MILESTONE COMPLETION REPORT
CONTRACT NUMBER : 263-C-00-99-00017-00

To: Brenda Doe
Cognizant Technical Officer
USAID Mission to Egypt

CC: Pamela Morris
Director, Contracts Division
USAID Mission to Egypt

From: Jestyn Portugill
Chief of Party

Date: April 14, 2001

Task Number:	*6*
Task Description:	*Innovative Marketing Communication Activities Generating Increased Demand Among specific Market Segments*
Milestone No:	**6.7**
Milestone Description:	**Analysis of market niche groups distributed to IEC committee/working groups**
Source of Verification:	**Audience niche groups data analysis disseminated to partner agencies.**
Planned End Date:	**January 31, 2000**
Status:	Completed
Comments:	The attached study, "Market Segmentation—Niche Analysis for the Promotion of Family Planning Services and Products," was presented to official agencies, partners and stakeholder on 14 February 2001 by Dr. Carol Underwood of JHU/CCP, Dr. Fatma El-Zanaty of EDHS and Mr. Ron Hess, JHU/CCP. A second presentation was made on 10 April 2001 for those who could not attend the earlier meeting. Discussions followed both presentations. A list of attendees is attached, along with the study and slides which highlight significant findings. The study and slides were distributed to participants. Utilizing data from the EDHS, the presenters estimated the size of each market segment based on the "life stages" model that is the foundation of the study. The oral presentation and discussion concentrated on identifying market segments of most interest to

A

partner organizations and recommended strategies for capturing those audiences. Data and analysis relating to the "spacers segment" are now being utilized in the design of a media campaign to promote increased sales of Depo-Provera. Analysis derived from the study's "life stages" model is helping identify differentiated marketing niches for the two injectable contraceptives prescribed and sold by PSP-affiliated physicians and pharmacists: Depo-Provera and Mesigyna.

B

Market Segmentation

Niche Analysis for the Promotion of Family Planning Services and Products

Carol Underwood and Fatma El-Zanaty

I. Introduction

The major focus of Egypt's family planning program is the moderation of population growth rate so that it is commensurate with the absorptive capacity of the economy and environmental constraints. Policies, programs and services supportive of family planning must be in place if women are to use modern contraceptive methods and use them successfully. Research findings attest tothe notable achievements of Egypt's family planning policy and programs over the past two decades. By 2000, the contraceptive prevalence rate among married women reached 56 percent, representing a 130 percent increase over the rate recorded in 1980. Concurrently, the total fertility rate dropped from 5.3 births per woman in 1980 to 3.5 in 2000.

A recent study found that Egyptian women are increasingly adept at making contraceptive choices consonant with their stated fertility desires.[1] More and more women are choosing to contracept within two months postpartum so as to increase birth intervals between children. Tellingly, women are increasingly likely to rely on contraceptives after the first or second child, rather than waiting until their actual family size has outpaced their desired family size. With demand for family planning advancing steadily, the challenge for the program is to identify those populations that remain in greatest need of services and those groups where growth in contraceptive use can be accelerated.

In response to this challenge, we present herein a market segmentation framework that links contraceptive products and services with distinct population groups defined by their reproductive life stage and socio economic status. Method choice is determined in large part by a woman's stage in the reproductive life cycle, which include age, expressed fertility preferences—whether a woman intends to delay her next pregnancy or cease childbearing altogether--and her breastfeeding status. Source of service is related to method choice, access, and socio-economic status.

To ensure that women have ready access to effective contraceptive methods requires, among other factors, increased efficiency in the supply of services. In short, the three service sectors—public, NGO and private—must be able to identify and cater to the needs of their 'natural' markets. To make accurate assessments regarding the market share each sector can be expected to attract, policy makers need sound information regarding consumer demand for family planning. Once cognizant of the relative market share each sector could absorb, public sector decision-makers should promote services for their 'natural' audiences. While the public sector is vital in any national economy to provide a safety net to those whose means do not allow them to make use of non-public sector services, its relative size will depend upon income distribution and ability to pay, among other factors. Given limited national budgets, it is vital that those who can afford to pay for services in the NGO and private sectors seek services in those sectors and do not overtax the public sector. As targeting poor clients for free or subsidized services has proven costly and difficult to administer (Mills 1991), governments tend increasingly to rely on self-selection. In such a market, it is important to give policy and program advisors in the various service sectors information so that they can attract clientele to the service sector that best responds to the demands of

[1] El-Zanaty, F. and L. Kemprecos. 1998. "Changing Patterns of Contraceptive Use during Women's Reproductive Life Cycles in Egypt: An Analysis of the 1995 EDHS." Unpublished paper prepared for the Johns Hopkins Center for Communication Programs, Baltimore, MD.

both potential and current family planning consumers considered in light of their economic circumstances.

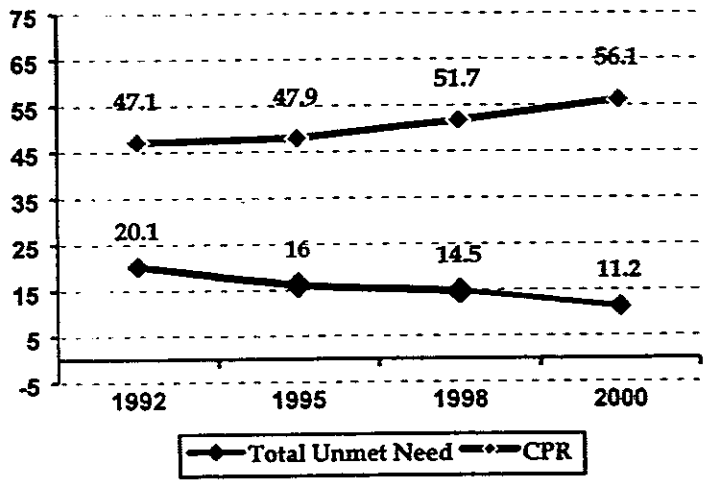
The purpose of this study is to respond to the aforementioned policy and programmatic needs. The specific goals of this study are:

- to identify and quantify market segments for family planning according to consumer demand criteria;
- to identify program growth opportunities for contraceptive products (pill, IUD, injectables); and
- to identify program growth opportunities for family planning service sectors (public sector, private doctors, pharmacies, NGOs).

II. Consumer Market

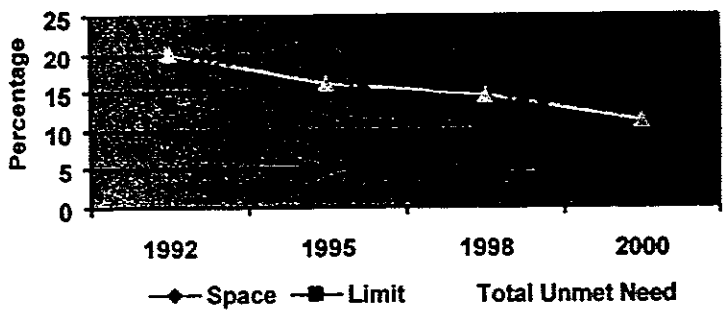
Trends in Contraceptive Use

Chart 1: Trends in Contraceptive Prevalence Rates and Trends in Unmet Need, 1992-2000



Contraceptive use has increased significantly over the period of interest and, as of early 2000, stood at 56 percent. Even as contraceptive use has increased, "unmet need" for contraception has decreased. The literature refers to individuals who state a desire to delay their next pregnancy two or more years, are fecund, yet do not rely on contraception as women with "unmet need for spacing." Women who express a desire to cease childbearing, are fecund and do not use contraception are referred to as individuals with "unmet need for limiting." The steady and significant decline in unmet need over the past eight years attests to women's enhanced capacity to match fertility desires and contraceptive use (see Chart 2). The discussions that follow in this paper are predicated on the argument that fertility preference, as reflected in a "need for family planning," is a significant factor in determining consumer demand.

Chart 2. Percentage of Women with Unmet Need for Spacing and Unmet Need for Limiting, Egypt, 1992-2000

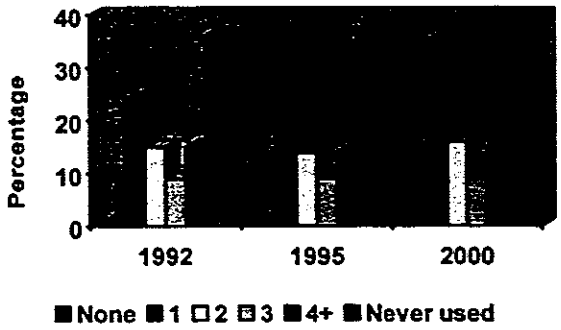


Unmet need is an important issue that will be addressed in more detail below. But we will first examine other major factors that have contributed in Egypt to the increase in contraceptive use and the concomitant drop in unmet need, resulting in lower fertility rates. In particular, changes in parity at first use, timing of postpartum use and patterns of use duration have all contributed to decreased fertility.

Timing of Contraceptive Use

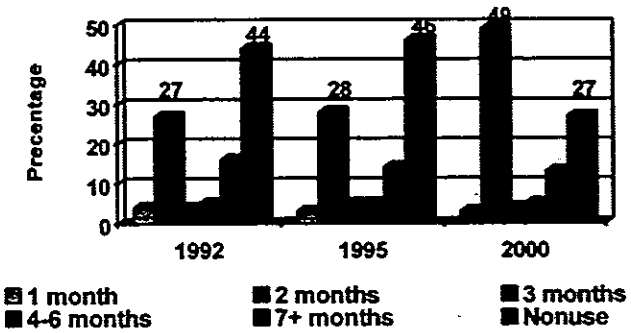
Women are increasingly likely to contracept at lower parity, as seen in Chart 3. While some 24 percent of women first used contraception when they had only one child and an additional 15 percent at a parity of two in 1992, these percentages had increased to 35 at parity one with an additional 16 percent at parity two by 2000. Concomitantly, the percentage of women who had never used contraception dropped from 36 to 25 percent over the eight-year period. These use patterns are in keeping with declining ideal family size. Family size at first use of contraception is an important proximate determinate of fertility since early use of family planning will shorten the length of time a given woman is susceptible to pregnancy.

Chart 3. Percentage of Women by Parity at first use of contraception, Egypt, 1992, 1995, 2000



Postpartum women—defined for the purposes of this analysis as women who had given birth within the past six months[2]—contributed to the increase in CPR and were significantly more likely to contracept in 1998 than was true in 1992 or 1995. As shown in Chart 4, women who had given birth in the past five years turned to contraception more quickly postpartum in 2000 than did their counterparts in the 1990s. In 1992 some 35 percent of this group of women used contraception by the third month postpartum. By 2000, this percentage had increased to 56 percent. Concurrently, nonuse dropped precipitously—from 44 percent in 1992 to 27 percent in 2000.

Chart 4: Percentage of women (among all who gave birth in the past five years) by months postpartum at use, 1992-2000, Egypt



But perhaps the most striking conclusion one can draw from this chart is that most women who use contraception during the postpartum period initiate use during the second month, which is optimal given that fertility often returns by the 40th day postpartum unless the woman adheres to exclusive breastfeeding. These facts demonstrate that women are increasingly adept at using contraception to meet their fertility goals. In short, many women have become, in the words of Zanaty and Kemprecos (1998), "expert family planning users."

