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EXECUTIVE SUMMARY

The Futures Group Vice President Robert H. Smith and ICSMP Consultant John U. Farley travelled to India at the request of USAID/Delhi Population Officer Gary Merritt for the purpose of examining the potential market for oral contraceptives that might be served by a combination of private sector and subsidized commercial sales programs.

Smith and Farley provided technical assistance leading to the development of a USAID/Delhi project paper from April 23 through May 11, 1982. They were joined in Delhi by USAID consultant B.R. Deolalikar who helped prepare other issues for the project paper.

The consultant team undertook an analysis of the current commercial sales of oral contraceptives, identified potential obstacles to the expansion of a social marketing project, and prepared a preliminary marketing plan for introducing oral contraceptives in a social marketing context. It is the conclusion of the study team that a modified social marketing project for oral contraceptives is feasible and practicable and can achieve, in conjunction with increased commercial oral contraceptive sales, a market of approximately 42 million cycles annually by 1988.

I. OBJECTIVES

The objective of this consultancy was to examine the potential market for oral contraceptives that might be served by a combination of private sector sales and subsidized commercial sales. More specifically, in support of USAID PP: Social Marketing Subpurpose 2.2, the objective was to "improve and expand government-sponsored and private systems for the . . . distribution . . . promotion/advertising and retailing of oral contraceptives so that sales . . . of oral pills reach (100) million cycles per year by 1988."

In order to accomplish the above objective the team interviewed representatives of the Government of India, selected pharmaceutical companies engaged in the manufacture and sale of oral contraceptives, advertising agencies, manufacturers and distributors of OTC products and representatives of general packaged goods manufacturers. Because the time available was short (2 weeks), it was necessary to establish a series of operating assumptions. These assumptions, which were critical to the final recommendations, were as follows:

- o For the foreseeable future oral contraceptives are available only through a registered chemist shop upon the presentation of a prescription from a licensed physician. It is also acknowledged that most pharmaceutical products sold in India are readily available without a prescription.
- o The target market for oral contraceptives is to be self-selecting (i.e., no group was to be a priori selected such as the rural poor).
- o Organization and management issues and potential problems concerning oral contraceptive production/procurement are to be dealt with under a separate consultancy.
- o The term "marketing" was defined to include issues of distribution, promotion, advertising and pricing.

II. THE CURRENT COMMERCIAL MARKET FOR ORAL CONTRACEPTIVES

Oral contraceptives are now available in both the public and the private sector, with 1981 figures indicating sales of about 6.5 million cycles in the private sector, compared with 1.3 million cycles going through public sector institutions. This means about 500,000 couples now use oral contraceptives secured in the private sector.

A. Brands and Producers

Oral contraceptives are now marketed by six foreign-based pharmaceutical firms using conventional pharmaceutical marketing practices. The products now receive relatively little attention, and none of the producers sees significant growth opportunities under existing market conditions. The significant producers of oral contraceptives are:

Commercial OCs Sales and Market Share

<u>Manufacturer</u>	<u>Brands</u>	<u>Share</u>
Wyeth	Ovral, Ovral - L	50-55%
Organon	Lyndiol	30-40%
German Remedies	Gynovlar, Primovlar	10%
Ciba-Geigy	Noracyclin	small
Parke Davis	Norlestrin, Orlest 28	small
Searle	Ovulen, Ovulen 50	nil

B. Prices and Margins

Retail prices, which are subject to control by the Bureau of Industrial Costing and Pricing, are generally low by world standards:

<u>Producer</u>	<u>Brand</u>	<u>Price to Consumer (In Rs.)* (including tax)</u>
Wyeth	Ovral-L	3.89
	Ovral 21	5.08
German Remedies	Gynovlar 21	9.20
	Primovlar	4.65
CIBA-GEIGY	Noracyclin	4.63
Organon	Lyndiol	4.90
Searle	Ovulen	6.01
	Ovulen 50	5.60
Parke-Davis	Norlestrin	8.55
	Orlest 28	4.21

* 9 Rs. = US\$1.00

The price of one of the largest selling brands (Ovral-L) is probably consistent with families with incomes of Rs. 800 to Rs. 1000 per month. Based on the current income distribution, about 3 million urban families constitute a reasonable target, and current sales indicate 20% to 25% penetration of this market.

