

THE COMMERCIAL DISTRIBUTION OF  
CONTRACEPTIVES

A Consultancy In Jamaica

14 - 30 November 1985

William P. Schellstede  
Executive Director  
Population Services International

## TABLE OF CONTENTS

	<u>Page</u>
Executive Summary	1
I. Introduction	9
II. CDC Performance	11
A. Distribution	11
B. Cost	17
III. Financing the CDC Operation	23
IV. Alternatives in Management and Finance	26
A. Financial Planning Issues	26
B. Product Management Concerns	28
C. Organizational Considerations	31
D. Funding Implications	34
V. Donor Assistance	36

## EXECUTIVE SUMMARY

The objective of this consultancy was to examine the recent performance of the Commercial Distribution of Contraceptives (CDC) operation of the National Family Planning Board with regard to the extent of its distribution, its cost efficiency, and its plans and prospects for the future. The exercise was informed by the notion that this operation must be justified in its demand for resources within the context of the national population effort. To this end I have attempted to develop the material required to advise USAID of the relative success of the CDC enterprise and whether it requires and/or can successfully absorb additional resources. I have had discussions with the key figures involved with the CDC operation, reviewed the available documents, and visited representative sales outlets. While some of the data were not complete, it has been possible to come to some reasonably firm conclusions:

1. The CDC represents an important part of the national family planning effort. The following estimates developed during this visit demonstrate the point:
  - 1983 share of use rate reported in CPS: 18-21%.
  - 1984 share of all contraception delivered by the three major elements of the Government supported program: 25-28%.

1983 and 1984 share of Government supported non-clinical contraception: 44%.

2. The cost of distribution through the CDC operation is strikingly low. Even though all project costs have not been allocated, using data available, the cost in 1984 can be estimated at J\$1.06 per couple-year of protection, or about US 21¢. It has not been possible to develop costing estimates on other elements of the national program but it is suggestive of a substantially higher cost in the clinic based program that the Ministry of Health estimates that its clinics served an average of 260 family planning clients each in 1983.
  
3. Investment in the CDC operation has not been adequate. While sales have increased substantially in the past seven years, the population problem to which the project is addressed is acute. The CDC approach has clearly demonstrated its potential for delivering contraception. Yet funds have not been made available to provide it with professional marketing management or to allow it to advertise at acceptable levels and it has consequently been unable to use in any adequate way one of the most fundamental tools of modern marketing. Thus, what otherwise might be described as cost efficiency may in this case be indicative of an inappropriate allo-

cation of resources: With professional management and sufficient advertising, it is clear that more contraceptives would have moved through the CDC operation; furthermore, the need for better management and adequate levels of advertising will become even more acute in the immediate future.

4. The constraint to higher levels of investment in the CDC operations seems to stem conceptually from an early assumption that social marketing could be and should be financially self-sufficient in Jamaica, and further, that CDC self-sufficiency must somehow be defined in terms of income to the NFBB vs. its expenditures on the operation. Thus, while the officers of the Board recognize clearly the difficulties described above, they have found it virtually impossible to resolve those difficulties within the confines of these considerations about self-sufficiency.
  
5. The prospects for self-sufficiency within the present model are not good. Not only does the enterprise share the difficulty of low prices with other social marketing projects, the potential market as a whole is so small in Jamaica that there is little scope for high volume to produce the greater revenues upon which self-sufficiency would depend.

These observations have been discussed widely with the individuals associated - formally and informally - with the CDC project. It must be said that they were hardly surprising to anyone. Suggestions for the resolution of these problems were also discussed, and some measure of consensus developed concerning the recommendations which appear below. I would emphasize that for the most part the immediate problems are of a more structural than of a technical nature. By that I mean what is wanted now is more in the way political and administrative action than of developing new marketing strategies. It is my impression that the NFPB is prepared to take the steps that are needed; clearly no one else can.