Importantly, breastfeeding duration has not changed significantly over the eight-year period as shown in Table 1 (below). This is a significant finding as the overall trend toward earlier postpartum use of contraception sometimes occurs with a parallel decrease in breastfeeding duration, thus increasing the overall cost of contraception to the program. Moreover, nonusers tended to breastfeed their infants only

[2] This definition of postpartum encompasses those women who could, theoretically, rely on exclusive breastfeeding to protect themselves from unplanned pregnancies.

Table 1. Mean duration of breast feeding* for most recent pregnancy in the year 1992, 1995 and 1998								
Users of modern contraception			Non-users			Total		
1992 (n=1012)	1995 (n=2082)	1998 (n=1761)	1992 (n=1519)	1995 (n=2305)	1998 (n=772)	1992 (n=3280)	1995 (n=4387)	1998 (n=1784)
15.78	15.98	15.9**	16.21	15.90	16.7	15.98	15.94	16.35
(9.34)	(9.0)	(9.01)	(9.07)	(8.8)	(7.95)	(9.2)	(8.9)	(8.4)

*Excludes right censored observations (women who are still breast feeding at the time of interview)
** Moderately significant (p=0.05) for differences between users and non -users of methods of contraception

slightly longer than did users in 1998. In 2000, mean breastfeeding duration overall was 17 months (data not shown), thus confirming no reduction in breastfeeding duration even as contraceptive prevalence increases steadily.

Increasingly, women who wish to space pregnancies are enjoying safe, extended birth intervals. Among women who use contraception to space, the median birth interval increased from 27.7 months in 1995 to 28.9 months in 2000. Still, nearly one-quarter of young mothers—that is, ages 15-19—have birth intervals of less than 24 months. Among limiters, the mean birth interval is about 35 months.

As can be seen in Table 2, young women report shorter use duration than do their older counterparts. Additionally, limiters' use duration is significantly longer than that reported by spacers.

Table 2. Mean Months of Contraceptive Use Duration among "Spacers" and "Limiters"		
Age	Spacers	Limiters
15-24	10.7 months	13.3 months
25-34	20.2 months	29.5 months
35+	48.5 months	·57.2 months

III. Expressed Fertility Desires and Contraceptive Use

While the broad picture presented above regarding contraceptive use trends in Egypt is heartening, about one of every ten women of reproductive age or approximately 1.2 million women express a desire to limit or delay childbearing yet do not rely on contraception. Therefore, this group of women constitutes a important population segment for family planning programs as their articulated desire to postpone or limit childbearing suggests that they are likely contraceptive users. The following two sections are organized around the assumption that fertility desires together with perceived fecundity influence use dynamics, including method choice. Therefore, the concerns of women who wish to delay their next pregnancy (spacers) will be examined first, followed by a section that reports the concerns of women who want to cease childbearing (limiters).

Contraceptive Use to Delay Pregnancy: Demand for Spacing

The 'demand for spacing' category includes two groups of women, the first—women who are current users of contraception and report that they want another child but not for at least two years—has been the subject of this section. The second, those with "unmet demand for spacing" or women who do not rely on contraception yet do not want a/another child for at least two years, are an important audience for family planning programs.

In designing messages for women with unmet need for spacing, it is useful to examine what distinguishes them from women with met need for spacing. To do this, we need to introduce a concept that becomes increasingly important as our discussion unfolds: namely, socio-

Table 3. Distribution of Respondents by Socio-economic Status (SES)		
SES	1992	2000
Low	13%	18%
Middle	39%	52%
High	48%	30%

economic status or SES. The (SES) index used in this paper was created on the basis of household ownership of durable goods and other possessions determined to allow for differentiation among groups. Factor analysis demonstrated that SES calculations for urban and rural residents should be calculated separately using a slightly different "basket" of consumer goods.[3]The socio-economic index was then divided into three groups (indicating low, medium, and high socio-economic status). The groups were based not on an even tripartite division but, rather, on the points at which the distribution reflected distinct divisions. For the most part, the same categories were applied across the entire period of interest. Therefore, the shift from the lowest SES to the middle and upper categories reflects the enhanced ability of Egyptians to purchase these particular durable goods, whether a result of increased income or a decrease in the costs of certain goods is not known (Table 3).

As shown in Table 4, among the total sample of married women of reproductive age (MWRAs) in 2000, some 3.6 percent have an unmet need for spacing. Based on population estimates for 2000, this indicates that about 382,000 women in Egypt have an unmet need for spacing. Of these, some 158,000 live in rural Upper Egypt and about 90,000 live in rural Lower Egypt. Half of the women with unmet need for spacing have only one child.

TABLE 4. PROFILE of SPACERS: Comparing Unmet vs. Met Need

	Prospects (Unmet Need: 3.6 % MWRA)	Customers (Met Need: 11.4% MWRA)
Market Size:	382,165	1,210,190
Median Age:	25 years	25 years
Average Parity:	1.6	1 child
Education	43% None	62% Secondary+
SES	36% Low-SES	24% Low-SES
Residence	68% Rural	53% Rural
Approval:		
Self/Husband	92%/73%	98/95%
Intention to use	79% soon	
Health Concern/ Side Effects	6% express concerns	

Unmet need for spacing is negatively associated with educational attainment, socio-economic status, and urban residence. Unmet need is particularly high among women who have had no formal education and who are of low socio-economic status. Women with unmet need for spacing have a slightly smaller average family size (mean number of children is one) than do those with met need (mean number of children is 1.6). In 2000, there was no difference in the mean or median ages of women with a met versus an unmet need for spacing.

About 92 percent of women with an unmet need for spacing personally approve of family planning. Women with an unmet need for spacing were less likely to believe that their husbands would approve of

[3] Factor analysis demonstrated that SES calculations for urban and rural residents should be calculated separately using a slightly different "basket" of consumer goods. All the durable goods were given equal weight in calculating the index. Possession of a refrigerator, color TV, electric fan, stove, water heater, and sewing machine was used for calculation of socio-economic index for rural areas. For the urban areas, the goods used were refrigerator, color TV (replaced with phone for 2000 data), video, electric fan, stove, and a car. The Cronbach's internal consistency coefficient for socioeconomic index for rural and urban area was respectively 0.74 and 0.72. The socio-economic index so created was thus a continuous variable indicating the number of durable goods possessed by a household.

family planning (73 percent) than were women with met need (95 percent). Still, only 17 percent believe their husbands actually disapprove of contraception. Among women with unmet need for spacing, 79 percent intend to use contraception within 12 months and only 12 percent have no intention of using

Chart 5. Method choice among women who want to delay pregnancy, 1992, 1995, 1998

Table 5: Amount Paid for Methods by SES

SES	IUD	Pill	Inj.
High	26.95	3.57	6.70
Medium	13.70	1.75	3.98
Low	9.39	1.43	2.99

contraception. Moreover, only six percent of this group of women expressed concerns about potential health consequences or side effects. In sum, women with an unmet need for spacing hold highly positive attitudes towards family planning. It is vital, therefore, to explore which methods are most suitable for this group of women.

Among all current users of contraception who want to delay their next pregnancy, the IUD is by far the method of choice (see Chart 5). The pill lost some ground between 1992 and 2000, but injectable use increased among this group of women.

As shown in Table 5, the price women paid for the various methods is highly correlated with SES, thus confirming the usefulness of the SES index. The fact that low-SES women pay, on average, over 9 Egyptian pounds (LE) for the IUD despite the fact that the cost is much lower in the public sector reflects the fact that low-SES women seek services from the private and NGO sectors as well as from the public sector.

Niche Audience: Young Mothers

Breastfeeding Women

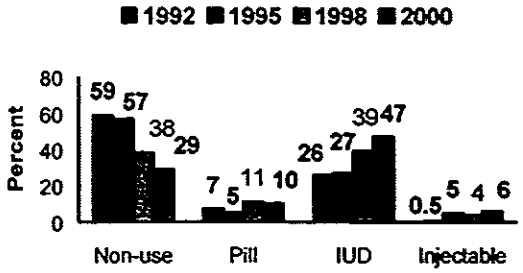
Fully half of all women who report contraceptive use for purposes of spacing their pregnancies are breastfeeding. The 2000 EDHS reports that 85 percent of the respondents approve of family planning following a woman's first birth. This together with the fact that 35 percent of the sample reported first contraceptive use after the birth of their first child and 55 percent contracept by the third month postpartum suggests that new mothers are an important audience segment to address in the next few years. It is particularly vital to reach this group of women early in the postpartum period as consistent, early use will prolong birth intervals and reduce the overall fertility rate of this cohort of women.

Women who are breastfeeding their infants and decide in consultation with their physicians to use hormonal methods must choose appropriately. While the DMPA injectable contraceptive (the three month, progestin-only injectable) is safe for use by breastfeeding women, women who seek a quick return to fertility do not favor this method. Therefore, women who want to protect themselves from pregnancy

temporarily are encouraged to rely on the progestin-only pill (POP)—*if started at least six weeks after childbirth*, the IUD or barrier methods.[4]

While most new mothers in Egypt turn to the IUD to protect them from an unplanned pregnancy, recent years have also evidenced a significant increase in the use of the progestin-only pill (POP). Progestin-only methods are acceptable *if started at least six weeks after childbirth.*[5] The twofold increase in use of the oral pill by breastfeeding women who gave birth in the six months prior to their interview is telling (Chart 6). This significant increase in pill use is likely to be a result, in part, to the widespread availability of the POP in 1998.

Chart 6. Shifts in Method Use Among Breastfeeding, Postpartum* Women Self-Identified as Spacers, Egypt 92-98



*For purposes of this report, 'postpartum' refers to women who gave birth within the past six months.

Contraceptive Needs of Non-breastfeeding "Spacers"
Women who are no longer breastfeeding have a range of methods available to them, but among those who use contraception to space pregnancies a quick return to fertility is important. *Fifty percent of spacers are no longer breastfeeding an infant or child.* This group of women can rely on the IUD or combined oral contraceptives. Additionally, a monthly injectable (trade name Mesigyna), which contains estrogen and progestin, has recently become available in Egypt. Anecdotal evidence indicates that young women like this method because it is "easy to remember," particularly when contrasted to oral contraceptives. Young mothers should be encouraged to consider the POP and Mesigyna as well as the IUD. While DMPA is also an option, the slow return to fertility is a deterrent to use among women who want a quick return to fertility once they decide to have another child.

Method choice is central since the degree of comfort with the method in tandem with the effectiveness of a given method will influence the timing of the second pregnancy. The median birth interval of 34 months reported in the 2000 EDHS falls well within medically recommended guidelines. Yet, 24 percent of birth intervals were shorter than 24 months(as noted previously). Additionally, women 15-19 reported an average birth interval of 21.6 months and women ages 20-29 reported a median birth interval of 29 months. Clearly, young mothers should be encouraged to extend the birth interval. Again, this group of women should been encouraged to consider the one-month injectable as well as the IUD.