Pharmaceutical retailing margins are also low by world standards, with ethical drugs carrying a margin of 12 percent (fixed) and wholesaling a margin of six percent (not fixed).

C. Distribution

Oral contraceptives are available to consumers through chemist shops which are in turn supplied through pharmaceutical distribution channels involving both direct sale and the appointment of stockists and wholesalers. According to an Operations Research Group (ORG) study, urban chemist shops are distributed by town class as follows:

<u>Type of Town</u>	<u>Number</u>
Metro	5,470
Class I	11,752
Class II	5,837
Class III	5,873
Class IV	<u>7,418</u>
	31,041

About 10 percent of these urban shops also function as wholesalers, and ORG has identified 6,308 chemists which it classifies solely as wholesalers in urban areas. ORG also estimates that there are an additional 22,733 chemists in rural areas -- that is in towns of less than 10,000 population.

While the chemist shops provide adequate urban distribution and do not now constitute a constraint on further urban market development, rural coverage is much spottier in comparison with other marketing systems. For example:

- o Brooke Bond estimates that it sells tea to slightly less than one million outlets.
- o TTK distribute Gripe Water to 50,000 outlets concentrated in urban areas and including 20,000 general stores and 5,000 grocery stores as well as chemist shops.

Significant expansion of oral contraceptives sales outside of urban areas would require the use of outlets other than chemists which do not provide adequate depth of distribution in rural areas.

D. Selling Support

The heart of pharmaceutical marketing communications is the medical representative (detailman) who calls on physicians whose practice indicates the usefulness of particular drugs. The representative promotes his firm's products, leaves samples and is probably the primary source of information to physicians

on pharmaceutical preparations and their use. The representatives also call on selected chemist shops. While practices vary, there are great similarities as well. Firms maintain fixed call cycles of one month (or less) with key doctors, one to two months for high prescribers, with less frequent or occasional calls for other physicians. It is unusual for a representative to promote more than three or four products on a call, so a broad line (as the IDPL offering 150 products) tends to receive attention on only a few key large volume lines. The sizes of medical representative forces for major firms range from less than 100 to nearly 400.

Experienced medical representatives are expected to make about 10 calls per day, and are paid Rs. 2,000 - 3,000 per month, with perhaps half of that again for allowances. On the basis of a 24-day month, a call would thus cost Rs. 10 to Rs. 12. Important products are promoted up to 3 times per year, and a minimum of four calls is needed to promote a new product. The introduction of a new product prompts wage negotiations with the medical representatives unions due to the increased product line.

E. Advertising

While advertising to consumers is not now possible because of regulations governing advertising channels for ethical pharmaceutical products, OCs are advertised in medical journals. There is no indication that firms marketing oral contraceptives feel that this restriction is an impediment to market development, although it is important to note that they are committed to traditional methods of pharmaceutical marketing.

As a basis of comparison with other consumer package goods, the media advertising budget used to maintain a leading brand of toilet soap was

Rs. 5 million last year. Estimates for advertising needed to support a national launch in a similar product class run from Rs. 10-15 million.

F. Barriers to Expansion of Markets for Oral Contraceptives

The barriers to expansion of the market for oral contraceptives include:

1. Physician resistance
2. Prescription requirements
3. Limitations on advertising, particularly to consumers
4. Limitations on physical availability

1. Physician resistance

The relatively minor penetration of oral contraceptives appears to have been caused in part by unwillingness of private physicians to encourage clients to use oral contraceptives. By contrast, pill usage in many other countries where the pill is more readily acceptable is much higher.

