EVALUATION OF SOMARC III

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LIST OF ACRONYMS

A&B	social classes A&B (higher income group)
ACE	Association of Condom Endorsers
AIDSCAP	AIDS Control and Prevention Project
ASHONPLAFA	Honduras Family Planning Association
AVSC	Association for Voluntary Surgical Contraception
BEMFAM	Family Planning Association of Brazil
C&D	middle and lower income groups
CA	Cooperating Agencies
CAR	Central Asian Republics
CEPEO	*Importadora e Comercializadora de Produtos Farmaceuticos (Brazil)*
CONAPO	National Population Council (Mexico)
CSM	contraceptive social marketing
CTO	Cognizant Technical Officer
CYP	couple years of protection
DKT/PSI	DKT/Population Services International
DMPA	Depo-Provera (trade mark of depo medroxy-progesterone acetate)
EOP	End of Project
FEMAP	Association of Mexican Private Family Planning
FP	family planning
GOB	Government of Brazil, Government of Bolivia
IA	implementing agency
IEC	information, education, and communication
IMS	Intercontinental Medical Statistics
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
KAP	knowledge, attitude, and practice
LIUSH	London International US Holdings
LOE	Level of Effort
LOP	Length of Project
LTM	long-term methods
MEXFAM	Family Planning Association of Mexico
MIS	management information system
NGO	nongovernmental organization
OC	oral contraception
OYB	operational year budget
POLICY	Policy Analysis, Planning, and Action Project
PR	public relations
PROFAMILIA	*Asociacion Pro-Bienestar de la Familia (LAC)*
RTF	Return to Fund
SM	social marketing
SOMARC	Social Marketing for Change Project
SOW	Scope of Work
TA	technical assistance
TOT	training of trainers
VFT	vaginal foaming tablets
VSC	voluntary surgical contraception

PROJECT IDENTIFICATION DATA

1. **Project Title:** Contraceptive Social Marketing III

2. **Project Number:** CCP-3051-C-00-2016-00
(Core Contract)
CCP-3051-Q-00-2017-00
(Requirements Contract)

3. **Contract Dates**

Agreement signed:	September 30, 1992
End Date:	September 29, 1997

4. **Contract Funding:**

Core Contract Value	$39,961,237
Requirements Value	Unlimited
Core Obligations to date: $34,380,493	
Requirements Obligations to date:	$13,101,990

5. **C.T.O.** Tom Morris

EXECUTIVE SUMMARY

The Social Marketing for Change (SOMARC III) Project is a social marketing program set up under funding from the United States Agency for International Development (USAID). The contract began in September 1992 and is scheduled to run for five years from that time. The funding comes in two forms: the first is a core funding of nearly US$40 million, and the second is based on "Q" type contracts which allow buy-ins from country Missions. The latter is open-ended to the extent that local Missions can buy in as much or as little Level of Effort (LOE) as they require from SOMARC's management. Despite recent changes to the USAID budget process, open-ended demands will continue to be made for the remainder of SOMARC III.

USAID has broad expectations of the SOMARC III Project--expectations which have been expanded from the two previous SOMARC projects ran by The Futures Group since 1983. The current work statement requires that SOMARC cover existing markets where **contraceptive product sales** are the main thrust focused on both family planning (FP) and HIV/AIDS-prevention; **expand long-term methods (LTMs)**, which require a different approach; develop the marketing of **services**; provide technical assistance (TA); and be used as a **reference source** to Missions on marketing activities. The emphasis in SOMARC III is to develop the capacity to deliver LTMs for family planning as well as keeping previous projects going and developing them.

The Futures Group has achieved a commendable output in the first half of the SOMARC III project and the contractor's requirements have been well performed to date. The deliverables set have mostly been matched or exceeded numerically, regional offices are in place and operating effectively, and the budgets are well in control and on track in terms of expenditure. The details on outputs to date are shown in chapter 4 and, at the time of this midterm evaluation, directionally, the activities of the project are progressing well.

One of the major reasons for exceeding the contracted outputs has been a greater demand for contraceptive social marketing (CSM) activities under SOMARC III than originally anticipated, mainly funded through Mission buy-ins. While outputs have exceeded requirements, the open-ended nature of the "Q" contracts has placed enormous strain on budget and staffing, nevertheless, The Futures Group team has managed this variable part of the SOMARC project well.

During the lifetime of the three SOMARC projects, various "generation" models have developed using increasingly more commercial and private sector input. In turn, they replace the need for USAID to continue to fund commodities and/or CSM activities as countries progress from one generation to another toward self-sufficiency. To this end during SOMARC III, successful efforts have been made to develop the longer term methods for family planning and a new venture to market FP services and FP service providers. SOMARC used subcontractors to assist in this.

Particular subcontractor success has been achieved in training and public relations (PR), and continued effective utilization of marketing input on HIV/AIDS. Less successful in the early

stages of SOMARC III has been the link-up with AVSC to provide medical experience and collaboration. This is now being addressed. Also contacts have been made with commercial suppliers of contraceptives with varying degrees of success in various countries.

The executive management of SOMARC is highly qualified and experienced and the personnel are extremely dedicated to their project. SOMARC opened up a fourth regional office which has improved management communications at the country level. Training of local management has taken place, but there is still a need to develop cross-fertilization of ideas and experiences not only with SOMARC country advisors but also with the cooperating agencies. A financial management information system (MIS) is now in place and, again, with a little more work, these facilities can be fully utilized to improve information flow of actionable marketing data.

Extensive market research has taken place and this is at about the right Level of Effort, given the wide and varying nature of SOMARC projects. In media, efforts have been made to explore global and regional branding, with some success in the latter; but global branding seems to be a less worthwhile objective. PR programs have been well developed but, inevitably, some problems have arisen during SOMARC III in countries where social and religious constraints have hampered progress. The PR effort can be used in the future to obviate these.

Although there was to be an increased emphasis on long-term methods during the current contract, the development and implementation of an LTM strategy has been a little slower and less consistent than desired. Recorded couple years of protection (CYP) in terms of products sold increased dramatically in 1994 with considerable business being achieved in sales of intrauterine devices (IUDs). Unfortunately, both recorded LTM unit sales and CYPs could fall a little during 1995, but this is due to changes in reporting in Egypt and Indonesia, rather than actual declines. This is more to do with these countries being taken over by the private sector and sales data not being provided to SOMARC, rather than failure of the projects. However, in order to demonstrate continuing growth in SOMARC markets, more focused effort needs to be placed behind the launch of Depo-Provera. This is now being done, with launches imminent in eight countries.

In terms of marketing of services, there have been some notable successes and considerable experience has been gained during SOMARC III. Great care needs to be placed on ensuring quality of care in situations where SOMARC provides short-term TA for services marketing and also where it has a more direct implementational role. Training is being carried out, but monitoring of activities to ensure continued quality of care needs to become a regular part of SOMARC's tasks. In those cases where the introduction of SOMARC into the arena is because of local Mission buy-in to TA, it is felt important that criteria are established at the outset which ensure that the SOMARC effort is optimally utilized, and that the Implementing Agency (IA) is equally accountable for the funds being expended against this effort.

The budgeting process has been difficult during the early stages of SOMARC III. Due to delays in obtaining formal approval of "Q" contracts, some core monies were spent on consultants for work on Q contracts. In addition, formal approval for some "no-cost" amendments took considerable time. This situation is now improving but, nevertheless, it has resulted in some line items of the budget being at or above ceiling, despite the overall budget being on track. The

recently revised USAID budget procedure will significantly reduce the amounts received from buy-ins, which in turn will increase demands on LOE at the central level and will reduce the availability of future funds for management and TA. An amendment is therefore needed to raise the core LOE ceiling to accommodate these additional demands. A further change to be considered is that, in future, no-cost extensions may be more difficult to obtain. Such extensions have been an ongoing part of SOMARC III to date, and a mechanism needs to be worked out to cope with this eventuality.

The USAID required drive toward self-sufficiency is an important feature of the SOMARC III contract. This aspect is highly dependent on the nature of the country and the project. Of the 20 SOMARC III country programs measured, four are at 0 percent self-sufficiency, mainly due to only having just started. Nine are first or second generation models and are at less than 40 percent sustainability. The team believes that these country programs would suffer a reduction of services if USAID funding were to be reduced or withdrawn. Seven countries have a self-sufficiency greater than 41 percent and are generation three or four models. These programs could probably continue in operation even if USAID funding were to be reduced, although this action is not recommended at this time. It is thus of utmost importance that USAID and SOMARC continue to evaluate together the nature and aims of the programs, and revise the sustainability objectives on a case by case basis, especially since SOMARC is tasked with continuing to target Social Classes C&D population groups.

The team considers it important that a further SOMARC project be continued after 1997. CSM has much to offer USAID in its Population and Health and Nutrition activities, and various directional options can be taken. In considering these options, there is much to merit the development and refinement of products and services in existing countries, and the objective of moving in-country projects along the "generation" spectrum toward self-sufficiency. Equally, the team believes that SOMARC's skills lie especially in the careful development and promotion of LTMs, particularly involving Depo-Provera in countries where there already exists a product selling operation. At the same time, it seems sensible for Missions and others to utilize the wealth of knowledge and experience within SOMARC, but care must be taken not to allow this to detract from other more proactive programs. Finally, options arise for expansion into health and nutrition product category areas, other than FP, but again caution is advised. Overall, USAID/Washington and SOMARC need to agree on the priorities of any future SOMARC project.

The real question to be jointly examined for a future project is expansion, or efficient expansion, covering access to C&D groups. This is a key strategy and, unless determined, may result in the dilution of SOMARC's efforts. In any future project it may be more advisable to concentrate SOMARC's energies, rather than try to assist a large number of country projects that have a wide range of potential efficiencies and effectiveness.

SOMARC III has been given a wide range of objectives. The output achievement to date is highly commendable, and generally the deliverables are on track to being reached or exceeded within the contract period. Much has already been done, and it is believed the recommendations given will further improve the current SOMARC III project for the remainder of its life. The recommendations are proposed with the objective of assisting SOMARC's management in being

somewhat less task orientated and in better utilizing their undoubted skills in fulfilling USAID deliverables both in quantity and quality.

SUMMARY OF RECOMMENDATIONS

It is recommended that SOMARC III should continue and a further social marketing program be initiated to follow on after 1997. In this context, and in consultation with the implementing agency, USAID/W needs to reach an agreement as to what are the priorities for any future SOMARC project will be.

Current SOMARC III Budget

Central Level Funding and Expenditures

SOMARC's efforts to facilitate the USAID approval process for budgetary changes needed throughout the project are supported by the team. USAID/W should make every effort to complete the outstanding requests for approvals that are more than two months overdue.

As soon as possible USAID/W and SOMARC need to resolve how the budgetary and LOE gap created by the changes from buy-ins to operational year budgets (OYBs) can be reconciled. Both this and the potential effect of changes in Mission budget procedures should be jointly examined by SOMARC and USAID.

Country-level Budgets and Expenditures

Although the need for no-cost extensions to delivery orders does not appear to be any particular problem due to SOMARC's management, both the central level and participating buy-ins should try and expedite expenditure rates in order to better "protect" their budgeted LOE levels.

Sustainability and Cost Efficiency

Quantitative tables have been derived which can be used to define and monitor the self-sustainability of projects, and these should be maintained by SOMARC to work with IAs to reach established targets.

Technical Assistance

In cases where the technical abilities of the SOMARC team are called in, USAID/W should examine each case to determine that the funding provided is being cost-effectively used, and that there is the ability and an improved desire to implement the recommendations by the local USAID Mission.

SOMARC and the IA need to identify more explicitly what TA is needed to obtain agreed-upon targets and what will be the reciprocal responsibility of the IA once it has received the TA. In this manner both parties will become more jointly accountable.

SOMARC Management

Long-term Methods

For the remaining life of the contract, SOMARC should continue and increase its efforts to launch long-term methods in as many countries as possible which are designated as FP markets. Since no other social marketing organization has a focus on long-term methods, SOMARC should use its comparative advantage to expand the commercially available method mix.

In those countries where it has pill and condom experience, in the remaining years of the contract, SOMARC should focus its promotional efforts on Depo-Provera, thus taking advantage of the commercial systems already in place. Given the in-house experience gained thus far, DMPA is the long-term method which has the greatest potential for programmatic success for SOMARC.

Although developing experience in marketing sterilization, which is a service and not a product, SOMARC should consider making its voluntary surgical contraception (VSC) promotion a longer term priority. The promotion of VSC will still require significant institutional investment to achieve the necessary level of expertise.

SOMARC should utilize its working relationship with AVSC to foster stronger bonds with the medical community in countries where they work. Corps of influential physicians (and other providers) could be used more effectively to garner support for long-term methods and to avoid negative publicity. In the short term, it is recommended that AVSC field a team member in SOMARC/W offices instead of seeking approval for a full-time medical director. In the longer term, it is recommended that SOMARC develop a more "organic" relationship with a medical service delivery group, such as AVSC, to develop skills and experience jointly.

Quality of Care

Before promoting the services of any service delivery site or group of sites, SOMARC should have mechanisms in place to ensure that those services are of high quality. A pre-intervention assessment, as well as periodic monitoring, should continue to be done to ensure that SOMARC is expanding access to quality service.

Having made the above assessment, SOMARC should ensure that <u>sustainability</u> of quality is addressed in program design, implementation, and phase-out plans.

In studies designed to monitor quality of services, SOMARC should ensure that
a) discontinuers are included in study samples, and b) quality of care monitoring is not superseded by measuring marketing effort.

Training

Present activities should be continued, as the needed training mechanisms appear to be in place. Management linkages can be strengthened through more cross fertilization of expertise and experience across countries. More international sharing of country and regional staff strengths should be accomplished through cross-country visits.

Media

Global branding of products is probably not achievable on a major scale although opportunities to make use of existing brand names across countries should not be ignored if practical. Progress toward more regional campaigns, whether generic or brand specific, should be continued, and umbrella logo promotions should be emphasized using the mass media.

Where possible, SOMARC should strengthen PR on social or religious constraints issues in all countries where it starts a project and also in countries where may be potential problems.

Research

SOMARC should continue to explore efficiencies in research through simplifying data topics in baselines. At the same time they should consider expanding baseline data across all economic groups, especially in those more mature markets where manufacturers may fear loss of sales to the Social Classes A&B market.

SOMARC should explore more opportunities for cooperative research with other agencies and also ensure that formative research covers all potential relevant opinion leaders.

Strategic Marketing Planning

It is recommended that during the remainder of SOMARC III, promotional expenditures at the country level should be redirected to address the STD/AIDS market for condoms and to promote the sale of oral contraceptives (OCs), injectables, and other LTMs.

Marketing Models

SOMARC should continue to determine the most suitable model for each country's environment. Movement toward newer generation models should be encouraged to improve cost effectiveness and the prospects for self-sustainability. It will not always be possible, but where donated

products are currently supplied, it should be ensured that a clear strategic plan exists to move toward commercial market supply in a committed time frame.

Sourcing

SOMARC should continue to work toward developing sound contacts with commercial suppliers, and this function should be vested in its head office staff.

While there is little place for a centralized buying function within SOMARC, it could provide a better link between the commercial companies and their distributors, agreeing on general base prices and possibly consolidating provision of stock to SOMARC programs to obtain an improved cost-effective supply.

MIS and Monitoring

Development of simplified spread sheets to support reports compiled by SOMARC/W should be encouraged and these should be made in a compatible format and made available to the field.

SOMARC should investigate the available data sources by country and commence to regularly collect these data in order to better influence both commercial and marketing decision making.

Collaboration with HIV/AIDS-prevention Programs

To ensure that condom promotion funds are used most effectively, it is recommended that the Office of Population and the Office of Health and Nutrition, together with SOMARC, collaboratively develop a long-term condom promotion strategy. The strategy should try to ensure that the approaches meet multiple needs of consumers by paying heed to both AIDS/STD and pregnancy prevention.

In its involvement with purely AIDS prevention, SOMARC should maintain its focus on condom promotion as its primary contribution. SOMARC should continue to aim for some level of cost recovery, although due to the urgent need for expanded condom access and the high level of donor interest in AIDS, cost-recovery standards should be less exacting for condom sales than for other contraceptives.

1. BACKGROUND AND HISTORY

Social marketing programs initially began as technical assistance (TA) operations and this developed such that, in the 1980s, one of these was formalized into a USAID contracted program—Social Marketing for Change (SOMARC I). The definition of a contraceptive social marketing (CSM) program was then accepted as "the use of conventional marketing techniques, as are used in the field of normal consumer products, for the sales, distribution, promotion, and advertising of products such as contraceptives and health care products, in the social arena, aimed at producing behavioral change in the habits of consumers."

SOMARC I commenced in 1983 and, although it had limited objectives at the time, the managing company, The Futures Group International, was seen as innovative and ambitious. The objectives of SOMARC I were to develop and implement new CSM programs and, in addition to providing TA to existing CSM programs, were aimed at designing and implementing studies which addressed cross-country and evaluative issues. This also provided an information resource. Already SOMARC was beginning to form as an authority on the application of sound marketing techniques in the pursuance of social change goals, incorporating academic and commercial principles. The first SOMARC project contract under USAID lasted five years and funding of US$20 million allowed the operation to implement 13 programs and to provide TA to 10 existing CSM programs. In line with emerging USAID objectives, SOMARC I developed initial cost recovery and sustainability strategies, as well as commencing to pursue alternative means of obtaining commodities for CSM programs. One of the initial, main cost-recovery mechanisms was Return to Fund (RTF). In RTF the pricing structure was organized to build in a margin which would be retained by the country program, with the eventual aim of providing a self-sufficient resource for marketing and product purchase in the longer term.

By 1988, the SOMARC I project had gained further support and was re-awarded for a further five years under a US$33 million funding from USAID. Under SOMARC II the objectives changed slightly and, with SOMARC's growing reputation, it was asked to develop training modules in the areas of strategic marketing, financial management, market research, marketing communications and contraceptive technology training. In addition, the program had to launch 8-10 new CSM projects and continue to supply TA to ongoing SOMARC I activities. The climate changed during the life of SOMARC II because alternative sourcing, cost recovery, and increased donor participation were becoming increasingly important to USAID. There was also pressure from USAID to develop innovative types of promotion and advertising and work toward improving indigenous marketing and advertising skills.

Eleven new programs were started during SOMARC II, under USAID direction, the focus was concentrated on the Africa region and increasing emphasis was placed on the emerging problems with AIDS. Continued assistance was provided to 14 other programs although private sector resourcing had limited success and, despite strenuous efforts, obtaining increased donor involvement was not very successful. Also at this time, the self-sufficiency strategy (RTF), which evolved during SOMARC I, was modified as it became apparent that it was untenable in some country programs.

SOMARC III was awarded in 1993 at a value of nearly US$40 million with the additional obligation of encouraging local Mission buy-ins to take further advantage of SOMARC's operational expertise. The major thrust in SOMARC III is to develop the marketing of long-term methods (LTM's), transfer existing programs to commercial supply of commodities, and further involve private sector initiatives as pressure on USAID funding grows. In addition to the specific objectives named in the awarded contract, there is a continuing reliance by USAID on the SOMARC project to help develop marketing skills in local programs, further utilizing the experience already present in the organization. SOMARC III has now been running for three years.

With SOMARC projects now having been operating for over 13 years, many programmatic developments have been noted. Four models or "generations" of CSM projects have evolved over The Futures Group/SOMARC experience. Essentially these models express four different levels of employment of the commercial sector to manage and promote CSM products.

1. First generation model projects are implemented where no commercial sector manufacturing or distribution channels are available and use donated product and develop their own distribution systems.

2. Second generation models utilize existing commercial distribution systems but use donated product.

3. Third generation models employ both the commercial manufacturers and distribution systems but resident CSM project management is required to support the marketing effort.

4. Fourth generation models supply advertising and promotion support to the commercial sector and no CSM management presence is required.

All models can be maintained by contributed financial resources from aid funds to reduce costs and thus provide products to low-income consumers at affordable prices. The more mature generations of models are the more likely to be able to recover costs and, as market penetration expands, become self-sustaining through total cost recovery.

The term generation indicates that projects mature from one model to the other. However, as this maturity depends entirely on the availability and effectiveness of the commercial sector in each program country, the key to maturity is the development of the commercial sector. This does not happen as a matter of course, nor is it prerequisite on the SOMARC III project that all markets should mature through the generations.

The current midterm evaluation seeks to examine the success or otherwise of SOMARC III in fulfilling these goals, and to provide pointers, where relevant, where improvement can be made to achieve USAID overall objectives.

2. METHODOLOGY

Following planning meetings and briefings in Washington, D.C., with a SOMARC team, subcontractors, commodity suppliers, and a USAID Cognizant Technical Officer (CTO) and country officers, the five person evaluation team split up for field visits. Two members of the team visited Brazil and Mexico, one member went to Uganda, and a fourth team member visited Philippines. All trips were of about seven-eight days duration and included meetings with the in-country SOMARC staff and distributors, government departments, CSM partners, and other interested Cooperating Agencies (CA). The fifth team member remained in Washington and conducted telephone interviews with USAID Missions and project distributors in various SOMARC countries. In addition, the team examined training, research, and other documents in detail and conducted interviews with the SOMARC subcontractors.

Many detailed questions were raised during the course of the evaluation and further meetings and interviews were held with SOMARC, USAID, and subcontractor personnel.

The various topics in the Scope of Work (SOW) were divided among the team members according to individual areas of expertise and, following draft documentation, presentations were made to SOMARC's management and interested USAID parties.

Subsequent meetings were held with USAID personnel to clarify the team's observations on possible future directions in which the project might develop.