Contraceptive Use to Limit Childbearing: Demand for Limiting

Since women who wish to cease childbearing are at a different stage in their reproductive lives han are women who want to delay childbearing, their contraceptive needs are different from spacers. Between 1992 and 2000, the average number of months postpartum at use has dropped significantly among limiters (data not shown.) By 2000, nearly 76 percent of women who used contraception following the birth of their last child used a method by the third month postpartum. The youngest cohort turned to contraception earlier than their older counterparts (data not shown). Interestingly, women who report use for purposes of increasing the birth interval, i.e., spacers, seem to turn to contraception earlier than do

[4] Combined oral contraceptives (COCs) are another medically accepted method for breastfeeding women if started at least six *months* after childbirth.
[5] Hatcher, R.A., Rinehart, W., Blackburn, R., Geller, J.S. and Shelton, J.D. The Essentials of Contraceptive Technology. Baltimore, Johns Hopkins University School of Public health, Population Information Program, 1997. Third printing 2001.

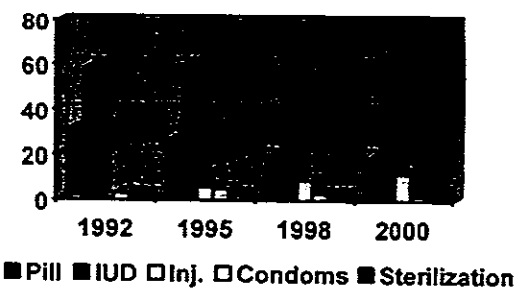
TABLE 6. PROFILE of Limiters: Comparing Unmet vs. Met Need

	Prospects (Unmet Need: 7.6 % MWRA)	Customers (Met Need: 44.7% MWRA)
Market Size:	806,793	4,745,218
Average Age:	35 years	35 years
Average Parity:	3.5	3.4
Education	80% None or Primary	38% Secondary+
SES	38% Low-SES	29% Low-SES
Residence	65% Rural	52% Rural
Approval:		
Wife/Husband	93%/80%	98%/94%
Intention	62% soon, 9% later	
Health Concern/ Side Effects	15% express concerns	

"limiters" or those who contracept after deciding that they want no more children. (It may be that this is the more difficult decision to make, so it takes somewhat longer to seek contraception.)

Again, it is useful to compare and contrast some characteristics of women with met versus unmet need. As shown in Table 6, some 7.6 percent of MWRAs or about 800,000 women have an unmet need for limiting. The median age of women who want to limit future childbearing is about 35 years of age. Among this group of women, there is no difference between the median age of women with a met need versus those with an unmet need for contraception. Again, women who are less educated, of low SES and live in rural areas are more likely to have an unmet need for contraception. Women with an unmet need for limiting are more likely to have experienced the loss of an infant child than are their counterparts with met need for limiting (25 percent versus 14 percent, respectively).

Chart 7. Method choice among women who want no more children, 1992-2000



Among women with an unmet need for limiting future pregnancies, about 63 percent report that they intend to contracept within 12 months of the interview. Yet, 28 percent report that they have no intention of using family planning at any time in the future. Some 15 percent report that one of the reasons for nonuse is that they are concerned about side effects or potentially negative health consequences. In short, while there is a substantial subgroup of women who fall into the category of having an unmet need for limiting yet are expressly reluctant to rely on modern contraceptive methods, the majority of women in this group are good prospects for family planning use in the short term.

About 20 percent of limiters are breastfeeding, but only three percent have given birth within the past six months. Therefore, we will not explore method use among this group of women except to say that

nonuse among postpartum women declined sharply between 1995 and 2000 (data not shown). This trend confirms that Egyptian women are increasingly adept at the expert use of family planning.

While the IUD remains the dominant method among women who use to limit births, both the oral pill (at 19 percent) and injectables (at nine percent) are more popular than among women who are contracepting to delay or space their next pregnancy (see Chart 7).

Niche audience: Contraceptive options for breastfeeding limiters.
Approximately 20 percent of limiters are breastfeeding. While it is always important to reach all breastfeeding women early in the postpartum period to avoid short birth intervals, it is particularly important to reach those women who want to cease childbearing. In many cases, the postpartum IUD is ideally suited to their needs, but other viable options are available. In particular, the POP and the DMPA injectable contraceptive can be introduced six weeks after childbirth.

Non-breastfeeding limiters
Fully 80 percent of limiters fall into this category. Since most limiters are no longer breastfeeding, it is important to focus on long-term methods for this group of women. Method choices for limiters who are not breastfeeding are many. It is particularly important, however, that this group of women rely on long-term methods. The IUD, DMPA injectable and the one-month injectable are all appropriate unless contraindicated.

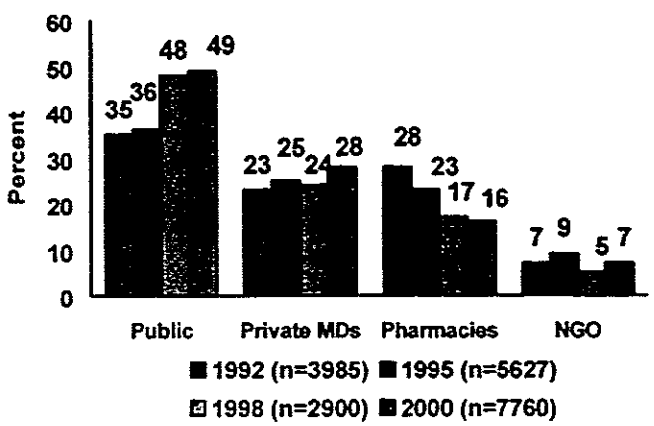
IV. Market Opportunities for Family Planning Services and Products

Trends in Service Sector Utilization

Up to this point, we have discussed consumer segments by focusing on consumer demand as reflected in reproductive life stage, desired fertility, breastfeeding status and socio-economic status. Demand, of course, must be answered with appropriate and adequate sources of supply. This section will examine market opportunities for contraceptive services and products.

In both 1992 and 1995, one-third of modern contraceptive users obtained their contraceptives from the public sector (Chart 8). In 2000, 48.6 percent of contraceptive users reported that the last place at which they sought services was from a public sector clinic, facility or hospital. This marks a 42 percent increase in public sector use over 1995. While this represents a success for the public sector, it also reflects a shift away from pharmacies and NGOs in terms of sector share.

Chart 8. Percent Distribution for sources of modern contraceptive method, Egypt 1992-2000



When examining the demographic characteristics of women in the various sectors, it is clear that age was not a factor as the shift towards the public sector was similar for all age groups (data not shown). The shift from the private sector to the public sector

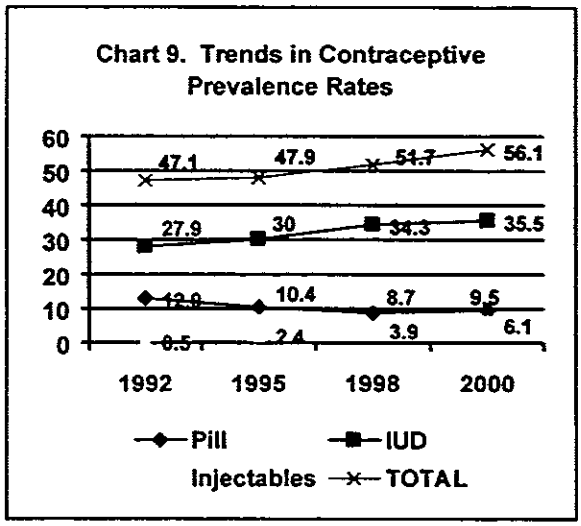
increased more dramatically among the rural population (46 percent) than among urban dwellers (35 percent). By region, the smallest increase in the public sector share was in urban Upper Egypt, where the increase was 32 percent, while *the most dramatic increase in public sector share was in rural Upper Egypt at 63 percent.*

Table 7. Source of Service by Method among Married Women of Reproductive Ages (row %), Egypt 2000

	Public	Private MDs	Pharmacies	NGOs	TOTAL
IUD	54	36	0	10	100
Oral contraceptives	11	6	82	1	100
Injectables	82	11	3	4	100

*This table reflects source of service, which in a small percentage of cases was different from the source of the contraceptive product.

Among IUD and injectable users, there was a clear shift to the public sector over the period of interest, though the major jump occurred between 1995 and 1998. In short, users of the methods commonly relied on in Egypt--with the exception of pill users-moved in large numbers from the private to the public sector. (This trend data is not shown.) Table 7 shows that, in 2000, 54 percent of IUD users obtained their service from the public sector, 36 percent from private physicians and 10 percent from NGOs. By 2000 nearly 82 percent of all injectable users sought services from the public sector. Because the actual number of injectable users was quite small prior to 2000 (235 in the 1998 DHS), it is not possible to look at trends in sector share among this group of women other than to note that most users are public-sector clients. Pharmacies accounted for over 80 percent of the oral-pill market throughout the period of interest.



At this point, it is useful to present a graph with trends in contraceptive prevalence by method since source and method are often related. For example, the fact that the pharmacy-sector share decreased over the 1990s reflects a decline in oral contraceptive use rather than a shift away from the pharmacy to other service providers among pill users. (This issue will be taken up more fully in the concluding section of the paper.) Between 1998 and 2000, the IUD and the pill both grew about one percent while injectable use accounted for an increase of just over two percentage points (Chart 9).

Appropriately, low SES women are significantly more likely to use the public sector than are high SES women. Slightly more than 60 percent of low SES women, some 48 percent of middle SES women and about 30 percent of high SES women obtained contraceptive methods through the public sector (data not shown) in 2000.

Next, we look at market share by SES among IUD users—the only group in which there are sufficient numbers to make this comparison since pharmacies dominate the oral contraceptive market and the public sector dominates the still-small injectables market. As shown in Charts 10 and 11, between 1995 and

2000 there was an influx into the public sector of clients from all SES levels. Similar patterns regarding trends in service sector use were found when we examined sector use by husband's level of educational attainment, thus confirming the usefulness of the SES index created for this study (data not shown).

Chart 10. Source of IUD Insertion by SES, Egypt 1995

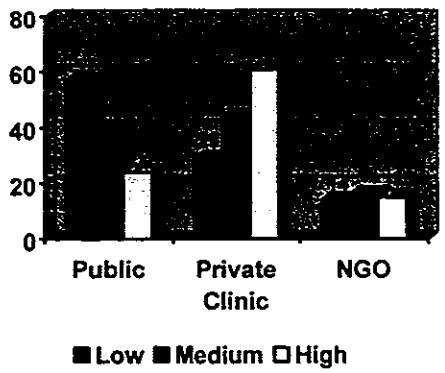
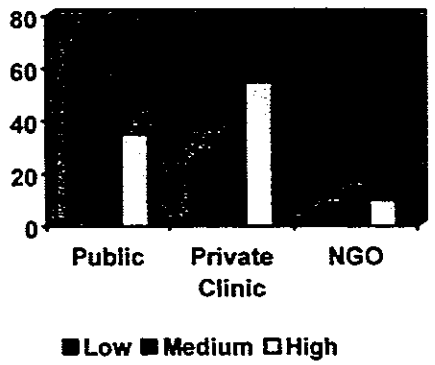


Chart 11. Source of IUD Insertion by SES, Egypt 2000



By examining sector share in urban versus rural Egypt, we can better understand where the shift from the private to the public sector took place. As shown in the Appendix (Charts A-1 and A-2), the shift from the private to the public sector was significant between 1995 and 1998 in rural Egypt. Yet, in urban Egypt, the primary shift from the private to the public took place among respondents of low or medium SES (see Appendix).