OC Use in Selected Countries

	Percentage of women of reproductive age using some form of family planning	Percentage of those practising using OCs
Indonesia	33	57
Thailand	40	41
Malaysia	36	49
Philippines	39	13
India	25	3

Source: Population Bulletin: The World Fertility Survey: Charting Global Childbearing and similar data for India.

Securing active cooperation of the physicians, combined with product-specific advertising might double the sales of oral contraceptives in India -- that is, add 4

to 6 million cycles to the current level. This could be achieved by appropriate detailing without the need to change any policies.

2. Prescription requirement

Oral contraceptives are a Class III pharmaceutical requiring prescription. There are indications, however, that the Government is willing to consider relaxation as evidenced by the policy of allowing health workers to provide a three-month supply before a medical examination is required. It is widely known that in practice OC's are purchased without prescription. The moving of OC's from Class III to Class IV would have the effect of freeing up pricing, perhaps leading to more aggressive producer promotions.

3. Limitations on advertising

The inability to advertise oral contraceptives is particularly problematic as regular newspaper coverage of potential dangers of the pill cannot be countered by manufactureres in the public mass media. Product-specific, generic or preferably brand specific, media advertising aimed at countering these stories might also have the effect of doubling the current market -- that is, adding another 4 to 6 million cycles of OCs. This would require a change in policy governing advertising as well as active public relations with the medical community to gain their concurrence. There are indications that such measures would be acceptable to government at this time.

4. Limitation To Physical Distribution

Physical distribution of OC's is limited to about 30,000 chemist shops, which are effectively limited to urban areas. In order to achieve deeper rural distribution, it will be necessary to expand the distribution system to incorporate

other classes of shops now precluded from handling oral contraceptives. Based on descriptions of other branded consumer products, full village-level distribution of heavily promoted and appropriately-priced OCs might produce sales approximately equal to those projected in the urban market. Such a venture would require changes both in the prescription law and in the law governing channels of distribution for pharmaceuticals. Because the government (and probably physicians) may resist such changes, it is unlikely that such a solution could be effected in the five-year time frame under examination.

III. PROPOSED PROJECT

A. Introduction

It is the consultants' opinion that a modified social marketing project for oral contraceptives is feasible and practicable and can achieve, in conjunction with increased commercial oral contraceptive sales, a market of approximately 42 million cycles annually by 1988. In brief, the proposed project, through a phased process, will initially focus on the generation of primary demand for oral contraceptives at the consumer level while at the same time attempting to lessen and/or eliminate the perceived antagonism among the Indian physician population toward the use of the "pill". Conceptually, the project envisions an intensive media campaign targeted at urban fertile age couples along with a series of seminars and symposia for physicians focused on the use, safety and desirability of using oral contraceptives for delaying the first pregnancy after marriage and for spacing children after the first child is born. Only after an intensive promotional effort is completed (approximately 2-3 years) should a new subsidized brand of oral contraceptive be introduced into the market, and then only if the price of commercially available products increases to a level where significant segments of the target population are not able to purchase it. This

plan also assumes a change from Class III to Class IV for oral contraceptives prior to launch of the subsidized product.

B. Institutional Arrangements

Experience to date in social marketing projects has shown that most effective use of commercial mass communication and commercial mass distribution systems in a responsible and cost efficient manner requires an organization and a professional staff with skills and experience gained through similar activities in the private sector. The particular nature of a social marketing effort, which attempts to harness the technology of the commercial business world, requires a correspondingly unique organization. Such an organization must be in a position to fit comfortably within the framework of current groups working in the field of family planning and contraception while at the same time have credibility in the commercial sector within which it must operate. Additionally, the organization must have adequate flexibility to respond to changes in its market place, recruit new personnel quickly, pay salaries commensurate with the commercial world and pay its bills in a timely manner.