3. PURPOSE AND OBJECTIVES

3.1 SOMARC III

The overall purpose of SOMARC III is to "increase the availability of contraceptives among low- and middle-income groups using commercial techniques, and to establish realistic cost-recovery schemes and targets in all sales programs."

In order to achieve this purpose, several objectives were developed which can be found in the Scope of Work (Annex A). In summary, the objectives aim at increasing modern contraceptive method prevalence rates especially by promoting long-term methods, and ensuring correct effective use of contraceptives. On the cost side, the objective is to ensure operational efficiency to minimize costs and maximize sales and still maintain financial access by C&D consumers in the poorer countries. At the same time, there is increased pressure to seek out alternative sources of commodities, and further involve the private sector in providing commodities and support for distribution and promotion costs. Finally, there is the continuing obligation to develop innovative promotion and advertising techniques and to institutionalize the information, education, and communication (IEC), strategic marketing, and financial skills in the host countries.

In essence, there is pressure on the SOMARC III project from USAID to contain costs, improve the input from other organizations while still continuing, improving, and expanding CSM programs. This is a wide range of USAID objectives, and demands a high level of developed expertise and resource in the SOMARC team.

The detailed objectives at the outset of SOMARC III were to continue programs in 15 countries, expand programs in eight countries and initiate programs in six countries, concentrating on the Office of Population's BIG Country strategy. Although increasing contraceptive prevalence was a key USAID objective, this was never quantified. Assistance was to be concluded in at least five countries. SOMARC was required to provide TA in 10 countries, conduct at least 25 in-country training seminars along with four regional workshops. There were to be up to five market research special studies and information dissemination was to be strengthened as was MIS. The innovative strategies included marketing of LTMs and services, regional and global branding of products, social marketing of additional products, privatizing distribution, and pursuing financial and business development.

3.2 Evaluation

The purpose of the present evaluation is to assess SOMARC III's performance in the following areas:

- The extent to which SOMARC has accomplished the project design objectives;
- How the organization and management of the project has influenced its accomplishments;

- Whether the strategies and activities of the design are the best ones to accomplish the project purpose;

- Whether the special issues built into the project have been appropriate and beneficial.

In addition, the evaluation was expected to identify what activities should receive USAID support after the end of SOMARC III and under what mechanism. Following discussions with the team regarding the latter point, the SOW was amended by the CTO. It was considered inappropriate that the team should consider the "mechanism" by which any future activity should be funded.

FINDINGS

4. OUTPUTS

SOMARC III's contracted outputs over the five-year life of the project are to continue programs in up to 15 countries, expand programs in up to eight countries, initiate new programs in up to six countries, conclude assistance in at least five countries, and provide short-term TA in no more than 10 countries. At least 25 percent of these programs have to cover LTMs.

At the midterm stage of SOMARC III, these objectives have mostly been achieved or exceeded. There are currently continuing programs in three countries, plus a further 11 countries where programs have been expanded, as well as continuing earlier CSM work. New programs have been initiated in nine countries and six countries have been graduated. In five countries, programs have been phased out under USAID direction. Short-term TA has been provided in six countries and LTMs are being promoted in 12 of 22 continuing, expanding, or new programs.

Training is an important aspect of SOMARC III and one of the four required regional workshops has taken place with another one planned for 1995 and the two remaining ones during 1996. Six out of the required 25 in-country training seminars have taken place, plus 13 training of trainers (TOT) workshops, followed by 483 local trainings as a result of the TOT workshops.

SOMARC III is required to conduct up to five market research and multi-country special studies. As at the time of the evaluation, four of these have been designed and are waiting to go into the field.

The MIS system has been strengthened by adding computers to programs in seven countries. In the area of information dissemination and public relations (PR) there has been much activity. Information on CSM's successes, lessons learned, and new techniques has been disseminated to a mailing list of 829 addresses. Over 70 presentations have been made and a library is maintained with nearly 7,600 titles. Public relations strategies have been developed and implemented in seven countries and media training has been conducted in those seven countries, with more to follow.

Innovative efforts have been implemented in advertising, with regional communication campaigns, umbrella logo campaigns, marketing of LTMs and services, privatizing distribution and business development, and financing, amongst others.

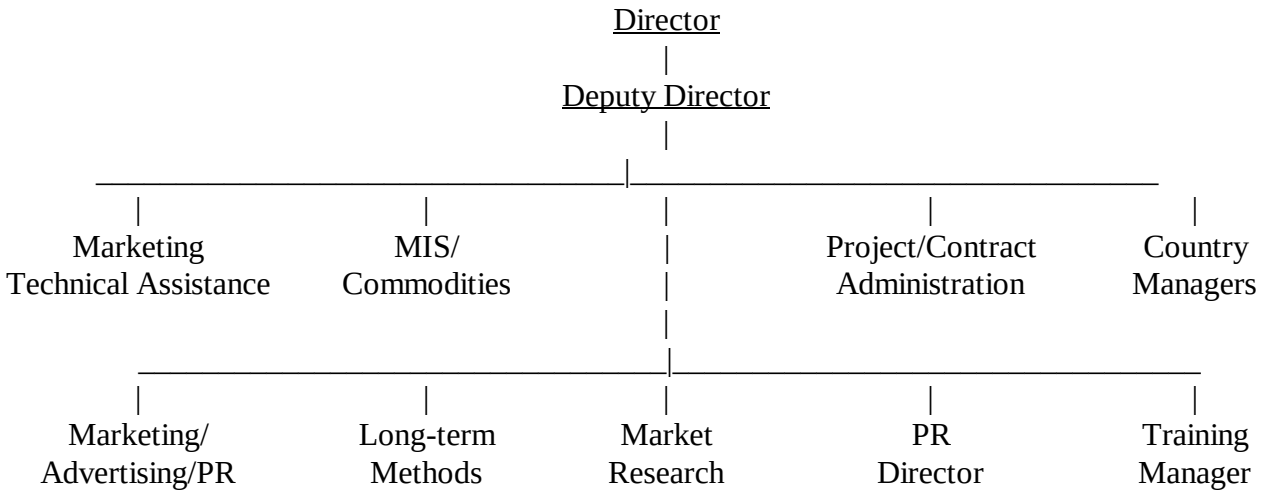
To date, SOMARC III has generally achieved, and in many cases exceeded, its quantitative outputs. The major reason for exceeding the contracted outputs has been a greater demand for CSM activities under SOMARC III than originally anticipated, mainly funded through Mission buy-ins. While outputs have exceeded requirements, the open-ended nature of the "Q" contracts has placed enormous strain on budget and staffing.

5. SOMARC

5.1 Management

The SOMARC/W management is highly professional at all levels, and the goals and objectives of SOMARC appear well-communicated throughout the organization. There is a strong focus on meeting objectives which are set out in each of their contracts, and this is reinforced by making selected elements of these objectives a crucial part of SOMARC's internal team evaluations. As an example of this, each of the country managers' market plan objectives are translated into specific elements of their yearly evaluation.

The organization chart for the staff at SOMARC/W is shown below:



This chart suggests a relatively "flat" organizational structure with heavy demands on the director and deputy director, although responsibilities are shared between them. While the director and deputy director in SOMARC/W have a strong background in social marketing of contraceptives and both have broad field experience, this structure focuses a high demand on them at the executive level.

The implementation effort of their staff appears high in view of the multiple demands on SOMARC's time. However, it seems that the initial assessment of resources against the multiple demands that resulted as the project progressed was not entirely well conceived. For example, there are over 25 countries currently managed by a resident advisor or country manager, and some require technical assistance, thus increasing the amount of required management input. Another instance is in Uganda, where an antibiotic program is being added to the current social marketing (SM) program without apparent a thorough assessment being made of the impact of this on SOMARC's current programs.

Measurement of management efficiency can take a number of forms. The evaluation team focused on three areas: management of the process to product launch, management of SOMARC's relationship to the private sector, and management of the subcontractors.

5.1.1 Timing

The time from inception of a country project to product launch is a much debated issue. It is often assumed and not unreasonably, that as an organization such as SOMARC gains experience with a product or service launch, then the next time a similar product situation arises the period of development will shorten. It is also the case that an organization's methodology and approach can lead to differing periods of time taken to get to a launch state. There are nearly always differing constraints in different countries, including social, cultural, and political, as well as commercial constraints. It is therefore extremely difficult to determine precisely what effect SOMARC's management efficiency has on a project in terms of timing.

In the three steps to product launch (assessment of the environment in order to identify potential blocks or delays to implementation, planning the launch, and implementing logistics/tactics) the only area that SOMARC needs to pay more attention to is in the early "assessment of the environment" module.

SOMARC clearly understands the need for planning and the logistics/tactics process to launch condoms and OCs. Selection of distributors, advertising agencies, conduct of market research and all the other elements which support a launch appear appropriately routine to SOMARC. Nevertheless, political issues continue to be a major obstacle to shortening the time to launch in countries where SOMARC starts new work. For example, despite clear initial market research in Senegal, a government official suggested designs for the condom package. To overcome this objection, additional research was required, thus extending the launch time period. Once the design issue was resolved, it took SOMARC five months to introduce Protec condom.

The introduction of OCs is a more complex process than the introduction of condoms, because the same political issues tend to be present, along with those from additional "stakeholders" from local pharmaceutical distributors. Additionally, training activities involving the medical community and pharmacists must be implemented. There is some evidence that time to launch has been decreased for OCs, though the available data are selective and incomplete. In 1989-1990 during SOMARC II, it took 11 months to launch Minigynon in Haiti and nine months in Ghana. In 1993 during SOMARC III, it only took five months to introduce the same product in Bolivia and four months to introduce Pilplan in Haiti in 1995.

The time it takes to introduce Depo-Provera has clearly decreased over time: from 13 months in the Philippines in 1993 to eight months in Haiti in 1995. This product represents a new level of complexity relative to OCs. Not only does Depo-Provera require all the support elements for OCs, but overcoming the regulatory and medical issues as well as conducting the training program is a lengthy procedure. It appears that SOMARC has been able to move the product into the commercial market but, based on sales results to date, other elements to support a successful launch need more consideration.

Thus, it appears that the management learning process is becoming effective, with time to launch products decreasing as experience grows. The SOMARC "process" is very thorough and, in absolute terms, the time to launch products may seem lengthy. This is perhaps in comparison with other CSM programs where "seed activity" has already taken place prior to program approval. However, for the purpose of SOMARC III, the management process and effort do assist in getting effective projects to launch in an appropriate time period, notwithstanding that some attention needs to be directed at country-specific constraints.

5.1.2 Private Sector Relationships

In view of SOMARC's contractual obligation to promote stronger reliance on private sector sourcing, the development of relationships with the private sector is key. As USAID relinquishes buying contact with suppliers for CSM purposes, SOMARC's management of its relationship to the private sector can best be characterized as maintenance of "soft contact." In the course of the evaluation, three private sector companies (Wyeth, Finishing Enterprises, and Upjohn) were contacted concerning their relationship to SOMARC. Some good and some less favorable accounts emerged.

Each company expressed some concern over the potential for market erosion of their products where SOMARC is operating, and one company said they would have liked to have seen SOMARC's business plans. Despite these concerns, none offered any examples where market erosion had actually taken place, although such a case could likely have been clarified using Intercontinental Medical Statistics (IMS) data before and after market entry of a SOMARC project. SOMARC on the other hand has shown that commercial markets have expanded wherever they have entered the market place. Indeed, one company indicated that SOMARC contacts had been useful in aiding their attempts to enter into the Egyptian intrauterine device (IUD) market.

While it is difficult to credit SOMARC entirely with this positive effect, it should be noted that there has been no documented negative effect. Of some concern is the fact that none of the companies contacted indicated any way in which <u>they</u> could be of assistance to SOMARC.

There appears to be little, if any, formal relationship between SOMARC and these private sector companies, and little contact other than informal phone calls have been made. However, this may be changing as, with an eye to the future, SOMARC has met with the Upjohn group in Kalamazoo, Michigan, and outlined their worldwide approach to the marketing of Depo-Provera.

Recommendation

1. **SOMARC should continue to make "soft contact" with this element of the private sector. This group does not appear to have any strong motivation to assist SOMARC in their efforts, but this should not deter efforts for greater cooperation.**

5.1.3 Subcontractors

The management of subcontractors has been good with one major exception—the AVSC subcontract. SOMARC clearly understands the roles that the public relations group, T. Baugh, and marketing organizations, Porter/Novelli, perform. These firms have been used whenever there is a specific need. SOMARC has less knowledge of medical training, and the training subcontract with Development Associates has developed into one which appears well managed. Development Associates maintains a staff person at SOMARC/W headquarters, and this has the advantage of ensuring that training needs are in line with SOMARC's critical path for TA and product launch.

The AVSC subcontract has been a slightly weaker point in an otherwise strong subcontractor management performance. AVSC seemed to anticipate a substantial amount of collaboration on the ground. However, in many cases, AVSC and SOMARC are not working in the same countries and potentially fruitful in-country collaboration has not been possible. There have been a number of activities utilizing the AVSC staff, but to date only one written detailed action plan between SOMARC and AVSC has been completed. Equally, AVSC has not appeared to be particularly aggressive in pursuing joint projects.

The reasons for this lack of performance are essentially conjectural, but lack of an in-house presence, in the manner of Development Associates, has meant that AVSC has not been able to determine how they can get on the critical path of SOMARC projects in the same effective way. In the early years of the project, there was an apparent lack of understanding on SOMARC's part on how to best utilize a medical service team, and, similarly, on AVSC's part, on how to enter into the world of medical sales and marketing. These reasons have been contributory factors to the lack of potential achievement of demonstrable results in the project. A recent example is in SOMARC's approach to being forced by the supplier to change over OC brands, and the potential impact of this on users. There has been little interaction with AVSC on the potential medical effects of switching from one brand to another, and SOMARC's field personnel are still unsure of this impact.

SOMARC recognizes that along the line in the figure below, there are increasing medical needs in order to market/sell the corresponding products and services.

Condoms	Orals	Depo-Provera	IUDs	NORPLANT	Sterilization

As one moves to the right of the line, more medical input and support is required to optimize the marketing/sales effort. Despite SOMARC's efforts, the current operation is not well staffed to meet these increasing medical/support demands. SOMARC has requested support for a full-time medical director, and this highlights their current understanding that they need more medical input to their marketing/sales initiatives. On the other hand, waiting for approval to hire a medical

director only postpones the need for SOMARC to develop a strong relationship with a medical service delivery group.

Recommendations

2. **In the short term, it is recommended that AVSC field a team member in SOMARC/W offices instead of seeking approval for a full-time medical director.**

3. **In the longer term, it is recommended that SOMARC develop a more "organic" relationship with a medical service delivery group, such as AVSC, with the objective of developing joint skills and experience.**