Another approach to understand more thoroughly why the public sector gained market share relative to the private physician and NGO sectors is to examine the cost factor. As can be seen in Chart 12, cost remained fairly steady in the public sector over the eight-year period and even shows an increase in the percentage of users who paid four Egyptian pounds (LE) or less for the IUD insertion.

Chart 12. Cost of IUD Insertion Public Sector 1992-2000

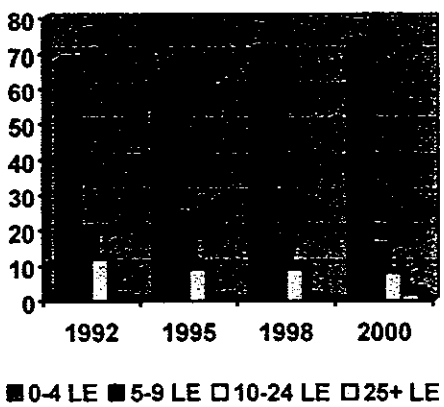
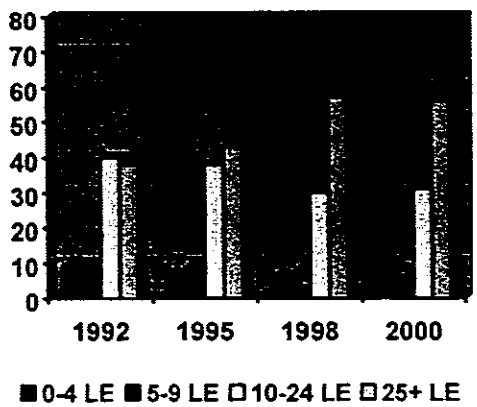


Chart 13. Cost of IUD Insertion Private Sector 1992-2000



In the private sector, however, there was a clear and steady increase between 1992 and 1998 in the percentage of users who were paying at the high end for IUD insertion with over half of all IUD users reporting that they paid 25 LE or more for insertion (see Chart 13). The jump in price for the IUD may be attributed in part to the fact that private physicians' access to the highly subsidized CopperT IUD was phased out in 1995. Even so, most of the fee for the IUD obtained through the private sector is the cost of insertion rather than the cost of the method. (These two costs were not always reported separately by respondents, so changes in costs of the IUD itself cannot be assessed with this data.) Costs in the NGO sector were in the middle range with 55 percent paying 10-24 LE for insertion in 1998. (Data not shown.)

The price distribution for IUDs held fairly steady between 1998 and 2000. Yet, there was a drop of almost three pounds in the average amount paid for the IUD in the private sector (Table 8). In 2000 the mean price paid for the IUD (including insertion) in the public sector was 4.24 Egyptian pounds, while NGO clients paid an average of 13.2 LE and private sector clients paid 32 LE.

Table 8: Mean price [illegible] by Source of Service [illegible]

	YEAR	
SOURCE	[illegible]	[illegible]
Public	4.95 LE	4.25 LE
NGO	[illegible]	[illegible]
Private	35.03 LE	32.20 LE

At this point, it is useful to look again at the mean prices paid for the IUD by SES (Table 9). There is little difference in IUD cost by SES among public sector clients. In the private sector, however, low SES clients reported paying an average of 24LE, middle SES clients reported paying 29 LE and high SES clients paid 42LE. This may be that, since clients are likely to frequent clinics in their own neighborhoods and clinic costs will vary by the value of real estate, the higher costs may have taken expenses into account and actually reflect similar profit margins for services rendered to clients across SES.

Table 9: Amount Paid for IUD by Source of Service and SES

SES	Public	Private	NGO
Low	3.99	23.8	9.52
Mid	4.06	29.25	12.92
High	5.60	42.23	16.98

Alternatively, physicians may charge clients according to their apparent "ability to pay." This possibility is lent some support by the fact that, in the even in the NGO sector, SES is related to price paid. Low SES clients pay an average of 9.5LE, middle SES clients pay 13LE and high SES clients pay an average of 17LE. Yet, these price disparities, too, may be reflective of the types of NGO frequented by or accessable to the different SES groups. It is interesting to note that, while the average price paid for the IUD in the public sector (Table 8) is somewhat lower than the average price paid by lowSES women, the middle SES group paid an average price very close to that charged in the NGO sector, that is 13 LE.

The average cost of oral contraceptives remained fairly stable between 1995 and 2000, but no comparisons across sectors can be made since nine out of ten users purchased oral pills from the pharmacy (as discussed above and shown in Table 7). Low and middle SES clients selected lowercost oral contraceptives paying on average 3.4LE and 4.2LE, respectively, while high SES clients paid an average of 9.7LE per cycle. Fewer than 150 respondents reported purchasing the pill from a private physician or from the public sector. Likewise, comparisons across sectors cannot be made for injectable users since eight in ten injectable users obtained the injectable from the public sector, where prices actually dropped between 1995 and 1998 when the Government of Egypt decided to increase the subsidy for the injectable. Injectable prices dropped even further by 2000 at which time the average price paid per injectable was 2.26 LE.

The shift to the public sector between 1995 and 2000 can be explained in part by the Gold Star program, which brought higher-quality services to the public sector by instituting the systematic use of quality indicators to evaluate clinics. At the same time, the enhanced quality of publiesector services available at the Gold Star Clinics was highlighted in public service announcements as well as through other venues. These clinics attracted clients from a range of incomes by offering reliable services at lower prices. In short, the public sector had a distinct cost advantage, whichresulted in the increased utilization of the public sector by all groups, including the better-off groups.

V. Recommendations and Conclusions

In this paper, we have examined the needs of different population groups with respect to their reproductive life stages and ability to pay together with a close analysis of contraceptive products and service sectors. The underlying purpose of this approach was to provide recommendations regarding the market growth opportunities for different service sectors andcontraceptive product categories.

In recent years, considerable effort has been devoted to strengthening the private sector's ability to provide family planning goods and services. Egypt, where donors have funded privatesector initiatives to promote private clinics and pharmacies as well as several NGOs that provide family planning and reproductive health services, is a case in point. The argument is often made that donor and publiesector funds cannot be guaranteed in the future; thus, a robust private sector is necessary to ensure the sustainability of family planning programs in the developing world.

It might prove useful to step back for a moment and examine this assumption. The World Bank publication, *2000 World Development Indicators*, presents data from 161 countries regarding public and private health expenditures as a percentage of a given country's gross domestic product. A quick review of the relevant tables (pages 90-93) reveals that, with the exception of the United States, public expenditures for health exceed private expenditures. Indeed, public expenditures outweigh privatesector expenditures two to one, on average, in high-income countries. [6]This strongly suggests that a dominating role for the private sector in financing thehealth sector is not a necessary condition of sustainability, even if for political and economic reasons policy makers decide it is desirable. (The aforementioned publication does not provide information regarding family planning expenditures by sector.)

In low- and lower-middle income nations, private sector health expenditures typically exceed public expenditures (World Bank, 2001). Yet, in the family planning arena, some 80 percent of modern contraceptives are provided by the public sector (Hopstock et. al., 1997).[7] The government sector dominates in most of the major countries of the world that are home to large numbers of contraceptive users, including China, India, Bangladesh, Mexico, Turkey, Pakistan, Kenya, Vietnam and the Philippines, among others (Ross, Stover & Willard, 1999). Indonesia provides the major exception to this rule and is often cited as evidence of a successful governmental effort to expand the role of the private sector, whose share jumped from 24 to 57 percent between 1991 and 1997 (Ibid.). A close look at source by method, however, reveals that even in Indonesia, tubal ligation, vasectomy, and the IUD are predominantly provided through the governmental sector. In fact, the IUD is, with few exceptions, provided by government-sector facilities throughout the technologically developing world.

---

[6] It is difficult to make cross-national comparisons due to the wide range of data collection procedures followed. Therefore, these percentages should be read as indicative rather than as actual.

[7] Latin American countries, which have often faced opposition from the Church regarding family planning, are the exception to this rule. Mexico and Peru are the only Latin American countries in which the public sector predominates in the provision of family planning goods and services.

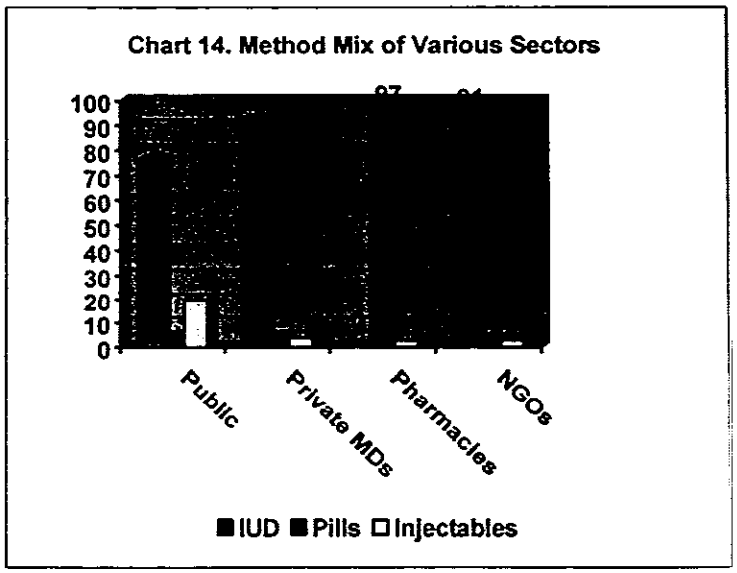
Given that the IUD is the primary method in Egypt, these data are thought provoking. Indeed, the analysis of sector and product trends in the Egyptian market also reveals this linkage between sector share and method mix: as oral contraceptives lost market share to the IUD, pharmacies—an important provider within the private sector—lost ground to the public sector. In short, as the public sector, where the IUD predominates, enhanced its ability to attract clients through the Gold Star campaign there was a concomitant increase in IUD use. (The data also demonstrate that physicians, whether in the private or NGO sectors prescribe the IUD at a much higher rate than they prescribe other contraceptive methods, but the sector share of private physicians did not increase in the 1990s.) As we reconsider the data presented above, it is important to consider the implications of method mix with respect to sector share in the modern contraceptives marketplace.

While the actual and potential client bases for the various service sectors often overlap, the market-conscious decision maker will identify those audience segments that are most likely to seek services from the sector he or she serves. The market niche analysis presented above identifies population groups according to their reproductive life stage and socio-economic status and examines trends in the use of contraceptive products and services by those audiences. The balance of this section turns to specific recommendations for each of the major sectors based on the foregoing analysis.