It is for the above reasons that we recommend the identification of an existing non-profit or private organization or the establishment of a new non-profit organization to carry out this project. If a new organization is formed it should have a Board of Directors composed of prominent Indian business leaders with an interest in family planning whose professional and career backgrounds provides them with the necessary skills to assist the organization in attaining its objectives. It is also anticipated that representatives of the Indian Government's Ministry of Health and Family Welfare would also be represented on the Board although not with controlling interest. It would be the responsibility of the Board to initially recruit a staff professional marketing executive to initiate the

mass media campaign and to design and implement the physician seminars and symposia. At a later date, should it be decided that a socially marketed oral contraceptive should be introduced, it will be the responsibility of the marketing executive to recruit additional staff to carry out that phase of the project.

We feel that the recommended level of participation of the Government of India is optimal since it will provide assurances that the project will operate within the guidelines and towards the objectives of the national population program while at the same time allowing professional management the flexibility and independence to exercise their expertise in commercial marketing. Also, the involvement of the government on the Board will help assure that the project is represented and "protected" within the Government itself and that additional resources of the government can be made available to assist in furthering the goals of the organization.

C. Potential and Target Market for the Program through 1988

The program target market will be couples of appropriate age who have easy access to the pharmaceutical distribution system and who have adequate income to purchase oral contraceptives regularly. This definition effectively limits the potential market to urban married couples not now practicing some form of contraception.

i. Potential Market

a. Market Size

The overall potential market is urban married women aged 15 to 44 who have access to the pharmaceutical system. Applying the 1971 census ratio of urban married women aged 15 to 44 (160 per 1000) to the 151 million urban

population yields a potential of 24 million eligible urban couples among the 110 million married couples in all of India.

Between now and 1988, there will be an increase of 42 million women aged 15 to 44 in the population of whom approximately 10 million will be urban. This will yield an additional 7 million married women to the overall potential market, which will then be 31 million.

b. Current Practice in The Potential Market

Of the current population of 110 million married couples, 24 percent or 24.4 million are estimated to be sterilized or using conventional contraceptives. Approximately, 30 percent (8 million) of this group are urban, leaving 16 million urban target couples unprotected. If current sterilization patterns continue through 1988, urban sterilized couples will rise to 9 million, leaving a potential of 22 million non-contracepting couples.

Approximately 500,000 couples in India are currently using oral contraceptives purchased in the commercial sector, and the vast majority of these are in the urban population. An anticipated doubling of this rate by 1988 will leave a potential market of 21 million at that time.

2. The Target Market

The target market definition involves revision of the potential market through consideration of the following factors: appropriateness of the product (age and parity), ability to purchase even subsidized products (measured by household income), ability to deal with relatively complex messages and directions for product use (operationalized as literacy), and having access to the pharmaceutical distribution system. The revision based on these considerations is not necessarily serial, as, for example, education and income are correlated.

a. Access to Distribution

In 1981, there were 2,273 towns with populations of 10,000 and larger containing 96 percent of urban population. The distribution of retail pharmacies is as follows:

Distribution of Pharmacies by Town Size

	<u>Number of Towns</u> (1981)	<u>Performing Retailing Pharmacies</u> (1979)
Metro	12	4,430
Class I (100,000 to 1 million)	204	8,461
Class II (50,000 to 99,000)	270	4,698
Class III (20,000 to 49,000)	739	6,226
Class IV (10,000 to 20,000)	<u>1 048</u> 2,273	<u>7,247</u> 31,062

Source: ORG. Census of Chemists - 1979, interpolated from Table 1.