#### Recommendations

1. The Board should negotiate with Grace-Kennedy, the current product distributor, for detailing the low dose pill. About two years ago USAID arranged a supply of Norminest as a second oral contraceptive for the CDC project. To date, largely because it has not been cleared for sale (and advertising) as an over-the-counter product, the product has not been distributed. It is unlikely that the Board will have funds to hire a person to detail the pill to doctors (which is the only method for promoting

an ethical product). Grace-Kennedy should be approached to see if they will include the pill in the line of products they are presently detailing for a larger margin of the retail price than they retain for distributing Panther and Perle.

2. The Board should attempt to restructure the CDC program so that its operations are directed by professional marketing management. One possibility is to establish a company under the Board which would have the responsibility for marketing the CDC products. Such a company could also handle commercial products in related lines in order to generate more revenue for the CDC operation. However, unless or until the company were handling an extensive line, its cost would probably represent a substantial deficit to the Board. It might also require considerable time to establish such a company and to define its legal and operational parameters.

An alternative that seems more expeditious would be to contract with Grace-Kennedy to take charge of the overall marketing function on behalf of the Board. (Other companies might also offer the facility to do so.) A possible disadvantage in this option might be that the scope for profit to the company could be so low that the CDC products would fail to command adequate attention from its top management. On the

other hand, the cost of handling the CDC products within a large company would be spread across its entire line. Indeed, it seems that in a market like Jamaica, such is often the practice of multinational firms which, in a larger market, might opt to establish their own offices. For a margin of the selling price of the products - a larger margin than that presently retained by Grace-Kennedy for only distributing the products - the firm would be charged with defining problems in marketing for examination with research, developing marketing plans and budgets for the Board's review and approval, suggesting needed communications strategies for execution by the advertising agency, and so forth. The Board would continue to exercise its prerogatives with regard to population policy and to monitor the program for its performance and its responsible use of public funds.

4. USAID should consider a proposal from the Board for financial support to the CDC project over the next three to four years. Even the increase in sales revenue that can be projected over the next few years will probably not be adequate to fund advertising and promotion at a higher level of frequency and reach, a level that is quite likely to be required now that prevalence is reaching 50 percent: the additional couples who must be persuaded to use

contraceptives will be increasingly difficult to reach in terms of communications and distribution, and the need for additional resources will be even greater than it has been in the past. Furthermore, the funds required to launch the new condom (and the new pill as an OTC product) are not currently available, and the increased revenues which are being projected are predicated upon a level of advertising much higher than it has been in the past. Without a fresh infusion of funds, the project is likely to continue to struggle along with barely exigent activity.

The text of this report examines one possibility in which USAID would assume the costs of packaging and advertising over a period of four years. The cost to USAID is estimated at U.S. \$716,000. The result (within certain assumptions about additional costs to the Board met from revenue) would be a capital fund held by the Board in the magnitude of U.S. \$418,000. The income from such capital at current rates of interest would approximate the effect of doubling sales revenue. The viability of the Board's assuming financial responsibility for the project at a reasonable level of activity would become vastly more realistic to expect than is the case at the present. This one option for enhancing project improving impact and the project's financial

base is not meant to exhaust the possibilities. It does, however, suggest that USAID's participation in the project at this time not only could have a profound impact on project output, but it would also place the project in a much sounder position for the long term.

## I. Introduction

The subsidized sales of contraceptives to pursue population objectives has been adopted as an element of national family planning programs in perhaps fifteen countries. The Commercial Distribution of Contraceptives program in Jamaica, initiated in 1974, is one of the early efforts. Like several of the more successful projects, it was implemented through a U.S. Technical Assistance contractor, Westinghouse Health Systems, with funding from USAID, and utilized local commercial firms as subcontractors to carry out packaging, distribution (Grace-Kennedy, Inc.) and advertising (Dunlop, Corbin, Compton Associates, Ltd.).

