

PW-ACE-311

**Nation Building,
One Family at a Time:
The Story of SOMARC**

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The Futures Group International (TFGI) is a research and consulting corporation providing technical assistance to both the public and private sectors in developing countries. It has managed the Social Marketing for Change (SOMARC) Projects from 1980 through 1998 as a contractor to the U.S. Agency for International Development Office of Health, Population, and Nutrition. The current project director is Tennyson Don Levy.

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Suggested citation

Heilig, Gabriel, *Nation Building: One Family at a Time: The Story of SOMARC* (Washington, DC: The Futures Group International, September 1998).

Library of Congress Catalog Card Number: 98-73975

Prepared by The Futures Group International with support from the U.S. Agency for International Development under the SOMARC III Project, USAID/CCP 3051 C 00 2016 00.

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Photo credits: Gretchen Bachman, Dee Bennett, Michael Cannon, O'Malley, Andrew P. Smith, Vanessa Hedwig Smith, and The World Bank Photo Library.

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EXECUTIVE SUMMARY

*People are always talking about how much better everything will be
once we finally get to outer space
Well just where the hell does everyone think we are?*

R Buckminster Fuller

This book discusses the family planning choices and reproductive behaviors of tens of millions of men and women throughout the world, and how the choices they make—or fail to make—affect our common future. Not many “contract deliverables” address the starkest issues of life and death. Of necessity, this one does.

This report summarizes a series of efforts the U.S. Agency for International Development (USAID) has sponsored in the areas of population growth and reproductive health. As such, it contains and conveys strong values. For one thing, it places a high value on the act of bringing human lives into existence. Were this not so, we would simply abandon newborn children to their fates and move on to other issues.

This report also places high value on the needs of any community—whether in a tiny village in Nepal or a bustling metropolis in Mexico—to receive millions of new lives and care for them, while providing care to millions more already born. This is a heavy burden not only for the individuals and couples involved, but for the national governments that must address the consequences of private choices made by millions of their people.

USAID has responded to the challenge of population growth through a sequence of pioneering policy decisions and investments implemented via the SOMARC initiative.

- Investments to educate couples who want to plan the size and spacing of their families
- Investments to educate the choices and behaviors of sexually active unmarried adults
- Investments in the ability of governments and NGOs to build societies in which the tension between development and population reaches a sustainable balance
- Investments in strategies that are beginning to reduce the spread of HIV/AIDS in some of the most vulnerable countries in the world
- Investments in training, documenting, and disseminating the work of professionals who have dedicated their careers to this field

It is difficult in an official history like this to capture the sweep of a 17-year, multi-leveled, international effort. Inevitably, among thousands and thousands of pages of official trip reports, country reports, progress reports, technical evaluations, and statistical data, a great deal has been omitted.

This book tries instead to tell a story—a story that is occurring now and one whose outcome is still in doubt. The present report cannot sum all this up in one tidy computer printout. The issue of family planning is anything but tidy.

There is no easy answer to the question of population growth on our planet. So many concerns—philosophical, religious, medical, economic, political—are bound up in this one question that it lies far beyond the scope of one “contract deliverable” to satisfy all of these legitimate and searching issues. USAID and The Futures Group International have committed almost two decades to this work. Much has been attempted, much achieved, and much learned. This document recounts some of these attempts, victories, and lessons. A great deal remains to be done. Yet the SOMARC initiative shows us that maps toward future effectiveness can now be drawn.

Among the many lessons that learned during SOMARC’s 17-year effort are

- The distribution of contraceptive social marketing (CSM) products can be done most effectively through a combination of traditional and non-traditional marketing strategies (See discussion in Chapters 2, 3, 4, 7, 9, 11)
- There is no “one size fits all” strategy in family planning that can be guaranteed to product results in every case. Local considerations vary greatly, and matter greatly (See discussion in Chapters 4, 5, 9, 10, 11)
- Using the existing commercial distribution system within a given society increases a CSM program’s potential for long-term sustainability by involving the resources of the commercial sector (See discussion in Chapters 4, 5, 7, 10, 12)
- Advertising that uses method-specific and brand-specific approaches can be effective in motivating behavior change (See discussion in Chapters 4, 7, 9)
- Regionalized branding and advertising offer a cost-effective way to market condoms (See discussion in Chapters 4, 7)
- Building partnering arrangements with NGOs and private sector firms is essential to the long-term success of CSM initiatives. Alliances with the private sector and with NGOs offer the surest way to institutionalize CSM programs over the long term (See discussion in Chapters 4, 11, 12)
- The moderate pricing of CSM products can greatly influence low-income users to buy these products. This motivates local retailers to carry these products, building additional momentum (See discussion in Chapters 4, 6, 12)
- Fully subsidizing the market for CSM products poses a major obstacle to the long-term viability of CSM initiatives by restricting the growth of private sector involvement in these programs (See discussion in Chapters 4, 6)
- Policy restrictions on CSM products discourage the private sector from developing commercial markets for these products (See discussion in Chapters 4, 6)
- HIV/AIDS prevention initiatives can be supported effectively through CSM strategies (See discussion in Chapters 4, 8, 11)

This report is presented in two parts. Part One discusses the development and deployment of the SOMARC initiatives and the major lessons learned. Part Two looks at how methods used during SOMARC can strengthen the sustainability of future family planning efforts.



CHAPTER 1

THE NEED FOR SOCIAL MARKETING

You can pay me now, or you can pay me later

U S television commercial

The phenomenon of “population momentum”

Individual and collective poverty are both the cause and the result of rapid population growth in societies ill equipped to receive so many new souls. This grinding cycle is called “population momentum,” as millions of children beget millions more, despite the fact that birthrates may actually be falling. To illustrate, over 80 million children a year have been born in developing countries throughout the current decade, 1990–2000, even though many of these nations are successfully making a demographic transition to a cycle of lower birthrates. The number of children being born keeps rising—the result of “population momentum”—as high birthrates in prior decades have generated large numbers of young people who now push the number of new births progressively higher, although birthrates themselves are finally declining.

The implications of this fact for U S foreign policy are obvious, and they are ominous. The United Nations forecasts that by the year 2015 over 1.2 billion women aged 15–49 will be in union—not counting those

in China. This challenge to international development efforts has been summarized in The World Bank’s report, *Population and Development*.

Population momentum can be reduced by investments to increase educational opportunities, to expand reproductive health and family planning information and services, and to reduce maternal and child mortality. Slowing population growth sooner rather than later could reduce future global population size by 2–3 billion when global population finally stabilizes at the end of the next century. Delaying such investments will only add to the ultimate costs of poverty reduction.

Add to this the spectral HIV/AIDS epidemic, and threats of a long predicted “population bomb” become all too real. The fact is 75% of all AIDS cases now occur in nations that are among the worst prepared to combat this disease and the behaviors that spread it. The mass media may be bored with “another AIDS story,” but the virus is reproducing.

Held once every decade, World Population Conferences provide a broad and informed

perspective on critical issues in the area of population policy. In 1974, discussion and debate focused on how to reduce the high rate of population growth in the world's poorer countries. Developing countries seized the policy initiative in 1984 when the richest donor countries became embroiled in the abortion issue. The 1994 Conference held in Cairo linked population policy to developmental issues that empower women, including reproductive health, as well as with other issues that affect any nation's ability to develop itself and its people.

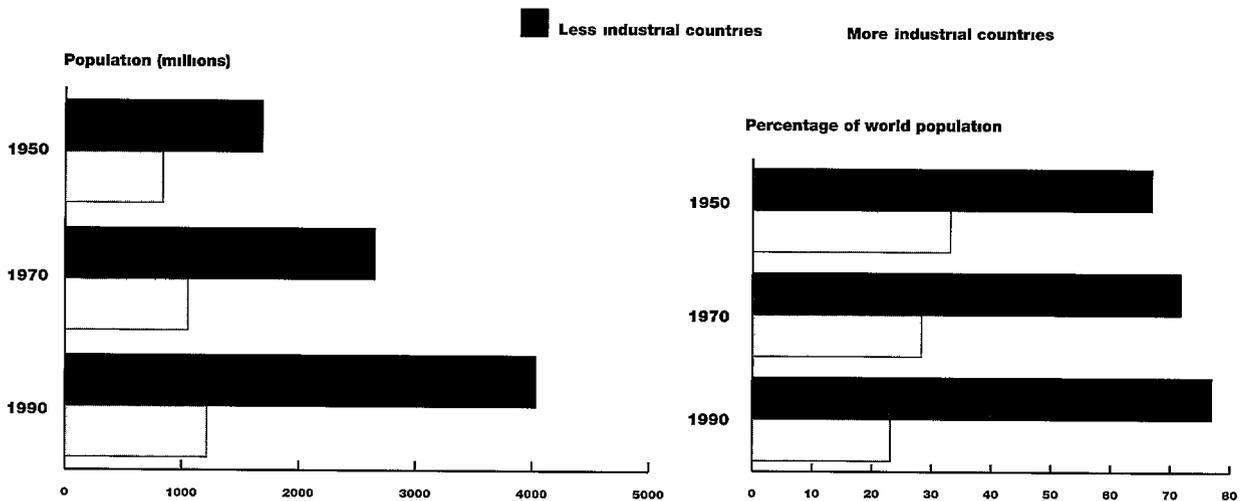
Population issues are complex at both the policy and human levels. USAID has sought to integrate these perspectives by mounting sustainable programs that can address these constellations of issues. In attempting this, several concerns are paramount:

- 1 **Slowing population growth remains a critical international priority**, especially in the poorest nations. High fertility rates and demographic trends toward a younger average age keep fueling population momentum. The number of absolute births is rising steeply. This trend must be addressed before the situation becomes overwhelming and paralyzing.
- 2 **Family planning remains a key factor in economic development**. Studies repeatedly indicate that developmental and population stability are deeply linked. USAID's effectiveness in bringing down birthrates means that we have joined the battle, not won it. We must remain engaged if we are to translate short-term victories into long-term gains.
- 3 **Population programs must offer quality services, not just effective products**. Behavioral change is an incremental, interactive process. Products alone do not generate the motivations that change reproductive behaviors. Couples need practical information and instruction about how to use these family planning products and services. This type of counseling—creating an atmosphere that is conducive to change—is as important as the contraceptives themselves.
- 4 **Quality services will stimulate demand** for contraceptive information, products, and services. Demand often spreads by word of mouth, until a critical mass of social approval is achieved. However, the corollary also is true: poor delivery of these services has a corrosive effect on the local reputation of family planning in precisely those communities that need it most. The human element of person-to-person communication is vital, whether this occurs as physician to patient interaction in a clinical setting or as gossip in a local village market.
- 5 **Population programs should be integrated with social policies that address poverty reduction objectives**. Policies that strengthen women's ability to plan the size of their families and also to plan their careers are especially important.
- 6 **Country-specific strategies are necessary**, taking into account the needs, cultural and religious values, and institutional readiness of a society. There is no "one-size-fits-all" way to build family planning programs that involve private behaviors which are easily miscommunicated. Local perceptions—or misperceptions—matter a great deal.

The challenges posed by “population momentum” are depicted in these graphs

POPULATION AND PERCENTAGE DISTRIBUTION OF THE WORLD

1950-1990



- 7 **Private-sector providers must be engaged actively** When commercial manufacturers, distributors and NGOs are engaged in an integrated way in family planning, developing nations can build programs that become self sustaining
- 8 **Self-sustaining strategies are efficient and essential** These programs can be developed most cost efficiently by using commercial channels SOMARC has shown that consumers will pay for family planning products and services, if these are available at prices that are affordable to consumers, while also being profitable to providers These market forces must be harnessed and guided toward a balance that is self-sustaining over the long term

Population momentum: USAID's response

The strategy developed by the U S Agency for International Development (USAID) has been to engage these issues experimentally and persistently USAID's initial strategy was to work with the public sector and also with private voluntary organizations in donating contraceptive products By the early 1980s, however, it had become clear this approach was not sustainable over the long term Recognizing this, USAID became the first major international donor to begin building alliances with the private sector for the purpose of bringing down population growth

USAID has now provided two decades of leadership, working collaboratively with the private sector to provide affordable family planning products and services. Through its funding of the Social Marketing for Change (SOMARC) initiative, USAID has supported millions of couples in over 40 developing countries in learning how to choose the size and spacing of their families. SOMARC, in turn, has pioneered building in-country infrastructures that integrate marketing expertise, government support, and private-sector providers committed to making low cost, high-quality, family planning products and services available in societies with widely differing cultural and economic circumstances. SOMARC's design, delivery, and implementation of a mixed public/private social marketing system has been a pivotal accomplishment. International efforts to achieve sustainable population growth are far from over, but a usable base of action research about how to do this is now available.