Given the above distribution it can be said that virtually all of the potential market has access to the pharmaceutical distribution system.

b. Literacy

Literacy rates nationwide are approximately 47 percent for all males and 25 percent for all females. Reports also indicate that the rates are "much higher" in urban than in rural areas. Applying literacy ratios of two thirds of urban males and half of urban females directly to the potential market as defined above yields a target of 10.2 to 14.0 million literate households.

c. Income

Ability to pay, which represents a major consideration in defining a target market, depends on the anticipated price of oral contraceptives which in most cases must be set at a fraction of one percent of monthly income. Based on 1978 national media audience survey of income figures and allowing for an increase in nominal income since that time, approximately 40 percent of households have monthly incomes of Rs. 500 or greater, with that fraction ranging from about 50 percent in towns of 500,000 or more to 32 percent in towns below 100,000. A price of Rs. 2 would thus reach a target of approximately 8.2 million.

d. Age Structure and Parity

Based on current medical thinking, older women will probably not be encouraged to use the pill. Based on 1981 projections, women 35 to 44 constitute about 24 percent of women in the reproductive age group. Since the mean age for sterilization in 1979-1980 was 30.4 and nearly half were over 30, a substantial fraction of these older women have already been removed from the target as current practitioners. Nonetheless, the remainder may serve to reduce the target market slightly.

Similarly, there may be relatively little use of OCs by women before the arrival of the first child. Various surveys estimate this fraction to be 16 percent of the target population.

e. The Target Market

Combining income, literacy and access to the distribution system, it appears that the target market ranges from 40 to 50 percent of the potential, or from 8.2 million to 10.2 million couples.

Because of desire for children and factors such as age and parity, subsidized commercial marketing programs have seldom achieved more than 20 percent penetration of target market, implying that such a program would yield 1.6 to 2.0 million customers by 1988. The range of projected volumes is thus from 21 million to 26 million cycles of pills.

As mentioned earlier, more open promotion of oral contraceptives should cause growth in the commercial market, perhaps equal to or double current sales of 6.4 million cycles to 12.8 million by 1988. Volume forecasts for 1988 through commercial and subsidized commercial channels might thus be:

Potential OC Sales, 1988

Through the private sector

Current level	6.5 million
Increment due to improved attitudes of physicians	4 to 6.5 million
Increment due to generic or brand-specific media advertising	4 to 6.5 million

Through social marketing program 21 to 26 million cycles

<u>Totals:</u>	Cycles	35.5 to 45.5 million
	Couples protected	2.65 million to 3.5 million

At this point, sales in each sector should be at equilibrium, growing over the long term as a function of growth in the number of urban families with monthly incomes greater than Rs. 500 at 1982 prices.

D. Required Marketing Research

Prior to the initiation of any substantive marketing activities, it will be necessary to conduct a series of market research studies in order to accomplish the following: (i) to determine current attitudes of physicians and chemists

regarding the safety and use of oral contraceptives for the target market, the degree to which these attitudes are based on fact and experience, and methods by which any negative attitudes may be overcome by new information and education, and (2) to determine attitudes of both men and women in the target population toward contraception in general and toward oral contraceptives in particular. This research is particularly important in that the pharmaceutical companies engaged in marketing oral contraceptives have done little if any consumer research and the physician research which has been done has not focused on contraception.

Additional consumer research will need to focus on package design, message content, advertising pre-testing and advertising awareness. These latter studies should be time-phased throughout the life of the project, depending upon which stage of activity is being undertaken.

It is our contention that a series of small group sessions, both with physicians (influentials, general practitioners and OB-GYNs) and separately with consumers (males and females) will initially yield the most meaningful results. We recommend that eight physician group and ten consumer group discussions be held in about four major metropolitan areas. This research is estimated to cost approximately US\$10,000 and should be undertaken as early as possible. A subsequent consumer survey should also be conducted to quantify the results of the focus group sessions and should consist of a urban sample of approximately 2,000 respondents (estimated cost is in the neighborhood of US\$23,000). The Indian Market Research Bureau also maintains a syndicated rolling sample of 40,000 households that can be used for periodic market updating. In addition, the recent national KAP study completed by ORG should be extremely valuable once the data have been released by the GOI.