In 1977, when the Westinghouse contract came to a close, management of the CDC program transferred to the Jamaican National Family Planning Board (NFPB). The project was and is expected to cover recurring operational costs through sales revenue. Grace Kennedy continues to serve as the prime distributor, and packaging is also under contract to a local firm. Advertising is handled by an outside agency but is conducted according to specific instructions from the NFPB.

Personnel costs are covered with NFPB general funds and USAID/Jamaica still supplies commodities. The NFPB has hired two persons to work on the project. They assist with distribution when needed and otherwise perform duties as directed by the NFPB's Executive Director. From time to

time an individual has been designated "Marketing Manager," but in fact the project has not been able to attract and keep the level of marketing expertise needed because of funding limitations and salary level restrictions imposed on NFPB because it is subject to civil service guidelines.

## II. CDC Performance

### A. Distribution

The recent history of the social marketing operation, using 1978 as the first year in which the National Family Planning Board (NFPB) assumed full managerial and financial responsibility for the CDC project, is summarized in Table 1 below.

Table 1: NFPB Subsidized Product Distribution and Contraceptive Value 1978 - 1984

<u>Year</u>	<u>Condom (pieces)</u>	<u>CYP*</u>	<u>Oral Contra. (cyc)</u>	<u>CYP*</u>	<u>TOTAL CYP</u>
1978	801,648	3,016	175,572	13,506	21,522
1979	885,168	8,852	220,548	16,965	25,817
1980	948,816	9,488	259,848	19,988	29,476
1981	1,045,872	10,459	305,148	23,473	33,932
1982	1,110,986	11,100	307,404	23,646	34,756
1983	990,789	9,908	345,152	26,550	36,458
1984	1,454,968	14,550	432,516	33,270	47,820

\* It should be noted that these calculations have been done using 13 cycles of oral contraceptives and 100 condoms per couple/year of protection (CYP); while the figure of 13 cycles is widely accepted and corresponds to the number of yearly menstrual cycles, the figure of 100 for condoms is an international convention, used primarily to compare the programmatic value of the distribution of different contraceptive methods. While it is meant to correspond to coital frequency, the actual rate of use by the average couple varies greatly from country to country; the Government of India, for instance, uses 72 condoms per couple, while the NFPB uses 192 condoms per couple. For purposes of this report, unless otherwise noted, the international convention will be used.

Source: NFPB

It can be seen that the growth in sales has been constant and reasonably consistent, averaging 14.5 percent annually over seven years. In order to relate this distribution to the national problem, its contraceptive value must be compared to the population at risk. The conventional figure used is the number of married women of reproductive age (MWRA). Social conditions in Jamaica make the legal category of marriage inadequate for the purpose. (The percentage of births in wedlock seems to be decreasing: 1979: 19.0%; 1980: 17.9%; 1981: 17.0%; 1982: 16.6%. Source: Demographic Statistics, 1983, Tables 19 and 20.) The 1983 Contraceptive Prevalence Survey defines the category at risk as being "in union," i.e., married, cohabiting, and "visiting." The CPS also states that the census figure for the proportion of women between the ages of 15 and 49 was 24 percent in 1982 (p. 34), and that 69.9 percent of the women of that age group in 1983 were in union (Table 3-3). Thus, from the population estimate for 1983 of 2,135,800 (Demographic Statistics, 1983), we can estimate the number of in-union women of reproductive age to be 358,300 ( $2,135,800 \times 24\% \times 69.9\%$ ). Assuming a population growth rate of 2 percent and a slightly higher proportion of women in the reproductive age group and a similar proportion of women in union, we can estimate the population at risk in 1984 to be 373,600 ( $2,178,500 \times 24.5\% \times 70\%$ ). On this basis, the sales of CDC products represent some 10.2 and 12.8 percent of national contraceptive needs in 1983 and

1984, respectively. It is important to credit this performance in an international context: The other two social marketing projects that are generally accepted as successful, those in Egypt and Bangladesh, deliver about between 5 and 8 percent by this same measure.