In coordinating this effort, USAID mounted a three-phase, private-sector strategy implemented through SOMARC I (1984–89), SOMARC II (1989–92), and SOMARC III (1992–98). This program also built new sets of skills, linking the worlds of commerce and international development. SOMARC has blended commercial advertising with interventions in village markets and other social structures not ordinarily reached by mass media. Social marketing has reintroduced a basic factor into the marketing equation: the

human element. Although mass communications have played a key role in the SOMARC approach, so have one to one interpersonal communication skills and strategies.

SOMARC has been able to reach couples in rural areas where no infrastructure for mass communication exists. These are precisely the people who most need information that will enable them to change their reproductive choices and behaviors. In one country after another, SOMARC has proven its effectiveness in reaching these critical segments of a nation's population—the “C” and “D” socioeconomic groups: lower middle and low income groups.

SOMARC has been successful in forging new partnering arrangements and coalitions. For example, in Nepal, SOMARC helped to create the country's first advertising agency, and in Ghana, the Philippines and Uganda, SOMARC worked with the countries' national midwives associations. These new coalitions have been created to outlive SOMARC's work by strengthening public awareness of family planning and by building an infrastructure of public and private organizations that will continue working together after SOMARC leaves. This has been one of SOMARC's most important achievements.

Now that these public/private collaborative structures have been implemented, building these alliances may seem like an obvious step to have taken. But these steps were not so obvious 20 years ago.

CHAPTER 2

SOCIAL MARKETING: NEW TOOLS FOR CHANGE

Originality is a return to the origins

Antoni Gaudi

Reaching beyond “mass marketing”

Social marketing often gets confused with its cousin, social advertising. For example, running a series of “AIDS kills” ads is far different than actually changing the behaviors of millions of sexually active men and women.

Doing that takes more than TV ads, it requires engaging a target audience in the actual process of change. This is what social marketing is designed to do.

The need for social marketing can be seen in a variety of contexts:

- Millions of children around the world are not immunized, even though vaccines are available. Often, their mothers do not visit the healthcare providers who could provide vaccines to these children because professionals often do not talk respectfully to poor, uneducated women. In such a situation, who needs to be educated—the mothers or the doctors? The truth is both need it. Advertising alone cannot do this. Advertising is anonymous. Some other process is required that is more engaging on a personal level, one that can build the type of social consensus that motivates behavioral change. Social marketing offers part of the answer.
- Worldwide, over 40,000,000 children suffer from a chronic deficiency of Vitamin A. Although foods containing Vitamin A may be plentiful, the necessary information is often not accessible. Social marketing can provide this information, counseling, and instruction.
- Although cigarette smoking is declining in the United States, in many other areas of the world it is growing—and with it, all of smoking’s downstream medical problems. To meet this threat to public health, social marketing efforts are needed.
- 90% of AIDS cases occur in the poorest of nations—75% in Africa. Heroic efforts by some nations are beginning to halt this trend. This requires active participation—from street theater groups bringing the message as they travel from village to village, to midwives talking with their neighbors in markets, to enlisting the commercial sector to make and sell affordable contraceptives. All of these are part of a comprehensive social marketing campaign.

Social marketing applies commercial strategies to social issues. The goal: behavioral change. The purpose of SOMARC’s work in family planning, for example, has not been

simply to sell contraceptives, but to influence the decision-making of millions of couples in poor countries. This basic shift from merely considering a choice to actually making it is what SOMARC's work has been all about.

Reproductive choices are made by sexually active women as well as by men. Perceiving and respecting this fact itself requires a shift in values: valuing a woman's choice, as well as her participation in building a family or a nation. Achieving this level of attitudinal change requires more than a few televised ads.

Social marketing does not necessarily require the use of TV. What it requires is **access to those people who are persuasive in shaping a target group's decisions**. If our goal is to persuade women to use family planning measures, the targets of a social marketing campaign might include (a) women between the ages of 15–49, (b) workers in healthcare centers near where these women live, (c) the female family members of these women, and (d) local leaders whose views these women and their family members respect. Aligning all of these levels of market forces requires building alliances with opinion leaders, officials in government agencies, and the private sector to create a new social context that together can reshape public attitudes. At its best, all of this is what social marketing does.

None of this is automatic, however. A great deal remains to be done on the theoretical and practical levels if social marketing is to achieve its potential for positive social change. USAID's review of child survival projects outlines the intellectual and operational challenges that still remain in refining social marketing strategies.

Among the issues USAID identified are

Long-term sustainability Social marketing programs typically operate with limited funds and within limited project lifetimes. If these programs are to succeed, they must become sustainable over the long term. There is no other durable solution.

Five factors increase the chances of sustainability:

- (1) developing the support of host country institutions,
- (2) making a social marketing program's successes visible throughout the host country,
- (3) integrating programs with existing delivery structures, both public and private,
- (4) providing sufficient training to people who will work in the program after its formal funding ends,
- (5) opening new revenue sources before the formal program period ends, particularly from the private sector, so the program can continue uninterrupted.

Assessing and documenting results

Successes and failures alike need to be studied. Too often, researchers have had only limited success in identifying the specific effects that social marketing has achieved, as contrasted with other factors at work in the same public arena. We need carefully researched and well-documented project evaluations, using quasi-experimental designs where the actual effects of social marketing interventions can be identified, isolated, and examined in depth.

CHAPTER 3

THE EVOLUTION OF SOCIAL MARKETING

Human history is a race between education and catastrophe

H G Wells

Conceiving SOMARC

One of the first social marketing programs was conducted in India. The government had made a decision to involve its private sector in distributing condoms at a highly subsidized price. Only limited support for advertising was to be made available. Primary focus was placed on expanding distribution options. The strategy was "If we distribute enough condoms, people will use them." This strategy was to be implemented through the support of a number of multinational corporations, including Union Carbide, that were operating in India. However, problems arose in getting firms to participate as a cost of doing their regular business in India.

Problems such as this led USAID to become interested in harnessing the commercial sector for family planning purposes. USAID commissioned a study, *Distribution of Contraceptives in Eight Countries*. Among the countries studied were Venezuela, Panama, Jamaica, Korea, Iran, and Turkey. This study's findings showed significant potentials for distributing all types of contraceptives, as well as the potential for cost recovery, based on volume. The lower middle income group, Class C people traditionally lacking in affordable access to contra-

ceptives, were identified as a primary market. Classes A and B, upper and upper-middle socioeconomic group consumers, enjoy economic access to contraceptives, Class D, low income consumers were already receiving free contraceptives at medical clinics. The core need was affordable contraceptives for Class C consumers.

On the basis of this study, USAID solicited proposals for interventions for two of the countries studied, Jamaica and Korea. Both had emerging middle classes, a favorable demographic mix, and desirable geographic distribution factors. Initial interventions were designed to increase distribution, not to change behaviors. Pharmacies and clinics were major targets. USAID also provided a follow-on contract for continued work in Jamaica, where the problem was governmental restrictions on the advertising and distribution of contraceptives. For example, oral contraceptives could be distributed only with prescriptions. No advertising at all was allowed.

To offset this policy, a series of meetings with the Minister of Health persuaded the government that all grocery stores in Jamaica could be reclassified as National Family Planning Board outlets. As a result, oral contraceptives were allowed to be purchased without pre-



scriptions. This was followed by a letter-writing campaign and by radio debates. The effect was to recast Jamaica's national dialogue in a tone that was more supportive of USAID's objectives.

At the time, USAID was the largest purchaser of contraceptive social marketing (CSM) products. Until 1980, USAID's support of CSM programs was funded through country-specific contracts with U.S. technical firms. Technical assistance for CSM feasibility assessments was largely handled through individual consultants hired by the American Public Health Association on behalf of USAID.

In the fall of 1980, USAID began its worldwide assistance to CSM programs. The International Contraceptive Social Marketing Project (ICSMP) was funded by USAID at \$2.3M and was implemented by The Futures Group. This initiative was designed to provide not only technical assistance to CSM programs, but to offer funding to act on technical recommendations from these initiatives. The ICSMP project mandated that up to three new CSM programs would be launched. ICSMP's results strongly suggested that a more focused effort be created. Under USAID's sponsorship, the Social Marketing for Change Project—SOMARC—was launched.

SOMARC I: Contraceptives and consumers

SOMARC I was a five-year contract issued by USAID in 1984 to The Futures Group and its team of subcontractors: Porter Novelli, The Academy for Educational Development, and John Short & Associates. SOMARC I was given the mission of developing CSM projects capable of delivering high-quality, low-cost contraceptives to low-income consumers. The focus was on strengthening the distribution of condoms and oral contraceptives. These were basic

products, and this is where USAID wanted SOMARC I to concentrate. USAID's longer-term goals included creating markets for CSM products that did not rely solely on donated products and were able to become self-sustaining. These, however, were not the aim of SOMARC I. The objectives of SOMARC I included

- Providing technical assistance to currently existing CSM programs
- Designing and fielding 5–10 new CSM programs
- Designing and fielding 4 regional and 1 international conferences for CSM personnel
- Designing and conducting professional research in the CSM arena
- Developing dissemination methods to reach CSM practitioners worldwide

SOMARC I orchestrated a systematic approach to marketing contraceptive products to couples in the target population. From the outset, SOMARC focused on meeting the needs and cultural styles of its intended consumers. Before any strategies and marketing message were designed, every SOMARC I program conducted research on the attitudes and practices of its key target populations, gathering information about any barriers that might prevent potential “contraceptor couples” from accepting and using these products. There was much to learn.

SOMARC's consumer-oriented approach was achieving results. In Mexico, the nation's leading business magazine, *Expansion*, singled out SOMARC's Protektor condoms as its “Marketing Hits of

1988”—alongside “800” telephone numbers and wine coolers. SOMARC's relationship with the Mexican government's Ministry of Health, CONASUPO grocery stores, and the pharmaceutical firm, La Campana, were applauded as examples of what a social marketing alliance could achieve.

The results in Mexico were striking.

RESULT

- Protektor condoms increased their market share from 1% in 1986 to 20% in 1988.
- Moreover, when nationwide consumer sales dropped by 4.3% in 1988, sales of Protektor condoms increased by 112% between 1987–88.

Between 1984 and 1989, SOMARC I launched 13 new CSM programs, while also providing technical assistance to 10 existing CSM programs. In addition, The Futures Group conducted in-depth assessments of programs in 9 additional CSM countries—which later formed the nucleus for extending the first phase of CSM initiatives during SOMARC II.

RESULT

- Newly launched programs were sited in Indonesia, Barbados, Bolivia, Brazil, Dominican Republic, Ecuador, Mexico, Peru, St. Lucia, St. Vincent, Trinidad, Ghana, Liberia, Morocco, and Zimbabwe.
- Existing programs receiving technical assistance included Bangladesh, Sri Lanka, Nepal, Egypt, Honduras, Guatemala, Nigeria, El Salvador, Colombia, and Jamaica.
- Country assessments were conducted in

Uganda, Malawi, Mali, Rwanda, Turkey, Honduras, Haiti, Ivory Coast, Paraguay, and Sudan

During the first several years of SOMARC I, efforts concentrated on improving the distribution of donated condoms and oral contraceptives (OC). This was achieved primarily by increasing the number of physical locations where consumers could buy these products. This was not always easy. Due to policy restrictions in various countries, the promotion of contraceptives often had to be negotiated and renegotiated. Many lessons were learned during SOMARC I regarding the importance of getting government officials and other attitude shapers to support efforts to build distribution capacity. These efforts soon began generating strong results.

RESULT

- By the end of SOMARC I, three of the longest-running CSM programs had reached a point where their sustainability was assured.
- In Mexico, a country where USAID-donated condoms had initially been required in order to ensure an affordable price to low-income consumers, condom sales revenues grew to the point where they were enough to cover all marketing and promotion costs.
- In the Dominican Republic, the marketing of oral contraceptive products had become self-sustaining by 1989.
- In Indonesia, DuaLima Red condoms were supported completely by the private sector.
- In Peru, 43% of all consumers of vaginal

tablets were women who had never bought such products before.

In short, the SOMARC approach to social marketing was proving its worth—not only as public policy, but as a force in the marketplace.

SOMARC I was continually adapting proven commercial marketing techniques, including

Consumer profiles SOMARC staff developed profiles of CSM consumers in various program countries. These profiles defined pertinent facts and characteristics of the consumers buying CSM products and also allowed program managers to evaluate their effectiveness in reaching CSM targeted audiences.

Mystery shoppers In Ghana, by asking pharmacists and chemical sellers for contraceptive advice, mystery shoppers were able to monitor the effectiveness of SOMARC's training sessions that these pharmacists and chemists had attended. In Morocco, mystery shoppers checked the feasibility of condom retail displays in pharmacy outlets. By asking for specific brands, they were able to identify those pharmacy clerks who were actively promoting CSM brand condom products.

Product branding and promotion Since all of SOMARC I's products were donated, all had to be given names if they were to be sold. This was a major opportunity for exploring product branding and promotion strategies. SOMARC I used this opportunity to build brand identities. Some of these brands, such as Protector condoms, have proven to be durable commercial successes, generating repeated success in commercial markets as different as those in Zimbabwe and Bolivia.