Prospective Client Groups by Sector

As shown in Chart 14, the IUD is the dominant method provided in the public sector as well as by private physicians and NGOs. Yet, the client base for each of these sectors is not identical. The major distinction is SES or the ability to pay.

Table 9 (next page) presents a summary of primary market opportunities for the various sectors by method. These recommendations should not be read as restrictive, but rather as suggestive of which audience niches are the most likely prospects for the various sectors and which methods are likely to suit both client and sector. The fact that the three service sectors are well established in Egypt bodes well for the sustainability of Egypt's family planning program.



Public Sector

The analysis thus far suggests that the public sector is most appropriate for women who rely on the public sector safety net or are otherwise in need of low-cost methods and services. Approximately 440,000 thousand women are of low SES and 600,000 women are of mid-SES and are prospects for limiting or spacing. Breastfeeding postpartum spacers are a very important niche group for the public sector. These young, low-SES women need to safeguard their health by preventing accidental pregnancy as well as establish a pattern of expert family planning use early in their reproductive lives. Another very important market segment for the public sector is the group of low-SES limiters, who are in need of long-term methods. There are approximately two times as many women with unmet need to limit births as there are women with unmet need to space.

Table 9.	Primary Market Opportunities by Method and Sector			
	Public	**Private MDs**	**Pharmacies**	**NGOs (CSI)**
(# women)	Low, Mid SES 1,040,000	Mid, High SES 590,000	ALL SES 1,200,000	Mid SES 600,000
IUD	Spacers **Limiters**	Spacers **Limiters**		Spacers **Limiters**
Injectables				
One-month*		Non-BF Spacers & Limiters	Non-BF Spacers & Limiters	Non-BF Spacers & Limiters
Three-month DMPA**	BF & Non-BF Limiters	BF & Non-BF Limiters	BF & Non-BF Limiters	BF & Non-BF Limiters
Oral Contraceptives				
Progestin only**			Postpartum	Postpartum
Combined OCs*			Non-BF Spacers & Limiters*	Non-BF Spacers & Limiters*

*Combined hormonals can be used for breastfeeding women six *months* postpartum.
**Progestin-only methods are recommended for breastfeeding women *if use commences at least six weeks after childbirth*

Private-sector Physicians
Physicians working in the private sector will continue to attract clients primarily from the mid and upper-SES groups, but are an important alternative even for low-SES clients. There are about 150,000 women who are of high SES and express an unmet need for contraception. Private-sector physicians should also consider hormonals as an alternate method for some of their clients.

Pharmacies
While pharmacies carry all contraceptive methods, their main market opportunity lies in hormonal methods, particularly the category of oral contraceptives (OCs), which they dominate. The 2000 EDHS found that OCs constitute 97% of the method mix sold by pharmacies (Chart 16) and 82 percent of all OCs sold in Egypt are purchased from pharmacies (Table 7). Pharmacies are positioned to serve all SES groups with premium-, mid- and economy-priced contraceptive products. Thus the potential *new* market opportunity for pharmacies comprises all women with unmet need, numbering approximately 1.2 million. Women at different reproductive life stages need different types of contraceptive methods. Thus, young breastfeeding women with unmet need, numbering approximately 200,000, become prime prospects for the progestin-only pill (POP), which possesses the rapid return to fertility desired by spacers. Breastfeeding women wishing to limit births, numbering roughly 240,000, are also prospects for the POP, as well as the longer-lasting 3-month injectable, DMPA. Non-breastfeeding women with unmet need to space or limit births are good prospects for a number of methods: the one-month injectable which has recently entered the Egyptian market, the universally available combined oral contraceptive (COC), and DMPA. Pharmacies can also promote the IUD, but it has a relatively weak customer base since most clients purchase the IUD only for insertion by a physician. The 2000 data show that only two percent of IUD users purchased their IUDs from pharmacies. (This does not, however, account for physician purchases of the IUD from pharmacies.)

NGOs
Mid-SES clients are the natural audience segment for NGOs. At 600,000 strong, midSES women constitute the largest group of women with unmet need. The IUD will be the preferred method of many of these women, particularly limiters, but NGOs should also consider increasing prescriptions for hormonals when appropriate.

A Potential Niche Audience: Newly married couples
Family planning service providers in all sectors should begin to consider another population segment that has not been addressed in this article—namely, nulliparous women. Women who have not yet given birth to a child have been omitted from this study because only two percent of them express a desire to delay childbearing (EDHS-2000), or have any unmet need for family planning. Still, this very large group of women—about 600,000 in number who are not pregnant, or 5.6% MWRA—may well be interested in *learning about family planning*. In several countries with large Muslim populations similar to Egypt, government policy requires all engaged couples to go through premarital counseling that focuses heavily on family planning information. This approach could be particularly beneficial in Egypt. The goal would be to give young married couples information about specific contraceptive methods as well as where to get services should they decide to contracept. There need be no effort to persuade young couples to delay their first pregnancy, but instead, to inform them where to obtain services and how to delay pregnancy if and when they decide that is the right choice for them.

APPENDIX A. Source of IUD Insertion in

Chart A.1 Source of IUD Insertion by SES,Rural Egypt 1995

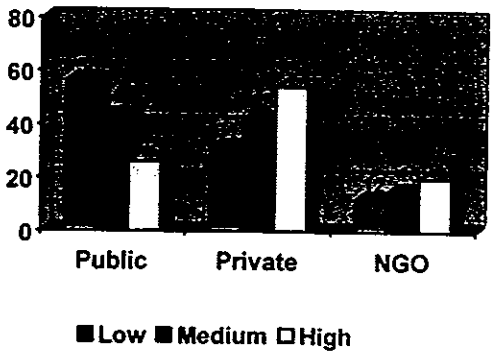
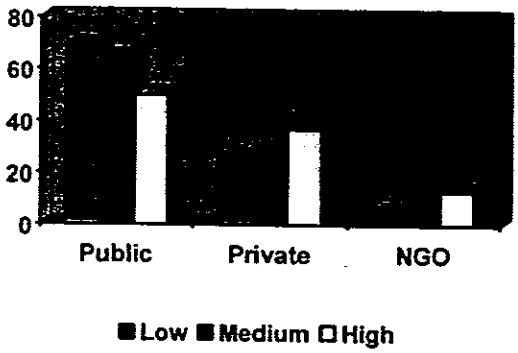


Chart A-2. Source of IUD Insertion by SES, Rural Egypt 1998



Egypt, 1995 and 1998 by Urban/Rural Residence

Chart A-3. Source of IUD Insertion by SES, Urban Egypt 1995

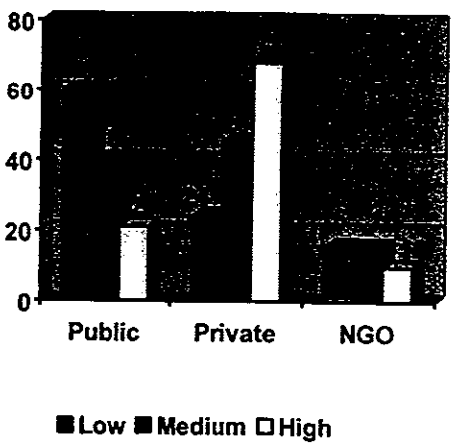


Chart A-4. Source of IUD Insertion by SES, Urban Egypt 1998

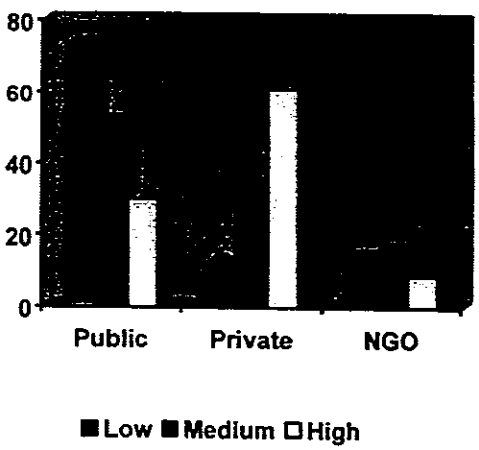
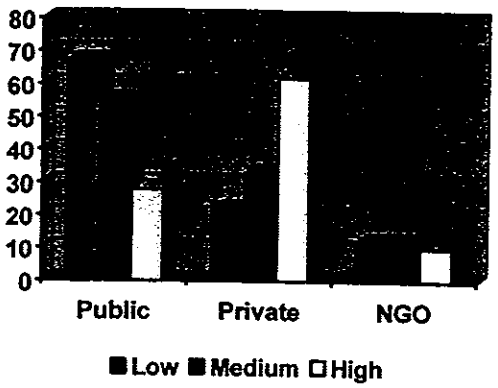


Chart A-5. Source of IUD by SES, Urban UPPER Egypt 2000

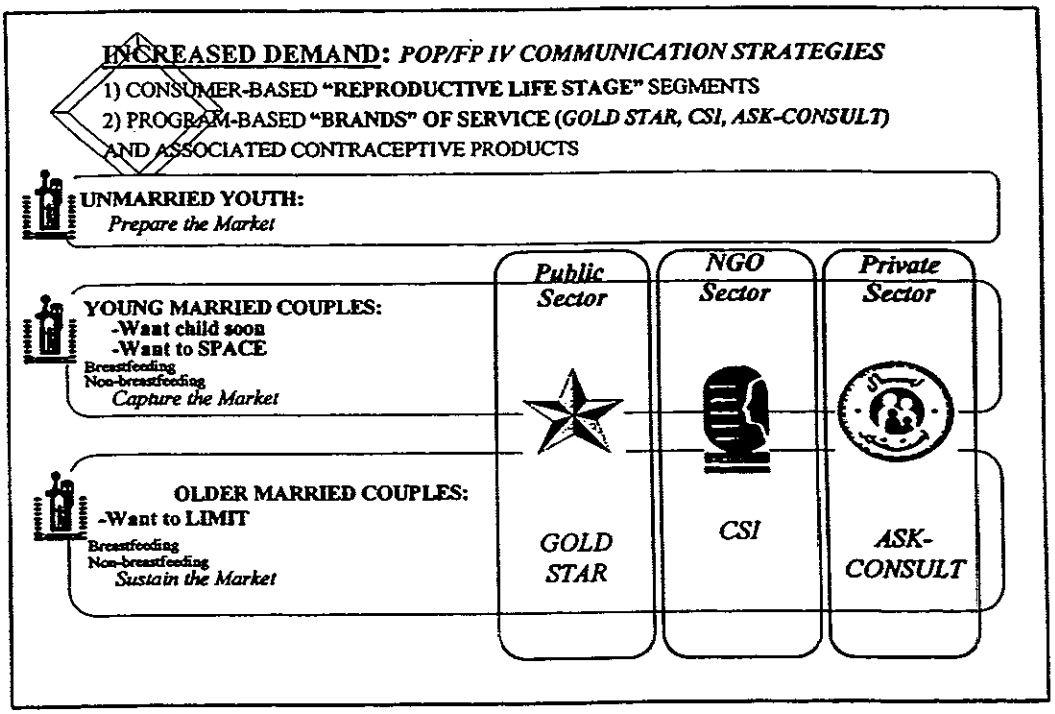


MARKET SEGMENTATION
Niche Analysis

- INCREASED DEMAND -
Task 5

GOAL: Market Segmentation

- **To identify and quantify market segments for family planning according to consumer-demand criteria; and**
- **To identify program-growth opportunities and formulate strategic action plans for:**
  - contraceptive products (pill, IUD, injectables) and
  - FP service sectors (public sector, private doctors, private pharmacists, NGOs)