It is rather more difficult to relate this distribution to the national population program. Estimates of service delivery through clinics have been made on the basis of reported client contact, and these estimates have not been disaggregated by method, except for the "new acceptors" and "female acceptors (revisits)" (Demographic Statistics, 1983, Tables 68 and 69); it is consequently difficult to rework such figures so that they are comparable with the CDC distribution. However, on the basis of the 1983 CPS, it is possible to infer some relationship between reported contraceptive use and CDC distribution:

Table 2: Contraceptive Prevalence of Modern Methods and NFPB/CDC Subsidized Sales, 1983

<u>Method</u>	<u>CPS%</u>	<u>CPS Women*</u>	<u>CDC-CYP</u>	<u>CDC-CYP**</u>
Pill	19.3	69,152	26,550	26,550
F. Steril.	10.9	39,055		
Inject.	7.6	27,231		
Condom	7.6	27,231	9,908	5,160
IUD/Vag.	3.0	10,749		
		173,418	36,458 (18%)	31,710 (21%)

\* Based on estimate of 358,300 15-49 year old, in-union women in 1983; see text for explanation.

\*\* Assuming 192, as opposed to 100, condoms per CYP.

Source: CPS 1983 Table 6-3 and NFPB-CDC sales figures.

On this basis, one may estimate that NFPB's subsidized sales in 1983 accounted for some 18-21 percent of modern method contraception. In 1984, while prevalence figures are not available, contraceptive distribution through clinics has been colated; it is thus possible to compare CDC sales with the other major component of the national effort. Because sterilization performance is also broadly known, it is possible to include a broad estimate for sterilization coverage in 1984, as well.

Table 3: Clinic Distribution, Government Financed Sterilization, and CDC Sales By Method, 1983 and 1984

<u>Year</u>	<u>1983</u>			<u>1984</u>		
	<u>Clinic</u>	<u>CDC</u>	<u>CYP</u>	<u>Clinic</u>	<u>CDC</u>	<u>CYP</u>
Pill	224,270	345,152	43,802	310,092	432,516	57,124
Inject.	85,814		21,454	102,853		25,713
IUD	2,813		7,032*	4,216		10,540*
Cordom	604,446	990,789	15,952	933,363	1,454,918	23,883
Sperm.	5,132		1,026	5,349		1,069
Steril.	5,896		<u>44,220*</u>	6,587		<u>49,402*</u>
TOTALS			133,486			167,731

\* It should be noted that for the purposes of examining modes of distribution and their progress, the CYP values of IUD's and sterilizations are projected into the future based on estimates of the average period of their effectiveness; the values used here are 2.5 years for IUD's and 7.5 years for sterilization.

Source: Ministry of Health, Health Information System, and NFPB-CDC Dept.

Table 4 develops from these same data estimates of the relative share of total distribution among the three program elements.

Table 4: Contraceptive Distribution by Principle Elements of Government Population Program, 1983 and 1984

<u>Element</u>	<u>83 CYP</u>	<u>% Share</u>	<u>84 CYP</u>	<u>% Share</u>
Clinic Dist.	52,808	40%	70,509	42%
Sterilization	44,220	33	49,402	30
CDC Sales	<u>36,458</u>	<u>27</u>	<u>47,820</u>	<u>28</u>
TOTALS	133,486	100%	167,731	100%

Source: Ministry of Health, Health Information System, and NFPB-CDC Dept.

Even though these data do not include the distribution of certain hospitals and private clinics or sales by private doctor and the conventional commercial system, nevertheless it is apparent that the CDC operation is delivering something in excess of one quarter of the contraception in the overall program supported by the government. Even if the figure of 192 condoms per couple/year of protection is used, the percentages of the two years are reduced only to 25 and 26. Moreover, if IUD insertions are subtracted from clinic totals, then it can be said that the CDC project accounted for about 44 percent of all non-clinical contraceptives delivered in government-supported programs in the two years.