Customer panels This technique had never

been used before in CSM programs. SOMARC adapted this technique to give CSM managers a way of getting longitudinal data on contraceptive use among consumers, as well as information regarding consumer choice patterns, levels of consumer satisfaction with different services, methods and products, and actual levels of consumer knowledge.

Product tie-ins and “on-pack” promotions

This marketing technique encouraged consumers to try various CSM products, by providing samples tied into the purchases of other popular products. In Indonesia, for example, Dualina condoms were offered with the purchase of Gillette razor blades. In this way, the new condom product soon was in millions of Indonesian homes and soon became a much more popular choice both as a contraceptive product and as a consumer purchase. Thus, both the commercial and the social goals of this social marketing effort were achieved.

Sponsorships In a similar way, SOMARC introduced the use of sports tie-ins and event sponsorships by manufacturers of condom brands as a way of reaching men in prime CSM target segments. In Mexico during World Cup soccer games, for example, the promotion of Protektor condoms used radio and print advertising of World Cup events to spread its message. And in Barbados, the manufacturer of Panther condoms sponsored a race car in that country’s season-long rally competition.

SOMARC I demonstrated the effectiveness of blending these and other commercial marketing techniques in informing and motivating the millions of individual decisions and behaviors that must occur in order to move the process of social change forward.

SOMARC I: Results

SOMARC I achieved the following outcomes, among many others:

RESULT

- SOMARC I demonstrated that low-income people will buy contraceptive products. In such different cultures as the Eastern Caribbean, Peru, Indonesia, and Mexico, SOMARC I found that 32–47% of CSM consumers are first-time users of contraceptive products. And of these, 67–95% are from its target audience of moderate to low-income groups.
- In Indonesia, SOMARC assisted doctors and midwives in obtaining approval to dispense contraceptives, enabling them to serve as a trusted distribution channel for CSM products—a first for Indonesia.
- In Ghana, as a result of SOMARC’s training of chemists, the government agreed to allow oral contraceptives to be sold in thousands of local chemist shops.
- In Barbados, marketing tests using the “day after recall test” technique showed the effectiveness of condom advertising that had already been aired—and led to a decision to expand this ad campaign.
- In Brazil, the need for training rather than simply distributing products became apparent when SOMARC’s team found that oral contraceptive users who visited a doctor were no more likely to use these pills correctly or to be better informed than users who had not seen a doctor.
- In Egypt, the continuation rates for con-

sumer use of CSM product brands are at least as strong as the continuation rates for other contraceptive brands or for other types of contraceptives, including clinic sources

- In Peru, Barbados, and Pakistan, SOMARC I learned that a variety of factors encouraged private-sector involvement in the CSM campaign. These included profit levels as well as less tangible factors such as improving the private sector's relationships with governmental agencies.
- In the Eastern Caribbean, a regional distributor of condoms negotiated a working relationship as the local distributor for a U.S. manufacturer.
- An Indonesian advertising agency, based on its work in the CSM campaign, is now developing a nationwide ad campaign to promote private-sector family planning services in Indonesia's urban center.
- The CSM related data processing system that was developed in the Dominican Republic also has enabled that country to monitor its family planning sales much more closely, making this initiative more central in the planning of its Ministry of Health and related public agencies.

SOMARC II: Expanding and refining the strategy

The SOMARC II team continued to work with CSM programs initiated during SOMARC I while extending these methods to new target countries.

This outlines SOMARC II's expanding efforts

SOMARC I (continuing programs)

Barbados	Ghana
Bolivia	Indonesia
Brazil	Mexico
Dominican Republic	Morocco
Ecuador	Peru
Egypt	Zimbabwe

SOMARC II (new programs)

Benin	Philippines
Haiti	Rwanda
Honduras	Swaziland
India	Togo
Malawi	Turkey
Mali	Uganda
Nepal	
Paraguay	
Papua New Guinea & South Pacific	

Once the initial five-year effort conducted by SOMARC I had clearly demonstrated the wisdom and effectiveness of a comprehensive contraceptive social marketing strategy, SOMARC II undertook to deepen the success and refine the techniques developed during SOMARC I. Among the key objectives for SOMARC II were

Expanding from CSM products to HIV/AIDS The longer SOMARC's efforts continued, the more clear it became that simply "pushing products" was not the answer to the complex social, cultural, family, or individual needs of people in developing nations. Simply donating or selling CSM products were not sufficient responses to the challenges posed by population growth—or, more recently and drastically, by the HIV/AIDS crisis. More than new products were needed

Instruction, counseling, and confidence also were going to be required, these could not be found on the shelves of local pharmacies. These had to be developed—patiently, yet urgently—in response to the dual crises of population growth and HIV/AIDS spreading across the developing world. This shift in thinking expanded the focus of program activity from SOMARC I to SOMARC II.

Expanding the development of training programs to rapidly share information and instruction across the broad spectrum of CSM programs, products, and services. These trainings included instruction in alternative contraceptive technologies, market research techniques, strategic marketing management, financial management, and in the integration of marketing communications. Trainings were conducted for CSM staff from 34 nations.

Quality of services and care provided The shift from CSM products to services carried a responsibility to ensure these services would be provided with care, respect, and medical effectiveness. SOMARC II concentrated on building long-term partnering relationships with private- and public sector distribution points of contact with consumers. Clinic staffs were trained in CSM services and in counseling skills. Follow-up referrals and visits by service providers were also instituted.

Expanding cost recovery and graduation SOMARC II defined “graduation” into full self-sufficiency as the ability of a CSM program to support all its marketing costs including initial purchase, promotion, distribution, and ongoing administration. Partial self-sufficiency referred to programs that had to cover



some of their marketing and advertising costs. The success of SOMARC I in building toward self-sustaining CSM programs led to a renewed effort during SOMARC II to strengthen and broaden the strategy of graduating individual products or country-wide CSM programs. SOMARC II developed and implemented financial cost recovery and self-sufficiency plans for all SOMARC I programs. In all CSM countries except Ghana these financial plans included a graduation strategy.

SOMARC II achieved the following

Graduation

Dominican Republic
Microgynon oral contraceptives

Dominican Republic
Lo-Rondal oral contraceptives

Indonesia
DuaLima Red condoms

Indonesia
Blue Circle products

Barbados
Panther condoms

Mexico
Protektor condoms

Partial graduation

Papua New Guinea
Protector condoms

Bolivia
Protector condoms

Ghana
Panther / Protector condoms

Mali
Protector condoms

Malawi
Protector condoms

Uganda
Protector condoms

Ecuador
Microgynon oral contraceptives

Morocco
Kinat al Hilal oral contraceptives

SOMARC II: Results

RESULT

- SOMARC II successfully expanded its product-branding strategy. Both the Protector condom and PilPlan oral contraceptive product lines were introduced in multiple markets. Protector has been successful in Mexico, Zimbabwe, Lesotho, Bolivia, Rwanda, Uganda, and other new markets.
- SOMARC II succeeded in developing a private sector support infrastructure by working with advertising agencies and distributors of contraceptive products. This built a local institutional base that has proven invaluable in building toward a successful graduation strategy, both for individual products and entire programs.
- In Indonesia, condom use among urban men increased by almost 70% in two years. This increase was particularly dramatic among men in the lower-middle class, where condom usage rose from 3% in 1988 to 9% in 1990. By 1990, nearly 70% of all DuaLima Red condom users were men in SOMARC's target market of moderate-income to low income groups.
- In the Dominican Republic, sales of oral contraceptives grew by 390%. By 1990, 92% of all users of the CSM oral contraceptive Microgynon were in the middle or lower middle classes.
- In Morocco, SOMARC II launched a marketing program for Protex condoms in 1989. Only 4.5% of urban men inter-

viewed in 1988 said they used condoms. By 1990, this number had climbed to nearly 24%. A profile of Protex users in 1990 found that 67% were in the middle and lower middle classes.

- In Ghana, the use of Panther condoms grew from 9.3% in 1988 to 30.2% by 1991. Fully 98% of Panther users are men in the middle and lower-middle classes, and 70–80% of the users of oral contraceptive and vaginal CSM products are also in these social classes.
- In Zimbabwe, condom use increased dramatically during SOMARC II. In 1988, condoms were used by 21% of men in Zimbabwe’s urban areas. By 1991, the use of condoms had increased to 56%—and these men, 85–90% of whom were in the middle and lower-middle classes, reported using condoms specifically for “family planning purposes.”

**SOMARC III:
Graduation and sustainability**

SOMARC III moved programs forward toward “graduation” and sustainability. The focus was on establishing levels of quality control that would support long-term sustainability.

SOMARC continued to provide assistance to 14 countries where CSM programs had begun, while phasing out project activities in non-priority countries for which funding was not available.

The following chart indicates the spectrum of programs conducted during SOMARC III, ranging from new programs to those being expanded, graduated, or phased out.

New programs

Madagascar	Senegal
Jordan	Kyrgyzstan
Kazakhstan	Moldova
Niger	

Continuing programs

Ecuador	Swaziland
Guatemala	Peru
India	

Expanding programs

Brazil	Haiti
Indonesia	Morocco
Mexico	Turkey
Nepal	Uganda
Philippines	Jamaica
Egypt	

Graduated products

Dominican Republic	Turkey
Morocco	Togo
Papua New Guinea	Zimbabwe

Technical assistance

El Salvador	Russia
Honduras	Ghana

SOMARC III expanded the use of complex, longer-term contraceptive products and services, including Depo-Provera, Norplant, IUDs, and sterilization. All of these required greater access to, and more reliance upon, the skills of medical service providers. This in turn necessitated the development of a

network of service providers and more in-depth training programs to equip providers to care for and communicate effectively with consumers of CSM contraceptives

Quality control issues became more significant during SOMARC III as the complexity, interactivity, and long-term nature of CSM products and services kept increasing. Simple marketing was no longer sufficient. Active collaborations with medical agencies and professional associations had to be developed to ensure quality control.

SOMARC began working with the then named Association for Voluntary Surgical Contraception (AVSC)—now called AVSC International—in developing a series of new instruments including long-term country assessment models, service delivery indicators, site assessment guidelines, and various program evaluation and monitoring tools.

Financial constraints led SOMARC III to intensify its work toward achieving sustainability in project countries to assure supplies of the CSM services being marketed. Resource intensive CSM services were included only in countries where commercial products were available for use—to prevent an over reliance on donated products because resources might soon become unavailable to support these donations. This required more interactions with the private sector.

As an example, SOMARC III negotiated agreements with Pharmacia & Upjohn to provide Depo Provera in the Philippines and the Dominican Republic, Norplant was targeted for implementation in Mexico and Turkey, programs were negotiated to pro-

mote non-scalpel vasectomy services in Mexico and Jamaica. Country project strategies were targeted across the full spectrum of CSM products and services, from the least sophisticated and least costly to the most sophisticated and most resource- and service-intensive—from condoms and oral contraceptives to clinical methods such as sterilization, IUDs, and Norplant.

In addition, SOMARC III provided a broad range of technical support to existing in-country agencies and their programs. In Mexico, SOMARC III assisted MEXFAM, a private nonprofit family planning association, in developing a comprehensive service-oriented marketing strategy. MEXFAM's goals were to increase its client base, to identify additional markets for its services, and to improve its cost recovery system.

SOMARC III also provided in-depth assistance to the Central Asian Republics of the former Soviet Union, where SOMARC assisted government owned health centers in conducting studies and in implementing strategies for the privatization of these services. SOMARC III provided this type of assistance to newly privatized clinics, with a primary focus on improving the level of service provided at these clinics. Similarly, in both Mexico and Turkey, SOMARC III conducted feasibility studies regarding the prospect of marketing family planning services through a franchise system. To support quality training, SOMARC III developed a version of the family planning and health-care services marketing training module. This was pilot-tested in Turkey and Mexico during 1994.



SOMARC III: Results

SOMARC III moved beyond the existing CSM paradigm, introducing and integrating new practices. These ranged from advertising and promotional strategies to alternative methods for expanding distribution at the local level, as well as new ways to strengthen sustainability, cost recovery, and the private-sector service delivery infrastructure.

RESULT

- SOMARC III created partnering arrangements with private-sector manufacturers of contraceptive products. Some 35

Memorandums of Understanding (MOUs) were generated during SOMARC III, helping to stabilize the economic underpinning of CSM projects in countries where USAID has made investments. These partnering arrangements remain active.