5.2 Regional

Regional offices have now been opened in Rabat for West Africa; Nairobi for East/Southern Africa; Jakarta to cover the Far East and Asia; and Mexico for the LAC region. In staffing terms, the experience of the regional managers is less broad than that of SOMARC/W staff. The tendency has been to recruit personnel with a business background, and each regional office has at least one person with these skills. But, for example, the regional manager for East/Southern Africa has no previous experience in SM or FP. The field management structure of SOMARC III is as shown below:

```
                                   SOMARC/W
                                      |
     ------------------------------------------------------------------------------------
     |                  |                  |                  |                  |
Asia Regional     East/Southern             |            Mideast/West        Americas
                  Africa Regional           |            Africa Regional     Regional
                                            |
                          Central Asian Republics (buy-in)
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There are two exceptions to the overall reporting structure. The first is the Uganda program which reports to the East Africa regional office on paper, but in reality the links between the Uganda program and SOMARC/W are best described as direct. The second is in the Central Asian Republics (CAR) where the contract is based on local support and a resident advisor who reports directly to SOMARC/W.

The regional organization structure appears to have been successful in providing some efficiencies in management of regional programs. The regional offices implement and/or provide TA to projects in their regions or others as requested. Given that the Morocco office has a research manager, the African offices can and do coordinate on research projects. Where there are resident advisors, it appears that the regional offices provide TA where requested and general oversight to ensure that time commitments in the project are met.

Regional managers meet at least once a year in a formal context, but it appears likely that these meetings focus on SOMARC work and leave little opportunity for either formal or informal exchange of detailed experiences. In any event, the annual meeting may not be the most useful setting for peer group information exchange and training, and there is probably scope for better use of "other country" experience being conveyed to CAs and distributors. Nevertheless, some cross-pollinization is already taking place among the regions and, where it is occurring, it seems to be effective (e.g., Morocco TA is being used in the East Africa region). Additional work across the regions can strengthen not only the regional offices but also the country programs in which SOMARC is working.

There is a also a wealth of experience within the SOMARC country programs at operational levels. This comprises not only SOMARC country and regional staff but also counterparts in the IAs. They have much to offer and, given the variety and breadth of different SOMARC programs, exchange of experiences at peer group level can only be beneficial.

Recommendations

4. SOMARC should utilize regional program workers to assist in other countries, thus providing TA by regional/country personnel who have experienced similar problems.

5. The regional meetings should be structured to allow "experience and cross learning" time for the regional staff in the host country on a rotated basis.

5.3 Institutionalization

The biggest contribution of SOMARC in countries in which they have worked is in the introduction of social marketing concepts and the training of the local commercial sector. Historically, prior to SOMARC projects being introduced, many countries tended to concentrate on serving the more profitable A&B markets. SOMARC has been successful in influencing existing commercial structures to focus some resources to serve the C&D clients' markets. An example of this is the now graduated Turkey project. Working with a Turkish distributor who had previously avoided condom distribution, SOMARC played a significant role in persuading the commercial interests to enter into the sales and marketing of condoms. This program began in SOMARC II and graduated at the start of SOMARC III. Similarly, in developing the marketing of family planning services, social marketing ideas and methods are being adopted by the collaborating IAs.

6. MARKETING ACTIVITIES

6.1 Marketing Strategies

6.1.1 Marketing Models

The system of "generation models" has been described earlier and the term "generation" implies that projects can mature from one model to another. It is not a prerequisite of the SOMARC program that it matures projects as a matter of course. At the outset of a new program, it is important that USAID recognize, define, and agree on the type of country program and in which generation that program falls. It is also important to note whether there can be a reasonable expectation and in what time frame that project can mature from one generation to the next, if at all possible. It is reasonable that the more mature the model the more cost effective are the inputs, which is, of course, a prime USAID objective. Whereas the search for program efficiency may better be met by SOMARC concentrating on a core set of maturer markets, the objective of maximizing cost effectiveness may be mitigated by USAID country requests to undertake projects which require early generation models. At this time, in 19 primary program countries, SOMARC is operating one generation I program; seven generation II programs; eight generation III programs and three generation IV programs, thus demonstrating a fairly balanced spread of business.

This issue of generational progression by SOMARC is an important consideration where the program positions itself as a model for self-sustainability, especially when directing it's marketing effort at the C&D group market. In theory, this group has the income to purchase products or services at a price which, providing the market is sufficiently expanded, could enable the program to become self-sustaining eventually. If sustainability is the prime objective, then this model can compare favorably with other CSM programs which provide heavily subsidized products to lower income groups.

However, the sustainability objective should not outweigh other considerations. In opening up new markets, it is always better to select the most suitable model for the project purpose and for each country's environment. It behoves USAID to assist in this process by accepting that some projects will be, at best, only cost recoverable for the foreseeable future, and the demand for sustainability should not necessarily outweigh other objectives.

SOMARC has matured projects from the second to the third generation through replacement of donated products by commercial products in Morocco, Barbados, Mexico, Peru, and Zimbabwe. Maturing markets, however, is a slow process. SOMARC reports that out of their total condom sales in 1992 63 percent were of donated products. The donated products level had only decreased to 56 percent in 1994, thus implying little real transition from one generation to the next during SOMARC III. This is partly due to the nature of the projects that have started during SOMARC III. It is also due to SOMARC continuing to add contraceptive sales their data even when it has matured/graduated a program. With earlier programs often being based on condoms, this inflates the apparent proportion of condoms in SOMARC III's total business.

There is no indication in this evaluation that the choice of generation model employed by SOMARC influences the success or failure of a country program. The level of marketing inputs across all models have been adopted and, where failures have occurred, they have occurred across all models. The determining factors, for programs not performing well include the effectiveness of local implementing agencies which may not always have been of SOMARC'S choosing; government regulatory or approval constraints; inefficiencies or a lack of commitment from manufacturers or distributors. All the same, whereas the broad strategic objectives are clear—for example, that the project will maximize sales to C&D groups in order to move toward a self-sustaining model—the movement toward more easily sustained and more cost-effective models is slow.

Recommendations

6. USAID should work with SOMARC to determine and continue emphasis on the most suitable model for each country's environment and program.

7. Where appropriate, SOMARC's objectives and activities should be to assist programs to move toward newer generation models so as to improve cost effectiveness and the prospects for self-sustainability.

8. Where donated products are required, and if clearly possible from the outset, SOMARC should ensure that a strategic plan exists to move toward commercial market supply in a committed time frame.

6.1.2. Strategic Marketing Planning

As indicated above, there are various points of entry for projects along the generation spectrum and several ways in which the project can evolve over time. In the case of FP, the product development cycle in many countries has tended to begin with condoms and move through the introduction of hormonal contraceptives (orals and injectables) and on to other LTMs. Each step in the product development cycle leads to more complex marketing and behavioral change issues, and toward the promotion of ethical products and into issues of service delivery and quality. This process is well understood at SOMARC and has developed well in many countries.

There are other countries where CSM programs have commenced further along the development spectrum. As opportunities arise for commencement of projects in this way they should continue to be taken where appropriate. Of course, in the case of HIV/AIDS CSM programs, the marketing of condoms is prerequisite. In addition to the work on HIV/AIDS, this contributes to the FP effort since many consumers, especially women, know that condom usage has FP benefits also. However, if the focus is on HIV/AIDS, it does not necessarily follow that the above FP generational cycle will necessarily be followed. This has a major impact on the way SOMARC is seen to be following its generational model brief.

The constraints and strategic planning issues for LTMs are covered in chapter 8. With SOMARC III's mandate to develop LTMs and increase CYPs, and run an AIDS program at the same time,

country and regional managers have to decide on promotional budget allocations between product lines. There is a case for a stronger strategic marketing plan to reduce absolute growth in condom marketing expenditures and allocate more money to promote the FP market for hormonals and LTMs. This could be achieved by a more accurate targeted approach to promoting condoms to those groups most at risk from STD/AIDS. Of course, this approach will depend on the realities of each market.

The results obtained during SOMARC III to some extent camouflage the drive toward LTMs in the overall sales data. Projected sales in 1995 show a growth in condom sales of over 50 percent while OC sales are expected to grow only to about 7 percent and injectables and other LTMs to about 2 percent. This is partly due to the phasing of projects but is heavily influenced by large percentage growth for condoms in some West African countries and, to a greater extent, the launch of condoms in India.

SOMARC understands well how to target products to the C&D groups (see section 10.4). Regional and country managers endeavor to accomplish this objective through distribution outlet selection where this can be achieved; through brand positioning and media planning, as well as pricing decisions. In the poorer African countries where A&B groups are in very small numbers, such positioning efforts are largely irrelevant.

There are countries where Population Services International (PSI) markets brands at heavily discounted/subsidized prices at the same time that SOMARC is trying to pursue its C&D targeting strategy. It is reasonable to assume that while PSI's efforts draw some sales from potential SOMARC C&D group markets, SOMARC's brand advertising has opened up markets for PSI brands. In countries where this competitive situation exists, SOMARC has made efforts to address it. For example, in the Philippines, SOMARC has made efforts to reposition its condom brand. This has been done in order to clearly differentiate SOMARC's brand from PSI's lower cost brand. In theory, both projects should be targeting C&D consumers. However, the shift of the SOMARC product to a more up-market positioning does risk attracting business from the A&B consumers, which should be recognized by USAID. There is also some anecdotal information which indicates that condom distributors, particularly PSI, are more interested in increasing total sales per se and, therefore, are not effectively targeting distribution to C&D outlets. Finally, there may also be some synergy from other programs where there are active local government, private voluntary organization, and nongovernmental organization (NGO) activities.

SOMARC's marketing strategies for LTMs are based on the need to ensure quality care networks that can be promoted as reliable service delivery points. Mostly, these strategies have been found to be quite effectively developed. In Turkey, SOMARC's Business Development & Financing plan has been employed to give loans to the development of service delivery outlets. SOMARC understands that it is necessary to train pharmacy staff to give basic advice on pills and injectables and it has undertaken training in many countries. However, the success rate of such programs has generally been limited, as has the evaluation of such effort (see chapter 9).

Innovative use of non-traditional forms of distribution have been launched in a number of countries. For example, the Uganda Market Day Midwives Program, which operates in collaboration with the Uganda Private Midwives Association, places trained midwives in

community markets who sell products received at wholesale prices. This innovative activity has had some success and since 1993 a pilot in 50 markets has sold over 43,000 cycles of Pilplan through this system.

In Kazakhstan, SOMARC is contributing to the development of the newly emerging privatized distribution systems by providing support to training of sales teams in detailing and sales skills. This activity might well be expanded through linkages to other USAID programs to support the development of the private sector in ex-communist countries.

In Zimbabwe, SOMARC is setting up a system of loan mechanisms to assist local distributors to expand sales to rural areas with loan guarantees supplied from Johnson & Johnson. It must be assumed, however, that this activity is outside the scope of the overall objective to target SOMARC products at the C&D market.

The marketing of non-contraceptive products is about to be launched in Uganda through the marketing of antibiotics to treat STDs. The product line is entirely compatible with SOMARC's existing distribution system. Directionally, this seems a very positive move, especially since anecdotal research indicates that providing solutions to STD problems directly impacts on AIDS-prevention issues.

Recommendations

9. For the remainder of SOMARC III, consideration should be given to redirecting promotional expenditures at country level. This could be done through more selective targeting in the STD/AIDS market for condoms and a concentrated spend on orals, injectables, and other LTMs.

10. In the CAR states, consideration could be given toward expanding support to private distribution systems through linkages with other USAID programs.

11. Efforts toward developing rural distribution systems in Africa should be continued, but only if the reach to C&D sustainable markets is achievable.

12. The Ugandan activity in linking STD antibiotic sales to the social marketing mix should be formally researched in order to determine possible linkages between this program and AIDS-prevention issues.

6.1.3 Marketing Management Training

SOMARC's contract specifies that the project will train managers and staff in all aspects of marketing and marketing management. Training is a particularly relevant function due to the contractual cap placed on salaries of SOMARC's management and staff. This limits the recruitment of experienced brand managers from the commercial sector, since such personnel are generally well paid and may not be attracted to a career in social marketing. It is interesting to

note that, out of eight SOMARC regional and deputy managers, only one comes from a social marketing background and one from the commercial sector with brand management experience. Despite these limitations, SOMARC has mostly developed a strong team of regional and country managers. However, during the early stages of SOMARC III, the need to train and orient relatively inexperienced SOMARC country staff and newly recruited head office staff led to delays in program implementation. The establishment of regional offices has been a significant factor in allowing a closer level of support structure to country managers and advisors than could have been supplied from SOMARC/W.

One regional workshop has been held—in Latin America on financial management—and more regional workshops are planned in Rabat (1995) and Nairobi (1996) and will include strategic marketing management. A fifth workshop is required under SOMARC's contract but is not yet planned. Five in-country training workshops are held each year and, although designed primarily for service provider training of trainers, they also improve the skill levels of regional and country managers (see section 6.3).

SOMARC has produced a number of training modules to improve in-house management skills and to enhance the capabilities of the advertising agencies, research firm, and implementing institutions that the SOMARC project works with. Training modules include Integrated Marketing Communications, Financial Management, and Family Planning Services Marketing. Technical Assistance also plays a key role in a training context by working with in-country associates to improve the quality of their work and inputs in a more informal, on-the-job manner. This seems to have been particularly effective in the area of PR and media materials development and in the training of LTM and oral provider systems.

The most important element of training SOMARC managers has clearly been on-the-job, as the opportunity for formal training workshops have been limited. As part of the on-going marketing process, creative think-tank solutions on a local basis will continue to be important, as will be the exchange of experiences and information. The development of regional offices has certainly contributed to this, as does the regular e-mail contact between countries, regional offices, and Washington. This aspect of the project deserves continued attention.

Recommendations

13. Current training activities should be continued as the needed training mechanisms appear to be in place. SOMARC should consider how best to manage practical experience information flow across their regions.

6.2 IEC

6.2.1 Media

A significant contribution to increasing demand for products and services in a CSM program is the promotional and mass media support put behind the contraceptives. In broad terms during SOMARC III, such support has involved moving of condom "positioning" from that of a family

planning product to both an STD/AIDS-prevention and family planning product. However, in some countries the positioning rightly continues to be concentrated solely on STD/AIDS prevention. A significant contribution has been made by using mass media for the promotion of ethical hormonal products and also the development of LTMs through the promotion of service delivery outlets.

A general review of available media and promotional materials demonstrates a relatively high level of capacity and competence in the formulation of creative and media strategies and in the utilization of in-country creative and media resources where adequately available. In general, both media planning and brand positioning strategies are designed to aim products at the C&D market where this can practically be accomplished.

In some countries where the mass media promotion of family planning products is either banned or restricted, SOMARC has achieved success in either gaining approval for the use of mass media or has found ways to get around restrictions. For example, creative treatment of the condom TV spot in Turkey effectively gets round the ban on mentioning the word "condom"; and the generic overbranding of hormonals in the Philippines avoids brand specific advertising.

A number of innovations in the IEC effort have been achieved, and regional branding and advertising campaigns have been developed (see Chapter 11.2)

Umbrella logo campaigns are an innovative approach to "packaging" products under one banner. This has been successfully developed in the Blue Circle campaign in Indonesia, in identifying multi-product sales or service outlets, and circumventing restrictions on the promotion of ethical products. In the latter case, the Red Apple campaign in Kazakhstan includes seven products and the Couples Choice campaign in the Philippines combines three orals and an injectable. Building on these successes, it is suggested that this form of overbranding could be developed in many more countries.

6.2.2 Public Relations

SOMARC III contains a significant PR component. This is designed to support the communications process in country programs and to disseminate program information to associates, clients, and CAs among others. A newsletter called "Highlights" is produced nine times a year, a wide range of Occasional Papers have been produced, and a series of practical guides covering public relations and advertising, research, training and social marketing guides is under production.

Specific PR campaigns have been developed with country partners in the Philippines, Jordan, Jamaica, Turkey, Nepal, Senegal, and CARs with considerable success.

In the Philippines, SOMARC has also launched an innovative initiative in establishing an Association of Condom Endorsers (ACE), funded by USAID/Philippines. The association brings together all parties involved in the distribution and promotion of condoms and those active in the

STD/AIDS-prevention field. A significant budget for PR and direct advertising is included in the activities of ACE.

6.2.3 Media Training

A further significant innovation has been the introduction of "Media Training" programs which are designed to help develop a cadre of spokespersons for SOMARC programs. This is particularly valuable in countries with social or religious constraints to the concept of family planning, and also valuable in developing skills in public speaking. Media training activities have been implemented in seven countries and are planned in four more.

The issue of media training highlights one weakness of SOMARC planning. While this is a highly innovative approach, it has been slow in developing and, unfortunately, has been introduced quite late in the program. In the Philippines, for example, it was predictable in 1992 that religious constraints to the program could be counterproductive. In 1993, there was significant reaction which impacted on the sales effort, on sales, and on the attitude of the manufacturers to the program. SOMARC quickly held discussions with local opinion leaders and decided not to exacerbate the potential furor. However, had SOMARC initially used a strong public relations effort before the brand specific media program got fully under way in 1993, it might have greatly assisted in offsetting some of these negative reactions. The local advertising agency has now developed some interesting ideas as to how this might have been accomplished. Their idea is similar to the approach Nestle used when its baby foods were under a similar attack, which was by saying that "Breast Milk is Best." The Philippines country advisor was thus managing a crisis situation which SOMARC has now developed tools to help avoid.

However, as these kinds of social and religious constraints to programs are so well known, this "crisis management" could have been avoided if these tools had been developed and provided earlier. This indicates that there is a degree of ad hoc reaction in some aspects of SOMARC's work, rather than consistent strategic planning. The signs are that this issue now seems to have been resolved.

Recommendations

14. SOMARC should continue to emphasize brand specific (or umbrella logo) promotions through the use of mass media.

15. Where possible, SOMARC should strengthen PR on social or religious constraints issues in all countries where they start a new project and in countries where there may be potential problems.

6.3 Market Research

Within the marketing process, four basic research tools are used: qualitative formative research to form the basis for message and media development; quantitative research for baseline studies and

follow-on evaluation; messages and materials testing; and retail audits, sales tracking, and implementation monitoring studies.

In general SOMARC effectively implements research protocols in all these research methodologies in each country based on the individual country and product needs. Local research resources are used where possible. Over 137 research projects have been conducted to date in SOMARC III.

From time to time, views have been expressed from a variety of sources that social marketing programs may undertake too much research. Conducting research is partly a requirement influenced by donors such as USAID to track shifts in baselines beyond just a basic set of sales parameters. In addition, because social marketing projects are more complex in issues of behavioral change compared to general commercial products, formative research is much more important in social marketing in order to probe social, religious, or practical blocks to product introduction. At the same time, because of budget considerations, there is always pressure on CSM projects to reduce research expenditures and the SOMARC project is no exception. In general, the team believes that the level of research that has been undertaken in SOMARC is about right considering the large numbers of cultures and product ranges that the project is dealing with.

One example of SOMARC's efforts to limit the cost of research is that baseline and evaluation studies have been generally restricted to researching the C&D target audience only. Sometimes such research is limited to sales data only. Limiting the scope of research in this way reduces research expenditures, but SOMARC must take great care to ensure that adequate data is being collected. Baselines should be used to track progress so that marketing strategies can be redirected, if necessary; baselines are more effective and less costly if this is their sole purpose. The redirection of message development and tracking of attitudinal issues can safely be left to the initial formative research, thorough message and materials testing processes, and occasional qualitative research as required.

One area which needs examination is the proposition made by several commodity suppliers that SM programs were taking sales away from their higher priced and more profitable products. In countries where this may be a concern of manufacturers, IMS data may be available which can help clarify the situation. In addition, conducting a baseline study which addresses this question would be useful. Costs could be minimized by asking a short set of key questions which addresses all social sectors and expands them to the total market so that these concerns can be analyzed appropriately.

There are a few points worth noting in the formative research process. Certainly in the Philippines and Niger, where religious issues could have been expected to have impact on programs, expanding the initial formative research to include religious leaders would have assisted in identifying their reactions and to finding early solutions.