While contraceptive use figures are often difficult to compare with distribution figures, the exercise is useful in providing a rough check on the disposition of the contraceptives that are distributed with government and donor support. And while the categories used in the 1983 CPS are not as useful as they might be (it would be preferable to have

the respondents identify the brands of pills, condoms, and spermicides used in order that the source may be more specifically determined), Table 5 is an attempt to compare contraceptive use as defined in the CPS with CYP's derived from distribution.

Table 5: Contraceptive Use Vs. Contraceptive Distribution, 1983

<u>Method</u>	<u>Clinic: CPS</u>	<u>Clinic: Dist</u>	<u>Pharm. and Others: CPS</u>	<u>CDC: Dist</u>
Pill	35,959	17,252	31,810	26,550
Injec.	25,052	21,454	--	--
Condom	10,892	6,044	15,249	9,908

Note: The "CPS" figures are derived from the percentages given in Table 6-10 of the CPS applied to the estimates of contracepting women by method derived here in Table 2.

Source: CPS 1983 Tables 6-3 and 6-10, and Ministry of Health, Health Information System, and NFPB-CDC Department.

In the case of the apparent difference between reported use and clinic distribution, according to the NFPB statistician, clinic personnel have yet to appreciate adequately the need to report issuing contraceptives. It is interesting that the figures for injections most nearly coincide; it is possible that because of the medical implications of that method, more care is taken to account for its use. It is to be hoped that any steps taken to enhance the reporting of clinic distribution would not inhibit service delivery. In the case of reported use of contraceptives purchased at pharmacies and "other" sources and sales reported by the CDC project, it is clear that much of the difference would be

accounted for by the sales of commercial brands. In any event, the figures given in Table 5 strongly suggest that there is little difficulty in either the clinic or the CDC programs with diversion of commodities.

#### B. Cost

Given the obvious conclusion that CDC sales represent a substantial proportion of the contraception being delivered in Jamaica, it is important to examine the question of the cost of that delivery. Table 6, on the next page, gives in summary form the operational expenditures, sales revenue, net cost, and cost per couple year of protection (excluding the cost of the contraceptives) for the past seven years of operations.

It must be noted that not all costs of the CDC operation are included here. For instance, commodity clearing and handling, warehousing, office space, supplies and utilities, and general administrative support have not been included; there are also significant research and technical assistance costs that could be defined as operational costs. Most significant, perhaps, is that the substantial policy and management support given by the project both at the enterprise and operational levels by the top officers of the NFPB have not been allocated in these costings. Thus, it must be said that at this point the exact cost of the CDC operation is not fully known, but that it is, in fact, higher than those given here.

Table 6: Balance Sheet Summary and Operational Cost per Unit

Output of CDC 1978 - 1984

<u>Year</u>	<u>Expenses</u>	<u>Sales Rev</u>	<u>Net</u>	<u>CYP Dist.</u>	<u>Cost/CYP*</u>	<u>US\$</u>
1978	J\$20,870	J\$47,277	J\$26,407	21,522	--	--
1979	65,430	62,297	(3,133)	25,817	--	--
1980	82,868	68,996	(13,872)	29,476	--	--
1981	130,534	72,130	(58,404)	33,932	J\$1.44	\$0.81
1982	128,429	126,673	(1,756)	34,756	0.05	0.03
1983	145,961	94,003	(51,958)	36,458	1.42	0.43
1984	210,132	159,435	(50,697)	47,820	1.06	0.21

\* Surplus revenue in 1978 applied to cost in subsequent three years.

Source: NFPB-CDC Sales Figures and Finance and Administration Department;  
average yearly exchange rates supplied by USAID/Kingston, Division of  
Health and Population.