- The stress on developing partnerships included working with local providers such as midwives and focusing on building strong relationships with major organizations in the fields of population and development. The World Bank, other donors, the European Union, and many NGOs

- SOMARC III expanded its marketing strategy to build new networks of CSM-related services to complement the products it had promoted during SOMARC I and II. These networks, including clinics in the Central Asian Republics, have enabled SOMARC to reach and sustain higher levels of consumer acceptance of CSM products and services.
- SOMARC III expanded its existing communication strategy, focusing on public relations and advocacy related interactions that helped to stabilize and consolidate public opinion in favor of using CSM contraceptives.
- In the Central Asian Republics, SOMARC III developed privatization strategies for medical and pharmaceutical firms throughout this vast region. SOMARC has played a pivotal role in working collaboratively with the Ministries of Health in four of the Central Asian Republics, assisting them in privatizing portions of their pharmaceutical and contraceptive procurement systems, as well as in strengthening their distribution infrastructures. SOMARC III also studied the feasibility of facilitating the privatization process by creating fully private pharmacies.
- SOMARC III was successful, as in Jamaica, in divesting itself of programs that had reached the point of self-sustainability.
- In the area of training, SOMARC III added a new "Quality Customer Service" component to its existing contraceptive technology and safety training module. This new QCS component provides service providers at all levels with clear quality standards for their customer interactions. It also is aimed at motivating these service providers to conduct an ongoing process of monitoring their technical capability by providing technical information and skills development exercises and accessible reference and instructional materials. For example, in the Philippines SOMARC implemented a series of product-oriented trainings for pharmacists and retailers in the area of oral contraceptives.
- In Zimbabwe, SOMARC III successfully graduated its primary CSM product—the Protector condom, from USAID assistance into a self-sufficient product able to compete effectively in the open market. To ensure maximum marketing and distribution, SOMARC shifted Protector's brand management to Johnson & Johnson, the only commercial distributor able to continue aggressively marketing the Protector condom product to the target population.

CHAPTER 4

VISIBLE LESSONS, INVISIBLE VICTORIES

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Geoffrey Chaucer

Many lessons, but no formula

In the field of population growth, success is literally hard to see. USAID's efforts, as conducted through the SOMARC initiative, have aimed at producing non-events: births that do not happen in societies that cannot adequately receive them, cases of HIV/AIDS that do not spread in nations whose health-care systems are already stressed to the breaking point. In short, the more successful SOMARC has been, the less its results have been visible. When situations seem normal, the tendency is not to notice that anything important has changed.

SOMARC's success refutes the view that social behaviors are "too complex" to be promoted using commercial techniques, or that CSM products are "too controversial" for commercial distribution, or that social markets are "too hard to analyze properly", or that the private sector will not be a reliable partner in projects with social goals. On the contrary, SOMARC's results indicate the opposite. Social marketing programs have proved they can work quite well across a broad array of political and cultural environments.

SOMARC's efforts have generated a great deal of practical learning. However, because each marketing situation is unique, these lessons cannot simply be collected into a brief "how-to" manual of do's and don'ts. There is no way to "paint by the numbers" when addressing issues as volatile as contraception or family planning. These issues continue to be controversial in the United States, and they are no less so in other parts of the world.

In order to work effectively in cultures as different as Papua New Guinea, Mexico, Egypt, and Nepal, the SOMARC team has had to enter a culture and find ways to use contemporary marketing approaches in environments that may have had little exposure to such strategies. The common denominator in SOMARC's work has been a deep concern for individual couples and their informed choices, a sense of respect for women as mothers and as economic citizens, and a sense of worried hope about the future.

But there is no formula. In the field of population growth, we are working without a net. However, although there is no formula, there is a form. This patient work and its blending of approaches represents years of learning.

done in the field. Thousands of staff years and professional observations stand behind each of these lessons.

SOMARC's major lessons learned include

Distribution of CSM products and services is best explored through both traditional and non-traditional marketing outlets. This ability to choose among a repertoire of alternatives plays an important role in reaching the people who most need to be reached, increasing the likelihood that they will actually change their reproductive and contraceptive behaviors.

Learning to work effectively with both the private commercial sector and with NGOs is essential. One of the most useful roles SOMARC has played has been to serve as an honest broker and catalyst, integrating the best intentions and operational strategies which in the private and public sectors have brought to this work. This is not a case of "either or"—but of "both and." It would be just as foolish to ignore the leverage that an interested commercial partner can bring to this work as it would be to neglect the immense contributions of NGOs that have spent years working tirelessly in this field.

Using existing commercial distribution infrastructure greatly increases a CSM program's potential for long-term sustainability. The first CSM programs designed and supported their own separate distribution networks. These systems proved costly to sustain because all costs were borne by SOMARC and its sponsors. Increasingly, SOMARC has learned that creating partnering arrangements with commercial manufacturers and

distributors of CSM products and services offers a sound, long term solution with sufficient incentives to ensure its viability. Couples that need contraceptives are willing to buy them. Enabling these products to be sold at a low, yet profitable, price achieves important social goals while encouraging the private sector to become an active partner in a social marketing program. This is not a matter of "contaminating" social goals, but rather of strengthening them so that their chances of sustainability are increased.

Both method-specific and brand-specific advertising are important in motivating changes in private behavior. In the past, family planning campaigns often focused on messages addressing general behavior, emphasizing such characteristics as small family size or the idea of responsible parenthood. The assumption was that merely distributing these messages by itself would increase awareness enough to change behavior. Through its years of consumer research, backed by its efforts in the field, SOMARC has found that there often are specific reasons for people not using contraceptives—concern about side effects, lack of accurate information, the arrogant attitudes of some physicians and healthcare providers, or the sheer lack of information about contraceptive alternatives. SOMARC has learned—and has demonstrated—that in order to be effective in changing behavior, advertising messages must motivate consumers to move through a product adoption continuum that reaches from initial awareness to consideration of alternatives, to trial, and then to repeated use. Campaigns that do not include specific brands often do not move consumers through this continuum.

Regionalized branding and advertising are a cost-effective way to market condoms. After repeated research, SOMARC has identified a number of striking similarities in consumer preferences for the condom. This applies in terms of product names, logo designs, packaging, and promotional slogans. Across the many regions in which SOMARC has done this work, the name “Protector” and the general theme of protection have been almost universally supported and repeatedly selected by consumers as appropriate and appealing. For example, the Pan-African Protector condom campaign has been implemented in Uganda, Malawi, Zimbabwe, Ghana, Togo, Benin, Mali, Rwanda, Swaziland, and Lesotho. The same name also has been tested—and successfully launched—in cultures as different as Mexico and Papua New Guinea. Global branding strategies reduce the cost of advertising and production—a major positive factor in ensuring continuity and sustainability.

SOMARC has demonstrated the value of integrating longer-term methods, related health issues, and HIV/AIDS initiatives into CSM efforts. Concerns about population growth do not exist in isolation from other reproductive health issues. These concerns can be integrated with them in a way that generates new levels of cost efficiency and overall effectiveness. In countries like Indonesia, social marketing can play a pivotal role in assisting governments to make the transition from public- to private-sector delivery of healthcare products and services.

The careful pricing of health products can greatly influence low-income users to purchase them and will motivate retailers to promote them. SOMARC has demonstrat-

ed that, even among moderate to low-income groups, consumers will buy family planning products. Price points that encourage consumers to enter this market are of vital importance in motivating them to make these purchases—and to use what they have bought. These pricing decisions also must provide a reasonable profit margin to manufacturers and distributors. SOMARC’s experience has shown that these dynamics can build a sustainable market system. This also works to the advantage of those very poorest people who cannot afford to purchase these products: they benefit because their country’s healthcare system is less taxed by the birth of children who would otherwise require resources the very poorest also need.

Policy restrictions on CSM products tend to discourage private-sector partners from developing commercial markets for these products. In some cases, SOMARC has been able to work around these barriers. In Malawi, SOMARC successfully encouraged the government to waive a prohibitive 35% tax on contraceptive products. And in Mali, SOMARC assisted local program staff in applying for customs exemptions for all CSM and contraceptive products. However, more needs to be done in this area.

Social marketing desensitizes the issue of publicly promoting contraceptive products and strengthens public interest in family planning. In Turkey, SOMARC succeeded in gaining approval for that country’s first brand-specific advertising campaign for condoms and oral contraceptives. The resulting publicity created additional attention for family planning issues. In the wake of SOMARC’s efforts to introduce contracep-



tive advertising—not only in Turkey, but in many countries—commercial manufacturers and distributors of contraceptive products have pursued mass media approaches to promote their own products as well. This helps to create a shift in public attitudes in favor of family planning as a responsible choice for millions of adults in these countries.

Subsidizing the market can be a major obstacle to CSM efforts. For example, in Indonesia doctors and midwives received free contraceptives from the government for two years. This policy undercut the government's attempt to move the users of contraceptive products from public to private-sector suppliers.

SOMARC was successful in persuading government officials to eliminate these sources of free products and assisting doctors and midwives in obtaining approval to sell con-

traceptive products. These interventions have been important in expanding Indonesia's private sector participation in support of the effort at family planning, moving this initiative beyond the confines of CSM into a broader national initiative.

SOMARC's experience identifies specialized issues that still need to be explored. These include:

- (1) the creation of a positive "halo effect" that CSM products can confer on the sale and use of other contraceptive products,
- (2) the development of additional price elasticity studies, using historical sales and price records of CSM projects or conducting controlled field experiments where sales are monitored at different pricing levels to determine what price spurs maximum sales,
- (3) studying the motivations for CSM "product drop outs," in order to improve product continuation rates,
- (4) developing an optimum resource allocation model to identify those factors in each country that determine the type of CSM implementation model to use, and also to identify countries that would offer the greatest cost benefits for introducing a new CSM project.

There is a need to build ongoing evaluation and feedback loops into the program cycle. Strong, sustainable programs do not grow by themselves. They must be built with accurate and current information. This evaluation process must be conducted not as an "add on" at the end of a project, but as an integral part of its development.

PART TWO

SOMARC AND BEYOND

Introduction

Part Two addresses themes and lessons that emerged during SOMARC, discusses how SOMARC responded to them, and shows how SOMARC's responses point toward future USAID efforts

This process of challenge and response is best understood by looking at the specific stories of individual SOMARC projects. Policy statements are often abstract. Results are concrete.

Several of the case studies described in Part Two point to the next stage of social marketing strategies for contraceptives and reproductive healthcare. This next stage of USAID's work will focus on building a broad new structure of alliances with private- and public sector organizations. The goal is to create self-sustaining systems that can survive the eventual withdrawal of USAID funding. Sustainability is desirable from both sides of a donor-recipient relationship. These stories show how SOMARC's evolution has moved toward this natural transition point.

These case studies also outline pragmatic strategies for moving this venture beyond SOMARC's initial goals. USAID's intention is to integrate public- and private sector forces that can achieve policy goals in the area of population growth.

These stories from the field show how SOMARC has addressed these goals and incorporated many of their lessons—moving these projects toward USAID's intended goal of long-term sustainability.



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CHAPTER 5

MOVING FROM INDIVIDUAL PRODUCTS TO NETWORKS OF SERVICES

The example of Turkey

Turkey is a nation of 65 million people. Its “middle income” economy is growing rapidly despite relatively high inflation and an uncertain political environment. Turkey is becoming increasingly urbanized and as a result private healthcare has become one of the fastest-growing sectors of the national economy. The public healthcare sector has had trouble, however. Despite the Turkish government’s intention to provide essentially free healthcare to its people, the government has found it increasingly difficult to keep up with urban sprawl or with the needs of its poorer regions in less developed areas of southeastern Turkey or urban centers in Turkey’s northeast.

Turkey is among the 10 largest countries in USAID’s Population Health and Nutrition Center’s portfolio. USAID and its partners now face the challenge of helping Turkey’s family planning system to survive this process of rapid urbanization and a planned phase-out of USAID funding. To meet this dual challenge, Turkey must become self-sufficient in providing free contraceptives to its poorest people, while it must shift reproduc-

tive and family planning care to the commercial sector for those of its people who can pay for these services—a daunting challenge.

Turkey’s private sector has demonstrated enormous potential for broadening its role in providing family planning products and services. In 1991, SOMARC launched two ventures in Turkey. In June 1991, SOMARC worked with both the public and private sectors, assisting the commercial pharmaceutical firm Eczacıbaşı Ilac and the Turkish Family Health and Planning Foundation in launching the Okey condom campaign. This was the first time any private-sector firm had agreed to purchase and import contraceptive products designed specifically for marketing as a low priced, quality condom.

RESULT

- Within two years, the Okey condom had attained a leading market position, selling over 7 million condom products.
- By the end of 1993, the Okey condom was completely self-sufficient.
- By 1996, Eczacıbaşı had taken over both the promotion and production of the Okey condom brand.

- In 1996, Eczacıbaşı sold over 10 million condoms

The success of the Okey condom was matched by the marketing of an oral contraceptive. Launched in December 1991, this product was the result of a collaboration among the three leading manufacturers of oral contraceptives: Wyeth, Schering, and Organon. These three agreed to work in tandem with the SOMARC initiative, by marketing six of their low-dose oral contraceptive products under an umbrella campaign. This overall social marketing campaign was designed to reduce the fears of many Turkish women about oral contraceptives.