In the area of special studies, SOMARC is proposing that in-depth lifestyles studies relating to condom use be undertaken in Mali (completed) and expanded into Uganda, the Philippines, Nepal, India, and Indonesia. However, no social marketing program for condoms, particularly

ones addressing STDs and AIDS should neglect such a study at the very beginning of the program, either through new formal research or through the analysis of existing information. In fact, in the Philippines, the entire condom promotion is based upon a lifestyle approach and has already been launched. The team believes that this lifestyle approach could have been built into all SOMARC condom programs from the start of SOMARC III, rather than being left to the remaining years of the project, and now being proposed as a special studies category.

Within the special research studies proposed there are four categories—Lifestyles, Monitoring Graduated Programs, Price Elasticity, and Impact of Marketing Private Family Planning Service Delivery Systems. While it is sensible to examine these topics on a one-off basis, it is suggested that it would be preferable to conduct these studies as part of the on-going SOMARC program rather than as unique pieces of research.

Recommendations

16. SOMARC should continue to explore efficiencies through simplifying data topics in baselines, while at the same time expanding baseline data across all economic groups in more mature markets where manufacturers may fear loss of sales to the A&B market.

17. SOMARC should explore more opportunities for cooperative research with other agencies and also ensure that formative research covers all potential relevant opinion leaders.

6.4 TRAINING

In addition to training SOMARC marketing management and providing media training, the SOW designates training, alongside education, as the key vehicle for assuring quality of care in SOMARC's programs. Despite its pivotal role, it is doubtful if using training alone is efficient in achieving quality. Some limited training has been undertaken in the marketing of service delivery systems, particularly in Turkey, but no evaluation of this effort was available. Also, in the case of pharmacists, many studies show an unimpressive record of training's ability to improve performance. That said, quality of care training under the SOMARC project has been comprehensive and well-designed. The manuals closely follow the components outlined as quality indicators in USAID's EVALUATION Project, one of the seminal documents for quality of care.

Recommendation

18. SOMARC and USAID should work together to ensure that the project's training succeeds in not only giving providers new capacities, but in improving performance.

7. Financial

7.1 BUDGET

7.1.1 Central Level Funding and Expenditures

The SOMARC III project is funded by both "core" funds and "Q" contracts, which are an open-ended facility for buy-ins from local Missions. Due to the nature of these Q contracts and through no fault of SOMARC, some constraints were encountered by The Futures Group during the first 18 months of the project that impacted on progress management of the project budget. However, these constraints were often overcome as Futures chose to temporarily draw upon central activities funds to initiate and/or sustain activities while awaiting USAID approval for both the buy-in itself and for personnel related approvals. In particular, some of the budgetary problems encountered include:

1. Originally, there were time lags (six months) in getting buy-ins approved (e.g., Jordan), but now these Q contracts are approved in approximately one month. Thus, the time period for USAID approvals for project buy-ins requested by Missions has improved significantly since the inception of the SOMARC III project. However, at the time of the evaluation, there is still pending a request from SOMARC for an amendment that would approve the 11 additional country projects that are currently operating.

2. Non-funding amendments have often not received timely USAID approval. In particular, the Q contract requires that all personnel must receive prior USAID approval. To date, almost none of the personnel added or charged to the project in the last 11 months have been approved in writing, even though requests for approvals for all personnel changes have been submitted by Futures to USAID/Washington prior to hiring.

On average, the central activity funding as well as the Level of Effort (LOE) is precisely on track—as of June 30, 1995, 17,154 hours or 54 percent have been used, and US$19,866,683 or 50 percent of the budgeted money has been expended. This average, however, distorts the fact that several line items are approaching or have surpassed line item ceiling levels. For example, the equipment and other direct costs line items are fully expended. From an operational point of view, one of the most serious concerns expressed by SOMARC is the fact that the short-term technical assistance budget is almost entirely spent. As a result, those countries currently on board may not be able to receive the technical support they need to operate in an optimal manner.

An additional factor is that the recently revised USAID budget process will significantly reduce the amounts received from buy-ins. This will result in a lesser ability of central activity funds to "carry" country activities as they await approval. In addition, the 15 percent LOE at the central level that was supposed to be funded from buy-ins will now lack sufficient funding. The result of this decrease from buy-ins will exacerbate the shortage of future funds available for management and technical assistance to be provided at the central level to the country projects.

It is anticipated that there will be a shortfall of 267.3 person months (or 18 percent) by the end of the project if existing staffing levels continue without a raise in the core LOE ceiling. This LOE shortfall amounts to an estimated US$7,451,690. Given the serious nature of the problem, the Office of Population, therefore, is requesting an amendment to raise the core LOE ceiling from the original level of 1,706.3 person months. The original contract approved a total estimated LOE of 1,885 person months and the amendment requesting a raise in the LOE and central funded budget ceilings will likely exceed the original ceiling of LOE months originally estimated for core and buy-in contracts.

The team reviewed the management budget of SOMARC III for reliability, timeliness, and use of funds. The SOMARC/W office has a wide array of financial and budgetary information available for both Washington, DC, subcontractor, and field expenses. The breakdown of the Washington office administration and subcontract expenditures can be seen in Annex C. This budget illustrates the distribution of funds, including TA and supervision from both the Washington office, as well as US$884,000 which has been paid to the subcontractors to date. Of note, as of June 1995, SOMARC III administrative costs incurred, including the Washington office, regional offices, and subcontracts are US$8,049,156 or 28.9 percent of the total project. This amount has not varied significantly from 1993 to present, and is therefore averaging approximately US$3,000,000 a year. While this may appear to be a significant proportion of the total amount, given the fact that this administrative expense also includes provision of TA, the overall administrative percentage of 28.9 percent does not appear unreasonable.

Recommendations

19. SOMARC's efforts to facilitate the USAID approval process for budgetary changes needed throughout the project are supported. USAID/Washington should make every effort to complete the outstanding requests for approvals that are over two months overdue if at all possible.

20. Discussions should be held between USAID/Washington and SOMARC as soon as possible in order to determine how the budgetary and LOE gap created by the changes from buy-ins to OYBs can be reconciled.

21. The potential effect of changes in Mission budget procedures should be jointly examined by SOMARC and USAID.

7.1.2 Country-level Budgets and Expenditures

SOMARC/W office has a very good picture of the current financial status of its operations at the country level. The expenditure rates at the country level appear to be generally at the expected levels. However, five of the 19 funded countries listed by SOMARC (Bolivia, Haiti, Jordan, Mali, and the Philippines) have received no-cost extensions to their Q contracts. In addition, no-cost extensions are being requested for Senegal, Niger, and the Philippines II, making eight total country projects with delayed expenditures, or 42 percent of the total active SOMARC country projects. Senegal, Niger, and the Philippines II were all to have completed expenditures by

August-September of 1995, but are only between 15 percent (Senegal) and 56 percent of completed levels as of June 1995 (see Annex C). Although many of these delays are due to the usual unanticipated delays in approvals and hiring, this could pose irrevocable problems should overall USAID funding experience cut backs. A possible future impact on SOMARC III is that "no-cost extensions" may be more difficult to get in the future, and a mechanism for this eventuality needs exploration.

Recommendations

22. Although the need for no-cost extensions does not appear to be any particular problem to SOMARC management, it is useful for both the central level and participating buy-ins to try and expedite expenditure rates in order to better "protect" their budgeted LOP levels.

23. SOMARC and USAID should explore mechanisms for dealing with situations where project funds are not expended by due date in the potential absence of "no-cost" extensions.

7.2 Sustainability and Cost Efficiency

7.2.1 Financial Sustainability

The issue of sustainability is reviewed in this section from the financial perspective, using the USAID interpretation that self-financing is defined as "an operation that can generate sufficient local income to cover total operating costs." The managerial and quality aspects of sustainability are discussed in other sections of this report.

Self-financing for family planning and social marketing operations is not easy to measure since there are basically four different types of CSM projects with which SOMARC is working. Using the generation definitions described earlier, there follows a summary of self-financing expectations for each type:

1. First Generation—Example: NGO operation such as in Bangladesh, Sri Lanka, Nepal, Guatemala. A new organization is set up with recurring costs, donated commodities, and donor bearing all initial costs. Self-financing in this case would require the ability of local revenues to take over paying for all donated operating costs.

2. Second Generation—Example: Existing distributors/implementing agencies use donated commodities, such as in Zimbabwe, Bolivia, Uganda, Ghana. Self-financing is the ability to recover cost of donated commodities. Assumption is that little to no recurring costs are donated.

3. Third Generation—Example: Existing commercial products are used through a combination of distributors assisted by SOMARC staff. There are no donated commodities, such as in Morocco, Ecuador, Indonesia, and Haiti. Self-financing is the ability and willingness of

independent distributors to be able to continue marketing commodities using commercial products at competitive prices. The assumption is that if USAID funding were to stop, this example would be considered graduated since there are no recurring donated costs to prevent the project from continuing.

4. Fourth Generation—Example: Maximizes the involvement of the private sector to where 100 percent is managed by private sector, and start-up donor funds are provided for advertising and promotion, such as in Turkey. Self-financing is measured by continuation of the private sector to sell commodities, probably with multiple priced brands, at competitive levels. Or, in the case of Turkey, to form a mutually beneficial alliance with an NGO and share in the profits. This example also assumes graduated status the moment any donor funding is stopped.

SOMARC initially provided three non-quantitative ratings for self-financing which it termed "cost recovery," "self-sufficiency," and "graduated." After discussions with the evaluation team, a more quantitative analysis was conducted, and SOMARC provided an excellent summary of the self-sufficiency status in financial terms of each of its active Implementing Agencies (see Annexes D and E).

Annex D assesses the current level of self-sufficiency as it relates to amount of time since inception of the project. It is assumed that the longer a project has been in operation, the more self-sufficient it will be. This is followed by SOMARC's assessment of how self-sufficient an IA will, or should, be at the time of completion of USAID funding and also the difference between current status and expected EOP self-sufficiency status.

It is interesting to note that some IAs such as those in Central America are <u>mandated</u> by USAID to reach certain target levels of self-sufficiency. Whereas others, such as those projects primarily in Africa and Central Asia, are not. In the latter cases where the IAs have no mandate for self-sufficiency, estimates were made of where they might be at End of Project (EOP). SOMARC recommends that the majority of projects should remain at around an 80 percent level, taking into account the desire to subsidize a portion of the IA activities in order to maintain access to the C&D groups.

Table 1 is a summary of the larger table in Annex D.

Table 1

Number of IAs by Level of Self-sufficiency

Number of IAs	Level of Self-Sufficiency %	% of 20 IAs
1	100%	5%
6	41%-80%	30%
4	11%-40%	20%
5	1%-11%	25%
4	0%	20%

There are four IAs that are at the 0 percent level and, being programs that have just recently started, have no revenues. The four include Jordan, CAR, DMPA in Morocco, and services in Turkey. In addition, there are two other countries that were not included in this exercise (and are not shown), since SOMARC is only providing TA in advertising and management (i.e., Swaziland and India).

There are nine programs which are considered first or second generation operations, and are also below 40 percent sustainability. These include Guatemala, Egypt, Mali, Niger, Senegal, Haiti, Togo, Uganda, and Nepal. Several of these have been operating for some years and it must therefore be assumed that in these countries any reduction/loss in USAID funding would result in a proportionate reduction in services. It may be that these should be where SOMARC targets most of their efforts in the next couple of years.

These seven countries that have self-sufficiency higher than 41 percent have programs that are either third or fourth generation (with the exception of Zimbabwe that was graduated). They include the CEPEO program in Brazil, Ecuador, Jamaica, Peru, Morocco, Indonesia, and the Philippines. These countries reflect programs with very few recurring costs paid by USAID, and are considered countries that could remain in operation if USAID funding were to be stopped. Information was not provided by SOMARC on either the Mexico (MEXFAM and FEMAP) or Honduras projects. In the case of MEXFAM, SOMARC is responsible for increasing revenues, and has been tracking the impact of their work on the revenue changes at the clinic levels. For FEMAP, the work with SOMARC just started in December 1994 and financial data is readily available as needed from FEMAP. The program in Honduras appears to be problematic—SOMARC indicates that there is little cooperation between it and ASHONPLAFA, the IA for Honduras. In fact, SOMARC has recommended that USAID/Honduras consider transferring the social marketing plan to another agency in Honduras.

Annex E provides a breakdown of how the SOMARC funds are being provided to the different IAs in terms of the amounts spent on commodities, sales force/distribution, marketing, and management. It is also another useful way of looking at self-sufficiency from both a financial and

managerial perspective. Those IAs that are only relying on advertising funds for example, can be assumed to be the least dependent on SOMARC funds as time progresses. Those relying both on management assistance as well as donated commodities, are assumed to be the most vulnerable. There is a need to ensure that, in such cases, management and other inputs from SOMARC are being effectively used by the IAs, so that this time and resource consuming effort may not be wasted.

In an attempt to obtain input from the IAs themselves as to their projected level of financial sustainability over the next two years, the evaluation team sent questionnaires to 15 IAs. Six IA responses were received, from the following countries: Nepal, Peru, Philippines, Jamaica, Haiti, and Mali. Of these, three of the country projects were actively using some form of measurement for cost efficiency.

In summary, SOMARC has an excellent array of information available to assess how self-sufficient each IA both currently is, and will be in the future. It is also clear from the information provided, that a significant proportion of the IAs are quite vulnerable to any loss or reduction of funding.

Recommendations

24. USAID/SOMARC should complete the IA self assessment exercise to illustrate any disparities between what SOMARC expects of the IA and what the IAs themselves think they can accomplish.

25. SOMARC should use the quantitative tables derived to monitor progress of self-sustainability and work with IAs on a semi-annual basis to aggressively reach self-sustainable targets established.

26. USAID should use this quantitative tool to monitor progress toward financial self-sufficiency and to assist with making budgetary allocation decisions.

27. SOMARC and the IAs should identify more explicitly the TA needed to obtain agreed-upon targets and the reciprocal responsibility of the IA when it has received the TA. In this manner both parties will become more jointly accountable.

28. SOMARC's investment of its time and resources should be more related to the degree of achievement and cooperative effort of the IAs with which they are working. USAID should assist SOMARC with the flexibility to prioritize their efforts.

7.2.2 Cost Efficiency

Cost efficiency of various programs has been reviewed in relation to cost per CYP. In addition, SOMARC recently updated a study comparing the average cost per CYP as it relates to duration of the individual programs, as well as the average CYP cost per life of the SOMARC projects

(Annex F). Not surprisingly, this illustrates that the longer the duration of the project the lower the cost per CYP. However, it uses an accumulated base of CYPs over time as the denominator, even when SOMARC activities have been graduated, therefore, potentially lowering the cost per CYP to a continuing degree.

Assessing cost efficiencies using the cost per CYP is one technique that can be effective when looking at trends over time. However, it does not necessarily reflect the quality and associated costs of the actions taken. For example, one organization might appear to have significantly lower costs per CYP than another, when in fact the former organization might be using condoms, whereas the latter might be using IUDs. The change in "composition" of the CYP over time for the same organization will also affect the cost per CYP without necessarily having any changes in efficiency.

It is suggested that there may be other unit cost measurements which are probably at least as effective as cost/CYP in determining cost efficiencies. Unit sales is probably one of the most reliable indicators. The cost per IUD provided would be an example. Similarly, the cost of SOMARC input to Brazil divided by the number of additional unit sales of contraceptives would be an indicator of how effective the SOMARC effort in that country is. The unit sales should not be an accumulated figure but more appropriately a quarterly and/or annual amount.

Although SOMARC keeps both financial and statistical data on a current basis, no other analyses on cost efficiency other than cost per CYP appears to be used. It is important for SOMARC, USAID Missions, and most importantly, the IAs to know how efficiently they are providing resources. If the IAs are not competitive, they will always need to be subsidized. Equally important from USAID's perspective, is the ability to assess who is utilizing USAID monies most efficiently and what the unit cost of providing SOMARC resources to increase sales in a particular country is.

Recommendations

29. SOMARC needs to provide cost-efficiency measures of their input provided to an IA when it is applicable. This information should be kept on a semi-annual basis, and the denominator should be unit sales incurred in a fixed time period, and not accumulated unit sales over the length of the project.

30. IAs need to maintain and provide cost-efficiency measures at least on a semi-annual basis.

7.3 Sourcing

For some years, as USAID budgets have become more restricted, there have been indications that supply of donated contraceptives from USAID will be curtailed for CSM and other programs. During the life of SOMARC III this has become reality and there is now real pressure to find other donors, or to convert programs to the commercial sector with distributors/agents buying products.

During SOMARC II, there were already moves to do this, with projects in Central and South America and the Caribbean, Morocco, and Indonesia already being moved from complete dependence on donated product. This action has continued within SOMARC III to date but with some problems.

Condoms

In many of the earlier CSM programs, products being marketed were condoms, and then more recently, OCs. With condoms, there were good reasons for USAID to procure the commodities and handle negotiations with the major suppliers since USAID had increased purchasing power, since it was buying for the public sector as well as CSM programs, and not only for programs ran under SOMARC.

In some programs where the distributors had to "buy" products under the Return to Fund (RTF) mechanism, there has been some criticism of this process. The preliminary requirement to look for USA-sourced products meant that operators complained that they were unable to take advantage of cheaper sources elsewhere in the world. Obviously, product quality is a prerequisite but, nevertheless, with several countries demanding the pre-testing of products coming into their market for sale to the public, useful standards could be maintained when looking elsewhere than USA for product.

More recently, where distributors have been informed that they could no longer expect donated USAID products for their CSM programs, they have been the first to propose cheaper sources of supply and in some cases have gone out to negotiate these themselves. In other instances, there is a reluctance to accept that donated products will cease to be supplied and there is inertia, with the view that either USAID, IPPF, or others will continue to supply free products. In the case of some programs, particularly those in Africa where current cost recovery is probably the best that one could hope for, this may not be such an unreasonable assumption on the part of the distributor, the local Mission, or indeed the CSM program contractor. And this continues to prevail. It is crucial in the markets where CSM programs operate, to understand whether or not they are marked as a market which can only look for cost recovery in the foreseeable future, or whether it can be destined as a market heading for sustainability or self-sufficiency. This obviously impinges on not only the supply of commodities but also the continued funding by USAID for marketing and other activities.

Oral Contraceptives

OCs tend to be a more recent introduction in SOMARC programs and have involved collaborative negotiations with the major pharmaceutical companies. Here, when USAID conducted the negotiations with contractors, there was an acceptance by the pharmaceutical companies that the products were to be used for both public and private sector programs. In very under-developed countries, the manufacturers have reasoned that the CSM programs can do little but good for them, since their commercial volumes are small and it would be costly for them to develop the market themselves. In other markets, where the commercial sector for OCs is well

developed, then acceptance of supply to USAID may have been more reluctant, but probably accepted by the providing company. This is on the grounds that if they do not supply their product for use by USAID, with the attendant development of brand recognition in the C&D sectors of the community, then they are opening the door to their competitors.

Now, as transition occurs from donated CSM program products to commercial direct provision, other problems are emerging. In markets where a pharmaceutical company has a dominant share of the whole market and high margins on their commercial product, there is sometimes a reluctance to deal with a CSM program at all. Of necessity, CSM programs offer a much reduced price which suppliers feel may cannibalize their own products, or result in the movement of stock to adjacent countries, with resulting difficult commercial consequences. Thus the price that the commercial companies are prepared to offer to the CSM distributor makes for difficult negotiations, and also requires that the providing organization has to satisfy itself about the ability of the recipient IA to control and monitor the distribution of its product into the trade to the their satisfaction. Implicitly, this may over-involve the pharmaceutical company in CSM programs and there have been experiences of some companies reneging on contracts after they have been set up. In the case of CSM programs this can be disastrous.

Graduation

In the transition to the use of commercial sources which supply directly, as opposed to donated product, SOMARC has been instrumental in negotiating with suppliers. In some countries this has worked well, but in other instances it is more the case that, in devolving management responsibility to the regional offices, there is little direct action from SOMARC/W. Obviously assistance has been given to distributors in providing introductions to the various commodity suppliers. However, since manufacturers are very often structured regionally, this is likely to result in an uncoordinated approach. In the absence of any globally agreed commodity supply, in-country transition could result in protracted negotiations and probably less advantageous prices.

Commodity Management

In the management of products in-country, the move toward directly commercially supplied product also has the potential for problems. In present situations where USAID has agreed to donate products, both SOMARC and the distributor are involved in estimating requirements and, usually via the local Mission, communicating these to USAID for central purchase. It is probably the case that the distributor feels that the provision of stock is within SOMARC's contract. With the move to commercially sourced products, this is likely to involve direct purchase by the distributor, probably with SOMARC's input on volume requirements, but the responsibility for stock management, ensuring regular delivery, payment, and so on is now in the province of the distributor. SOMARC's input may thus be reduced to simply providing necessary marketing and other inputs, and the distributor may feel that because of his increased commercial responsibility SOMARC's role is greatly diminished. This then becomes a problem of who "owns" the project. In many instances, the distributor will continue to need considerable assistance in marketing for some time, but the nature of the relationship will change purely because of who provides the