On the other hand, it is clear from even this cursory analysis that the costs are very low indeed. Compared with the costs of the Bangladesh Social Marketing Project, for instance, undertaken in country where all costs seem to be substantially lower, the Jamaican operation seems extremely cost efficient: the operational cost there (i.e., all costs including technical assistance except the CIF value of the contraceptives) in 1984 was in the magnitude of U.S. \$1.70. Of course, one might expect a higher cost in a project which does its own distribution (i.e., has its own sales staff and its own delivery fleet) and where the retail price of its largest selling pill is about one-fifth that of Perle (reflecting the greater poverty in Bangladesh). It is also significant that all foreign involvement is fully costed in the figure for Bangladesh.

It has not been possible to relate these costs to the costs of other elements of the Jamaican population program; in particular, the overall costs of the clinic operations have not been allocated by their health and family planning components and the Health Information System does not seem able to generate such figures. However, it seems quite evident that not only are the costs of the CDC operation low in an absolute sense, they are also very likely to be substantially lower than the cost of delivering contraception through the clinics. This hypothesis arises from the self-evident fact that it is cheaper to the NFPB (and hence to the Government of Jamaica) to allow the consumer to pay for

the distribution of the contraceptives (through trade margins) than it is to pay for that system directly through salaries to the logistics and clinic staffs. In order to test that hypothesis (and the cost differentials will be somewhat diminished by the relatively higher cost efficiency of clinic deliveries of methods with high CYP values, such as sterilization -  $\pm 7.5$  CYP's, IUD's -  $\pm 2.5$  CYP's, and injections -  $\pm 0.25$  CYP's), and thereby develop a virtually unassailable argument for additional funds for the CDC operation, it would seem that the NFPB has a unique opportunity now that it is beginning to open its own clinics: it should be possible to monitor costs (inputs) as well as units of contraceptive delivery (outputs) quite closely and thus generate the costing data the lack of which is presently inhibiting the type of analysis suggested here.

It must be emphasized that in demonstrating the high cost efficiency of social marketing, one is not necessarily arguing for the diversion of resources from the clinic-based program to the CDC operation. Rather, the problem seems to be that while the commitment of resources to the clinic program remain unquestioned (as it probably should: once better costing figures became available, it would be possible to attempt a cost/benefit analysis in which the cost of investments in family planning are examined in relationship to their economic return; I have no doubt that even the probably higher cost of clinic-based programs would prove to be an excellent investment opportunity for

Government resources), the CDC operation labors under substantial pressure to be self-financing. Why should it be?

Family planning is either important to the Government and people of Jamaica or it is not. If it is - and better costing and output data along with cost/benefit analysis will reinforce the consensus that it is - then within certain cost and policy parameters imposed by both prudence and reality, more family planning should be delivered, a notion quite consistent with A STATEMENT OF NATIONAL POPULATION POLICY (Revised, December, 1982). Within the context of that argument, it seems counter-productive to impose resource constraints on the CDC delivery system more harshly than on other elements of the population program. And yet, even with the limited data that are available, it seems clear that such constraints have been imposed in recent years. Table 7 breaks down CDC expenses by line item over the past seven years.

Table 7: Line Item Expenses of CDC, 1978-1984 (J\$)

<u>Year</u>	<u>Adver.</u>	<u>Packaging</u>	<u>Printing</u>	<u>Sal. &amp; Allow</u>	<u>Misc</u>	<u>TOTAL</u>
1978	10,065	-0-	-0-	10,800	6	20,871
1979	46,120	7,336	38	11,920	15	65,429
1980	7,627	16,559	22,428	36,252	1	82,867
1981	-0-	58,058	23,920	48,370	185	130,534
1982	17,274	36,583	9,820	64,748	3	128,428
1983	-0-	45,511	28,535	71,284	530	145,960
1984	<u>25,415</u>	<u>57,274</u>	<u>56,330</u>	<u>71,112</u>	<u>-0-</u>	<u>210,131</u>
	106,501	221,321	141,171	314,486	741	784,220

Source: NFPB, Finance and Administration Department.