TRENDS IN CONSUMER DEMAND

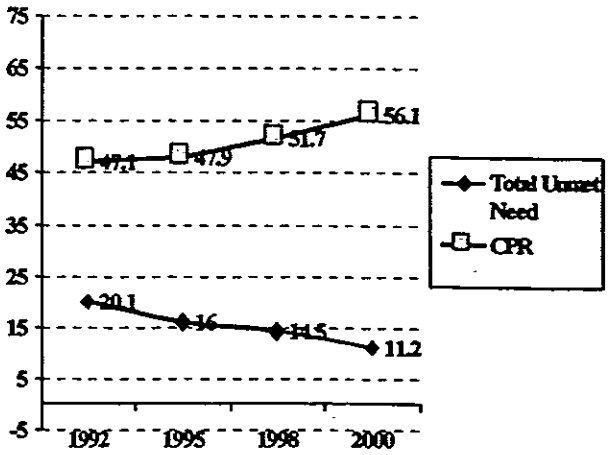
DISCUSSION POINTS

- CONSUMER DEMAND PREDICTED BY FERTILITY PREFERENCE, OR "UNMET NEED"
- SIGNIFICANT GROWTH IN FP AMONG WOMEN WISHING "TO SPACE" BIRTHS
- MORE WOMEN ARE BECOMING "EXPERT SPACERS"
  - ADOPTING FP AFTER BIRTH OF FIRST CHILD
  - USING FP WITHIN 2 MONTHS POST-PARTUM
  - HAVING SAFE, EXTENDED BIRTH INTERVAL

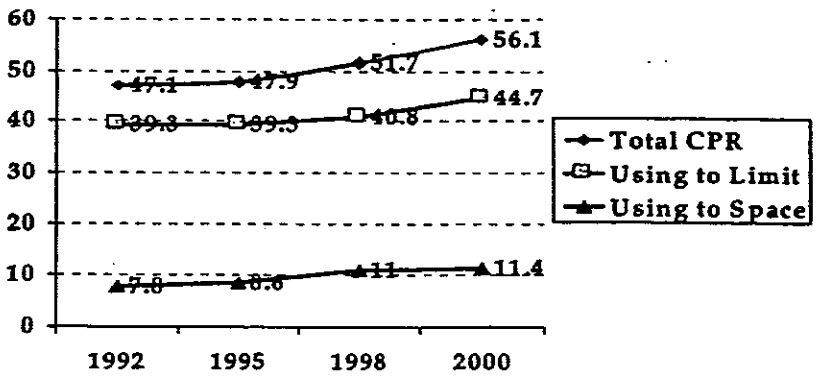
Trend:
Unmet Need "predicts" future family planning use.

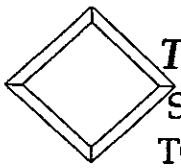
Definition: Unmet Need

- expressed desire to delay or limit childbearing
- not want child soon
- not pregnant
- not infecund



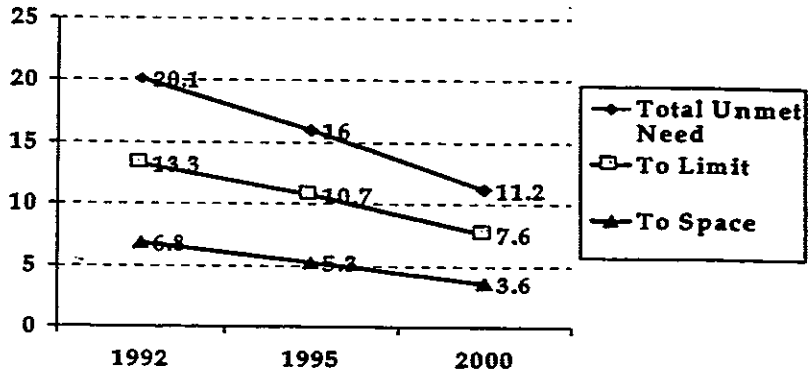
Trend:
SIGNIFICANT INCREASE IN "USING TO SPACE"

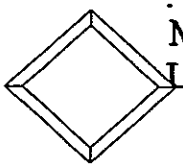




Trend:

SIGNIFICANT DECLINE IN "UNMET NEED TO SPACE"

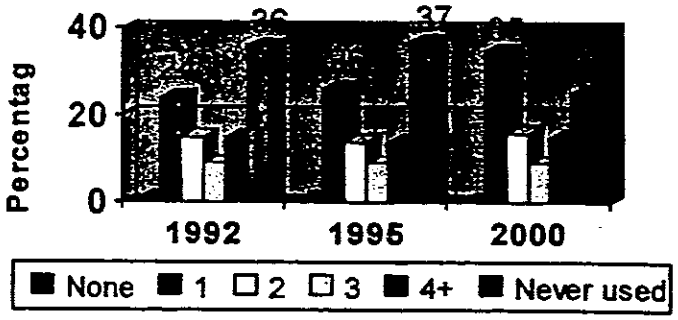




MORE WOMEN ARE BECOMING "EXPERT USERS" OF CONTRACEPTION:

- INITIATING FP AFTER BIRTH OF FIRST CHILD

Percentage of Women by Parity at first use of contraception, Egypt, 1992, 1995, 2000

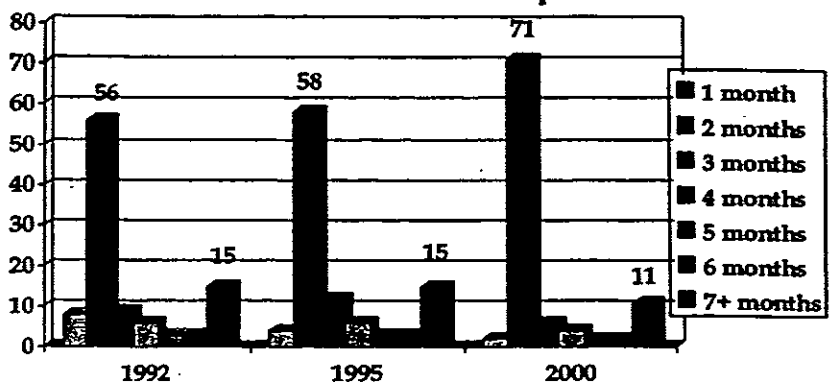


MORE WOMEN ARE BECOMING "EXPERT SPACERS":

-INITIATING FP USE AT 2 MONTHS POST-PARTUM (~40th Day)

Timing of Use after Delivery among Current User

Self-identified as Spacers



MORE WOMEN ARE BECOMING "EXPERT SPACERS":

- **SAFE, EXTENDED BIRTH INTERVALS ARE THE NORM**

- **Changes in birth interval, 1995 → 2000**
  - **Among spacers 27.7 → 28.9 months**
  - **Among all women 32.3 → 34.3 months**

MORE WOMEN ARE BECOMING "EXPERT SPACERS":

- **USE DURATION IS DETERMINED BY DEMAND & AGE (median use)**

Spacers	**15-24**	**10.7 months**
	25-34	**20.2 months**
	35+	**48.5 months**
Limiters:	**15-24**	**13.3 months**
	25-34	**29.5 months**
	35+	**57.2 months**

PROFILE OF DEMAND FOR FAMILY PLANNING IN EGYPT

	% MWRA		Est.Population(2000)
Total Demand	67.5 %		7,165,597
-Met Demand (customers)	56.1 %		5,955,407
-Unmet Demand (prospects)		11.2 %	1,189,958
Total Demand to Space	15.0 %		1,592,355
-Met Demand to Space	11.4 %		1,210,190
-Unmet Demand to Space	3.6 %		382,165
Total Demand to Limit	52.3 %		5,552,011
-Met Demand to Limit	44.7 %		4,745,218
-Unmet Demand to Limit	7.6 %		806,793

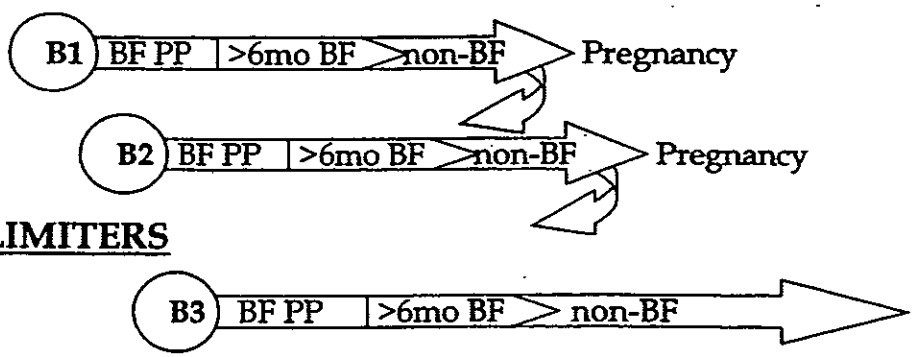
SOURCE: EDHS2000 and Foreit Population Projections (1%MWRA=106,157population)

MARKET SEGMENTATION FRAMEWORK

- **REPRODUCTIVE LIFE STAGE**
  - UNMET NEED (client-expressed fertility preference)
    - desire to SPACE BIRTHS;
    - desire to LIMIT BIRTHS
  - **BREASTFEEDING STATUS**
    - Breastfeeding
      - Breastfeeding Post-partum (6mos) (*Niche Group*)
      - Breastfeeding (>6 months)
    - Non-breastfeeding
- **SOCIO-ECONOMIC STATUS (SES)**
  - High, medium, low SES

MODEL OF "LIFE STAGE" MARKET SEGMENTS

SPACERS



LIMITERS

PROFILE of SPACERS: Comparing Unmet vs. Met Need

	Prospects (Unmet Need: 3.6 % MWRA)	Customers (Met Need: 11.4% MWRA)
❖ Market Size:	382,165	1,210,190
❖ Median Age:	25 years	25 years
❖ Average Parity:	1.6	1 child
❖ Education	43% None	62% Secondary+
❖ SES	36% Low-SES	24% Low-SES
❖ Residence	68% Rural	53% Rural
❖ Approval:		
Self/Husband	92%/73%	98/95%
❖ Intention to use	79% soon	
❖ Health Concern/ Side Effects	6% express concerns	

Breastfeeding Non-Breastfeeding Status among Spacers:

Breastfeeding	50.5%
(17 months median length of breastfeeding)	
❖ Breastfeeding post-partum (<6 months)	9.7%
❖ Breastfeeding > 6 months	40.8%
Non-Breastfeeding	49.4%
❖ Post-partum	.9%
❖ Others	48.5%

Socio-economic Status (SES) among Spacers:

Definition:

Socio-economic status is determined by ownership of those consumer goods determined to allow for differentiation among groups. Factor analysis demonstrated that SES calculations for urban and rural residents should be calculated separately using a slightly different "basket" of consumer goods.