products. This may have a deleterious effect on the project's progress, and it is necessary that SOMARC builds into its monitoring of the business at field level a regular involvement in ensuring that the supply of stock is well managed, given the distributors' lack of knowledge of pipeline delivery times.

SOMARC III Programs

In the newer programs where SOMARC has developed projects—particularly with longer term methods—or is marketing services, there appears to be a recognition from the outset that there is a need to establish a supply of commodities and services either through the direct commercial routes or by alternative financing sources. In general, where partnerships have been developed, commercial sourcing has been part of the project design, i.e., a third or fourth generation model.

Suppliers

Another aspect of sourcing is the relationship with suppliers. In countries where a commercial supply has been established, there is generally a good perception of CSM programs on the part of commercial companies. However, this is not universal. In some instances, problems arise because the prices required to continue CSM programs threaten the commercial operator's own market for the same brand, unless distribution channels can be isolated and are well controlled. One option is for the commercial company to offer a different brand from that being marketed in the commercial sector but, where this requires a change in brand from that previously supplied under USAID donated product programs, this can create acceptance problems by consumers. One such case in point is where Syntex has been supplying three brands to CSM programs but, now that Wyeth bid for and obtained the supply contract, they desire to provide one brand only. In some cases this brand is not registered in the markets and this may cause disruption of stock as well as enforcing an unexpected relaunch of these OCs with all the consumer acceptance problems that this can raise in addition to unforeseen costs to SOMARC.

During SOMARC III, products have been graduated from donated supply in six markets, in some cases with more than one type of product. There remain eight markets, where SOMARC has a continuing commercial program (aside from countries that receive TA only), where donated products continue to be provided. In 12 countries, sourcing of products is from commercial manufacturers only.

Recommendations

31. SOMARC should continue to work toward developing sound contacts with commercial suppliers, and this function should be vested in head office staff.

32. While there is little place for a centralized buying function within SOMARC, they could provide a better link between the commercial supplying companies and the in-country CSM distributors. Particularly for condoms, this would involve agreeing on general base prices and possibly consolidating provision of stock to SOMARC programs in order to obtain an improved cost-effective supply.

33. SOMARC should ensure that its country managers have a regular mechanism whereby the management of ordering and delivery of stock is a joint responsibility with the distributor. In programs where graduation is taking place, there must be a clear and effective handover of "ownership" of the project.

8. MANAGEMENT INFORMATION

8.1 MIS

The SOMARC project is supported by The Futures Group's extensive MIS systems for financial management. SOMARC appears to have implemented the financial and sales reporting systems at the central office level. However, similar systems to support field activities have not been developed. Every SOMARC field office has at least one computer on site, and most are linked to SOMARC/W via e-mail. This e-mail linkage between the central office and the field allows day-to-day needs to be communicated and resolved. However, there is no central support to assist the field offices in the use of computers to compile quarterly reports for USAID or in appropriate inventory systems to provide an early warning system to avoid "stock outs." The field projects collect the information requested by SOMARC/W and provide it in a typed form where it is re-entered in the database at SOMARC/W. A more efficient system is recommended in which SOMARC/W develops a system with compatibility to the primary database/spread sheets (e.g., PARADOX, dBase, Lotus, Excel) available in the marketplace today. SOMARC should be better able to capitalize on the current e-mail system in order to minimize errors and to decrease the amount of support work required when these data are compiled on a national level.

Recommendations

34. SOMARC should develop simplified spreadsheets to support reports compiled by SOMARC/W and make these available in a compatible format in the field.

35. Within the framework of this spreadsheet, SOMARC should develop an inventory system linked to sales figures and inventory held.

8.2 Monitoring

While financial reporting might be in place, marketing information is less well defined. There are regular reports of sales of products by country, but this seems to be the extent of regularly reported information. Many countries, where there is a distributor or agent, have information on distribution of product sales and sometimes by customer type. In several countries where there has been a sales development input, journey planning and customer record cards are becoming more widely used. These allow reporting and analysis of the customer base and can give some surrogate measure of consumer purchases, as opposed to sales into the trade. Analysis of the customer base can also allow improved targeting of sales force activity. However, there is not a mechanism presently which gathers these data on a regular basis for country, regional, or SOMARC/W use.

In those countries where the project involves services, as opposed to products, SOMARC has worked with the IA to collect formal data on its clients. This is not always used managerially by the IA, despite SOMARC's encouragement to do so; nor does SOMARC necessarily appear to be in the reporting chain.

In many countries DHS information is being gathered. Some of the information generated by these surveys can shed some light on the CSM activity and may provide a complement to unique market research studies.

SOMARC has much information available from the field but there is no formal reporting system now which makes these simply collected data readily usable by operating staff.

Recommendation

36. SOMARC should investigate the available data sources by country and start collecting these data regularly in order to better influence both commercial and marketing decision making.

8.3 CYPs

SOMARC/W provides sales data as well as CYP data to USAID/Washington by country, product, and time frame. Sales data are collected from the field and the CYPs are calculated centrally by SOMARC/W using a methodology consistent with that of USAID. It should be noted that CYPs from graduated programs are included as part of the calculation even after SOMARC has ceased spending measures on that project. This artificially increases the number of CYPs (and decreases the cost/CYP) in regions in which SOMARC is active and, as noted earlier, some care must be taken in any interpretation of cost/CYP in a given country or region.

In 1994, SOMARC reported sales/distribution of products resulting in 4,822,160 CYPs. A projection of 4,300,059 CYPs for FY 1995 is based on sales through the second quarter of 1995. Should this projection hold, it would represent an 11 percent reduction in CYPs from 1994. A likely explanation for this follows in the next section, and a full table of sales and CYPs is in Annex G.

9. LONG-TERM METHODS

9.1 Methods

SOMARC III has the mandate of increasing modern method prevalence rates using commercial channels, with greater emphasis on the promotion of long-term methods. In the long-term category, SOMARC has promoted IUDs, injectables, implants, and voluntary sterilization.

Table 2

Unit Sales/CYPs for Short- and Long-term Methods (1992-1995)

	UNIT SALES ('000's)			CYPs ('000s)		
YEAR	Short Term	Long Term	TOTAL	Short Term	Long Term	TOTAL
1992	81,071	2,928	83,999	1,945	1,825	3,770
1993	68,552	2,203	70,555	1,857	1,041	2,898
1994	86,150	2,503	88,653	2,049	2,773	4,822
1995	106,654	2,163	108,817	2,258	2,042	4,300

In 1994, the project's total CYP was 4,822,160; of these, the CYP attributed to long-term methods was 2,773,400. During SOMARC III, the percentage of CYPs attributed to long-term methods has increased 18 percent; this increase is due almost exclusively to the rise in sales of IUDs. This is shown by the fact that in 1992, 6 percent of the long-term method CYP came from IUDs, while in 1994 that percentage had risen to 83 percent. However, the forecast outcome for 1995 shows an 11 percent decline in total CYPs from last year. The exceptional gain in 1994 and the subsequent fallback in 1995 is due almost entirely to IUD sales in Egypt and Indonesia. These are both countries where the projects have been taken over this year by the private sector, and recorded sales for 1995 are only those known to SOMARC. In reality, it is probably the case that both sales and CYPs due to LTMs are continuing to increase in SOMARC markets.

Setting up the infrastructure to deliver long-term methods is resource intensive. Unlike condoms and to some extent OCs, the provision of LTMs requires clinical expertise. Technical competence, counseling skills, and referral mechanisms all assume a greater importance in the delivery of long-term methods. This increased complexity, relative to the launch of condoms, necessitates a carefully considered approach in which marketing is supplemented with strategies to address the clinical realities of LTMs.

While SOMARC has been justifiably deliberate in the launching of long-term methods, the effective results appear slower than would have been hoped for. Although IUD sales have increased, those for DMPA in particular have declined over the period of SOMARC III. In total, SOMARC sold 2.9 million units of long-term methods in 1992, declining to an estimated 2.2 million in 1995. Although product mix within the LTMs has altered such that CYPs have grown

over the period, in 1995 unit LTM sales will likely be 26 percent lower than LTM sales in 1992. DMPA, SOMARC's most actively promoted LTM, has seen decreased sales every year since 1992, while sales of condoms and orals increased by 29 percent and vaginal foaming tablets (VFTs) by 19 percent over the project period.

There are many reasons for DMPA's less than vigorous launch. Perhaps the major reason is the desirable, albeit time-consuming, design and implementation of strategies to address quality of care. In addition to focusing intently on ensuring quality of care, SOMARC's long-term method sales have been undercut by opposition to DMPA and sterilization in several countries, competition from locally-produced Depo-Provera in Indonesia, as well as tedious negotiation processes. Given the externalities presenting obstacles to LTM provision as well as the necessary emphasis on quality of care, SOMARC cannot be blamed entirely for sluggish sales.

However, one particular area where SOMARC could be more proactive is in the establishment of new working relationships with physicians and other family planning clinicians. Although SOMARC has carried out media and public relations training in several countries, the project could benefit from greater use of appropriately timed advocacy from the medical community. AVSC, given its long-term relationship with the medical community, represents an underutilized resource for SOMARC. Working in concert with AVSC to enlist the medical establishment, SOMARC could make expanded use of influentials to support maligned methods or new service delivery strategies.

Two examples of where the advocacy of the medical community could have played a larger role are as follows:

1. In Jamaica, where injectables received damaging newspaper coverage, SOMARC prepared no press response to the newspapers' erroneous reports. Although there was a trained, DMPA-friendly corps of physicians, agreement was reached with SOMARC not to produce a public response which might have allayed fears, because of potential political embarrassment.

2. The Office of Population of USAID/W, carefully monitoring quality of care, slowed the launch of DMPA in Nepalese pharmacies. Had the medical experts of AVSC with their recognized commitment to quality been utilized to fully endorse SOMARC's plans, USAID/W might have been more rapid to accept the concept of Depo-Provera provision in pharmacies.

Over the remaining life of the contract, the necessary groundwork seems to have been laid for SOMARC to proceed with attempts to launch and promote injectables. From its experience in Nepal, SOMARC has gained experience in launching a pharmacy injectables program. Although the model still needs validation that quality standards are being met, the experience will serve them well as they move into new markets. If the project is able to achieve success in Nepal, this program should help SOMARC to develop the experience and reputation for quality service provision, thereby paving the way for the project to see a dynamic record in the second half of the contract. Before the end of the contract, SOMARC anticipates that it will launch DMPA in Morocco, Haiti, Jordan, Mali, Madagascar, Uganda, Uzbekistan, and Turkey. Indeed, it has

already begun DMPA pre-launch activities in several of these countries. Even so, the launching of Depo-Provera in eight countries by September 1997 seems quite a stretch.

Voluntary sterilization promotion is being planned for Indonesia and Jamaica. In Jamaica, where SOMARC is promoting vasectomy services with AVSC's assistance. The project has prepared no-scalpel vasectomy communications strategies, client brochures, and media training guides. In Indonesia, SOMARC is meeting considerable obstacles from the government which is unwilling to use mass media to directly promote sterilization. However, SOMARC is exploring ways to communicate the concept of sterilization without directly mentioning it.

Recommendations

37. Especially in countries where SOMARC is not the only source of commercial commodities (i.e., when other operators are providing pills, condoms, and VFTs), SOMARC should aim to increase the percentage of long-term methods as a proportion of total sales. Since no other social marketing organization has a focus on long-term methods, SOMARC should use its comparative advantage to expand the commercially-available method mix.

38. In those countries where it has pill and condom experience, in the remaining years of the contract, SOMARC should focus its promotional efforts on DMPA. This would take advantage of the commercial systems already in place and exploit the method which has the greatest potential for programmatic success.

39. Although developing experience in marketing sterilization, which is a service and not a product, SOMARC should consider making its VSC promotion a longer term priority. The promotion of VSC will still require significant institutional investment to achieve the necessary level of expertise.

40. Taking into account the complexity of launching long-term methods, SOMARC should endeavor to be as realistic as possible in determining their timetable for long-term method launches. Project goals must be carefully formulated to ensure that consistent standards in formative research, training, or quality of care are maintained.

41. SOMARC should utilize its working relationship to foster stronger bonds with the medical communities in countries where they work. Using successful experience from some countries, corps of influential physicians and other providers should be used consistently to garner support for LTMs and to avoid negative publicity.

9.2 Quality of Care

CSM at its two extremes can offer easy, convenient, and inexpensive access to those who can safely use a product. At the same time, without proper care, it could lead to the distribution of products in a manner that is ineffective, or at worst, dangerous. SOMARC has put an array of

mechanisms in place to avoid the latter situation. The provision of quality services seems to be an institutional priority for SOMARC. The framework most commonly used for assessing quality of care includes the following six elements: provider competence, interpersonal relations, constellation of services, choice of methods, mechanisms to ensure continuity, and information provided to clients. Although the project work statement repeatedly emphasizes the need for an increased focus on quality in SOMARC III, there is no mention of the above framework. In the evaluation SOW, the concrete references to quality of care are limited to an assessment of the project's performance in increasing "correct, effective use of contraceptives." Unfortunately, the project to date has collected no statistically significant monitoring data on quality of care. Thus, it is not possible to evaluate the degree of quality at the project's current juncture, and the evaluation is limited to assessing the mechanisms the project employs to increase correct, effective contraceptive use.

However, SOMARC has implemented several mechanisms which help promote quality of care and correct, effective contraceptive use.

Recommendation

42. In order that any incidence of reduced or poor quality in services can be addressed effectively and promptly, SOMARC should continue to ensure mechanisms are in place which deliver rapid analysis and feedback to staff and managers on the quality of care delivered.

9.2.1 LTM Training

SOMARC has conducted 13 in-country training-of-trainers workshops on contraceptive safety and technology for selected physicians, pharmacists, nurses, and midwives. In the pharmacist training module, SOMARC has recently added a Quality Customer Service component to provide standards for client provider interaction and quality improvement. In Turkey, where SOMARC is marketing a network of high-quality family planning clinics, participating providers are trained to market their services through constant attention to quality assurance and customer satisfaction.

Training to ensure quality of care under the SOMARC project has been well designed. The quality assurance portions of the training manuals closely follow the components outlined in the EVALUATION Project's Quality of Care Indicators, one of the seminal documents for quality of care. The manuals are technically sound in discussing contraceptive technology.

The SOMARC work statement designates training, alongside education, as the key mechanism for assuring quality of care for SOMARC's consumers. Thus, training assumes a pivotal role in the project's approach to delivering quality services. However, there are reasons to be concerned about the efficacy of training in achieving quality since there is a paucity of data documenting that training successfully improves provider performance, particularly in the case of pharmacists. It seems that SOMARC is cognizant of these potential pitfalls.

Recommendation

43. SOMARC should examine regularly its training activities and continue to ensure that they result in an acceptable level of provider performance.

9.2.2 Information for Customers

SOMARC employs a variety of media to promote correct, effective use of contraceptives. For DMPA, SOMARC has developed an injection card which reminds consumers when they need their next injection. SOMARC has also developed consumer information brochures for DMPA, IUDs, and oral contraceptives which cover advantages and disadvantages, side effects, and warning signals. For pharmacists in countries where SOMARC has carried out pharmacist training, SOMARC has provided a quick reference manual and screening checklists to help ensure that information is passed onto clients. In some cases, SOMARC has designed mass media campaigns to educate consumers about side effects and improve knowledge of correct use. Given the growth in IUD provision, SOMARC has debated the provision of IUD client cards. This seems wise, given the necessity of reaching clients through a variety of media. However, at present, SOMARC has not adopted the provision of these cards.

9.2.3. Quality of Care for DMPA in Non-clinical Settings

In Nepal, where SOMARC has launched an injectables program in pharmacies, special attention has been paid to ensure quality of care. Before being invited to participate in the program, pharmacies were assessed for their capacity to provide the level of quality necessary for DMPA injections. Pharmacists were trained in DMPA provision, including counseling. SOMARC worked with Upjohn to design a special injection kit, complete with a user card and a sealed syringe. Pharmacists were provided with containers for sharp objects, countertop screening checklists, and a referral system with a local physician's association.

9.2.4. Monitoring

In the Nepal pharmacy injectables program, quality of care is being monitored through mystery shopper studies, client surveys, provider surveys, and monitoring visits. Although not statistically significant, the initial provider monitoring survey indicates that pharmacists appear to be screening clients correctly. Clients (N=66) report that they are informed about side effects. In the Turkey marketing of services program, providers are allowed to participate in the network after they are visited by a team of medical specialists who evaluate the facility in areas such as infection prevention, equipment and staff availability, case load, and availability of methods. Once established as part of the network, facilities are monitored by the project's medical advisor to ensure that minimum standards of quality are met.

Recommendation

44. SOMARC should ensure that a variety of monitoring methodologies are consistently used to measure quality of care. All methodologies have inherent problems,

therefore it is recommended that statements on quality be validated by several sources.

9.3 Service Delivery

Although SOMARC is doing a commendable job in ensuring that providers deliver at least a minimum standard of quality, there is room for caution. Much attention has been focused on quality in two of SOMARC's newer, flagship programs—pharmacy injectables in Nepal and marketing of services in Turkey—and these have been well noted. However, SOMARC is involved in expanding access to services in many other countries through either short-term TA or sustained assistance given to implementing agencies. Particularly in the case of technical assistance where SOMARC's role is more circumscribed, it is not clear that the project has always been able to adequately focus on the quality of care provided in service settings.

Before SOMARC agrees to promote or market the services of any service site, they should feel confident that the quality of care provided meets at least their own minimum standards. Increasing access is a worthy aim, but SOMARC must ensure that they do not risk promoting services that are poorly managed or could potentially put clients at risk. Perhaps of more concern is ensuring that quality will be maintained once SOMARC's assistance is phased out.
Since long-term method provision entails new areas of expertise and may present more potential dangers to clients, comprehensive monitoring, especially, during the early stages of a project is essential. To this end, SOMARC has planned several studies which will give a good indication of continuing quality of care.

SOMARC's studies monitor quality of care through client satisfaction, and these target <u>users</u> of the services. However, some clients <u>discontinue</u> use of a contraceptive method. Studies that address only continuers will be biased in favor of those who have been satisfied with the method and the provider; thus studies designed in this way may mask quality problems. Clients who have discontinued use of a contraceptive method may have experienced some problems which reflect on quality of care, or their experiences could be utilized to improve the service.

Also, attention should be paid to ensure that quality of care studies do not become vehicles that shift from the measure of quality to the measure of marketing effort. Eighty-three percent of Nepalese pharmacists cited that "Sangini [injectable] is better than the pill." Such a statement is far from being proof of quality, and SOMARC must ensure that clients are presented with choice of methods, despite the providers' preferences on marketing or other grounds.

Recommendations

45. Before promoting the services of any service delivery site or group of sites, SOMARC should maintain its mechanisms which ensure that those services are of high quality. A pre-intervention assessment, as well as periodic monitoring, should be done to ensure that SOMARC is expanding access to quality service.

46. SOMARC should ensure that <u>sustainability</u> of quality is addressed in program design, implementation and phase-out plans.

47. In studies designed to monitor quality of services, SOMARC should ensure that a) discontinuers are included in study samples, and b) quality of care monitoring is not superseded by measuring marketing effort.

9.4 AVSC

AVSC contributes as a subcontractor on an "on-retainer" basis, and has a role in SOMARC's LTM program. AVSC is called in to advise on medical issues, develop quality assurance systems, advise on integration of informed choice, identify local organizations with clinical and quality of care expertise and review/advise on strategies involving long-term methods. In one respect, the partnership between AVSC and SOMARC was apparently without adequate consideration of logistical matters. AVSC seemed to anticipate a substantial amount of collaboration on the ground. However, in many cases, AVSC and SOMARC are not working in the same countries and potentially fruitful in-country collaboration has not been possible.

When their assistance has been sought, AVSC has been able to offer valuable perspectives on medical and quality of care issues. The first attempts at collaboration seemed a bit tenuous—which was unfortunate because SOMARC could have benefited from more medical and quality input in the early stages of the contract. However, having come to better understand one another, the two organizations seem to have improved their working relationship. Given their mandate to promote long-term methods, SOMARC might wish to consider having an AVSC staff member sit in the SOMARC/W office, as proposed earlier.

10. ACCESS

One of SOMARC III's prime objectives is to work toward guaranteeing access to products and services, and in particular to C&D groups. Several variables affect this objective.

10.1 Pricing

Determining the optimal price for commodity distribution has two conflicting objectives under this project. One objective is to maximize access to the C&D levels of the population, and the other is to set the price so that it enhances financial sustainability. In addition, the situation is made more complex when the projects are working with commercial companies and the price is subject to negotiation between SOMARC and the commercial distributor. Where possible, SOMARC has conducted KAP (knowledge, attitude, and practice) studies to get an idea as to what price would best provide access to the C&D populations, and nine of these studies were conducted in the participating SOMARC countries. These KAP studies helped to determine the negotiating strategy SOMARC used in dealing with commercial companies and assisted IAs when original price levels were determined.

Establishing the starting point for the price of commodity sales is clearly a difficult exercise. For the purposes of this evaluation, it was difficult to review all countries to see if the prices were optimally established to help the C&D access while at the same time assist with self-sustainability. From the countries the evaluation team visited, it became apparent that sometimes the objective of self-sustainability was the <u>only</u> criteria in setting price.