RESULT

- In the first year, the Turkish market for oral contraceptives increased by 18%
- Within three years, the oral contraceptive product marketed by the SOMARC team had graduated into self-sufficiency
- Low-dose, low-cost oral contraceptives have now taken over the leading market share for this type of contraceptive product across Turkey

Engaging the private sector

By 1993, 75% of all oral contraceptives and 66% of all condoms were being purchased directly from Turkey's private sector. The success of these SOMARC initiatives paved the way for more complex partnering arrangements with Turkey's private-sector providers. Such collaborations were clearly called for. Only 28% of all IUD insertions and 15% of female sterilizations were being performed by private sector clinics.

This imbalance between the public and private-sector roles for clinical methods and the huge potential for private participation led SOMARC to seek new ways of involving the private sector in Turkey's race against population growth.

In 1994, SOMARC conducted an in-depth assessment of Turkey's private healthcare system. National statistics indicated that over 1,500 OB/GYN practitioners were in private practice. In Istanbul, a city of 11 million people, there were 60–70 private hospitals, as well as 500 privately run clinics, 3,000 pharmacies, and 800 OB/GYNs and 500 general practitioners—all in private practice.

The strengths of Turkey's private sector included a growing infrastructure that was already serving low-middle to low-income consumers. Women from all socioeconomic classes reported a clear preference for private-sector services—the result of a widespread perception that better service and shorter waiting times were available in the private sector. Many private sector clinics had waiting times of 15 minutes or less, while public sector waiting times often took hours. Turkey's women also felt that they could spend more time with their healthcare provider in a private-sector setting.

The private sector's weaknesses centered chiefly on the higher cost of these services. Less than 2% of these costs were financed by private insurance. The cost of all visits had to be paid for by consumers.

In terms of family planning, consumers were often unaware of these services even being available in the private sector. And the importance attached to family planning by

private sector providers was quite low. In many private-sector facilities SOMARC visited, physicians reported doing 200–300% more abortions than they provided family planning sessions. Private sector doctors had strong misunderstandings regarding the safety and effectiveness of modern contraceptive methods, especially oral contraceptives and injectables.

In conducting its research, SOMARC visited over 180 private-sector healthcare facilities in the greater Istanbul area. SOMARC's goal was to recruit OB/GYNs, GPs, and pharmacies to enroll as members of a new private-sector network of providers in the area of family planning and reproductive healthcare. Most facilities were quite interested in participating in such a network. Less than 2% declined to participate, mostly for religious or political reasons. The network was called KAPS, acronym for Kadın Sağlığı ve Aile Planlaması Hizmet Sistemi (Women's Health and Family Planning Service System).

RESULT

- By October 1996, the KAPS network included over 150 facilities, including hospitals, polyclinics, private physicians, and pharmacies.
- The KAPS network has grown from a complete unknown to a position where facilities outside Istanbul are now asking if they can join.
- Prior to the launching of KAPS in 1995, only 8% of non-family planning clients visiting private-sector facilities were aware that family planning services were available at these locations. By 1996, 32% of

women visiting these facilities knew that family planning services were available.

Building a common set of standards

SOMARC began building a common set of standards for delivering family planning and related healthcare services in such a network. Little regulation existed in this area, especially in the private sector. To ensure that participating facilities were offering high quality care, AVSC International worked with the SOMARC team in developing a site assessment form for use throughout the new network. Facilities that were found to be performing illegal procedures, or were not properly certified, were not offered membership in the network.

To ensure a baseline level of care across the network, each enrolling facility was asked to send their OB/GYN staff and related providers to a three-day training program on contraceptive technology, quality management, services marketing, and interpersonal communication skills. SOMARC designed this training program to ensure that the information being provided was up-to date and was presented in a family planning context.

RESULT

- These trainings were successful. Many healthcare providers left the training program with proactive ideas about how they could improve their own programs.
- One hospital fired its OB/GYN as a result of negative feedback received through KAPS community promoters.

- A pharmacist in Istanbul added a client counseling area, as a result of attending the KAPS training program
- Many clinics purchased equipment to ensure that every woman is provided a sterile speculum. As a result, SOMARC witnessed significant improvements in cleanliness and prevention of infections
- Before the KAPS network was launched, only 7% of abortion patients were given any counseling on family planning. By 1996, that figure had risen to 17%. In 1995, none of the post-partum patients in private clinics received any family planning counseling. By 1996, 31% did
- Several hospitals reduced the cost of tubal ligation services by 30%. Many other providers agreed to lower their fees. They also agreed to maximum fees for family planning and reproductive health-care services

Using integrated marketing communications and local community support

Launched in October 1995, the KAPS network was immediately supported by a comprehensive public relations campaign to increase recognition of KAPS among influentials and consumers

The campaign included a series of interviews on Turkey's TV stations as well as many radio stations. Almost all of Turkey's newspapers have carried articles about the KAPS network, and many women's magazines have also featured the network

Before the KAPS network was big enough to warrant media coverage, SOMARC organized a team of community promoters to increase public awareness of the network. The Turkish Family Health and Planning Foundation (TFHPF) and the private-sector firm MPR, a public relations company, worked closely with SOMARC in training women to visit public places in Istanbul to distribute brochures and to talk about KAPS with women in neighborhoods that had been targeted for this type of intensive, person-to-person campaign

The KAPS network now includes a hotline that anyone can call to learn more about the services that are available through the network. A hotline representative is available

Establishing affordable pricing levels

During SOMARC's research, price levels were repeatedly mentioned as a major reason among consumers not to seek out private family planning or reproductive healthcare, even though these consumers believe that private-sector care would be superior. The issue of cost clearly needed to be addressed

In addition, SOMARC negotiated with private-sector providers to lower their fees for a variety of reproductive health services. SOMARC also negotiated with private clinics and hospitals to post their fees visibly, feeling that making prices publicly known would reduce at least some of the concern about costs among prospective consumers

RESULT

- Providers agreed to post a price board in their reception rooms, indicating the cost of reproductive healthcare services



from 10 00 a m until noon every day to discuss questions with callers. This service is promoted through a series of flyers, as well as through community promotion teams and articles in the press and media.

RESULT

- The public relations campaign generated news coverage equivalent to more than \$800,000 in media advertising.
- By the end of 1996, over 12,500 women had been contacted directly by these community promotion teams.
- TFHPF and an advertising agency jointly developed three radio spots to increase awareness of KAPS to motivate women to seek out providers of family planning and reproductive healthcare services.
- By the end of 1996, the KAPS hotline had received over 10,000 calls.
- After the KAPS program had been in existence for a year, a follow-up survey

found that 90% of all clients using KAPS facilities were from the target group

Implications for future work

These results are encouraging. Just as encouraging are the implications for building this type of network elsewhere. Since KAPS was introduced in Turkey, other project

countries served by SOMARC—including Nepal, Mexico, and the Philippines—have begun building similar networks to enlist the private sector in their healthcare systems.

This is good news for USAID and for the growing number of nations moving toward sustainability.

CHAPTER 6

REFORMING POLICY: LEVERAGE FOR CHANGE

Policy and profit

The kind of issues addressed by social marketing initiatives are, almost by definition, frequently the subject of policy differences within a project nation's government. Because of this, policy reform often holds important keys to the success of social marketing efforts. SOMARC has found that policy reform is a crucial element in terms of building effective alliances with the commercial sector. Critical public policy issues include

- Government policies that restrict the services the private-sector may offer
- Policies that indirectly influence commercial markets, including a government's free distribution of contraceptives, irrespective of the commercial markets' willingness to establish affordable pricing for consumers—thus driving the private sector out of markets that only they can support on a long-term basis
- Organizational policy issues, including insurance companies' requirements regarding coverage of family planning products and services
- Policies that restrict specific types of services, such as injectable contraceptives or voluntary sterilization to women who already have borne children

After engaging policy issues for many years, SOMARC has developed a conceptual framework for addressing policy reform. Several broad categories of policy issues have been addressed

- Barriers to entry that make it difficult for investors to establish a new private-sector entity in a given market
- Restrictive licensing and accreditation requirements for private-sector providers, clinics, and other outlets
- Poor prospects for generating reasonable profitability. This is often made even more difficult by the untargeted use of no-cost, donated contraceptives, which then drive potential investors from the market. This type of barrier has been especially strong in Peru and the Philippines
- In a similar way, price competition in the form of no-cost public healthcare serves to drive private-sector providers of quali

ty services out of the market. Yet free services often are restricted to the very poor. This creates a void for moderate- to low-income consumers of these services. And they are precisely the group that most needs to be reached by low-cost private sector family planning services.

- Restrictions on products and services are often motivated by protectionist strategies among professional associations. For example, restrictions may be imposed on the insertion of IUDs or on dispensing injectable contraceptives. In Brazil, for example, a firm had to obtain separate licenses to market Depo Provera and the needles required to inject it. When a company attempted to market these products together, it had to get a license for this combined “new” product.
- Barriers to obtaining necessary knowledge and professional training also can impose a formidable obstacle. Restrictions on private sector participation in training programs can leave providers years behind in knowing essential information and techniques. This difficulty has surfaced many times as SOMARC has attempted to work with private sector providers—only to discover that these providers have been inadequate in terms of their training and knowledge-base. Fortunately, this is one area where effective public/private partnerships can be formed.
- Restrictions on advertising and other forms of mass communication also serve as powerful brakes on the progress of social marketing campaigns.
- Private sector interests rarely have a seat at the table when public policy is being

debated and decided. This exclusion also results in major gaps in the information available to private sector interests.

- Often, the structure of labor agreements involving public sector employees locks these workers into using public sector healthcare providers. This places an additional barrier on the evolution and development of the private sector in making quality healthcare available to all sectors of the population in these countries. Contracting with private providers in major urban areas would enable the public sector to focus its service delivery efforts on the rural poor, where private options are less available, while still allowing for full access to quality healthcare in urban areas among private-sector providers, who are quite plentiful in urban areas.

Despite all of these barriers to private sector healthcare, the overall trend among developing countries favors inclusion of private-sector family planning and reproductive healthcare providers.

The growing worldwide trend toward privatization of many public sector services, including healthcare, is a powerful force for change, despite the cumbersome restrictions mentioned above. Moreover, this trend toward privatization comes at a time when the international focus on family planning and reproductive health is growing—thus increasing the momentum toward inclusion of the private sector.

However, the level of the private sector’s involvement in strategically and structurally supporting the goals of the international community remains to be determined.



SOMARC has learned a great deal about implementing workable strategies in this area. Examples of SOMARC's effectiveness in influencing policy in this area include

RESULT

- SOMARC has worked in a number of countries to influence currency restrictions that have stifled the importation of contraceptives. This negotiation has been attempted in Uzbekistan, to enable international manufacturers of contraceptives to be able to bring their products to market at an affordable price point.
- In Brazil, SOMARC negotiated with Pharmacia Upjohn to reduce its prices for oral contraceptives, resulting in a major expansion of this market and the opening of significant opportunities for the private sector in Brazil's markets.
- SOMARC has effectively promoted private partnerships in Central Asia, Jordan,

- Morocco, the Philippines, Jamaica, and Brazil. In these countries, SOMARC has formed training partnerships with public-sector agencies and with in-country training experts to form strong new collaborative efforts to train healthcare providers to be more effective in terms of information and content and also in developing the skills to communicate with their clients.
- In Ghana, SOMARC was successful in facilitating the inclusion of private-sector physicians in Norplant training programs that had previously been restricted by the Ministry of Health to public sector providers and physicians.
 - In the Central Asian Republics, SOMARC successfully negotiated with officials in the public sector to include private physicians in a series of training courses being run by other agencies for providers in the public sector.
 - In Jordan, SOMARC successfully negotiated waivers to a series of restrictive censorship regulations prohibiting the broadcasting of method-specific TV advertising, by demonstrating to the censor board that these TV ads would have a strong positive impact on Jordan's families. The result of this intervention by SOMARC was that the Jordanian censor board not only allowed these TV ads to be broadcast, but actually made the air-time available at no charge.
 - In Turkey, where existing laws prohibited even the mention of the word "condom," a SOMARC developed TV ad campaign using only the condom's brand name, without mentioning either the method of contraception or the word "condom." This TV ad became extremely popular and helped to launch the condom market in Turkey.

CHAPTER 7

BUILDING PRODUCT FAMILIES

SOMARC has repeatedly demonstrated the effectiveness of product branding—not only for individual products, but to increase public awareness of family planning in general. Where government regulations against method-specific marketing have limited this approach, SOMARC has created a unifying logo to identify a “family” of CSM products. This family identity can then be used to strengthen and to focus public awareness of the quality and availability of these products. Examples of SOMARC’s effectiveness can be seen in Morocco and the Philippines.