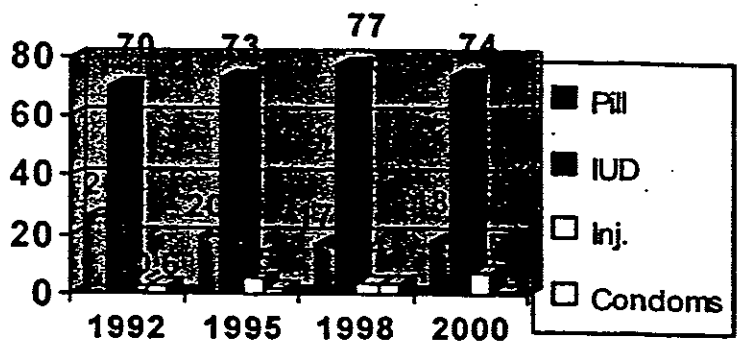
Socio-economic Status:	1992	2000
High	13%	18%
Medium	39%	52%
Low	48%	30%

Socio-economic Status (SES) among Spacers:

			Actual Cost (mean LE) for:		
			IUD	Pill	Inj.
SES	Met Need	Unmet Need:			
High	17%	11%	26.95	3.57	6.70
Medium	59%	52%	13.70	1.75	3.98
Low	24%	36%	9.39	1.43	2.99

Contraceptive Choice among Spacers

Method choice among Spacers, 1992, 1995, 1998, 2000



PROFILE of LIMITERS: Comparing Unmet vs. Met Need

	Prospects (Unmet Need: 7.6 % MWRA)	Customers (Met Need: 44.7% MWRA)
❖ Market Size:	806,793	4,745,218
❖ Average Age:	35 years	35 years
❖ Average Parity:	3.5	3.4
❖ Education	80% None or Primary	38% Secondary+
❖ SES	38% Low-SES	29% Low-SES
❖ Residence	65% Rural	52% Rural
❖ Approval: Wife/Husband	93%/80%	98%/94%
❖ Intention	62% soon, 9% later	
❖ Health Concern/ Side Effects	15% express concerns	

Breastfeeding / Non-Breastfeeding Status among Limiters:

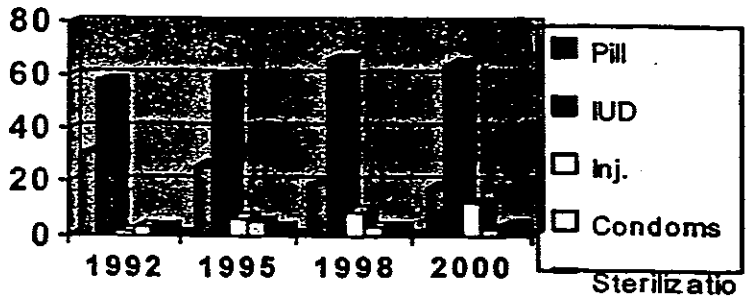
Breastfeeding	20%
(mean duration of BF is 17 months)	
❖ Breastfeeding post-partum (<6 months)	3%
❖ Breastfeeding > 6 months	17%
Non-Breastfeeding	80%

Socio-economic Status (SES) among Limiters:

			Actual Cost (in LE) for:		
			IUD	Pill	Inj.
SES	Met Need	Unmet Need			
High	19%	13%	26.95	3.57	6.70
Medium	51%	49%	13.70	1.75	3.98
Low	30%	38%	9.39	1.43	2.99

CONTRACEPTIVE CHOICE among LIMITERS

Trends in Method Choice among Limiters, 1992-2000



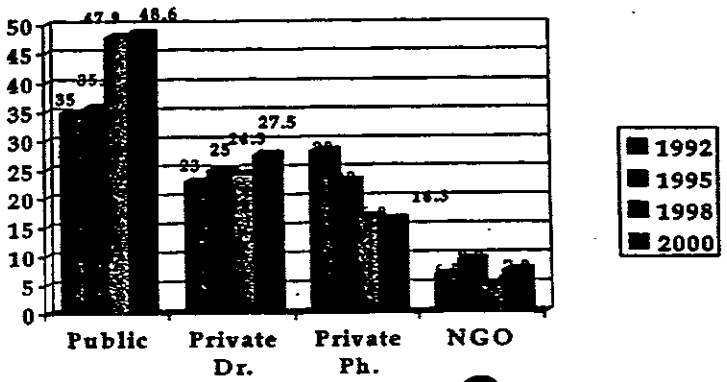
Service Sector and Product Market Opportunities:

DISCUSSION POINTS

- Sector Share Trends: Public, Private, NGO
  - Sector Trends in IUD Use
- Sector by Contraceptive Product
- Sector by SES
- Product and Sector Market Opportunities:
  - Life Stage by SES
- Conclusion:
  - Niche Markets
  - Niche market Results

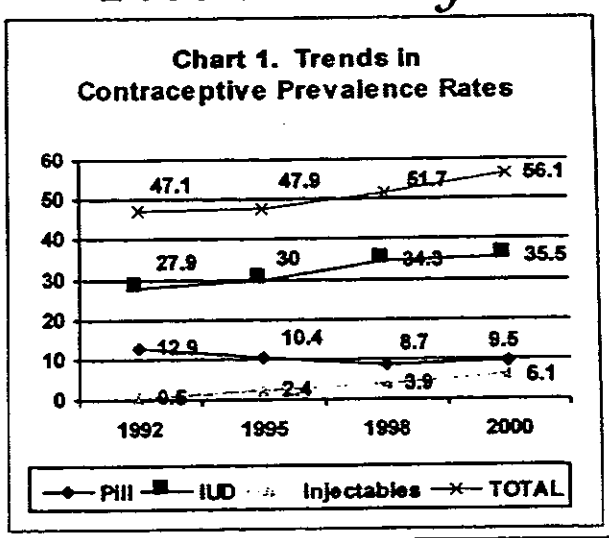
Program Opportunities:

SECTOR SHARE: Public, Private, NGO



Source: EDHS-98, EDHS-95, EDHS-92

Trends in Contraceptive Prevalence by Method



Source of Service by Method (% MWRA)

	Public	Pvt. Dr.	Pvt. Phar.	NGO	Total
IUD	54	36	0	10	100
Oral	11	6	82	1	100
Inj.	82	11	3	4	100

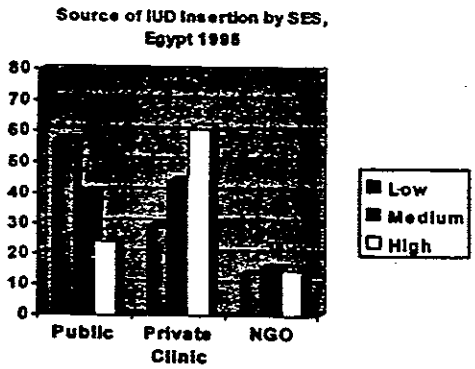
*Row percentages

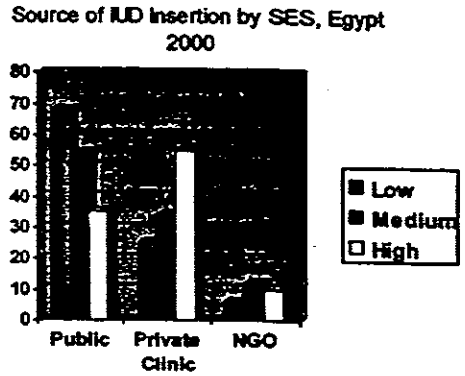
Source of Service by Method (% MWRA)

	Public	Pvt. Dr.	Pvt. Phar.	NGO
IUD	76	92	0	91
Oral	4	4	97	3
Inj.	20	4	3	6
Total	100	100	100	100

*Column percentages

SES Trends in IUD Share by Sector





Service Sector Use (%MWRA) by SES

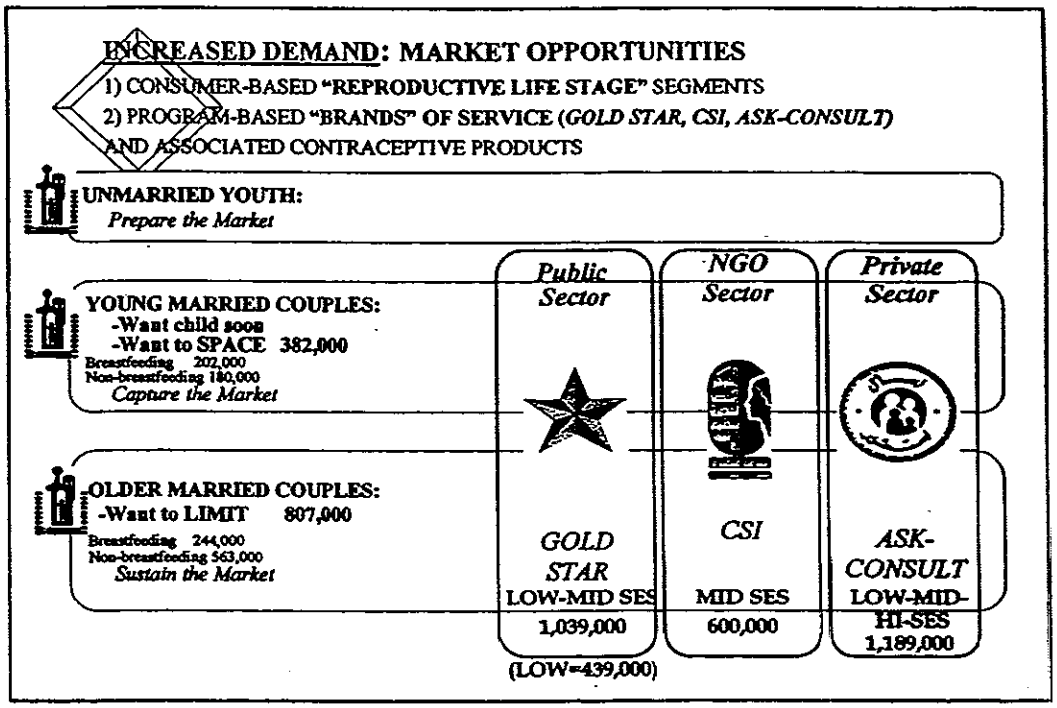
	Public	Pvt. Dr.	Pvt. Ph.	NGO	Non-User Prospects
High IUD LE 27.00 Pill LE 3.60 Inj LE 6.70	11.6	30.2	25.7	16.9	12.8
Med IUD LE 13.70 Pill LE 1.75 Inj LE 4.00	52.6	51.0	54.0	63.8	50.3
Low IUD LE 9.40 Pill LE 1.40 Inj LE 3.00	35.8	18.8	25.7	17.0	37.6
Total	100	100	100	100	100
Mean Range: 1.00 - 3.00	**1.76**	**2.11**	**1.95**	**2.02**	**1.78**

MARKET PROSPECTS by Life Stage by SES:

Stage Method	SES: Hi	Mid	Low	Total
Prospects for Spacing	(%)	(%)	(%)	(%)
Breastfeeding POP,IUD	0.2	1.0	0.7	1.9
Non-Breastfeeding IUD, COC, 1-mo Inj.	0.2	0.9	0.5	1.6
				3.59
Prospects for Limiting				
Breastfeeding POP,IUD, DMPA	0.2	1.0	1.1	2.3
Non-Breastfeeding COC,IUD,All Inj	0.8	2.7	1.8	5.3
				7.6
Total	1.4	5.7	4.2	11.2

MARKET PROSPECTS by Life Stage by SES:

Stage Method	SES: Hi	Mid	Low	Total
Prospects for Spacing	(1000s)	(1000s)	(1000s)	(1000s)
Breastfeeding POP,IUD	22	106	74	202
Non-Breastfeeding IUD, COC, 1-mo Inj.	22	101	57	180
Prospects for Limiting				
Breastfeeding POP,IUD, DMPA	21	106	117	244
Non-Breastfeeding COC,IUD,All Inj	85	287	191	563
Total	150	600	439	1,189



SES by Price Paid for Method

	IUD	Pill	Inj.	Sector
SES				
❖ High	26.95	3.57	6.70	Private
❖ Medium	13.70	1.75	3.98	NGO, Pvt
❖ Low	9.39	1.43	2.99	MOHP, Pvt.

