented and physicians began to hear of project activities, however, some practitioners began to contact project staff to inquire about opportunities for project participation. Within the parameters of C and D socioeconomic class areas, neighborhoods with natural “boundaries” were selected so that client flow created by project promotional activities would be channeled into the offices of nearby participating physicians. Potential partners’ clinics were also selected on the basis of their existing standards of care.

By the end of 1995, physicians from 20 clinical facilities in three neighborhood communities in Istanbul had agreed to become project partners as part of the KAPS (Women’s Health and Family Planning Service System) network. Once the training commitment was fulfilled, each physician was allowed to display the network logo at his/her practice site. SOMARC initiated media advertising of the network, and TFHPF staff began outreach promotion of network services in the targeted communities.

Market research undertaken by SOMARC in 1996 indicated that recognition among men and women in Istanbul of KAPS as a network of physicians offering family planning care and quality service was very high. Project promotion had succeeded in increasing knowledge and awareness of the services available through the network. This research indicated, on the other hand, that client flow to participating partners’ practices had not increased. Consumer trial/utilization of private practice OB/GYN physicians as a source of family planning services had evidently not been affected by the project’s promotional efforts. Additionally, exit interviews of participating physicians’ clients seemed to show that doctors were not raising the issue of family planning with clients who did attend their clinics for other reasons.

Further analysis by SOMARC management of the interim results of the ‘deal’ indicated three possible ‘flaws’ in the original project premise: 1) contraceptive services were not of themselves sufficient to draw significant numbers of Turkish women into the offices of private OB/GYN practitioners; 2) price of services was perhaps not as important as anticipated in consumers’ choice of OB/GYN physicians as family planning providers; and 3) the service provision behavior of private practice OB/GYN physicians—that is, their willingness to proactively address family planning issues with their clients—was not easy to change.

Data did indicate, however, that approximately 40 percent of participating OB/GYNs’ business consisted of provision of antenatal services (most deliveries occur in the public sector) and 8 percent of abortion services. Both these categories of existing clients of private OB/GYN practices appeared to be prime targets for future or immediate family

planning services, however, neither category was being provided with such services by the private OB/GYNs they consulted

The Revised Delivery—Part III On the basis of these observations, SOMARC management revised its statement of the “deal” to the project’s partner physicians and reformed its strategy for delivery. First of all, abortion clients were targeted as prime potential customers for contraceptive services. Rather than use the business potential of increased client flow as a motivator for physician participation in project service delivery, SOMARC staff presented physicians with the business and healthcare opportunities present in offering additional, family planning services to clients who presented themselves for another reason, abortion. To reinforce the motivating power that new business opportunities might have for changing partner physicians’ service delivery behavior, SOMARC staff used a two-pronged approach: 1) a new training methodology, and 2) involvement of physicians’ supporting clinic staff.

SOMARC staff employed a technique called academic detailing to encourage behavior change among partner providers. This technique is based on medical detailing procedures used by pharmaceutical companies in promoting their products to prescribing physicians. In academic detailing, however, the physician is called on at his/her practice site by a project representative who seeks to “sell” to the practitioner in a one-on-one setting a specified behavior—in this case, the proactive provision of contraceptive information and services to abortion clients. (Several studies from the United States have shown that academic detailing yields better results than do other types of continuing education programs for doctors.) Specific guidance was given to physicians as to the behavior desired. For example, fact sheets explaining choices of post-abortion contraceptive methods were created and distributed among physicians and their clinic staff during academic detailing visits. These fact sheets reiterated explicitly the key messages that physicians were asked to give their post-abortion clients. Handouts describing how post-abortion contraceptive services could improve clinic business were also developed and used during academic detailing calls. To further motivate physicians to change their service provision behavior, SOMARC staff solicited local representatives of contraceptive manufacturers for product samples that participating doctors could offer to their abortion clients. These samples also ensured that there was a range of contraceptive methods available in the doctor’s office from which abortion clients could choose.