In Brazil, for example, USAID provided 10 million condoms to BEMFAM to specifically assist it in achieving a higher level of financial sustainability. BEMFAM therefore intends to price the new brand of condoms only slightly below the price of the most expensive condom offered in the country. CEPEO in Brazil, however, is a competing USAID contraceptive sales operation and has sold almost all their IUDs to government hospitals and clinics who are most likely to treat the C&D groups. The problem is that CEPEO has not tracked the distribution of these IUDs, and there is no assurance that they are in fact reaching the C&D groups. CEPEO has conducted one "marketing study" with a sample of 31 physicians. Unfortunately, all but three of the physicians were treating A&B patients. The study indicated that oral contraceptives were much more acceptable to C&D clients, and IUDs were used almost exclusively by the A&B groups. Unfortunately, CEPEO could not get into the OC market initially, since no commercial enterprise was interested in lowering their prices. However, there are now negotiations taking place with a local distributor for an Own Label OC brand. The problem of positioning for CEPEO products is compounded by the fact that the newly hired executive director of CEPEO clearly intends to make financial self-sustainability the primary goal.

On the other hand, Mexico is establishing a project through CONAPO, a central government agency for the promotion of family planning. SOMARC is working with CONAPO and a private sector distributor, Schering, to specifically market oral contraceptives that will be targeted to the C&D populations. There is no doubt that if this program gets under way, it will be to provide

access to the C&D segments. In this case focusing on the C&D groups is guaranteed since Schering already provides a brand that has captured almost the entire OC market share for the A&B groups.

It is possible to a certain extent, to evaluate what happens over time to the commodity prices once they are established. In other words, are the KAP and baseline studies serving to establish a price that is focused at the C&D levels over time, or does the original price quickly rise faster than inflation indicating that the original agreements are not being respected.

SOMARC was asked to take one or two examples of commodities sold by each country and indicate the original commodity price, and then analyze whether or not the current price of the same commodity rose greater or less than inflation during the same time period. Annex F has the results of this analysis provided by SOMARC. It indicates that irrespective of whether the original price was appropriately set for accessing the C&D populations, the commodity prices themselves have almost always risen less than inflation. It should be noted that some countries did not have inflation information available, and the devaluation of the currency was used. The use of devaluation is only useful to the extent that the commodities were imported and the extent to which the country residents rely on other imported goods.

This table (Annex F) is a useful tool for providing rough estimates of commodity affordability, nonetheless, it does appear that commodity prices are rising at a rate less than inflation. This methodology can still only be considered a rough approximation of commodity affordability since inflation in many countries has risen much faster than income levels; therefore, still curtailing access. The situation in Peru is interesting to note only because it might ironically represent the opposite problem—the commodity price has fallen so much below inflation that it might not be as financially sustainable as it could be at present.

SOMARC II projects were more concerned with keeping original prices down than were SOMARC III projects. This may be partly due to the release of SOMARC from the RTF condition imposed by USAID, or it may be due to the greater need for current projects to survive with less donated funds. Although keeping prices within the purchasing power of C&D group consumers, the need to develop sustainable markets can create conflicting objectives for SOMARC. Just the same, in practice, prices appear to be relatively stable when compared to inflation.

10.2 Distribution

In countries where SOMARC projects sell products as opposed to services, distribution varies enormously from country to country. In most cases, products are available through the more conventional outlets such as pharmacies; but in some instances, SOMARC has appeared less successful in making distribution headway into the more general outlets which stock commodities and implicitly service C&D consumers.

In countries where services are marketed, access is the very subject of the marketing effort, and is the focus of advertising and promotion. Although messages may have been geared toward C&D consumers, it is not always clear that these people are the resultant recipient market.

It can be generally assumed that SOMARC projects are sufficiently well thought out that distribution access is an important criterion. However, SOMARC needs to expand and maintain its efforts to ensure that its social marketing programs not only provide the access they were designed to do, but that programs also provide access to the target market.

10.3 Service Delivery

In discussing the access afforded by the service delivery systems that SOMARC promotes, the question of over-expanding access is more salient than that of under-expansion. Social marketing, by definition, expands access by minimizing many of the process hurdles and medical barriers present in many service delivery settings. SOMARC has done a commendable job of making services more widely available, while at the same time attempting to minimize dangers sometimes associated with expanded access, such as inappropriate or unsafe distribution of ethical drugs. However, a problem could arise in service delivery settings, where the vigorous marketing of one method could exacerbate provider bias for that particular product, thereby limiting free choice for consumers.

Recommendation

48. In expanding access to certain methods, SOMARC should continue its vigilance regarding the potential problem of provider bias.

10.4 C&D Markets

A primary objective of SOMARC programs is to reach the C&D markets in countries in which they work. To ensure that these markets have been reached, data from market research programs (i.e., tracking studies) has been collected in selected countries. In Africa, tracking studies for Protector condoms in Malawi, Mali, Niger, and Uganda have been completed. These studies suggest that in each location, both awareness and usage of condoms among the C&D population has been increased. Some of the results are more compelling than others. The studies in Malawi and Mali are focused primarily on urban populations. In Niger and Uganda, the studies were conducted in rural areas in which the target C&D populations are in the majority. Thus, by inference, these research projects suggest that the target populations are being reached by the social marketing program that distributes condoms. No tracking studies of oral contraceptives have been completed in the African project area.

In Asia, research projects in Indonesia, Nepal, and the Philippines have been completed. The Indonesia research study is urban based and, given the demographics of the urban area, infers that the C&D population have been reached. This is demonstrated by the high awareness and usage of Blue Circle products. In Nepal, C&D men and women were targeted in the sample, and

awareness and usage were shown to have increased. Similar results were found in the Philippines.

In Morocco a sample of women from C&D populations indicated that total pill use had significantly increased. A random sample of couples formed the basis of the Turkey tracking study for both oral contraceptives and condoms. This study confirmed that the awareness and usage of orals and condoms was significantly increased among the C&D populations.

Due to budgetary considerations which would allow all sectors of the population to be researched, it is difficult to state definitively that the project is reaching the target population. However, the inference from the available research is that the product availability and the complementary advertising campaigns have increased awareness and usage of these products in the target population.

11. SPECIAL ISSUES

11.1 Collaboration with HIV/AIDS-Prevention Programs

In general, SOMARC has been effective in collaborating with AIDS-prevention programs, and particularly with AIDSCAP 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 for the project when viewed alongside other prevention approaches such as reducing partners or decreasing STD prevalence. Collaborators generally feel that SOMARC has been open-minded, without a fixed model they insist on applying in every setting. However, in Bolivia, SOMARC was not as responsive to the changing cultural winds on condoms as it might have been. Even though the government of Bolivia had abandoned its reluctance to promote condoms, SOMARC chose not to pursue aggressive condom promotion, despite the USAID Mission's request that they do so.

SOMARC III's communication expertise on HIV/AIDS mainly comes from Porter/Novelli, the marketing and public relations subcontractor with the largest AIDS portfolio of any communications group. Porter/Novelli presented a series of technical briefings to the SOMARC/W office on epidemiological updates, patterns of infection, programmatic models, and illustrative program examples. Although Porter/Novelli lacks expertise in the clinical aspects of the virus, SOMARC is able to draw on the clinical resources of AIDSCAP, when necessary, and has worked with local AIDS bodies in several markets independent of Porter/Novelli.

At present, both USAID's Office of Population and the Office of Health and Nutrition are promoting condoms through SOMARC and other agencies, but these USAID offices do not appear to have developed a coherent strategy. The current situation is one in which the same product effectively has two brand managers, each with their primary area of prevention—pregnancy for the Office of Population and STDs/AIDS for the Office of Health and Nutrition. However, because users of any contraceptive method have the potential need to protect themselves against STDs, approaches to family planning and STD prevention need to be linked. An integrated, consistent approach to condom promotion will help SOMARC and other projects to maximize their impact. Certain strategic decisions, however, (e.g., brand versus generic marketing or core transmitter versus general population) are best made at the country level.

Recommendation

49. In its involvement with AIDS prevention, SOMARC should maintain its focus on condom promotion as its primary contribution. SOMARC should continue to aim for some level of cost recovery, although due to the urgent need for expanded condom access and the high level of donor interest in AIDS, cost- recovery standards should be less exacting for condom sales than for other contraceptives.

50. To ensure that condom promotion funds are used most effectively, it is recommended that the Offices of Population and Health and Nutrition, together with SOMARC, collaboratively develop a long-term condom promotion strategy. The strategy should endeavor to ensure that approaches meet multiple needs of consumers by paying heed to both STD/AIDS and pregnancy prevention.

51. On the policy level, SOMARC should be more proactive in fostering a favorable policy climate for AIDS-prevention programs. Through its Futures Group connections with the new POLICY project, SOMARC should seek to promote, for example, modeling studies that demonstrate the impact of the social marketing of condoms on seroprevalence.

11.2 Global and Regional Branding

The exploration of the possibilities for global and regional branding for CSM products was primarily started at USAID's request. The resulting efforts have been only partially successful to date. The international branding of commercial products is generally successful where the manufacturer gains some benefit from an international reputation (e.g., Coca Cola), or where there are international lifestyle issues that people can copy from one country to another. SOMARC has attempted global branding by trying to develop the Protector brand name not only throughout Africa, including Madagascar, but also in Bolivia and other South American countries and Papua New Guinea. This has not been a particular success. In any case it is a rather ambitious and long-term strategy.

More success has been achieved with regional branding and advertising campaigns. The Pan-Arab television campaign covering OCs, DMPA, and IUDs was created for potential use in Morocco, Jordan, Egypt, Tunisia, Turkey, Yemen, Oman, and Palestine. The "Red Apple" overbranding for five oral contraceptives, a condom, and DMPA has been developed for use in CAR, and the Pan-Africa program for Protector condoms and Pilplan has been launched. The SOMARC regional manager has presented some interesting ideas on regional activities within Asia.

Recommendations

52. Global branding is probably not achievable on a major scale although opportunities to make use of existing brand names across countries should not be ignored if practical.

53. Given the continuing promotion of Depo-Provera, SOMARC could approach Upjohn to assess the value of a global PR venture linked to the launch of the product.

54. Progress toward more regional campaigns, whether generic or brand specific, should be continued. Consideration could be given to the use of regional popular

figures such as entertainers and sports personalities, which may assist in strengthening the "regional" impact.

11.3 Self-sufficiency

The levels of self-sufficiency of each of the implementing agencies participating in the SOMARC III project have been discussed earlier in section 7.2. The projects appear to fall into three categories: 1) projects that are highly dependent on USAID funds for either donated contraceptives or operational costs; 2) projects which are going to graduate irrespective of whether or not they will be self-sufficient; and, 3) those that are private commercial ventures that will be self-sufficient at projected completion date.

SOMARC's strategies in part reflect the type of project under way. Projects in the first category that are heavily dependent on USAID funding for operational costs tend to be projects that were started prior to 1994 in Latin America, or are projects such as those in Africa that will need continued support in order to operate. It is clear that a reduction of support to many of these organizations will result in a proportionate reduction in services.

The second category are those countries that were less dependent on recurrent operating funds (third Generation) and rely upon support primarily for advertising and promotion. Some of these, such as Jamaica, Jordan, CAR, and Morocco, are already close to or are actually covering at least the cost of the product. SOMARC estimates that in each of these countries, the project could be self-sufficient, but continued USAID support is recommended if the C&D groups are to be covered at the same current levels. Other projects in this category, such as BEMFAM in Brazil, MEXFAM in Mexico, Egypt, Nepal, and the TA minimally USAID supported condom distribution in Ecuador and Honduras, will have to reduce services or possibly close down if spending is reduced.

The third category which deals solely with private commercial firms often gets back to the conflict between expansion and self-sufficiency versus service and access to the middle and lower income groups. In this case, it appears that SOMARC is often playing a passive role in pricing, as long as the implementing agency demonstrates increased numbers of CYPs. It is advisable for USAID to take this into account as USAID funds become more limited. If expansion across any income group is acceptable, then several projects can justify continued USAID support.

SOMARC is currently faced with the task of having to help a large number of countries almost without taking into account how well each of the countries are using USAID money. It is clear that some country projects are not going to be self-sufficient because the general level of income of the country cannot support a large FP program. Other projects, however, lack either the management capacity or willingness to use USAID resources more effectively and efficiently. SOMARC does not necessarily have the flexibility of using limited resources where they will receive the greatest return on investment in terms of sustainable expansion or provision of services. It may be that SOMARC will need the ability to "cut their losses" and concentrate on those countries that have the greatest potential for using SOMARC resources.

In summary, there appears to be a significant proportion of current country projects that are either not going to survive significant funding cuts, or that will survive but are not currently concerning themselves with access to lower income groups. The issue is whether USAID and SOMARC should try and fund both of these groups, or if they should concentrate on funding those projects that specifically target middle and lower income groups, and are also using USAID funds in an efficient manner. The team recommends the latter course of action, although there will obviously be exceptional cases.

11.4. Technical Assistance

In addition to the ongoing technical assistance and training that SOMARC carries out with its distributors in markets where it is actively operating a CSM program, the SOMARC III contract has a provision for carrying out TA in 10 countries at USAID's behest. To date there have been six such assignments in Ghana, Colombia, Honduras, El Salvador, Guatemala, and Kyrgyzstan, with another project currently scheduled for Russia.

There are many ways in which the skills and experience of SOMARC staff can be put to use in assisting projects in various countries. In some instances, nonproject countries can avail themselves of training modules generated for active SOMARC programs. In other instances, countries can benefit from the more general experience derived from running CSM programs for some years. Although the use of training modules has its place, one of the major benefits to specific country programs is in taking advantage of SOMARC's experience to upgrade private sector providers' skills. All of these demand resources both in time and funding which have placed demands on the SOMARC team, particularly the head and senior regional office staff.

<u>Projects Undertaken</u>

Ghana runs its CSM program under a foundation agreement, and SOMARC provided training in marketing, distribution, PR, media, and financial and administrative management. These were provided by both SOMARC staff and one of its subcontractors.

In Kyrgyzstan the TA required was to provide a program in building technical expertise of public and private sector providers in contraceptive technology. In addition to giving TOT trainings by one of its subcontractors, SOMARC utilized the resource of one of its marketing personnel to develop an implementation plan for the marketing and distribution of commercial contraceptives and to develop a pilot advertising program supporting private sector sales.

Utilizing the services of the resident advisor in Colombia, work was carried out with the IPPF affiliate, PROFAMILIA, by reviewing marketing plans for commercial sector products, reproductive health services, and some ongoing private sector initiatives.

In Honduras, SOMARC helped the ASHONPLAFA CSM program to focus on financial management, organizational strategy, and a marketing plan to move toward cost recovery and the substitution of donated commodities, as well as consolidation of the marketing function.

El Salvador benefited from assistance in redesigning the distribution strategy to use local commercial distributors and to try to reach new audiences. In addition, a restructuring of the product portfolio and pricing structure took place along with providing guidance for the implementation of a KAP study.

Assistance to Guatemala was similar to that provided in the other Latin American countries and, although in an early stage, the proposal for Russia is to examine ways in which the pharmacy business can be assisted along with an examination of local production resources.

Most of these projects have come about through requests from local USAID Missions where there is a need to have a local problem solved and where the experience of SOMARC can be beneficial. The disadvantage to providing short-term consultative solutions on a "one-time" basis is the use of LOE from SOMARC's head office staff, where resources are already stretched by ongoing programs. Moreover, there is often little continuity and follow up to these consultancies at the country level, and quite frequently the implementation of the recommendations is left with local Missions who do not necessarily have the technical resources to do so successfully.

Recommendation

55. In cases where the technical abilities of the SOMARC team are called in, where possible, USAID/W should examine each case to determine that the funding provided is being effectively used, and that there is the ability and desire to implement the recommendations by the local USAID Mission.

12. THE FUTURE

12.1 Future Activities

The work statement requires that SOMARC cover existing markets where product sales are the main thrust; focus on both FP and HIV/AIDS; expand LTM's, which require a different approach; develop the marketing of services; provide TA; and be used as a reference source on marketing activities for Missions. This is a wide range of activities with which SOMARC is tasked and could be developed in a variety of ways. The change in USAID budgeting system will impact on the type of work and how this is handled.

Directionally, it is important that during the remainder of the project, SOMARC III focus on the marketing of LTMs. This area of business is most usefully served by SOMARC's ethos and approach to projects. This is particularly the case in the expansion of DMPA in those markets where SOMARC has acquired experience in product sales and, following on from the experience gained in marketing services, this too can be capitalized on where opportunities present themselves.

There have been suggestions from both USAID/W and Missions that the product range operated by a CSM program should be expanded. This has been based on the premise that where there is a sales and distribution system in place it can be used to distribute such products as oral rehydration salt sachets, bed nets, antibiotics and so on. Care should be taken before agreeing to this type of operation unless the existing distribution system is virtually ideal for the additional products. It should only be considered in countries where condoms, and perhaps OCs, are currently being marketed.

In the area of condom marketing for STD/AIDS prevention, it may be worth reconsidering the product messages and positioning. At present, positioning straddles both AIDS prevention and FP, yet successes have been demonstrated in other CSM programs by targeting condom business solely on an AIDS/STD platform. This consideration would be particularly relevant for new markets.

The provision of TA, although well within SOMARC's capacity, should be carefully considered given the LOE involved, as well as the financial investment. SOMARC should begin to develop a two-way work plan with the Missions and IAs. For example, if SOMARC provides workshops on financial planning, feasibility assessments, and marketing plans, the key factors are what the IA is going to do and when. The resources SOMARC provides should be an investment that merits a return from the IA. Indeed, SOMARC funds could be more contingent on IA follow-through, so that those IAs who utilize SOMARC input are rewarded and, at the same time, this enables SOMARC to transfer funds from those IAs who are not utilizing SOMARC input. USAID funding is too limited to continue to provide resources to IAs who are not demonstrating positive results.

Overall, USAID/W and SOMARC need to reach an agreement on what the priorities for the SOMARC project are. There is much to gain in the development and refinement of products and

services in existing countries, and the aim of moving in-country projects along the "generation" spectrum. Equally, the team believes that SOMARC's skills lie especially in the careful development and promotion of LTMs, particularly involving DMPA in those countries where there already exists a product selling operation. Naturally, it seems sensible for Missions and others to utilize the wealth of knowledge and experience within SOMARC, but care must be taken not to allow this to detract from other more proactive programs. Finally, options arise for expansion into health and nutrition product category areas, other than family planning, but again caution is advised.

The real question to be jointly examined is expansion, or efficient expansion, with access to C&D groups. This is a key strategy that does not exist empirically and, unless determined, may result in the dilution of SOMARC's efforts. It may be more advisable to concentrate SOMARC's energies, rather than try and assist a large number of country projects that have a wide range of potential efficiencies and effectiveness. Obviously, this will have a profound effect on the nature of SOMARC's staffing and required LOE, as well funding and the manner in which this is operated.

12.2 USAID Policy

Whatever the future structural configuration of the Center for Population, Health and Nutrition private sector projects, it is clear that the Center should continue its involvement in this sector. Private commercial sector activities are a focus unique to USAID in the population donor community and the Agency should continue to build upon its comparative advantage. In addition, in some developing countries, the majority of health services is delivered through the private sector, and this should be supported.

12.3 Support Mechanisms

Continued technical and financial support for social marketing at the central level is particularly important to ensure both innovation and improvement. This is particularly crucial given SOMARC's current and planned experimentation with long-term methods and marketing strategies.

Collaboration among the Population, Health and Nutrition Center private sector projects would undoubtedly add to the efficacy of the Center to develop the private commercial sector. SOMARC's strength—marketing of commercial products—is greatly facilitated by a policy environment favorable to the private commercial sector. Likewise, SOMARC's efforts in marketing the services of private sector providers would be greatly enhanced by high level government support for new health financing schemes. The new POLICY project and the Health Financing and Sustainability II Project could add value to social marketing efforts, be they for services or products. It is recommended that mechanisms be considered to promote collaboration among projects addressing the private sector, particularly given budget constraints the Center faces. Such collaboration could assume a variety of forms, including regular technical exchange and joint planning and implementation of country activities.

ANNEXES

ANNEX A

EVALUATION SCOPE OF WORK

Contraceptive Social Marketing III Project

The Office of Population (G/PHN/POP) has a five year contract (September 30, 1992 - September 29, 1997), worth $39.9 million, with The Futures Group to build on and expand the work accomplished by previous contraceptive social marketing (CSM) projects of the office (CSM I and II). Subcontractors to The Futures Group include Development Associates, AVSC, Porter Novelli, and T. Baugh & Company. Previously unemphasized contraceptive methods and marketing approaches are being introduced and marketed during this five year period. The proposed evaluation will examine the performance and accomplishments of the CSM III Project to date and will provide guidance to prepare for the follow-on project.

I. BASIC PROJECT INFORMATION

Project Name and Number:	Contraceptive Social Marketing III Project (No. 936-3051).
Contract Number:	CCP-3051-C-00-2016-00 (Core Contract) CCP-3051-Q-00-2017-00 (Requirements Contract)