Morocco: al Hilal

Morocco is a conservative Muslim nation of 26 million people. The political climate in Morocco is heavily influenced by the country’s Muslim religious hierarchy. SOMARC’s goals in Morocco included

- Improving the health of low income (Class C and D) socioeconomic groups
- Nurturing private-sector growth by actively promoting its participation in achieving social goals
- Expanding contraceptive choice for Moroccan couples
- Increasing contraceptive prevalence throughout Morocco
- Reducing the financial and administrative burdens on international donors and on the Moroccan government in providing CSM-related products and services

SOMARC has had a continuous history of involvement in Morocco, starting in 1988. These efforts now span four major products. SOMARC began by marketing Protex condoms. Its efforts expanded to include the Kinat al Hilal oral contraceptive, followed by the Hoqnat al Hilal three-month injectable and the Lawlab al Hilal IUD. A network of al Hilal service providers has been developed to support the availability of IUDs and injectables.

Protex condoms were launched in Morocco despite the fact that only 3% of Moroccan men were using condoms. The challenge facing SOMARC was to desensitize Moroccan men on the topic of condom use—while building a private sector market for their sale.

RESULT

- The private-sector market for condoms has increased more than 200% since the introduction of Protex condoms.

- The marketing of Protex has opened up the commercial market to other brands. The commercial condom market in Morocco has grown much faster than the total market for contraceptives in the country.
- The private sector has become a major source of information about condoms as pharmacies have become a powerful retail outlet.

SOMARC introduced the al Hilal marketing campaign in 1992, using two commercial oral contraceptives, Microgynon and Minidril, marketed under the Kinat al Hilal logo. Birth control pills are the leading contraceptive method in Morocco. However, most of these pills are provided by the public sector. SOMARC's goal in launching Kinat al Hilal was to increase Morocco's private sector's involvement in family planning service delivery through the introduction of oral contraceptives.

RESULT

- Kinat al Hilal has established itself in the marketplace. By 1996, the Kinat product line had graduated into self-sufficiency. Manufacturers and distributors market Kinat al Hilal without donor funding.
- A new MOU has been signed regarding future expansion and evolution of the al Hilal marketing program to establish a stronger public image for the Kinat product line and to increase sales by 10%.
- The use of public-sector oral contraceptives has diminished considerably—a striking achievement, since these have been available to consumers at no cost.
- SOMARC has achieved its major goal of shifting Morocco's family planning service delivery system to the private sector.

SOMARC's marketing of the Hoqnat al Hilal injectable contraceptive product line was initiated to expand further the options available to Moroccan couples, and to increase the private sector's participation in family planning. Because each new product line, such as injectables, requires a greater degree of counseling and consumer education, this process has simultaneously served to increase the delivery of family planning services and products across Morocco.

RESULT

- The Hoqnat al Hilal product line was launched in late 1996, aimed at women aged 18-40, with the support of a full marketing campaign including Pan Arab TV commercials, radio advertising, a public relations campaign directed both to consumers and to providers, brochures aimed specifically at a low-literacy audience, and simplified instructions for using injectables.
- By the end of 1997, one year after its introduction, over 2,600 pharmacies were stocking the al Hoqnat product line.
- 13,750 couple years of protection (CYP) were estimated as achievable for Hoqnat al Hilal during 1998.
- Pharmacia Upjohn has agreed to maintain a low price for this product in exchange for marketing support. Physicians and pharmacists are continuing to be trained, strengthening the market for al Hoqnat and the entire al Hilal product family.

SOMARC introduced its IUD device under the name Lawlab al Hilal. This product was launched in November 1997 with marketing support including mass media advertising, public relations, consumer and provider brochures, and broad distribution to over 1,500 pharmacies, as well as an aggressive campaign by a commercial distributor to enroll private physicians.

RESULT

- More than 500 private physicians have been trained by SOMARC in the proper use and fitting of IUDs
- Private physicians have committed to offer the IUD product line at a minimum cost

SOMARC's expanding success of the entire al Hilal product family led naturally to a major marketing threshold—moving from marketing products to marketing family planning services. At the inception of this effort, only 3% of all family planning services throughout Morocco were being delivered by the private sector—even though Morocco's private physicians make up 50% of all doctors in the country. SOMARC's objective has been to develop private-sector family planning service delivery through a combined campaign of training and promotion.

RESULT

- SOMARC has initiated a comprehensive training strategy to train general practi-

tioners in IUD insertion, counseling, and the full range of contraceptive technology.

- SOMARC has provided physicians and other service providers a series of consumer education literature for distribution in their offices
- SOMARC has begun linking and identifying service providers who have been properly trained with the already familiar al Hilal logo—signifying to Moroccan consumers that these practitioners and service providers can be relied upon to offer high quality, up-to-date services
- SOMARC negotiated with NGOs operating in Morocco to provide information to their clients about al Hilal products and providers. For example, six NGOs in Rabat, Sale, Fez, and Casablanca have been actively recruited for the al Hilal NGO Network. One important NGO, The Zakoura Foundation, is providing micro-credits for IUD insertion
- The al Hilal network of service providers who have been trained by SOMARC includes 300 physicians in Casablanca, Sale, Fez, Agadir, Meknes, Tangier, Tetouan, Skhirat/Temara, Kenitra, and Rabat. Over 300 additional physicians were due to have been trained by June 1998—making a total of 600 doctors across Morocco who now are trained and actively involved in the al Hilal network of service providers



CHAPTER 8

JOINING THE BATTLE AGAINST HIV/AIDS

The widening threat

In countries throughout the developing world, heterosexual contact has been found to be the principal mode of HIV/AIDS transmission. In urban areas, it spreads quickly. Even in rural areas, sex workers often pass the virus to truck drivers, who transport it to other communities along their routes, and then finally to their own homes. Silently, the virus spreads—until the cumulative effect overwhelms entire villages and regions. This deadly pattern has been observed repeatedly in many parts of Africa and Southeast Asia. Entire countries such as Thailand, Uganda, and South Africa are now threatened by the spread of HIV/AIDS.

In its 1996 Evaluation of SOMARC III, the Population Technical Assistance Project evaluation team reporting to USAID stated that “SOMARC has been effective in collaborating with AIDS prevention programs in selected countries where SOMARC is responsible for the social marketing of condoms. SOMARC’s role in working with AIDS prevention is condom promotion—a comparative advantage when viewed alongside other prevention approaches such as reducing partners or decreasing STD prevalence” (p. 59).

The case of Nepal

Although the epidemic is still at a relatively early stage in Nepal, the continual movement of sex workers and laborers across that country’s open border with India—and high-risk behaviors in vulnerable segments of Nepal’s population—make Nepal one of the Asian nations with the highest potential for the rapid spread of HIV/AIDS. As of 1996, the rate of infection was 1 in 15,000. By the year 2000, it is estimated that this ratio will have risen to 1 in 1,000.

A study conducted in 1994 among Nepali sex workers and their customers found that although awareness of HIV/AIDS was quite high, accurate knowledge of the disease, its transmission and prevention were quite low. Condom use was infrequent. Conditions for an epidemic in Nepal were present, and were growing. SOMARC determined that an intervention was necessary.

About half of Nepal’s population lives in the Terai, an area occupying approximately 20% of the land area along Nepal’s border with India. Studies have indicated that migrant laborers, truck drivers, and traders who cross this border often engage in unprotected sex

with multiple partners. To address this growing problem, AIDSCAP, a USAID-funded project directed against HIV/AIDS, contracted with SOMARC to conduct condom promotion and distribution activities in the Terai and Central Region areas of Nepal. The primary goal of this collaboration has been to improve condom accessibility and use among the target audience in this region.

SOMARC contracted with a local advertising agency, Stimulus Advertising, and a marketing research firm, HIMAL, to develop and deliver an integrated multimedia marketing communications campaign for condom promotion both to the general population and to the target group identified as being most at risk.

In addition, condom distribution in the project area was increased, making condoms available in a variety of stores and other outlets that had never previously carried these products. A wide range of media was used, from traditional marketing techniques to street theater and puppet shows in local villages.

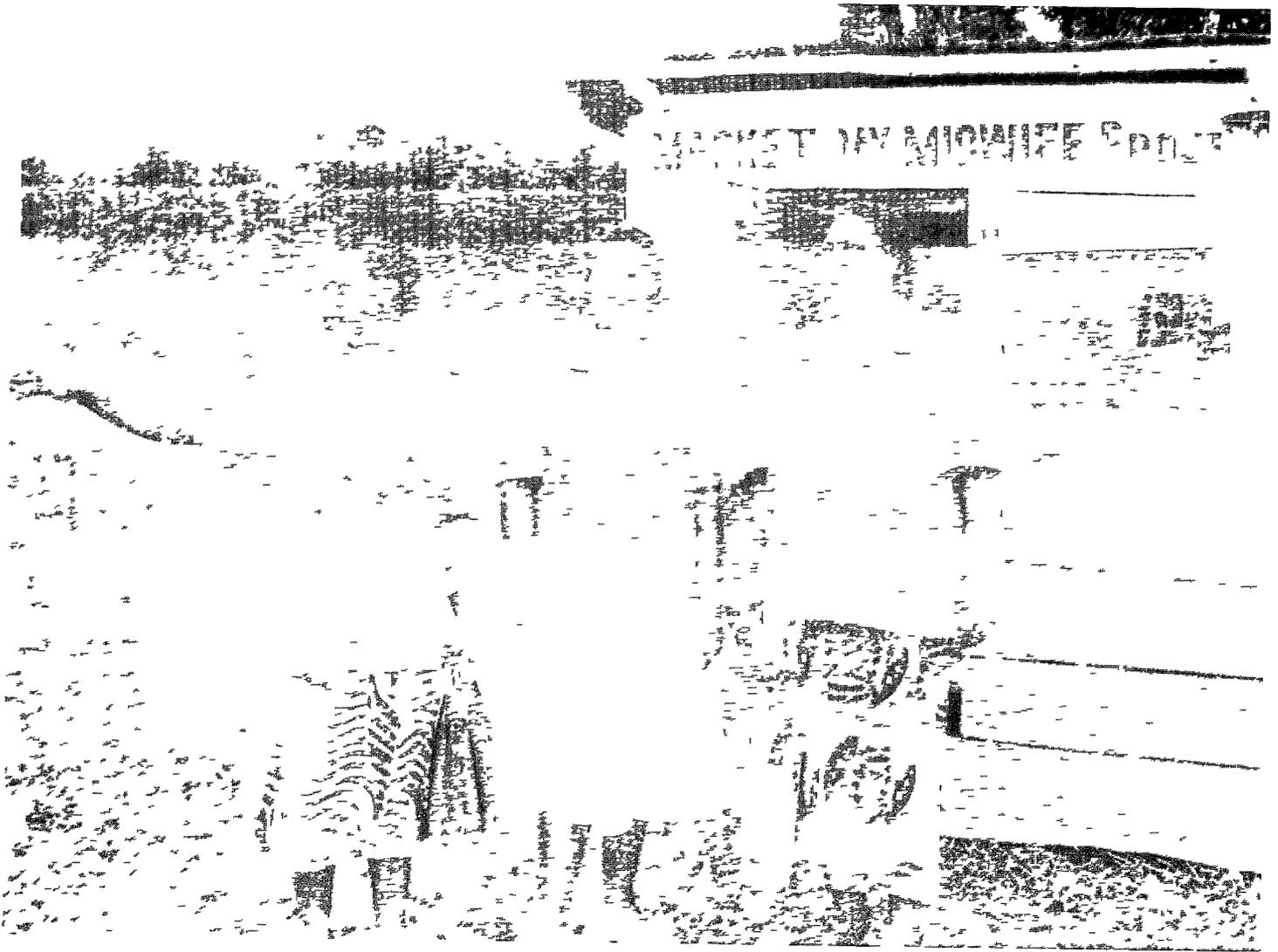
RESULT

- To reach truckers and commercial sex workers in the field, an attractive, easy to read comic book containing key messages about sexually transmitted infections and HIV/AIDS in particular was published. Stories in these comic books focus on a trucker and his assistant as they travel between Nepal and India.
- The condom logo character, Dhaley, communicates the message “Condom lehgown, AIDS behgown”—“Wear a condom, drive off AIDS.” Dhaley also is used in comic book stories as an off-camera commentator on the action. Forty-five- and 20-minute films of the same story are also shown in video-van productions at road stops on the highway and were shown to local TV audiences on World AIDS Day.
- Merchandising materials such as stickers, signs, mobiles, and special jackets for the motorcycle sales team were distributed, encouraging retail outlets to stock condoms.
- A retail display contest was created to encourage retailers to decorate their shops with condom logos and other promotional materials. This contest was effective not only in stimulating condom sales, but in making condom sales more acceptable throughout the Terai region.
- A goal of increasing condom distribution outlets by 50% was set for August 1996. This goal was reached nearly a year ahead of schedule.
- The target set for condom sales was 4 million units by August 1996. By December 1995, over 4.5 million units had already been sold.
- Over 3,000 new condom sales outlets have been opened along the trucking route. More than 90% of these outlets are ordinary stores, not pharmacies.
- Most importantly, condom use has risen dramatically. Among Nepal’s commercial sex workers, the use of condoms was reported to have increased to 76%. And 60% of these sex workers reported using condoms in their most recent previous sexual encounter.