Secondly, SOMARC staff saw that there were three clinic staff members with whom abortion clients typically had interaction: the receptionist, the nurse and the physician. Special care was taken to ensure that nurses, who in fact spent the most time with each abortion client, were included in academic detailing visits, and counseling handouts were created especially for their use.

Prior to the revision of the project’s “deal” with partner physicians and subsequent changes in the delivery strategy, less than 16 percent of abortion clients reported that they had discussed family planning with the project network provider. After only seven months and two rounds of academic detailing to participating physicians, however, 44

percent of clients seeking an abortion-related consultation said that a KAPS network provider had discussed family planning services with them

## **V LESSONS LEARNED**

Partnerships with commercial sector entities have proved “successful” in a variety of ways. The ways in which each commercial partnership contributed to achievement of the country’s family planning goals and the degree to which each partnership succeeded, however, have varied from marketplace to marketplace.

Overall, partnerships with the commercial sector have contributed to USAID’s family planning service delivery objectives in the following areas:

- Reliance on commercially available contraceptive products in many social marketing programs has reduced USAID/Washington’s commodities cost by more than US\$47 million over the last 10 years
- The availability and accessibility of modern contraceptive methods have been increased in many project countries
- The range of contraceptive methods readily available to consumers has been increased in a number of project markets
- Reliance on public sector resources for family planning products and services has been decreased in some markets
- Project activities have encouraged some contraceptive manufacturers to begin to include in their strategies the marketing of contraceptive products positioned to reach lower-priced mass markets rather than higher-priced niche markets alone

A number of lessons have been learned during the past 15 years that may shed light on the reasons for greater or lesser “success” from one commercial partnership to another or from one marketplace to another and that may be useful in improving and expanding the effectiveness of future commercial sector partnerships. The following section of this study outlines these lessons learned:

### **A What’s in it for them?**

- Perhaps the most important lesson learned, overall, is that there must be something in project participation that is of appreciable value/advantage to a commercial partner. Where such an advantage is not immediately apparent, potential commercial partners do not choose to participate. Where such an advantage is not delivered by project participation or is not delivered to the extent desired, commercial partners either drop out of project activities or contribute little if anything beyond their “usual and customary” efforts.

- The gain that commercial partners hope to receive through project participation is not confined to increased product sales or increased revenues from sales. What commercial partners see as “what’s in it for them” often varies from marketplace to marketplace or from contraceptive manufacturer to contraceptive manufacturer. Sought-after advantages may include, in addition to increased sales/revenues, corporate-level tax considerations, full utilization of regional or international production capability, maintenance or enhancement of market share/market leadership positions, opening of new markets, and support for introduction of new products.
- Research and development costs for a pharmaceutical product are paid at the corporate level and are included in the price of the product to the local or regional office. Marketing costs are largely born by the manufacturer’s local country offices. Any increased investments in marketing expected due to project participation/project agreements must usually, therefore, be advantageous to the specific goals of the manufacturer’s local office.
- “What’s in it ’ for commercial partners is often complex and a combination of factors. Social marketing program planners need to know more in general about what is important to commercial entities as well as what concerns/agendas drive their business decisions in each marketplace.

## **B Importance of Brand to Commercial Partners**

- The importance to a pharmaceutical manufacturer of maintaining or gaining market share leadership for its brands cannot be overestimated. To be able to say “More doctors recommend/prescribe our brand than any other” increases exponentially a company’s success in selling its existing products and in introducing its new products. A market-leading brand is “top of mind” for prescribing physicians and for pharmacists who may sell oral contraceptives, for example, without prescription. Companies are often willing at the local or regional level to sacrifice some part of their profit margin to maintain or grow market share.
- The overall commercial importance of market share, as described above, makes brand-specific marketing critically important to contraceptive manufacturers and distributors.
- The costs of medical detailing and/or promotion of pharmaceutical products for a local commercial partner are quite high. In Latin America, for example, the cost of a single visit to a physician by a company’s medical representative ranges from US\$60-80. For a commercial partner, anticipated profit from contraceptive sales (brand-specific) may not warrant the kind of concentrated promotional/marketing effort needed to grow the overall market for contraceptives or generally increase contraceptive prevalence (generic or category marketing), which is the ultimate goal of CSM projects.