Key Market Opportunities for Public Sector:

Target Market Segments:	Products*	Low-MidSES Group Size
		1,039,000 (Low=439,000)**
Spacers:		
Breastfeeding	IUD, PPIUD	180,000 (Low=74,000)
Niche: BFPostPartum (40th day)		
Non-BF	IUD, COC	158,000 (Low=57,000)
Niche: Women using less than 2 years		
Limiters		
BF PostPartum	IUD, PPIUD, DMPA	223,000 (Low=117,000)
Niche: BFPostPartum limiters (40th day)		
Non-BF	IUD, DMPA, COC	478,000 (Low=191,000)
Niche: Candidates for long-term non-BF methods		

NOTE: Prospects are nationally dispersed, with ~40% in rural Upper Egypt.
*NOTE: MOHP offers full cafeteria of methods; above products selected on basis of sectoral prices, customer SES profile and past customer purchase behavior.
**NOTE: MOHP has competitive advantage to serve low SES population (Low-SES paid avg. 9.39 for IUD)

Key Market Opportunities for NGO Sector:

Target Market Segments:	Products*	Mid SES Group Size
		600,000
Spacers:		
Breastfeeding	IUD, POP	106,000
Niche: BFPostPartum (40th day)		
Non-BF	IUD, COC, 1mo Inj	101,000
Niche: Women using less than 2 years		
Limiters		
BF PostPartum	IUD, POP, DMPA	106,000
Niche: BFPostPartum limiters (40th day)		
Non-BF	IUD, DMPA, 1mo Inj, COC	287,000
Niche: Candidates for long-term non-BF methods		

NOTE: Prospects are nationally dispersed with ~40% in rural Upper Egypt.
NOTE: NGOs offer full cafeteria of methods; above products selected on basis of sectoral prices, customer SES profile and past customer purchase behavior.
**NOTE: NGO has competitive advantage to serve mid SES population (mid-SES users paid avg. LE 13.70 for IUD)

Key Market Opportunities for Private PHYSICIANS:

Target Market Segments:	Products*	High-Mid SES Group Size
		750,000 (Hi=150,000)
Spacers:		
Breastfeeding	IUD, POP	128,000 (Hi=22,000)
Niche: BFPostPartum (40th day)		
Non-BF	IUD, COC, 1mo Inj	123,000 (Hi=22,000)
Limiters		
BF PostPartum	IUD, PPIUD, DMPA	127,000 (Hi=21,000)
Niche: BFPostPartum limiters (40th day)		
Non-BF	IUD, DMPA, 1mo Inj, COC	372,000 (Hi=85,000)
Niche: Candidates for long-term non-BF methods		

NOTE: Prospects are nationally dispersed*
NOTE: Private physicians offer full cafeteria of methods; above products selected on basis of sectoral prices, customer SES profile and past customer purchase behavior.
**NOTE: Private physicians have competitive advantage to serve high SES population with IUDs (high-SES paid LE 27.00 for IUD) and mid SES groups for hormonals

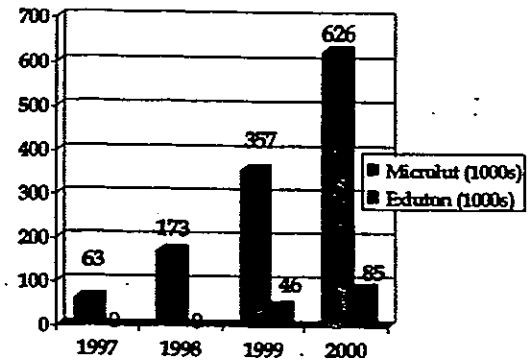
Key Market Opportunities for Private PHARMACIES:

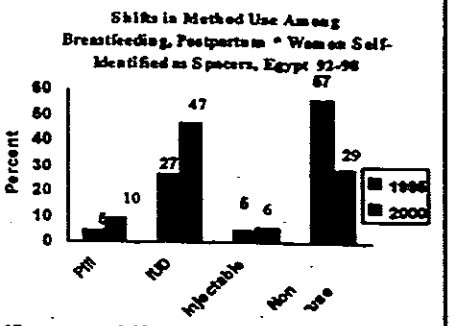
Target Market Segments:	Products*	High-Mid-Low SES Group Size
		1,189,000
Spacers:		
Breastfeeding	POP	202,000
Niche: BFPostPartum (40th day)		
Non-BF	COC, 1mo Inj	180,000
Niche: Women using less than 2 years		
Limiters		
BF PostPartum	POP, DMPA	244,000
Niche: BFPostPartum limiters (40th day)		
Non-BF	DMPA, 1mo Inj, COC	563,000
Niche: Candidates for long-term non-BF methods		

NOTE: Prospects are nationally dispersed with ~40% in rural Upper Egypt.
NOTE: Private pharmacists offer full cafeteria of methods; above products selected on basis of sectoral prices, customer SES profile and past customer purchase behavior.
**NOTE: Private pharmacists have competitive advantage to serve all SES populations with hormonals

Results:

Niche Marketing of POP to BFPP Women

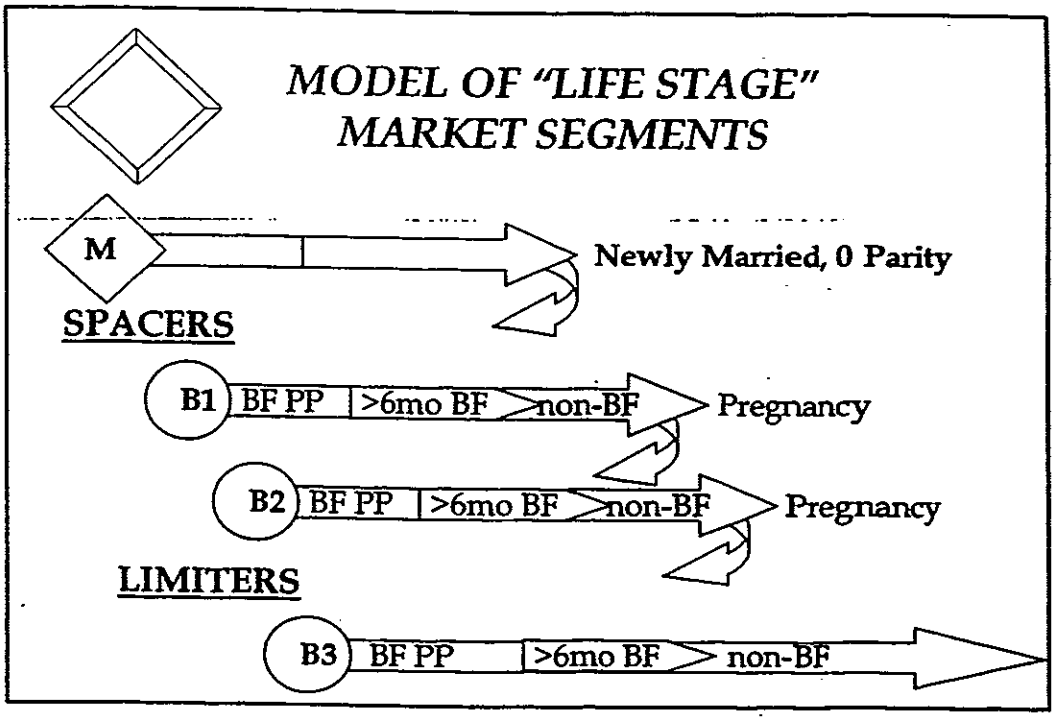




*For purposes of this report, 'postpartum' refers to women w gave birth within the past six months.

END

38



Profile of Newly Married Women, No Children

- 2.1% Unmet Need, ~98% want children soon
- 0.4% FP Use
- ~4.4% believe FP appropriate before first birth

- Potential Market
  - 5.6% MWRA (of 9% total 0-parity MWRA)
  - 595,000 women

MARKET SEGMENTATION PRESENTATION
Wednesday 14 February 2001

Name	Organization
Brenda Doe	USAID/Cairo
Shadia Atteia	USAID/Cairo
Nabila El Wakil	SIS/Cairo
Wafik Zaki	Schering AG
Galal Zaki	Intermarkets
Rania Zaki	Intermarkets
Ibrahim Youssef	MEDTEC
Raafat Ibrahim	MEDTEC
Mohamed Morsy	MEDTEC
Laila M. Kamel	Pathfinder POP IV
Shereen Nazih	Organon
Fatma El Zanaty	DHS Director
Carol Underwood	JHU/CCP
Tourhan Noury	USAID/Cairo
Michael Thomas	Pathfinder POP IV
Mohamed El Gammal	Research Consultant
Steve Reiman	Pathfinder POP IV
Omaima Abdelakher	POP IV
Magdy Khaled	Pathfinder POP IV
Samir Al Alfy	JHU/Pathfinder
Afaf Zaghloul	SIS/IEC
Steve Croll	Pathfinder
Mahmoud Youssef	JHU/Pathfinder
Sahar Abaza	SIS/IEC
Nafisa Moustafa	SIS/IEC
Radia Youssif	SIS/IEC
Jestyn Portugill	Pathfinder POP IV
Bill Mackie	Pathfinder POP IV

MARKET SEGMENTATION PRESENTATION
Wednesday 10 April 2001

Name	Organization
Sanaa Helmi	CSI
Mohamed Edress	CSI
Laurie Cobb	CSI Consultant
Tawhida Khalil	JHU Consultant
Gary Saffitz	JHU/CCP
Ron Hess	JHU/CCP
Mahmoud Youssef	Pathfinder POP IV
Bill Mackie	Pathfinder POP IV
Jestyn Portugill	Pathfinder POP IV