Core Contract Value:	$39,961,237
Requirements Value:	Unlimited
Core Obligations to Date:	$34,680,493
Requirements Obligations to date	$13,101,990

II. BACKGROUND

The Office of Population of USAID has been supporting centrally-funded CSM contracts for approximately 20 years. These contracts generally have provided for the following: 1) funds for technical assistance from specialists with expertise in contraceptive social marketing; 2) subcontracts with local CSM implementing agencies, which support advertising, packaging, and market research; and, 3) expertise in the procurement and management of contraceptive commodities. (The direct procurement of the commodities is <u>not</u> a part of the contract.) Major project activities have been supported in more than 25 countries.

A. CSM III Project Scope of Work

The purpose and objectives of the CSM III project are described specifically in the contract. The <u>purpose</u> of the project is to increase the availability and use of

contraceptives among low and middle income groups using commercial marketing techniques, and to establish realistic cost recovery schemes and targets in all sales programs. In order to accomplish this purpose, the following objectives were developed:

1. Increased modern-method prevalence rates using commercial channels, with greater emphasis placed on the promotion of long term methods.

2. Programs designed to pursue the dual objectives of cost recovery and maximized access.

3. Operational efficiencies are in place to minimize costs and maximize sales revenues while still maintaining financial access for C & D segment consumers in countries where full recovery of all operating expenses is unlikely. (The C & D segments represent the middle and lower middle economic class of a particular country, with A representing the wealthiest, and E the poorest.)

4. Wherever possible, the maximized use of alternative sources of commodities, eliminating reliance to USAID-sourced commodities.

5. Increased involvement of the private sector in the provision of commodities, support for distribution and promotion costs.

6. Increased correct, effective use of contraceptives.

7. Development of innovative promotion and advertising techniques.

8. Enhanced institutionalization of the skills of host country staff in IEC, strategic marketing and financial management.

B. Management Reviews

To date, there have been two Management Reviews of the CSM III Project. The first review took place in January 1994, while the most recent management review of the project was conducted in March, 1995. Both of these reports will be available to the evaluation team. Noteworthy recommendations from the recent management review were:

1. Early follow-on procurement. As a result of rapid consumption of the Level of Effort (LOE) and funding ceiling under the contract, it was

recommended that an early procurement for a follow-on project take place. Subsequently, however, that decision was reconsidered, and is not being pursued. Rather, it has been decided to seek a contract amendment which raises the LOE and funding ceiling. Such a change is necessary due, primarily, to the recent change in the Field Support funding process which obligates much more funding to the core contract.

2. Follow up on various contract amendments sought after the first review. These requests, generally, have involved requests of the Office of Procurement (OP) which would provide more flexibility for contract management to make needed contract changes, such as subcontracts, staff changes, etc, on a timely basis, rather than consistently making requests of OP. Another request was made to OP to raise the number of "New Countries" in which the project could work.

III. PURPOSE OF THE EVALUATION

The purpose of this evaluation is five fold:

A. Assess the extent to which the project has accomplished the objectives as set forth in the project design;

B. Assess how the contractual organization and management of the project have influenced its accomplishments;

C. Evaluate whether the strategies and activities noted in the design are the best ones for accomplishing the project purpose; and,

D. Evaluate whether the special issues built into the project were appropriate and beneficial.

E. Identify what activities (either current or new) should receive USAID support after the end of this project and under what mechanism(s).

IV. EVALUATION SCOPE OF WORK

At a minimum, the evaluation should address the following questions. Key questions which the Evaluation Team must address are marked with an asterisk.

A. The extent to which the project has accomplished the objectives set forth in the project design:

(*) 1. What have been the project "Outputs," as stipulated in the contract? Is the contractor on target for the accomplishment of all of the outputs stipulated in the contract? What has been the quality of these outputs?

(*) 2. To what extent has the project achieved its "Objectives," as stipulated in Section II.A., as well as in the contract?

B. Assess how the contractual organization and management of the project have influenced its accomplishments:

1. Project Organization and Management

(*) a. What are the organizational and managerial strengths of The Futures Group, and its subcontractors (as mentioned above), that have enhanced their ability to implement this project? Are there weaknesses that have had a deleterious effect on the project?

b. How has project management dealt with the delegation of responsibility to regional staff? What has been the result?

c. Has project management applied a monitoring and evaluation system of the subprojects to enhance management decision making?

d. Has project management provided adequate support and technical assistance to its field offices?

e. What have been the strengths and weaknesses of the contractual system designed by USAID for this project (the "Core" contract, with an accompanying companion "Requirements" contract for Mission buy-ins).

2. Financial and Level of Effort (LOE) Issues

(*) a. What are some of the issues regarding the financial management of the project and subprojects that affect accomplishment of project objectives, or have implications for follow-on activities? How has project management dealt with these issues?

(*) b. What has been the rate of project expenditure of funds compared with that which was projected or expected at the country level?

Have the funding and LOE levels been adequate to meet project requirements?

C. **Were the "Program Strategies" of the project, as stipulated in the contract, the best ones to accomplish the project purpose?**

(*) 1. Did the project include adequate research, baseline surveys, evaluations and assessments to demonstrate impact?

2. A major focus of this project is to increase contraceptive availability among low and middle income groups.

a. How successful has the project been in targeting sales to these lower and middle income groups?

D. **To what extent have the "Special Implementation Issues," as stipulated in the contract, been appropriate and beneficial for this project?**

1. Collaboration with AIDS Prevention Programs.
2. Regional & Global Branding.
3. Achieving Self Sufficiency.

E. **How effective has the project been with regards to the following factors:**

1. Country Selection? Has the project employed criteria for deciding upon which countries to have social marketing projects? Are their rationales and justifications useful and appropriate?

(*) 2. Regional Offices/In-country Presence. The contract calls for four regional offices. Has this been a good mechanism to ensure a strong enough presence in the countries where the project works?

3. Policy Environment. What evidence is there that the CSM projects of the Office of Population have been instrumental in affecting the overall policy environment in the countries where CSM projects have worked? Such impacts could include improved enhanced capability for the private, commercial sector to advertise and sell a variety of contraceptives, etc., and others.

F. **What needs or issues not addressed in this project should be addressed in a follow-on project?**

(*) 1. Based on lessons learned from the project to date, what modifications in project design, deliverables and funding levels are needed overall and across activities?

(*) 2. Is there a need for a follow-on project? If so, should the scope of such a project be broader? More narrow? The same? Why?

3. Assuming that there is a follow-on project, how should USAID handle the issue of contraceptive procurement for CSM? Should even more focus be put on commercial procurement, as opposed to product donated by USAID? What happens if a CSM effort is "too successful" in the "sale" of donated contraceptives?

(*) 4. What adjustments in program activities are needed over the remaining life of the project to successfully complete the project objectives?

5. What are the key contractual issues for a follow-on effort?

V. METHODS AND PROCEDURES

A. Review of Documents

The evaluation team will review all project documentation including but not limited to the following: the CSM III Project Paper, Semi-Annual Reports, trip reports, financial reports, all project related reports (i.e. project implementation reports, baseline studies etc.), the contract between USAID and The Futures Group, annual project work plans, the USAID management reviews and relevant correspondence. Additional reports that have been produced in fulfillment of the contract requirement will also be reviewed by the team.

B. Interviews

The team will interview the following: CSM Project headquarter staff; regional project staff; country office project staff; individuals and organizations working with The Futures Group on the project, particularly the subcontractors (Development Associates, AVSC, Porter Novelli, and T. Baugh & Company); USAID/Washington personnel; select Mission personnel; and, other CAs, NGOs and PVOs with whom the project has collaborated.

Within USAID/Washington, the team will meet with the G/PHN/POP staff, including the front office, the staff of G/PHN/HN/HIV-AIDS (for the appropriateness of the HIV/STD AIDS component), representatives of regional bureaus, and the Office of Procurement. Key donors and other project staff will be contacted by phone or in person whenever possible. The team will receive a list of essential contacts as well as a list from which they can randomly select persons to interview.

Prior to the evaluation, G/PHN/POP/FPSD will send a cable or E-Mail to appropriate field Missions for their input into this evaluation. The Missions will be asked to comment on past performance in these countries where the project has been active. Based on the review of Mission responses, the team may wish to follow up with interviews or E-Mail of Mission staff in countries not visited by the evaluation team.

C. Site Visits

After reviewing documents, the evaluation team will visit four key countries in which the CSM III Project has major activities. This will be done by having the team split in half, with each half visiting two countries. While in country, team members will meet with project staff, Mission staff, the project's country office staff, other donors and clients of the CSM project as possible and appropriate. Tentative choices for site visits include the following: the Philippines and Nepal by two of the team members; and, Mexico, ~~and Bolivia~~ by the other two members.

D. Time Frame

Four weeks will be allowed for the evaluation based upon the following schedule:

Week 1:	Washington
Week 2:	Country travel
Week 3:	Country travel, return to Washington
Week 4:	Draft Evaluation report, and debriefing of USAID and project staff

E. Team Composition

The team will consist of five individuals, although only four will be provided by POPTECH. These four will include a Team Leader, who is well versed in family planning service delivery projects of USAID. The other members of the team will have expertise in the following: Private Sector Service Delivery; Marketing; and, Mass

Communication. Finally, it is expected that the fifth member of the team will be an Evaluation Generalist, and will come from USAID, although not from G/PHN/POP/FPSD. As such, all costs related to a potential Evaluation Generalist would be covered directly by USAID.

Fluency in Spanish is required by at least two of the team members. For the other countries, POPTECH should be prepared to hire translators/interpreters for up to one week. In addition, at least two members should be well versed with USAID and projects of the Office of Population, particularly contracts. Further, they should all have a solid understanding of the role of the private sector in the provision of health and family planning.

F. Reports

The team will be responsible for the production of the following: 1) The CSM III Project Evaluation Report, which includes conclusions, as well as recommendations for the remainder of the project; and, 2) A list of suggestions and recommendations for a follow-on project or projects.

G. Funding and Logistical Support

All funding and logistical support for the CSM III Project evaluation will be provided through POPTECH, with the exception of the team member from USAID. Activities that will be covered include recruitment of the four core members of the evaluation team, payment of evaluation team members for a six day work week, support for all expenses related to the evaluation, logistical support and publication of the draft and final report.

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ANNEX B

TRIP REPORTS

TRIP REPORT - BRAZIL

In 1991, USAID nominated Brazil as a BIG Country and worthy of investment in CSM. The needs are greatest in the North East of the country, and that is where the SOMARC activity has been focused. Following a pilot study during SOMARC II, funding has been provided to two Brazilian organizations, CEPEO and BEMFAM, for technical and marketing assistance.

1. CEPEO

USAID conceived this organization, part funded by the PROFIT program as well as SOMARC, to procure and distribute contraceptives to lower income groups. The initial scheme was to focus on OCs, IUDs, and condoms. Discussions took place with both Schering and Wyeth for the supply of OCs such that products could be marketed to C&D groups at subsidized prices. Since neither manufacturer had a major profit generating stake in the market place they appeared willing to cooperate. Similarly, negotiations took place between CEPEO and London International US Holdings (LIUSH) to supply condoms. Again, LIUSH had little stake in the well-developed commercial condom market. Both sets of negotiations were protracted and both foundered. In 1994, the Government of Brazil (GOB) freed up the pricing policy for OCs which then allowed manufacturers to sell products at increased prices, and at much improved margins. Both Schering and Wyeth became disinterested in supplying products at cheaper prices for CSM programs and withdrew their participation. LIUSH reorganized their commercial South American operation and similarly refused to supply CEPEO. This then left the organization with its basic proposition as a CSM procurement operation severely weakened, now having only IUD's to work with.

The relationship with Finishing Enterprises has been much more satisfactory and, in March 1995, CEPEO commenced to sell IUD's, having been supplied 80,000 units by USAID. After six months of business, CEPEO has sold more than half of these and, because of its revised pricing policy, has already achieved its targeted annual budget of US$422,000. Their success is in part due to inheriting 700 IUD customers from a previous Pathfinder project, but also to its fairly aggressive marketing to private sector. Of sales to date, about 55% has been made to the public sector, 25% to the private sector, and the balance to NGOs. Prices differ widely to CEPEO customers, varying between R$6.70 for GOB purchases to commonly R$14.50 - R$23.00 to the private sector. Since private doctors charge R$30 for an IUD and anywhere between R$30-$500 for consultation and fitting, this tends to indicate that it is not only the C&D clients who are being catered for by CEPEO.

It is clear that the nature of the organization has changed during the duration of the project. Current CEPEO management is intent on turning the company into a commercial organization that makes a profit out of its business. Although some activity may be directed to a CSM program, this is no longer the prime objective of the company. New negotiations are taking place with various condom suppliers, JK in India, Aladdin, and others in Malaysia and Korea. These alternatives are being sought since it is believed that imported products still carry some cachet, as opposed to locally supplied products. It is intended that pricing will be lower than commercial brands, other than the locally manufactured market leader Olla, but not as low as would be required for a CSM program. However, some supply will be made to GOB and NGOs at a more favorable pricing. Negotiations are also taking place with a local OC manufacturer to produce an Own Label brand for CEPEO; and there are fairly well advanced packaging and promotional activities to repack IUD's to be sold to the private sector. There are no plans to introduce Depo-Provera at this time, although it would seem a likely candidate for CEPEO given their current and increasing contact with private sector doctors.

SOMARC's involvement appears to have been restricted to providing strategic assistance in the early stages of the project and more recently in TA in training. While their input has obviously been of value, it would seem that SOMARC is seen by CEPEO management more importantly as a source of funding, rather than for the actual help they could provide with the intended new marketing drive if mandated.

2. BEMFAM

This local IPPF affiliate has benefited from SOMARC input in developing a new condom brand. This has involved strategic help, research, development of brand names and packaging, and general commercial guidance. It was thought that CEPEO in its original form could provide products to BEMFAM, but there has been no cooperation between the two organizations, mainly due to supply as well as pricing problems. The climate changed during the period of SOMARC's assistance when it became apparent that BEMFAM would have to make their condom CSM project self sustaining in the light of withdrawal of USAID provision of free product in future. That said, USAID donated 10 million condoms for this program to get BEMFAM started and these are to be branded PROSEX and repackaged locally.

Although there is no fixed retail price maintenance in Brazil, trade pricing is such that the brand will be sold to the consumer at prices between the local brand leader, Olla, and Jontex, the dominant commercial brand. These two brands hold 70% of the 75 million condoms/annum market between them. Positioning is said to be for AIDS/STDs, since the GOB legislation does not allow mass media promotion of FP. However, the packaging, as for many other brands, appears to indicate dual usage.

Advertising is planned for local TV, radio, and print media in both Rio de Janeiro and Sao Paolo. Distribution is to be restricted to these states and it is planned, via two salespeople, plus two assistants, to sell product through 10 distributors and

four pharmacy chains. Retail distribution is primarily aimed at pharmacies and drugstores, of which there are some 6,000 in the two state capitals, and a further 6,200 in the state interiors. It is not planned to cover supermarkets in the early stages of the launch. With the limited sales resources proposed and BEMFAM's limited experience in a commercial venture such as this, obtaining widespread distribution coverage and regular continuing sound commercial business will not be easy.

While these plans are in place, they are a little academic at present. Quality is an important issue in the Brazilian market and rigorous testing of brands is conducted by the GOB testing organization INMETRO. The approval of the BEMFAM product by INMETRO has been extremely protracted and still not finalized, and brand registration has not yet been completed either. Products will not be imported from USA until these two clearances are obtained. Because of the length of time the project has been under way, the shelf life of the condoms is now down to three years. BEMFAM is very optimistic about how speedily they can react to recruiting sales personnel, and appointing distributors and printers, once the approvals are received. While package designs and advertising are prepared, it is probable that the necessary activities to launch the product will take considerably longer than the two months that BEMFAM is indicating. Unfortunately, this is symptomatic of their inexperience in the commercial sector and, now that SOMARC's involvement is complete, they may be sadly short of sound assistance if the project is to succeed.

SUMMARY

SOMARC has provided technical assistance to both organizations during the course of SOMARC III. In the absence of any continuing direct involvement, its role now remains one of watching rather than being actively implicated. While they have undoubtedly spent considerable time, thought, and energy with these two clients, both projects are examples of finite TA being less usefully implemented than might otherwise have been the case. Both organizations appear to want to pursue their own directions, and are attempting to make self-sustainability their primary goals, some of which may be against the CSM ethic that SOMARC represents in its overall contract. In the case of BEMFAM, in the absence of continued technical assistance, it seems unlikely that the condom project will be a resounding success. In the main, this is due to BEMFAM's current experience and style of conducting its regular clinic and AIDS program business. SOMARC's input was undoubtedly essential to get them as far as they have at present with launching a brand into the private commercial sector of the trade. However, commercial naivete may inhibit its continued progress. In the case of CEPEO, SOMARC has much to offer, provided USAID ensures an agreement between the parties to work together before further funding is approved, and indicates what inputs and outputs are expected of each organization.

Recommendations

56. USAID should re-examine their role in supporting CSM with SOMARC in Brazil.

57. Consideration should be given to further supporting the CEPEO operation by enlisting SOMARC's continuing marketing involvement. Attempts should be made to try to ensure a balance between self-sustainability and delivering products and services to C&D groups before continued funding is approved. Alternatively, USAID may decide to favor creating a self-sustaining presence only and SOMARC's involvement should be redefined.

58. Continued support for BEMFAM should only be provided if USAID is prepared to fund SOMARC's involvement for at least a three-year period. The roles of SOMARC and BEMFAM would need to be very clearly defined and possibly contingent on BEMFAM's performance.

TRIP REPORT - MEXICO

BACKGROUND

Team members A. Handyside and R. Brooks visited the SOMARC activities in Mexico, which is also the location of their regional office for Latin America. There are four full-time SOMARC personnel at the regional office to supervise activities in 12 Latin American countries. In Mexico, SOMARC is providing technical assistance for two nonprofit NGOs, FEMAP and MEXFAM. In addition, SOMARC is working with CONAPO (National Population Council) and Schering Mexicana. All rely on local donor or generated funds, and some receive funding from core initiative funds.

FINDINGS

The SOMARC work can be summarized as follows:

MEXFAM

SOMARC provides technical assistance and also serves as a "passthrough" to provide for management, promotional, and advertising costs. The primary objective of SOMARC assistance is to "increase the demand for MEXFAM services." It is important to note that SOMARC's assistance is dependent upon the approval of both IPPF and the USAID Mission. Currently, SOMARC has been asked to assist MEXFAM with its corporate image, marketing a product brand of contraceptives, training, market research for opening new clinics, pricing, advertising, and promotion. SOMARC will provide to MEXFAM a total of US$653,727 for MEXFAM staff and other promotional and advertising costs in addition to the TA. The ultimate goal of this work is to build up revenues for MEXFAM in order to help it become more self-sufficient when USAID funding is scheduled to end in 1997.

MEXFAM is extremely pleased with the assistance of SOMARC, however, the actual results of the SOMARC efforts are not very impressive at the moment. They can be summarized as follows:

1. Marketing research of new clinics - The objective of this effort is to analyze the population served, design the clinic staff and price structure accordingly, and project future income and expenses. The team asked to see the financial results of the three clinics that were started in 1994, where SOMARC TA in the market research was used. The following table illustrates the actual results of this clinic as of March 1995, compared to what was projected as a result of the marketing research.

   It is not unusual for the revenues to be overestimated, but it is noteworthy to see that the expenses were also grossly underestimated for two of these clinics. It therefore does not appear that the TA provided is having much of an effect when it comes to anticipating revenues and expenses of the new clinic operations.

Table B-1

Financial Results for 1994

Clinic	% Difference Estimated vs. Actual Income	% Difference Estimated vs. Actual Expense	% Self-Sufficiency
Tampico	-25%	+420%	29%
Veracruz	-39%	+23%	31%
S.L. Potosi	-10%	+164%	14%

2. Increasing the demand for services - SOMARC provides training, a full-time marketing specialist, and other advertising and promotional funds. SOMARC has maintained the projections of revenues, and as of the second semester, 1,923,585 pesos were projected, and 749,161 pesos were actually generated, or 64% of projected.

3. Self-sufficiency - At the moment, MEXFAM is expecting to be only 21% financially self-sufficient by year end 1995; 23% in 1996, and 30% in 1997. This is up from 19% in 1994.

4. Contraceptive sales and branding - At the moment, branding for a condom has been completed, but a distributor has not been identified, and there has been no condom sales as yet.

Mexico has been facing a financial crisis with the devaluation of the peso, and this has not helped MEXFAM.

Recommendation

59. Specific targets, such as projected income, need to be maintained as well as identification of what will be the impact of SOMARC work with MEXFAM.

FEMAP

SOMARC provides assistance to FEMAP in the same manner as to MEXFAM, with support for FEMAP personnel (e.g., the executive director), training, and technical assistance. The work primarily involves assisting FEMAP with the development of a marketing plan and FEMAP's expansion of services through affiliates. SOMARC has only recently begun efforts with FEMAP and has plans to increase its support to FEMAP during the next two years.

FEMAP has had considerable success with becoming a productive organization that now derives 59% of its income from local revenues and 18% from local donations.

It only depends on international agencies for the remaining 23% of income. FEMAP also is looking for a local distributor to market contraceptives.

Recommendation

60. **SOMARC should continue to concentrate its assistance on FEMAP as it begins to develop other revenue sources from affiliates and possible contraceptive sales.**

CONAPO

The National Population Council, CONAPO, is interested in working with SOMARC and Schering to initiate a commercial venture for the sale of oral contraceptives specifically to the E social class markets. CONAPO would like to initiate sales in three states within the next 12 months. For Schering, this represents a chance to penetrate the health centers and peri-urban physician and pharmacist market. Schering already has 12 pills on the market, ranging in price from US$2 to US$13 a cycle. All they lack is a product positioned at the lowest social class level, but this last level represents 50% of the population.