Approximately six to nine months prior to product launch it would be desirable to conduct a small scale survey among chemists generally to determine their practices regarding contraceptive sales and specifically to determine the optimum product introduction promotion strategy to insure adequate product placement.

Commercial market research firms - both free standing and as part of advertising agencies - are readily available in India and should be used to conduct the research. Proposals should be solicited from the top three companies.

E. Demand Creation

1. Detailing and Marketing to the Physician

In order to create acceptance of oral contraceptives among physicians, it will be necessary to design a marketing effort targeted initially to those doctors who are regarded as most influential, to OBGYN's and other doctors who primarily treat women and to female doctors. While it must be verified by research, it appears that OC's are not well regarded by physicians for three reasons: (1) negative publicity in the press about OC side effects, (2) lack of support by the Indian Government for OC's as a method of choice for family planning, and (3) competition for patients which result in a "curative" mentality and conservative practice modes.

We recommend, therefore, that a series of seminars and symposia be conducted early on in the project focusing on oral contraceptive safety and use. These seminars should draw on both domestically and internationally recognized experts in the field of contraception. In addition, direct mail pieces should be developed under the auspices of a well regarded Indian medical organization which could be sent to those physicians who cannot be reached through the seminar process.

After the initial demand generation has occurred, and assuming a brand name socially marketed product is introduced, it will be necessary to hire and train a small (approximately 20-25 person) detailing force to detail the new product directly to the physician. Three to four supervisors should also be hired (i.e., one for every seven detailmen). Assuming that one detailman can call on 10 doctors per day, a 25-person force will cover all the important physicians (about 30,000) twice each year. Therefore, if the detailing activity begins one year prior to launch, each influential physician will have been contacted twice before he/she is actually asked to prescribe a particular brand. This initial time will allow the representative to build up some rapport with the physician which will hopefully coincide with the conduct of the seminar and the direct mail promotion. In addition, special detailing and other promotional efforts should be directed to "maternity homes" and other appropriate health institutions.

2. Promotion and Marketing to the Trade

The target trade market consists of approximately 31,000 chemist shops located in towns of over 10,000 population. Assuming stockists and wholesalers will call on the large majority of the smaller outlets, it will be necessary to hire small sales force of about 20 people to call directly on the 12,000 most important chemist shops (annual cost about US\$50,000). This sales force should be in place about five months prior to product launch. Initial activities of the sales force will be to call on stockists and wholesalers. Approximately two months before launch they should begin calling on chemist shops.

The sales force should be equipped with point of purchase promotion for the chemist (posters, counter displays, buntings, etc.) and consumer "give away" leaflets on family planning and the use of oral contraceptives.

3. Advertising to the Consumer

In order to generate demand for oral contraceptives, it will be necessary to advertise directly to the consumer through mass media. Initially this advertising should be generic in nature and promote oral contraceptive usage. The advertising message should then move to brand specific advertising just prior to product launch. Because mass media advertising is central to the project, it will be necessary for the Government of India to agree to remove oral contraceptives from the requirements that ethical pharmaceuticals be advertised only in professional medical literature. This requirement must be met prior to the establishment of the project in order to insure its success.

The design and implementation of a mass media advertising campaign should be competitively procured through one of the major advertising agencies in India. The design and testing phase for brand name, advertising and packaging should take approximately six months. Media costs for initial multi-language advertising are in the range of US\$1 to 1.5 million plus \$250,000 production costs. Maintenance advertising after the first year would range between US\$500,000 to US\$650,000. A minimum three year campaign is necessary in order to evaluate the impact of the advertising effort on consumer behavior at anything resembling the national level.

While it will be the responsibility of the advertising agency to develop the most appropriate media mix, the mix is likely to be divided nearly evenly between cinema and press advertising. This media mix illustrates the problems faced by a program attempting to extend further than the urban market, as neither of the most effective introductory media are particularly useful in rural areas of India.