- Public awareness has risen sharply. A majority of people who were interviewed responded that they had seen condom messages on a billboard (60%) or had heard these messages on the radio (72%). Many others indicated that they had encountered these messages in pharmacies, movie theaters, via print materials, video-vans, TV, street theater, or in discussions with outreach workers. Over 75% of the target population identifies

condom messages as a source of information on AIDS prevention.

SOMARC's innovations have been adopted by the Nepali government's national AIDS prevention campaign. The collaborative linkage between SOMARC's efforts and the national campaign also has generated significant payoffs in obtaining media clearances and donated resources to assist the work of the SOMARC/AIDSCAP initiative.



CHAPTER 9

BUILDING A “MEDIA TUNNEL” STRATEGY

The Philippines

As a strategy for generating a climate of public opinion that supports behavior change on a large scale, the “media tunnel” offers strong benefits. The phrase refers to the coordinated use of a spectrum of mass media, public relations, and interpersonal communications tools, creating the effect of a “tunnel” of communication. Caught in this “media tunnel,” a target population cannot help noticing the new product or the intended new behavior. SOMARC’s work in the Philippines shows how this strategy can be used to good effect.

In the Philippines as late as 1992, under a conservative president, the open promotion of family planning was forbidden. However, soon after the election of a less conservative administration, SOMARC introduced a Couple’s Choice program to market family planning products including a range of quality contraceptives. The Couple’s Choice program was designed to promote Depo Provera and three low-dose oral contraceptive products. These were introduced in 1994.

Couple’s Choice used a “media tunnel” approach, combining television commercials with a broad-scale public relations campaign, frequent interviews by “influentials” on radio and TV, as well as newspaper and magazine

articles. The net result has been to create a strong impact on the Filipino public. The Couple’s Choice program also has had a significant impact on the loosening of TV advertising policy, enabling more assertive ads to be broadcast.

SOMARC designed several TV ads for Depo Provera and oral contraceptives that addressed the methods’ side effects, yet also demonstrated their benefits by showing a happier Filipino woman who has more time to spend with her family, her husband, and her career. The resulting ads have been successful in reassuring women that the side effects are normal, to be expected, and temporary. The Depo-Provera ad also has communicated three key selling points: that a single injection offers three months of protection, that it is medically safe, and that it has been proven to help women to space their families.

The SOMARC media tunnel reinforced the product’s public recognition factor, despite the fact that the brand names of contraceptives like Depo-Provera cannot be mentioned in Filipino TV commercials. SOMARC’s agency worked around this by using the program’s name instead. Couple’s Choice. Market research had indicated that Couple’s Choice had gained 90% name

recognition among its target audience and was seen as a trusted source of high-quality family planning products and services. To counter the ban on mentioning the product name, Couple's Choice ads used the generic term for its CSM product line, referring to Depo Provera as "the mouth injectable."

Result

- The media tunnel campaign has been a success. Even a year later, sales of CSM products climb in areas reached by the marketing communications campaign.
- Sales during part of 1997 increased by 88% over the same time period just a year earlier in 1996.
- A steep rise in the sales of all methods continued during the second and third quarters of 1997.
- Growing numbers of Filipino women have been reassured about the safety, side effects, and effectiveness of all Couples Choice products.
- Although this program has been criticized by church leaders and some political figures, the program's marketing communication has received no negative reaction nor any official backlash.

For a controversial program such as Couples Choice in a conservative country such as the Philippines, this has been a major victory. The scale of this victory is due in large part to the decision to use a media tunnel strategy as a way of gathering marketing momentum and gaining public approval. These have helped to create a broad context of public acceptance for what easily could have been a much more difficult marketing challenge.

CHAPTER 10

EXPANDING CHOICE

The case of Uttar Pradesh

For several decades, India's family planning strategy has depended on sterilization. But with nearly 40% of India's population now below 15 years of age, it will be very difficult to protect Indian couples by continuing to focus on sterilization as a form of contraception. The number of couples who choose family-spacing methods by using lower-cost methods such as condoms, IUDs, and pills must increase—significantly and soon.

How can India accomplish this? Oral contraceptives have had a discouraging history in India. Despite over 30 years of availability and major investments by the Indian government to promote their use, only 1.2% of fertile couples currently rely on this method of family planning.

SOMARC was invited to work in Uttar Pradesh (UP) to increase the general level of awareness regarding modern contraceptive methods—specifically, the use of condoms and oral contraceptives. The problems in Uttar Pradesh were like those affecting the rest of India: lack of easy, effective distribution, and the availability of accurate information. Too many men and women contin-

ued to believe gossip and misinformation. They were afraid to use a pill or a condom.

The problem, however, was more complicated than that. Even if they were persuaded to make the choice to use a pill, condom, or other contraceptive, existing distribution of pills and condoms beyond chemist shops was virtually nonexistent in Uttar Pradesh. Yet chemist shops accounted for only 15% of all potential distribution outlets. Thus, 85% of the potential outlets were not being used effectively.

Uttar Pradesh is one of the poorest states in India. Nearly half its people live below the poverty level. Only 20% of UP's population lives in an urban area. The typical woman born in UP has a life expectancy of 50 years. When she is about 15, she will marry, her family will be completed by age 26 with an average five births. A woman in Uttar Pradesh is likely to be illiterate and unlikely to work outside her home.

Nevertheless, the women of UP—some 90%—possess information about family planning. Yet only 20% practice any contraceptive method whatever, whether traditional or contemporary. For example, only 5% of the

women in UP use oral contraceptives, yet 40% indicate that they would like to use this form of family planning. Real potential for improvement exists.

In addressing the situation, SOMARC developed a consumer education outreach program that focused on urban areas located in six districts across Uttar Pradesh. The outreach program aimed to reduce the gap between the level of awareness about contraceptives—which was measured at 98%—and the actual use of contraceptives—then just 17%. The initial goal was to reduce people's fear of using oral contraceptives, so they could be marketed to reach many more consumers using nontraditional outlets.

Because two-thirds of SOMARC's target audience had no easy access to mass media technology, SOMARC decided to bring the message directly to the people of Uttar Pradesh. Working with its local public relations partner, SOMARC built an outreach campaign. SOMARC created street theater performances with family planning themes and set up information and marketing booths staffed by trained service providers in bazaars. SOMARC organized change agents to generate interest and sales. SOMARC also produced consumer brochures and developed a soap opera, news programming, and print articles—all aimed at this single theme. The results have been dramatic.

RESULT

- Sales of pills and condoms across UP's target districts have risen sharply. SOMARC's program began in December 1996. During the first six months of 1997,

sales of pills and condoms rose 300% above sales of these products for all of 1995–96.

SOMARC is partnering with India's Industrial Credit and Investment Corporation and with USAID in a Program for the Advancement of Commercial Technology/Child & Reproductive Health Program (PACT CHR). The goal of PACT CHR is to increase Indian couples' access to commercially available and affordable oral contraceptives. This approach offers a strong chance for improving the lives of millions of people across India, at the lowest possible cost. SOMARC will designate one of the low-dose oral pills for expanded distribution in private sector outlets beyond the pharmaceutical network—using grocery stores, small shops, bazaars. Private-sector companies can aggressively promote their products and get as wide a distribution as possible. This will expand access to these CSM products.

Building on SOMARC's success in Uttar Pradesh, this strategy can be introduced into other Indian states. It will require an integrated marketing and liaison campaign to build support for private sector distribution of these products. This campaign would aim to overcome the fears of using oral contraceptives. A full spectrum of social marketing activities would be conducted, including market research, public relations, advertising, distribution, and the field training of local participants. Finally, it would include coordination with governmental and health care agencies and private-sector companies to meet the program's broad objectives. Based on SOMARC's experience, the prospects for success are strong.

CHAPTER 11

REACHING RURAL COMMUNITIES

Working in rural Uganda

Uganda is an extremely poor African country of more than 20 million people. The national government is attempting to come to grips with an annual population growth rate of 3.4%. With a fertility rate approaching seven children per woman, Uganda's population is expected to almost double to more than 33 million people by the year 2025, according to the Population Reference Bureau's 1998 figures.

The majority of Uganda's population—nearly 90%—lives in rural areas. Surprisingly, knowledge of modern family planning methods among Ugandan women is quite high—90%—yet their use of contraceptives is very low. According to a 1995 survey, only 13% of Uganda's women were using any family planning method, traditional or modern, and only 7% used an accepted modern method.

In addition, the spread of HIV/AIDS in Uganda has been rapid. In 1995, World Health Organization researchers estimated that more than 1.5 million Ugandans were infected with the HIV virus—and 350,000 with AIDS.

SOMARC's program in Uganda began in 1991 to assist the Ugandan government in

achieving new health and family planning goals. In Uganda, however, reaching national goals is difficult. Infrastructure is weak, history and tradition are strong, and social change has often been violent.

In the family planning area, obstacles were evident from the start of SOMARC's efforts. Major obstacles included inadequate knowledge by consumers on contraceptive products and their use, as well as fierce opposition based on religious and cultural beliefs. These factors were further compounded by limited access to contraceptive products.

When SOMARC's initiative began, a reliable rural and up-country product distribution system for contraceptive products and services did not exist. No private commercial firms and only a few NGOs were engaged in distributing contraceptive products in these areas. In large cities, traditional sales outlets such as pharmacies, clinics, and small shops were the most common sources for purchasing condoms. However, in rural and up-country areas, few sales outlets consistently carried condoms or any other types of contraceptive products.

To begin building some positive momentum toward reaching Uganda's rural population, SOMARC joined with the Uganda Private

Midwives Association (UPMA) in developing the Market Day Midwives (MDM) project. The MDM project was designed to place traditional midwives in local markets throughout Uganda's underserved rural areas, to provide direct access to contraceptives and accurate information about using them. The MDM midwives received special training provided by SOMARC.

Rural marketplaces are centers of community activity, visited weekly by at least one family member. Twenty-four MDM midwives worked in 40 marketplaces, where they ran permanent stalls. Midwives were given uniforms—Pilplan shirts, hats, and a blue smock—making them easily identifiable. The MDM midwives sold Pilplan oral contraceptives and Protector condoms, and provided information about family planning and HIV/AIDS to men and women. In the market stalls, client confidentiality was protected by curtained partitions and inconspicuous entrances and exits. Several MDM midwives also worked as mobile service providers and carried products, pamphlets, client cards, and daily records in a bag with them as they canvassed the market. Public contact was frequent, yet relaxed.

MDM midwives met every other month at UPMA headquarters in Kampala to replenish their products stock and to compare notes. Problems were discussed and solutions were ironed out. A major aspect of an MDM's job involved community education and contraceptive advocacy. While doing mobile work, midwives had a great deal of contact with shoppers and other vendors in the market. They used this continual contact to gain the local community's confidence. MDMs edu-

cated people in large groups and initiated discussions with people who would not approach a SOMARC stall, because of cultural constraints, misconceptions, or shyness. These MDM midwives were SOMARC's front-line marketing agents.

In 1996, the Market Day Midwife project was evaluated in depth. Interviews with midwives, managers of the outdoor markets, marketplace vendors, and clients who had used their services indicated that Market Day Midwives were integral to these community markets.