The formation of a working group of these three organizations has numerous advantages. SOMARC will hopefully provide start-up expertise and funds from its initiatives budget. CONAPO has national leverage, and can obtain free television and radio advertising, and it can also provide the design and publication of educational materials. In addition, CONAPO has a work force of 20 people that can assist with this project.

This provides SOMARC with the opportunity to launch a national sales campaign with no recurring costs. In addition, SOMARC intends for the other two organizations to share in the start-up costs of this campaign. Another added spin off is that these oral contraceptives can be obtained at a discount price for both FEMAP and MEXFAM, thereby enhancing the family planning efforts as well as providing a potential source of revenue.

Recommendation

61. **SOMARC should give the CONAPO project top priority for its work in Mexico, and to the extent possible, receive USAID Mission support for focusing their efforts accordingly.**

62. **It is recommended that SOMARC note some of the lessons learned from the Turkey project for this launch in Mexico.**

63. **There is an urgent requirement for a SOMARC person who is very experienced in negotiating, and recruitment of such a person should take place as soon as possible to replace the regional director who has been promoted.**

TRIP REPORT - THE PHILIPPINES

Implementing Agency: Kabalikat Foundation
CSM Model: Provides promotional support to existing commercial brands

Products (start year):	Condom (1992)-	"Sensation" - Philusa Corp.
	Hormonals-	"Couples Choice" - Overbranded
	- OC's (1993)	- "Nordett" - Wyeth
		- "Marvelon" - Organon
		- "Microgynon" - Shering
	- Injectables (1994)	- Depo-Provera - Upjohn

Sales by retail value (in US$)	- 1992/93 - $ 783,360
	- 1993/94 - $ 949,520
	- 1994/95 - $1,615,999 (projected)
CYP	- 1992/93 - 30,065
	- 1993/94 - 39,791
	- 1994/95 - 72,169 (projected)
Total Spend	- 1992/93 - $1,088,192
	- 1993/94 - $1,331,357 (incl. contribution to Washington)
	- 1994/95 - $1,447,599 (incl. contribution to Washington)
Spend per CYP	- 1992/93 - $36
	- 1993/94 - $33
	- 1994/95 - $20 (estimated)

1. Management

The SOMARC country manager works through a local NGO--Kabalikat Foundation--who provides staff and office space. Kabalikat, however, leaves day-to-day management to SOMARC.

2. Meeting Objectives

The original activities of SOMARC III in the Philippines were well conceived to meet the objectives established by USAID. However, these objectives have only partially been met. Sales of condoms and OC's have been slow to develop but are expected to reach reasonable sale increase levels in 1995; the injectables launch has been slow, constrained by a lack of commitment from Upjohn; the launch of a second condom and expansion into long-term methods (sterilization) will not be achieved according to present planning.

3. Constraints

The primary constraints were:

- delays in government approvals at the outset of the project
- a slow process of confidence building with the manufacturers. Upjohn is still not fully committed to the Depo-Provera launch
- the need to run in a new SOMARC management team
- expressed and public resistance to the program from the Catholic church, particularly in 1993, which appears to have significantly affected sales in that year
- competitive pressures from DKT/PSI, particularly, from their heavily subsidized condom brand and, more recently, an OC brand
- reluctance to get behind the brand from the condom importer, for religious reasons. This delayed the distribution effort, but this has been largely resolved.

4. Impact

Condom sales increased to 1.3 million in 1994 from 583,000 in 1992. Sales in 1995 are projected at 2.4 million. OC sales increased from 252,000 in 1992 to 276,000 in 1994 with a projection of 431,000 in 1995. Injectable sales were budgeted to reach 60,000 vials in 1995 although this target will not now be met. Commercial market shares are expected to reach 22% for condoms and 19.6% for OCs. It is estimated that the total commercial market share of all brands in 1995 was 19% and a total SOMARC market share including the government sector will be 4.3% (if injectable targets are met).

5. Targeting C&D Groups

Product pricing, distribution outlet selection, media planning and brand positioning strategies are all employed to target products at the C&D market. There are inadequate inputs from tracking studies to determine the extent to which this strategy is being achieved. A recent tracking study indicates, however, that 10% of OC customers have come from the government sector and 27% are new OC users.

6. Pricing Strategies

The original negotiations fixed retail prices at US$2.20 per cycle of OC's; US$4.00 per injectable (including a prepacked syringe) and US$0.27 per pack of three condoms. These prices are within the SOMARC guidelines (1-2% of monthly income) for reaching the C&D group market. No detailed analysis has been done on profit margins achieved by manufacturers at these sales levels. It is possible that such an analysis would show that profit margins, particularly for the hormonal products, are more than reasonable.

7. Funds Returned to Project

Formulas have been agreed for return to project funds from the hormonal manufacturers but not from the condom distributer. However these funds are minimal and are expected to reach only $38,000 in 1995 out of a total spend (including for condoms) of $1.6 million.

8. CYP Achieved

CYP achievement is calculated as total sales divided by total SOMARC spend. This calculation gives a cost per CYP in 1994 at US$33 and an estimate for 1995 at US$20. However, existing brands which already have a market share are taken into account, USAID would be well served if they knew what additional sales SOMARC inputs helped generate.

9. Technical Assistance

The country manager appreciated the technical assistance received from SOMARC/W. Owing to the competence of the research, creative and media planning resources available to the project in the Philippines, the need for on-going technical assistance is not great. Future assistance in areas of AIDS prevention and in the development of training for provider networks, should LTMs be launched, are the main requirements foreseen. The need for approval from SOMARC/W for all media plans and materials was felt to be a burden on the project.

10. Self-sustainability

The CSM model employed allows for withdrawal of the inputs supplied by the SOMARC project at any time. The country manager intends to withdraw support for condoms at the end of 1995; for OCs at the end of 1996 and for injectables at the end of 1997. However, some minimal support is expected to continue for both the condoms and OCs until the end of SOMARC III. No estimates have been prepared as to what impact on sales may occur once promotion funding is withdrawn nor whether the manufacturers or condom distributor will continue the effort from its own funds.

11. Funding Issues

The project has been affected by a reduction in funding from USAID/Philippines and from the need to contribute 18% of its funds to support central management.

12. Innovative Strategies

AIDS Prevention
The project has positioned the condom to the STD/AIDS-prevention market and has evolved good working relationships with both the government and NGO sectors in this field. The project is leading the establishment of an Association of Condom Endorsers (ACE) which is an innovative program to bring together condom

distributors, government and NGO organizations and manage a combined mass media and promotional program.

Global Branding

The SOMARC regional manager is developing some interesting thoughts on the possibilities for global branding within the Asia region.

Recommendations

64. In general, the project is being well managed and the overall strategies are sound. It is recommended, however, that stronger relationships be developed with the manufacturers of hormonals and condom distributors to gain a better understanding of how the brands being supported by SOMARC III will continue after funding ceases. This is particularly important for the hormonal lines which are being promoted together under the Couples Choice branding.

65. The project needs to gain clearer understanding of its penetration of the C&D market; it's impact on attracting customers from the government sector; from other higher priced brands and in attracting new customers. The general directions for any longer term program should be toward longer term methods and toward considerations of how the program may become more cost effective and managed on a more commercially oriented model as regards overhead expenditures and operational efficiencies.

TRIP REPORT - UGANDA

1. CSM Model Employed

The Uganda social marketing program utilizes the so-called Phase II social marketing model. The project uses existing distributors/implementing agencies, donated commodities, and does some cost recovery. Currently, SOMARC/Uganda is selling 'Protector' condoms and 'Pilplan' oral contraceptives through a single distributor, Twiga Chemical Industries. The branding and marketing/promotion of both these products are part of the SOMARC African regional campaign. At the same time, SOMARC/Uganda has five sales persons funded through the cooperative DISH-SOMARC agreement. A resident advisor directs day-to-day activities.

2. Management

The management of the SOMARC/Uganda program at the resident advisor level is very strong, and substantial work has been done to strengthen management at the next level of management. The staff was very professional in their approach to the evaluation, and presentations on the organizational structure as well as their implementation methods were well-thought out and thorough.

The resident advisor has spent her first year setting the implementation direction for the next two years of the project. She appears very proactive in identifying problems. The evidence is that through her staff she has accomplished the following:

A. started a formal evaluation of NGOs for which SOMARC provides training and support to ensure that the SOMARC/Uganda effort translates into additional coverage of the target C&D populations;

B. initiated first steps toward a plan for the launch of Depo-Provera in the second quarter of next year;

C. initiated first steps toward the integration of the sale of antibiotics into the SOMARC/Uganda program.

3. Problems

The recent condom stock outage underscores the need to develop better early warning systems to avoid these outages. SOMARC/Uganda is currently developing some computer systems to track sales and associated data, and the development of a stock report coupled with a mid-year inventory check would be useful in minimizing the potential for outages. SOMARC/Uganda has the experience of a stock outage, and thus they have real-time numbers with which they can factor in

the time to obtain products. It is recommended that these elements all be brought together to develop an inventory system.

Currently there does not appear to be a Ugandan "replacement" for the resident advisor. Although the staff is capable, there is no one, as yet, to whom the program can turn should the resident advisor leave the station for an extended period of time. Some thought needs to be given as to whether a current staff member can be trained to step into this role, or whether an additional person should be recruited specifically for this position.

4. Impact

Protector condoms are the market leader in Uganda. SOMARC/Uganda and the supporting SOMARC/W and regional groups should be commended for the work that they have done in launching the product and, building and maintaining sales.

Pilplan has been launched, but there does not appear to be the same impact as that for the condom product. Reasons for this are complex, but the level of energy needed to build this product is more reliant on medical elements in the country, and this linkage does not appear to have been fully made. This has potentially negative implications for the launch of Depo-Provera which is likely to require event greater medical support. It is recommended that SOMARC/W develop programs to involve the medical community in the Uganda program.

CONCLUSIONS

SOMARC/Uganda is a well-managed program, and based on general comments from the evaluation team, represents one of SOMARC's strongest programs. Areas in which the program can be strengthened are through definition of staff succession and better integration of modern contraceptive programs within the medical community.

TRIP REPORT - NAIROBI, KENYA

This evaluation involved a one-day meeting with the SOMARC regional office for East Africa. The meeting with the director and deputy directors occurred in their offices. The regional office backstops the Uganda project and, at the same time, coordinates projects in Togo (West Africa), Zimbabwe, and the new project in Madagascar. General findings from this meeting are provided in the evaluation report.

ANNEX C

Current Expenses for
ADMINISTRATION
as of June 1995

	Current Month	Current Quarter	Expenses	-FY--1995- Budget	%	Remaining	Project to Date
	0	0	0				704
Subtotal	$ 0	$ 0	$ 0	$	0%	$ 0	$ 704
DC Other OOC	0	0	0				26
Subtotal	$ 0	$ 0	$ 0	$	0%	$ 0	$ 26
SALARY							
	0	0	0				0
Asia Technical	0	716	716				716
Consultants	0	0	0				7,199
Contract Administrator	567	1,669	6,444				36,668
Tech. Asst/DC Support	4,458	13,481	34,693				91,234
Deputy Director	2,924	11,121	25,542				70,042
Project Director	0	0	10,030				62,543
Information Dissemination	0	3,488	5,091				5,798
LAC Manager	1,770	4,662	4,597				5,297
LAC Technical 2	0	0	0				53
MIS/Commodities Dir.	3,303	9,230	25,823				92,205
Long Term Mothods	740	4,801	12,532				46,816
Market Research Manager	874	2,706	5,186				25,667
M.E./W.A. Tech/Research	0	0	0				2,470
M.E./W.A. Technical	0	0	-193				-146
Project Administrator	960	3,972	10,324				43,962
Marketing T.A./Field	0	716	5,510				5,510
Sr. Marketing T.A./Home	212	2,624	7,597				16,822
Short Term T.A.	464	930	4,919				59,702
Administrative Support	1,648	4,896	14,862				72,920
Subtotal	$ 17,919	$ 65,012	$ 173,672	$ 267,773	65%	$ 94,101	$ 645,476
OH							
Field/Res. Adv. O/H	1,576	4,842	9,057				12,286
US O/H	23,416	88,505	228,502				895,763
Subtotal	$ 24,991	$ 93,347	$ 237,559	$ 335,391	71%	$ 97,832	$ 908,048
ALLOW							
	0	0	0				0
ALLOWANCES, O/S	283	544	1,302				11,325
LAC Manager	270	270	270				270
Subtotal	$ 553	$ 814	$ 1,572	$ 26,688	6%	$ 25,116	$ 11,594
EQUIP							
DC Office Equipment	0	0	5,283				25,562
Subtotal	$ 0	$ 0	$ 5,283	$ 8,550	62%	$ 3,267	$ 25,562
SUBS							
Advertising and PR	0	0	0				13,017
AVSC	0	0	5,129				37,600
Dev. Associates	0	0	224,900				662,142

Current Expenses for
ADMINISTRATION
as of June 1995

	Current Month	Current Quarter	FY 1995 Expenses	FY 1995 Budget	%	Remaining	Project to Date
BUGS							
Field Sub	0	0	0				3,404
Implementing Agencies	0	0	0				1,400
Market Research	0	0	0				15,868
Path	0	0	0				45,126
BAUGH, TERRY (TB)	0	0	29,167				105,817
Subtotal	$ 0	$ 0	$ 259,196	$ 342,863	76%	$ 83,667	$ 884,374
TRAVEL							
DC/Regional Trav/Perdiem	4,653	9,548	14,284				73,769
Subtotal	$ 4,653	$ 9,548	$ 14,284	$ 72,112	20%	$ 57,828	$ 73,769
ODCS							
DC Phone/Fax	730	3,118	6,290				27,269
Library	280	4,722	11,276				33,548
DC Other ODC	17,043	35,606	156,338				354,735
Subtotal	$ 18,053	$ 43,447	$ 173,904	$ 123,810	140%	$ -50,094	$ 415,552
FEE							
Fee	4,116	13,197	53,832				184,430
Subtotal	$ 4,116	$ 13,197	$ 53,832	$ 73,144	74%	$ 19,312	$ 184,430
TOTAL	$ 70,285	$ 225,365	$ 919,303	$1,250,331	74%	$ 331,028	$3,149,535

Does not include Information Dissemination or Special Studies

SELF-SUFFICIENCY STATUS

Country (Data)	Start Date	Product/ Service	Current Self-Sufficiency (Inc./Dir.)	Projected Self-Sufficiency (Inc./Dir.)	Date Projected	Change	Notes
Brazil (1995)	1994	IUDs	65%	100%	1997	35%	
Ecuador (1995)	Sep-87	Condoms Pills (Nord) Pills (Micro) Preg. Test	41%	80%	2002	39%	
Guatemala (1995)	1984	Cond (SO) Cond (S) Cond (P) Pills (P) Pills (I) Iprogel Lirio	37%	100%	1997	63%	Includes USAID Iprofasa subsidy.
Haiti (1994)	Oct-89	Pills DMPA	22%	50%	2004	28%	Products projected
Jamaica (1994)	Apr-89	Pills (P) Pills (M) DMPA	75%	85%	2005	10%	Project can be 100% self-sufficient if no funding received.
Peru (1995)	Oct-86	Condoms	67%	100%	1997	33%	SOMARC costs also include limited support for other products.
Egypt (1994)	Aug-87	Condoms Pills IUDs DMPA	27%	80%	2002	53%	
Jordan (1995)	Feb-94	Pills IUDs DMPA Services	0%	80%	2002	80%	Products already self-sufficient. Continued CSM support recommended.
C A R (1995)	Oct-93	Condoms Pills IUDs DMPA	0%	75%	2002	75%	Products already self-sufficient. Continued CSM support recommended.
Morocco (1995)	Nov-85	Condom Pills	80%	100%	1996	20%	Condoms 100% self-sufficient. Pills 100% self-sufficient in 1996
Morocco (1995)	1995	DMPA Services	0%	75%	1996	75%	Continued CSM support for expanded program recommended.
Turkey (1995)	Sep-94	Services	0%	85%	2002	85%	Continued CSM support recommended.
Turkey (1995)	Apr-89	Condoms Pills (D) Pills (G) Pills (L) Pills (M) Pills (TNL) Pills (TQR)	100%	100%	1995	0%	

SELF-SUFFICIENCY STATUS

Country (Data)	Start Date	Product/ Service	Current Self-Sufficiency (Inc./Dir.)	Projected Self-Sufficiency (Inc./Dir.)	Date Projected	Change	Notes
Mali (1994)	Sep-88	Condoms Pills	8%	50%	2005	42%	
Niger (1995)	Feb-93	Condoms	4%	35%	2005	31%	
Senegal (1995)	May-94	Condoms	5%	50%	2002	45%	
Swaziland (1995)	Jul-91	Services	0%	NA	NA	NA	
Togo (1995)	Apr-91	Condoms	26%	100%	1995	74%	USAID phasing out by Dec 1995.
Uganda (1995)	May-90	Condoms Pills	9%	35%	2002	26%	
Zimbabwe (1995)	1988	Condoms	100%	100%		0%	Graduated program.
India (1995)	1994	Condoms Pills	34%	NA	NA	NA	Product subsidy levels unknown.
Indonesia (1995)	1995	AIDS/NSV	0%	NA	NA	NA	Limited technical assistance only.
Indonesia (1995)	1985	Condoms Pills IUDs DMPA	100%	100%	1994	0%	
Nepal (1995)	1980s	Cond (D) Cond (P) Pills (G) Pills (N) Pills (K) VFTs DMPA	11%	70%	2005	59%	USAID subsidy to CRS included in direct costs.
Philippines (1995)	1992/93	Condoms Pills DMPA	62%	80%	2002	18%	Products already self-sufficient. Continued CSM support recommended.

Note: 1995 data is for January through June. 1994 data is for entire calendar year.

Note: For countries using commercially-procured products where the price structure is unavailable, income from product sales is assumed to equal private sector expenses plus commodity costs. For countries where the price structure is available, private sector expenses are assumed to equal the difference between product cost and income from sales.

SELF-SUFFICIENCY STATUS

Country	Product/ Service	PERCENTAGE OF COSTS COVERED BY INCOME FROM SALES								NOTES
		Commodity		Distribution/ Sales Force		Marketing/ Advert/Promo		Management Impl. Agency/R.A.		
		Current	1997	Current	1997	Current	1997	Current	1997	
Brazil	IUDs	100	100	0	40	0	90	50	100	
Ecuador	Condoms	100	100	46	100	25	57	19	30	Current plans for phase out and 100% self-sufficiency by 2000.
	Pills	100	100	46	46	0	0	19	19	
	Preg. Test	100	100	46	46	0	50	19	19	
Guatemala	All comm.	100	100	40	100	35	100	30	100	100% self-sufficiency for donated products by 2000.
	All donated	0	50	40	90	35	90	30	90	
Haiti	Pills	100	100	100	100	80	100	40	100	100% self-sufficiency in both products by 2004.
	DMPA	0	0	0	0	0	0	40	60	
Jamaica	Pills	100	100	100	100	0	85	0	100	Project can be 100% self-sufficient if no funding received.
	IUDs	N/A	100	100	100	0	85	0	100	
	DMPA	100	100	100	100	0	85	0	100	
	NSV	100	100	100	100	100	100	100	100	
Peru	Condoms	0	100	100	100	0	100	0	100	
Egypt	Condoms	0	NA	100	NA	100	NA	0	NA	Products projected to be self-sufficient. Continued funding uncertain.
	Pills	0	100	100	100	75	100	0	NA	
	IUDs	0	100	100	100	100	100	0	NA	
	DMPA	0	100	100	100	0	100	0	NA	
Jordan	Pills	100	100	100	100	0	50-100	0	NA	Products projected to be self-sufficient. Continued funding uncertain.
	IUDs	100	100	100	100	0	50-100	0	NA	
	DMPA	100	100	100	100	0	50-100	0	NA	
C.A.R.	Condoms	100	100	100	100	25	25	0	NA	Limited condom promotion funds provided by private sector. Continued funding uncertain.
	Pills	100	100	100	100	0	0	0	NA	
	IUDs	100	100	100	100	0	0	0	NA	
	DMPA	100	100	100	100	0	0	0	NA	
Morocco	Condom	100	100	100	100	100	100	100	100	Condom at 100% self-sufficiency. Pill 100% self-sufficient in 1996.
	Pills	100	100	100	100	100	100	100	100	
	DMPA	100	100	100	100	20	75	25	50	
	Services	100	100	100	100	20	75	25	50	
Turkey	Condoms	100	100	100	100	100	100	100	100	Recommend continued CSM support for services network.
	Pills	100	100	100	100	100	100	100	100	
	Services	100	100	NA	NA	0	50	0	50	

SELF-SUFFICIENCY STATUS

Country	Product/ Service	PERCENTAGE OF COSTS COVERED BY INCOME FROM SALES								NOTES
		Commodity		Distribution/ Sales Force		Marketing/ Advert/Promo		Management Impl. Agency/R.A.		
		Current	1997	Current	1997	Current	1997	Current	1997	
Mali	Condoms	0	0	20	50	0	25	0	0	Not projected to be self-sufficient.
	Pills	0	0	20	50	0	25	0	0	
Niger	Condoms	0	0	20	50	0	25	0	0	Not projected to be self-sufficient.
Senegal	Condoms	0	80	100	100	0	50	25	50	
Swaziland	Services	NA	NA	NA	NA	0	100	0	0	USAID phasing out by Dec 1995.
Togo	Condoms	0	100	23	100	0	100	4	100	USAID phasing out by Oct 1995.
Uganda	Condoms	0	0	25	39	0	0	0	0	
	Pills	0	0	18	22	0	0	0	0	
Zimbabwe	Condoms	100	100	100	100	100	100	100	100	Graduated
India	Condoms	100	100	100	100	10	NA	10	NA	Product subsidy amounts unknown. Future
	Pills	100	100	100	100	6	NA	0	NA	funding level unknown.
Indonesia	Products	100	100	100	100	100	100	100	100	No on-going assistance for products.
	Services	NA	NA	NA	NA	0	0	0	0	Continuing short-term TA requested for VSC IE&C.
Nepal	Condoms	0	0	22	37	22	37	22	37	All donated commodities.
	Pills	0	0	22	37	22	37	22	37	
	VFTs	0	0	22	37	22	37	22	37	
	DMPA	0	0	22	37	17	37	22	37	
Philippines	Condoms	100	100	100	100	20	100	0	0	Continued CSM support recommended.
	Pills	100	100	100	100	20	50	0	0	
	DMPA	100	100	100	100	20	50	0	0	

CR=Cost recovery; SS=Self-sufficiency; G=Graduated; PO=Phased out.

ANNEX F

Average Costs for All SOMARC Projects

Year	$/CYP/Year	Cumulative $/CYP	$/CYP/Year with Overhead	Cumulative $/CYP with Overhead
1985	14.3	14.3	108.6	108.6
1986	43.6	43.2	70.2	95.0
1987	13.4	19.4	18.8	27.2
1988	12.0	15.2	14.2	18.1
1989	7.9	10.9	9.7	14.3
1990	3.1	7.2	3.7	8.6
1991	3.7	5.9	4.0	6.4
1992	4.7	5.5	5.8	6.9
1993	4.2	5.2	5.6	6.9
1994	4.0	5.0	4.9	6.1

Average Costs by Program Duration

Duration of Program (Years)	Number of Countries	$/CYP/Year	Cumulative $/CYP
1	15	33.5	33.5
2	15	11.4	17.5
3	15	10.1	13.8
4	12	5.7	10.6
5	9	3.3	8.4
6	9	2.4	6.8
7	8	2.2	5.8
8	5	2.2	5.3
9	2	1.6	4.8

SOMARC WORLDWIDE SALES/CYPS

SALES	CO	VF	OR	IU	IN	IP
1984	11,574,413	2,419,659	1,404,593	189,222	0	0
1985	17,019,554	1,065,020	1,596,067	216,924	0	0
1986	24,674,349	734,106	2,048,761	263,168	0	0
1987	31,721,820	1,644,184	2,855,539	286,999	0	0
1988	36,077,403	1,587,864	4,058,462	333,807	105,365	0
1989	50,442,381	4,772,961	10,989,341	425,802	880,220	0
1990	51,184,394	5,704,794	11,178,786	494,499	1,765,073	0
1991	59,184,728	7,342,752	12,960,450	496,407	2,083,436	0
1992	58,631,497	5,498,348	16,942,115	485,962	2,441,721	0
1993	44,476,219	6,573,720	17,502,125	217,775 (1)	1,984,951 (2)	134
1994	62,588,890	5,820,420	17,740,677	922,445	1,565,469	15,184
Est. 1995	82,093,222	6,750,434	17,810,457	633,295	1,513,221	16,009
TOTAL	#########	49,914,262	#########	4,966,305	12,339,456	31,327

SALES	SHORT-TERM	LONG-TERM	TOTAL
1984	15,398,665	189,222	15,587,887
1985	19,680,641	216,924	19,897,565
1986	27,457,216	263,168	27,720,384
1987	36,221,543	286,999	36,508,542
1988	41,723,729	439,172	42,162,901
1989	66,204,683	1,306,022	67,510,705
1990	68,067,974	2,259,572	70,327,546
1991	79,487,930	2,579,843	82,067,773
1992	81,071,960	2,927,683	83,999,643
1993	68,552,064	2,202,860	70,754,924
1994	86,149,987	2,503,098	88,653,085
1995	106,654,113	2,162,525	108,816,638
23,874	696,670,505	17,337,088	714,007,593

CYPs	CO	VF	OR	IU	IN	IP
1984	115,744	24,197	108,046	473,055	0	0
1985	170,196	10,650	122,774	542,310	0	0
1986	246,743	7,341	157,597	657,920	0	0
1987	317,218	16,442	219,657	717,498	0	0
1988	360,774	15,879	312,189	834,518	26,341	0
1989	504,424	47,730	845,334	1,064,505	220,055	0
1990	511,844	57,048	859,907	1,236,248	441,268	0
1991	591,847	73,428	996,958	1,241,018	520,859	0
1992	586,315	54,983	1,303,240	1,214,905	610,430	0
1993	444,762	65,737	1,346,317	544,438	496,238	670
1994	625,889	58,204	1,364,667	2,306,113	391,367	75,920
Est. 1995	820,932	67,504	1,370,035	1,583,238	378,305	80,045
TOTAL	5,296,689	499,143	9,006,721	12,415,763	3,084,864	156,635

CYPs	SHORT-TERM	LONG-TERM	TOTAL
1984	247,986	473,055	721,041
1985	303,620	542,310	845,930
1986	411,682	657,920	1,069,602
1987	553,317	717,498	1,270,814
1988	688,842	860,859	1,549,701
1989	1,397,487	1,284,560	2,682,047
1990	1,428,798	1,677,516	3,106,314
1991	1,662,232	1,761,877	3,424,109
1992	1,944,538	1,825,335	3,769,873
1993	1,856,817	1,041,345	2,898,162
1994	2,048,761	2,773,400	4,822,160
1995	2,258,472	2,041,588	4,300,059
23,874	14,802,552	15,657,262	30,459,814

1995 estimates based on first half sales performance.

(1) 1993 to 1995 fluctuations due to Egyptian market irregularities.

(2) Decrease due to switch to local manufacturers.

ANNEX H

CONTRACEPTIVE SOCIAL MARKETING (SOMARC) III EVALUATION

PRICE ANALYSIS

COUNTRY	PRODUCT	CURRENCY	PRICE 1992 OR AT INTRO	PRICE 1995	INFLATION 1992 - 1995	CHANGE PRICE %	REAL CHANGE
MOROCCO	Orals Various	Dirhan	8.70	8.70		0.00%	**0.00%**
					DEV.		
MALI	Protector *3	CFA	50.00	50.00	100.00%	0.00%	**-100.00%**
	Pilplan	CFA	100.00	100.00	100.00%	0.00%	**-100.00%**
UGANDA	Protector * 3	U Shilling	100.00	100.00	0.00%	0.00%	**0.00%**
	Piplan * 3	U Shilling	250.00	250.00	0.00%	0.00%	**0.00%**
					INFL.		
NEPAL	Dhaal Condoms	Ruppies	2.00	3.50	140.45%	75.00%	**-65.45%**
	Panther Condoms	Ruppies	3.75	8.00	140.45%	113.33%	**-27.11%**
	Gulaf OC	Ruppies	2.50	6.00	140.45%	140.00%	**-0.45%**
	Nilcon OC	Ruppies	6.00	8.00	140.45%	33.33%	**-107.11%**
	Kanchan OC	Ruppies	3.00	5.00	140.45%	66.67%	**-73.78%**
	Kamal VFT/9	Ruppies	4.50	6.00	140.45%	33.33%	**-107.11%**
	Sangini DMPA	Ruppies	40.00	40.00	NA	NA	**NA**
					DEV.		
NIGER	Protector * 3	C.F.A.	50.00	50.00	100.00%	0.00%	**-100.00%**
					INFL.		
PERU	Microgynon OC	N Soles	1.08	2.52	264.35%	133.33%	**-131.02%**
	Nordette OC	N Soles	1.08	2.53	264.35%	134.26%	**-130.09%**
	Depo Provera	N Soles	8.71	8.44	264.35%	-3.10%	**-267.45%**
	Lorophyn	N Soles	3.12	5.00	264.35%	60.26%	**-204.09%**
	Piel	N Soles	NA	0.84	NA	NA	**NA**
SENEGAL	Protec Condoms	C.F.A.	NA	150.00	NA	NA	**NA**
					INFL.		
GUATEMALA	Scudo Condoms	Quetzal	2.89	3.45	43.25%	19.38%	**-23.87%**
	Panther Condoms		1.24	1.50	43.25%	20.97%	**-22.28%**
	Perla OC		6.15	8.00	43.25%	30.08%	**-13.17%**
	Iproday OC		10.77	14.00	43.25%	29.99%	**-13.26%**
ECUADOR	Protektor *3	SUCRE	$750.00	$1,200.00	67.00%	60.00%	**-7.00%**
			1991	1995	**DEV.**		
HAITI	Minigynon OC	Gourdes	5.75	12.00	162.24%	108.70%	**-53.54%**
			1988	1995	88 - 95	88 - 95	
INDONESIA	PILL	US DOLLAR	990.00	1,500.00	77.16%	51.52%	**-25.64%**
LAUNCH 1988	DMPA	US DOLLAR	1,386.00	2,171.00	77.16%	56.64%	**-20.52%**
	IUD	USDOLLAR	6,000.00	6,000.00	77.16%	0.00%	**-77.16%**

CONTRACEPTIVE SOCIAL MARKETING (SOMARC) III EVALUATION

PRICE ANALYSIS

COUNTRY	PRODUCT	CURRENCY	PRICE 1992 OR AT INTRO	PRICE 1995	INFLATION 1992 - 1995	CHANGE PRICE %	REAL CHANGE
					INFL.		
PHILIPPINES	Nordette	PESO	46.00	59.40	25.93%	29.13%	**3.20%**
	Marvelon	PESO	49.00	62.75	25.93%	28.06%	**2.13%**
	Micorgynon	PESO	48.00	55.00	25.93%	14.58%	**-11.35%**
	Sensation	PESO	3.00	3.00	25.93%	0.00%	**-25.93%**
	DMPA	PESO	NA	100.00	25.93%	NA	**NA**
TURKEY	OK Condom	USDOLLAR	1.61	2.20	0.00%	36.65%	**36.65%**

NOTE: Depending upon available information, devaluation between local currency and US Dollars or Inflation rates were used to calculate the price variation in "real" terms.

ANNEX I

LIST OF CONTACTS

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ANNEX J

WORKS CONSULTED

SOMARC/Porter/Novelli, Family Planning and Health Servcies Marketing Trainers Manual

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