- A contraceptive manufacturer whose brand(s) are already market-share leaders in a given marketplace may be more likely to participate in program efforts to “grow the overall market” because their leading brands are most likely to capture the major share of that overall growth

## C Advertising

- Direct access to the consumer through mass media advertising is often a major selling point for commercial partners' interest in project participation. By limitations of regulation and law or by limitations of budget, pharmaceutical companies do not usually have direct access to consumers with their brand/product messages
- The generic or method-specific advertising usually implemented by USAID-funded contraceptive marketing projects has increased consumer interest in and demand for family planning services in many countries. Increase in consumer demand has also led to noticeable increase in supply of such services in some countries, especially by private practice physicians
- Commercial pharmaceutical partners in social marketing projects are interested, for many of the reasons discussed above, in increased brand share for their products. Generic, or method-specific, advertising does not deliver increased brand share. The difference in importance to a commercial pharmaceutical partner between expanding the overall market for contraceptives and expanding brand share for a selected project product has not always been sufficiently appreciated by social marketers
- The limitations of method-specific advertising in creating increased brand share for a selected product cause a special problem for projects that support contraceptive categories represented by multiple participating brands. Partners' dissatisfaction with this limitation is exacerbated when another contraceptive category in the same project is represented by only one brand. For example, the method-specific advertising of oral contraceptives in many country projects does not work to the brand advantage of any pill product because there are many brand choices for the consumer. On the other hand, the method-specific advertising of injectable contraceptives, when only Depo-Provera exists in the marketplace, does function to some extent as brand-specific promotion. There is no other injectable contraceptive brand choice for the consumer
- Project advertising that promotes the use of private sector providers (private practice physicians and retail pharmacies) for contraceptive goods and services often elicits physician complaints against pharmacists for “usurping” the perceived role of the physician
- The cost of mass media advertising is so high in some markets that commercial partners believe they cannot afford to use it even if legal and regulatory constraints on their access to the media are lifted

## **D      Role of Head Offices in Project Participation Decisions**

- Corporate head offices can and sometimes do exert their influence on local country representatives to participate in social marketing projects. This has been true especially of Pharmacia & Upjohn during the recent period of introduction/reintroduction of Depo-Provera as a contraceptive to most markets
- Wyeth-Ayerst, from whom USAID buys 48 million cycles of oral contraceptives annually, is consistently the pharmaceutical manufacturer least likely to support and/or allow project participation by its local country representatives
- A manufacturer's previous experience with a CSM project is often communicated (either formally or informally) throughout its regional offices and does carry weight that can be either positive or negative in local country representatives' decision-making. Intra-company communication at Schering AG has frequently worked to project advantage in "selling" partnerships to Schering's local representatives
- The strategy of positioning a selected brand(s) for a mass rather than a niche market appears to originate most frequently in corporate or regional headquarters rather than local offices

## **E      Place of Contraceptives in Pharmaceutical Business**

- Contraceptives do not "drive" the business of many pharmaceutical manufacturers—especially contraceptive brands that they are willing to sell at mass-market prices
- At least one major pharmaceutical manufacturer expects its *profit* from any given brand to equal at least 80-100 percent of that product's total cost (production, packaging, distribution promotion, advertising, etc.) Fifty to 60 percent of total product cost is the lowest level of profit performance that this manufacturer will accept from any of its brands under any circumstances
- Revenues from sales of contraceptives are seldom reported by retail pharmacists to exceed 3-5 percent of their total revenue
- Product detailing practices, costs of detailing and promotion, and sales commission/bonus patterns do not naturally favor placement of marketing and sales emphasis on lower-profit/lower-turnover products
- In countries where access to cash and/or hard currency is problematic for importers and retailers, low-demand products—as hormonal contraceptives for example, are often perceived to be in those countries—are not high-priority investments for the trade