F. Distribution

Physical distribution to chemist shops appears to be a relatively uncomplicated and straight forward activity. Adequate numbers of stockists (with their own sales force) and wholesalers exist in India to insure satisfactory product placement at the retail level. Margins for a new oral contraceptive product must be 6-8 percent of the selling price for stockists, 3-5 percent for wholesalers, and 15-18 percent for retailers.

As an initial recommendation we suggest that one distributor be selected for each state, although this strategy should be re-examined. It will probably take about 500 stockists and a similar number of wholesalers to adequately cover the country. In order to insure the stockist commitment to the product, it may be necessary to subsidize the operation of delivery vans.

G. Prices

The new socially marketed oral contraceptive product must be priced minimally one half of the current retail price of existing products. Since the least expensive and most popular current product (Ovral-L) sells for Rs. 3.89 there is little room for a new product to enter the market at this time at a significantly lower price. However, after the primary demand has been generated through the mass media, the reclassification of oral contraceptives from Class III to Class IV should be effected. Since Class IV drugs are not price controlled, this action should result in a price increase for commercially available OC's of at least 100 percent. Such an increase would then open the market up for the introduction of a new socially marketed product in the Rp.2.0-3.0 price range. A product priced at Rs.3.0 per cycle would enter the distribution chain at Rs.2.07 (returned to program) allowing for the appropriate margins mentioned previously.

Assuming that the target market penetration estimates given earlier are valid, and that the retail price would be Rs. 3.0 per cycle, the return to the program on an annual basis (minus commodity costs) would be in the range of US\$4.7 to 6.0 million. Assuming oral contraceptives can be supplied in the range of US\$0.18 per cycle, revenue would just pay for contraceptives. At maturity the net cost of the program would then be in the range of US\$1 million, assuming maintenance advertising costs of US\$650,000 and operating costs of about US\$350,000. The cost would be considerably more, of course, if the retail price is reduced or if marketing costs escalate dramatically over the next few years.

Time Phased Activity Chart

Establish or reestablish
 Separate Organization
 To Implement Project

Depth Studies with physicians, chemists and consumers on		Develop and test brand name packages, part of purchase promotion		Small surveys of physicians, chemists and consumers to track intro	Monitor sales statistics against targets	Consumer surveys to ascertain patterns of use	RESEARCH
Secure permission for advertising from Govt. Secure cooperation of physicians and chemist organizations to support advertising	Compete and let contract to ad agency for generic oral contraceptive advertising	Begin concept advertising and continue through life of project.	Develop and test brand specific advertising with physician, chemists and consumers	Launch full scale introduction of advertising in towns of greater than 100,000 population	Launch advertising in smaller towns; maintain advertising to larger towns and cities		ADVERTISING
		Develop several marketing plan for years 1 and 2	Develop specific marketing plan for year 1 and 2. Secure commodity supply	Launch in town to 100,000 population (approx. 200)	Launch in town of 10,000 and greater		MARKET PENETRATION
Design seminars for physicians and chemists on safety of pill	Secure cooperation of drug companies in seminar participation	Conduct seminars with physicians and chemists on safety of pill	Press and radio public relations program	MAINTAIN	PUBLIC RELATIONS	ACTIVITIES	PUBLIC RELATIONS
	Recruit detailing capability (about 25 reps)	Detail physicians and chemists in towns of 100,000 population		Detail products to physicians and chemists in towns of 10,000 and larger	Concentrate on reinforcement of earlier detailing efforts	Start detailing force expansion to non-pharmacy outlets	DETAILING
		Develop physical distribution program for urban chemists			Secure permission to remove pills from Rx. Secure permission for rural distribution in non-pharmacy outlets	Secure distribution system for pills in non-pharmacy outlets	DISTRIBUTION

-2 to -1½

-1

0

+1

+2

+3

Pre-Launch Activities

Start of Program

Post-Launch Activities