RESULT

- Clients said they benefited by having one-on-one counseling available without waiting in long queues at a hospital or clinic and they liked knowing that midwives were accessible to them if they experienced side effects or needed health questions answered.
- Evaluations showed that working in a stall and offering mobile services, were important in a market environment. From a client's perspective, the advantage of the stall was the privacy that it offered to adolescent girls or women who felt uncomfortable approaching the midwife under the always curious and often disapproving eyes of local elders. The stall location was essential in reaching vulnerable elements of the community.
- During a three-year period, 12.8% of total SOMARC Pilplan sales were attributed to the Market Day Midwives.
- MDM midwives found they could create a demand for family planning. In many

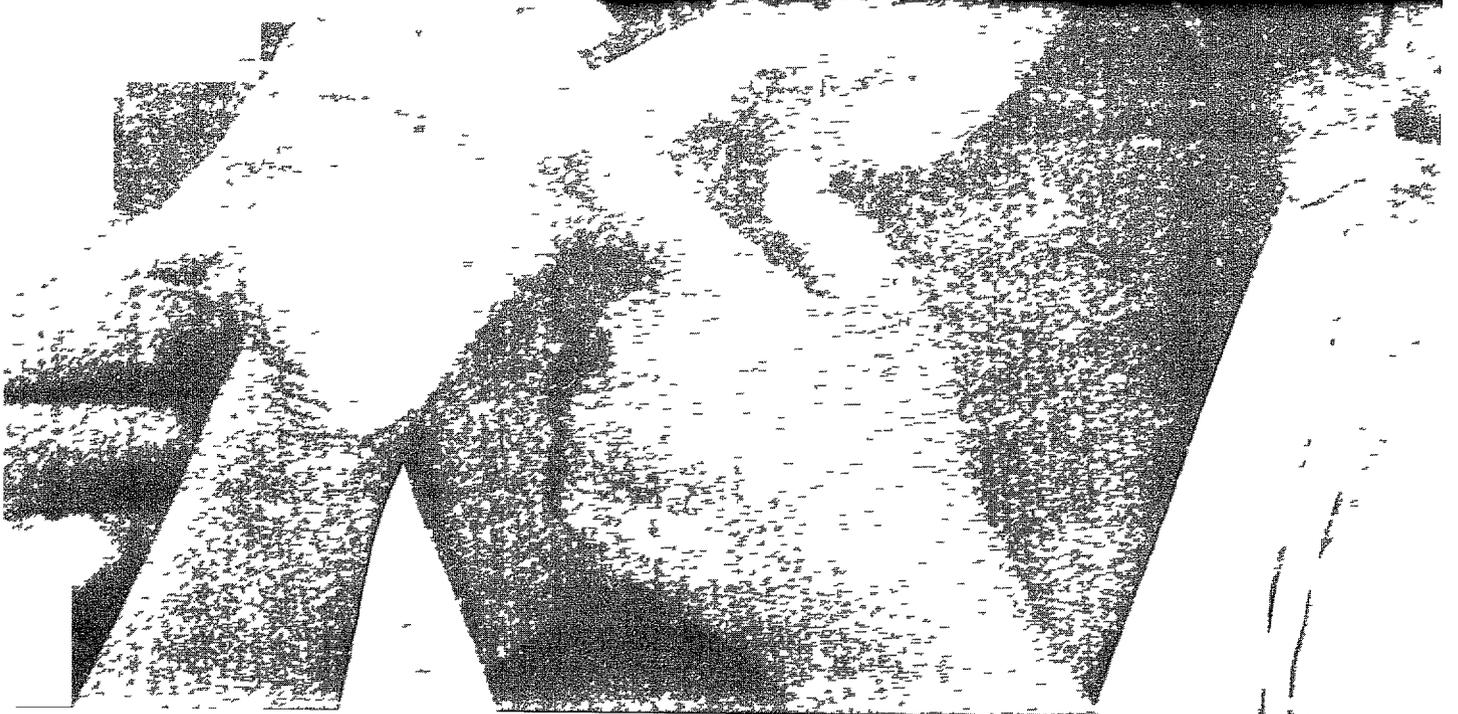
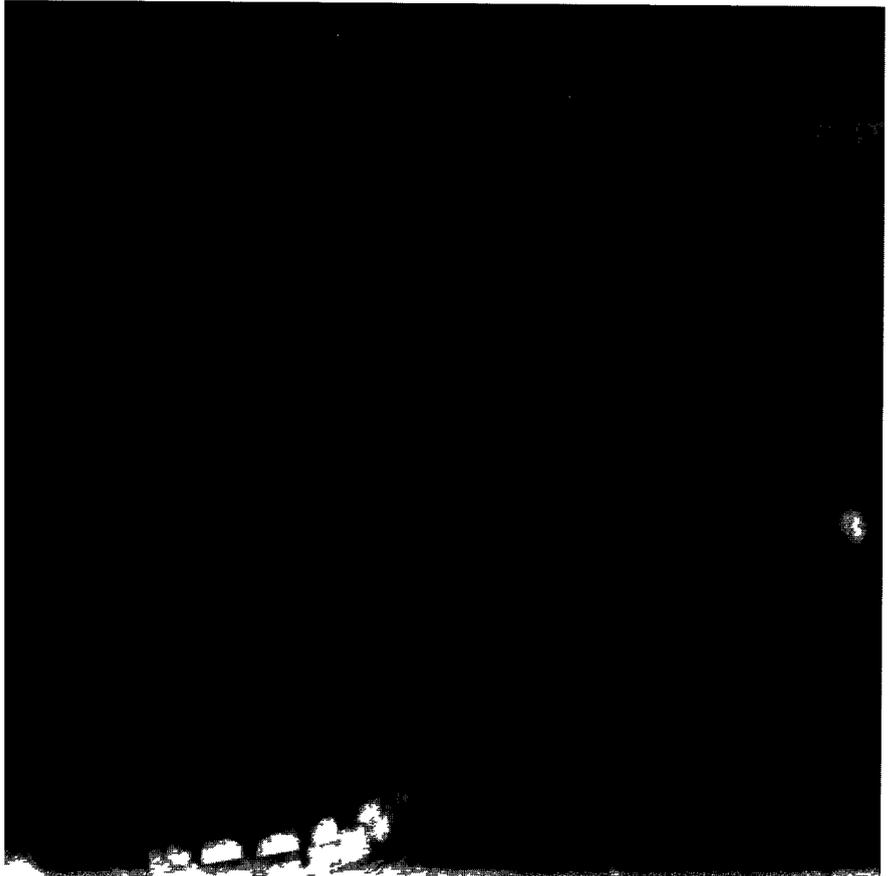
of the rural markets, the MDM midwife was the only family planning provider in the local area. Midwives counseled men and women about using condoms and pills for family planning and they counseled on the use of condoms for prevention of HIV/AIDS and STDs. They also provided high-quality Protector condoms at a low price.

At this point, SOMARC turned its attention toward the issue of self-sufficiency. Ownership of the market stalls was turned over to UPMA, enabling midwives to maximize their profits. Midwives were given training and technical assistance in marketing, management, business planning and budgeting. Midwives were enrolled into business planning workshops conducted by SOMARC and a representative from the USAID-funded Delivery of Improved Services for Health (DISH). This was done to help midwives better understand how many products they needed to sell in order to cover their expenses. MDM midwives were trained by SOMARC in administration of the DMPA injection. SOMARC-trained midwives then added DMPA to products offered in their market stalls.

RESULT

- MDM Midwives learned to give reliable contraceptive information, and gained the skills needed to provide counseling and follow-up services necessary to maintain a satisfied clientele.
- Market Day Midwives proved to be most successful when they were located in a market where they had permanent stalls and regular interactions with the other vendors and members of the village.
- Midwives gained the community's confidence by initiating discussions with potential clients.
- Midwives found ways to teach people in groups, creating a forum about contraceptives. Their stalls were decorated with promotional information and with brochures that clients could take home with them. This was effective.
- Midwives who offered mobile services had information that could be handed out to clients who did not have time for consultations. Many of these people later sought out counseling.
- As accessible entrepreneurs who had received training in marketing, business planning and budget techniques, MDM midwives became role models for the message that family planning is good for Uganda's families, and for its women.

As SOMARC's experience with Uganda makes clear, there is no market or marketplace too small or too rural to be ignored. Effective collaboration with nontraditional partners such as Uganda's midwives association can be enormously fruitful—not only in providing access to quality contraceptives, but in stimulating a positive climate of opinion that favors the choice, purchase, and use of contraceptives in cultures and regions that have had little exposure to family planning.



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CHAPTER 12

COLLABORATING WITH COMMERCIAL MANUFACTURERS

Brazil

The primary methods of contraception in Brazil are sterilization and oral contraceptives. Over 50% of all women of reproductive age in Brazil are sterilized and 27% use oral contraceptives. One of USAID's strategic objectives in Brazil has been to broaden the type of contraceptives available to Brazilian women. At USAID's request, SOMARC approached Pharmacia & Upjohn/Brazil (P&U) after P&U had registered the Depo-Provera injectable to develop a niche market breast-feeding mothers. This would have required P&U to charge a high price.

Brazilian women understood the convenience of Depo-Provera: three months of contraceptive protection from one injection. SOMARC saw a major marketing opportunity that it felt P&U was overlooking. Taking a broad consumer-oriented approach, using data from the 1996 Demographic and Health Survey, SOMARC developed a profile of women using injectable contraceptives and found that 8.7 million Brazilian women could be considered prospective consumers of Depo-Provera—if it was made available at an affordable price.

SOMARC approached P&U with its strategy of creating an alliance to offer Depo-Provera to moderate-income consumers, by promoting it on the basis of its striking convenience, since Depo only had to be administered four times a year. Detailed analysis of sales information had revealed that 78% of Brazilian women who were using oral contraceptives were already paying between \$3 and \$5 per month for this protection. Thus, SOMARC argued to P&U, if Depo-Provera could be made available at a comparable price, this would actually be a cost savings for Brazilian women. And that, combined with the increased convenience of Depo, would make it an extremely attractive choice.

In addition, SOMARC gathered and presented to P&U information indicating that over a 5-year period this type of low-priced mass marketing strategy would net P&U a 150% higher sales revenue potential than its intended high priced niche market strategy. Noting that in the United States—also as a result of direct-to-consumer marketing—sales of Depo-Provera had far exceeded P&U's expectations, a deal was struck. An MOU detailing pricing and marketing agreements was signed between SOMARC and P&U.

RESULT

- Sales to date have exceeded P&U's sales projections by more than 30% In fact, P&U's sales under the direct-to-consumer marketing strategy suggested by SOMARC are now projected to top P&U's sales under its high-priced, niche marketing strategy—exceeding it by more than 400%
- By June 1998, Brazilian women were able to obtain information about Depo Provera from multiple sources physicians, pharmacists, a toll free 800 number, direct mail, and public relations and advertising campaigns

CONCLUSION

THE ROAD AHEAD

The most dangerous place on the mountain is a few yards from the top

Tibetan proverb

As this report has indicated, contraceptive social marketing can shape public attitudes and private behaviors, even about issues as controversial as family planning. SOMARC has demonstrated this in arenas across the developing world. The success and lessons achieved by SOMARC will help to define future international efforts in this critical area. The recent study *Population and Development* makes clear how high the stakes will continue to be for the entire international community in developing effective and sustainable family planning programs.

The rationales for public sector action to speed up the transition to lower fertility in poor countries are strongest with respect to failure in the market for reproductive health/family planning information and services. The definition of supply has broadened to address a range of information and services that family planning programs provide. Efforts to influence attitudes toward family planning have often proved to be as important as the actual provision of contraceptives. (pp 47–52)

Products alone are not the answer to the challenge of family planning and population growth. Quality products must be integrated

with affordable, high quality, family planning services. As the evolution of SOMARC I, II, and III has shown, partnering arrangements with private-sector and NGO organizations will be essential to long-term effectiveness. These integrations—of products and services, public- and private-sector players, commercial and NGO linkages—all must be implemented. No one source or sector has a monopoly on “the answer.” All must participate in, and contribute to, a solution.

In addressing the linked issues of population growth and family planning, the path ahead of the international community will be difficult—but it is not without resources or successes. The SOMARC initiative has proven that innovative social marketing strategies can be effective across a wide spectrum of social conditions and cultural styles. However, there is no formula for success, and nothing is guaranteed. Each country presents individual problems in building an atmosphere supportive of change. Isolated breakthroughs are not the goal. Sustainable networks must be built and strengthened if success is to be achieved over the long term. Effective strategies must be shared. There is no short-term solution to the population

dilemma facing the international community. It will take courage, it will take work, it will take money, and it will take time.

Solid efforts such as the one represented by USAID's support of the SOMARC initiative must be sustained, magnified, and communicated, if they are to generate success in bringing down—and eventually balancing—population growth. There is no wise alternative to making this effort.

The private sector and its commercial strategies need to be harnessed to this effort. The private sector holds financial resources, distribution channels, tested skills, and a history of proven lessons that must be brought into play in this international effort. The vast engine of the consumer marketplace is a historical fact and an economic reality. It cannot simply be dismissed.

The commercial sector offers a level of drive that cannot be argued away by organizations that might prefer to think its motives are not “pure” enough to be trusted. That may be a tempting line of reasoning, but the issue of

population growth is not about purity. It is about survival. It presents us with a task that ought to call out the best in all of us, individually and collectively. No one individual or organization will solve this issue by working alone. Nor is there any guarantee that, even working together, we will address it strongly or effectively enough. But as the experience of SOMARC makes plain, our best chance lies in working at this issue together—and by doing that work collaboratively, urgently, humbly, and persistently.

The SOMARC experience offers no “fool proof” formula to victory or success. Instead, the story of the SOMARC initiative offers lessons, and it offers hope. One of the most important lessons it gives us is that successes are achievable—and have already been achieved. However, in order to move beyond initial victories, larger networks of effort, resources, and focus will have to be created and sustained. No quick strategy for long-term success exists. The rest of the job remains to be done.

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USAID Core Contract CCP-3051-C 00-2016-00for SOMARC III Scope of Work

COUNTRIES UNDER SOMARC I, II, III