## **F Mass Market for Contraceptives and Consumer Marketing**

- Commercial partnerships for contraceptive marketing will not replace the need for public sector and donor resources/effort in expanding overall demand for contraceptive services and for serving difficult-to-reach segments of the population. It is unlikely that commercial pharmaceutical entities will find it profitable in most market situations to invest significantly in activities aimed at growing the overall market for contraceptives rather than at increasing their brand share.
- Prices of project contraceptive products have increased when project-supplied funds for marketing support activities have ended. Sales revenues gained by manufacturers/distributors must cover the costs of marketing support.
- The degree to which commercial partnerships for contraceptive marketing have succeeded in creating sufficient “mass” markets for lower-priced contraceptives to sustain continuing, enhanced consumer advertising/promotion, product detailing, public relations activities, etc. beyond project funding periods is not clear in many markets.
- The definition of success for a commercial partnership in contraceptive marketing as creation of a commercially sustainable mass market for lower-priced contraceptives may not sufficiently recognize the range of positive impacts on contraceptive availability and use made by such partnerships.

## **G Private Providers and Family Planning Services Delivery**

- Family planning services delivery is not a big moneymaker for private practice physicians. Obstetrics, infertility treatment, and gynecology/treatment of infections are major sources of OB/GYN physician income. Physicians in many countries estimate that a client visit that includes contraceptive counseling requires 30-45 minutes, while a curative visit—for which the same office visit fee is charged—requires approximately 15 minutes.
- It is difficult to change the service delivery behavior of medical care providers—to make them more proactive in delivery of family planning counseling/services to their clients.
- “One shot” training of physicians and pharmacists does not effectively change provider behavior. A multi-channel, continuous loop of input and feedback over time appears needed to achieve behavior change.
- Private providers in many countries are distrustful of hormonal contraceptives in general and do not have current/correct knowledge of contraceptives.

- Private providers often promote those contraceptive methods that they can themselves directly dispense and therefore profit from. Insertion of IUDs, for example, is more profitable for the provider than prescription of an oral contraceptive.

## **H Donor and Host Government Supervision and Support of Commercial Marketing Programs**

- Effective marketing requires programmatic flexibility and prompt response to needs of and changes in the marketplace
- Host government and donor processes sometimes required for approval of project marketing elements can be time costly
- Approval/non-approval decisions for project advertising or promotional materials made by host government and donor staff are sometimes based on the appeal of these materials to those officials rather than on research results that indicate their effectiveness for target consumers and the trade
- When promised marketing support does not materialize in a timely way due to delays in governmental/donor approval processes or for other reasons, commercial partners become disenchanted and falter in their commitment to project activities
- Considerations for perceived political and/or cultural sensitivity sometimes inappropriately predominate over considerations for effective marketing
- Untargeted access to free public sector contraceptive products in a given marketplace can eliminate commercial partners' interest in marketing a lower-priced product to a lower-income market segment
- In some countries donor-supported economic assistance whose aim is to increase government revenues through new or more complete systems of taxation (sales taxes, import duties and value-added taxes) works against the objectives of concurrent donor-supported health and family planning objectives by increasing the price of contraceptive products to the consumer

## **I Legal/Regulatory/Policy Issues**

- Limitations on the degree of success of a given commercial partnership are often caused by constraints in the legal/regulatory environment for pharmaceuticals. These constraints include government price controls, regulations that prohibit brand advertising, value-added taxes on pharmaceuticals that raise their price to the consumer often by as much as 15-20 percent, and limited access to mass media
- Increased accessibility of contraceptives in the commercial sector does not often enjoy sufficient financial and/or policy leverage to facilitate change in the legal and regulatory environment that affects the pharmaceutical sector as a whole

## **J      Uniqueness of Markets and Replication of Successes**

- Each commercial marketplace (size economy, legal and regulatory environment, contraceptive prevalence rate etc ) is different, and the goals/needs of potential commercial partners vary from market to market
  
- The processes of project assessment and marketing planning can be replicated from one marketplace to another but not the specifics of project implementation