The conclusion to be drawn from this table is not that those whose responsibility it has been to make the decisions for the CDC have arbitrarily withdrawn funds from that operation. It is obvious that they appreciate the contribution that the CDC operation is making to the national population effort and its potential for increasing the magnitude of that contribution. But it is also clear that a marketing operation cannot be expected to maximize its impact without advertising, particularly when there is serious cultural resistance to the adoption of the products. And that is not to mention the difficulty the NFPB has had in staffing the CDC operation, especially at the management level. And again, it must be emphasized that these observations would not be surprising to the NFPB; to the contrary, the Board is acutely aware of the adverse impact of these constraints on the program. Quite simply, the problem is a present lack of resources, not the will to commit them.

### III. Financing the CDC Operation

The baldest statement of the requirement that CDC be self-financing which I was able to find comes from the end-of-project report prepared by Westinghouse: "The primary goal of the program was to achieve self-sufficiency by the end of Westinghouse involvement". ("Contraceptive Retail Sales Program - Jamaica," Westinghouse Health Systems, Columbia, Maryland, December, 1977, p. 66.) It is not my purpose to argue that self-sufficiency was not a proper objective of the program (although I would disagree with adopting it as a "primary goal"). To the contrary, the performance of the CDC operation over the past seven years - in terms of sales growth - is comparable to that of any other undertaking of a similar nature anywhere. And, to repeat, it has been done at a cost that should be the envy of population project planners. On the other hand, no one I talked with about the program believes that the effort has had support adequate to the challenge it is meant to cope with. The Westinghouse report quoted above goes on to lament that its pursuit of that goal had been frustrated by a failure to achieve approval for price increases. My own impression is that had those early price increases been approved - as well as those that would have been necessary to cover all subsequent increases in operational costs - the present price of the CDC product might very well be out of the reach of the very poor by now: Would the resulting self-sufficiency been worth it? I think not.

Operations at their present level are very nearly covered by sales revenue. Table 7 suggests that in 1983 and 1984 the operating deficit was in the magnitude of J\$51,000 per year. That deficit could perhaps have been covered by price: a 10¢ increase in the price of a cycle of pills and 2¢ on the condom would have covered it. But that is net to the project; trade margins - already low in absolute terms - would have increased that seemingly modest increase to perhaps 20 percent to the consumer. That is a significant increase. But more importantly, such an increase would not have financed the level of professional marketing input that is required, nor the higher level of advertising and promotion that is needed: in 1983 there wasn't any advertising.

The chairman of the NFPB has acknowledged that, under the present system of financing the CDC project, the Board cannot afford to provide the kind of professional support that is required. The launch of the low-dose pill and the thin condom seems to have been delayed at least in part by the lack of resources to finance the initially intense promotion effort that is needed. One means of increasing CDC income that has been considered, that of marketing commercially priced goods in addition to the subsidized contraceptives, is also presently impractical for want of funds to initiate it (and for lack of expertise devoted to planning such an undertaking). The ordering of packaging on a timely basis is directly dependent upon the timely receipt of funds from Grace-Kennedy, and, perhaps most painfully, there some-

times are simply no funds available for advertising. It is a hand-to-mouth operation, a situation that seems clearly inappropriate for an operation that is of vital importance to national concerns.

Moreover, it seems especially intolerable at this point in time: the 1983 CPS estimates prevalence to be about 50 percent. It is very likely that most couples who are well disposed towards family planning are already using contraceptives. Further increases in the prevalence rate can be expected to be increasingly difficult as they must be made among the ever more rural, more conservative, less educated, poorer, and among the generally most isolated segments of the population. To achieve success in these market segments will be expensive; it will require even more resources than those thought adequate in the past: the more difficult couples are more expensive to reach in terms of their demands on distribution channels, media reach and frequency and product presentation and mix. With regard to the problem of adolescent pregnancy alone, while NFPB has an ambitious generic program addressed to teenagers, virtually nothing has been done on the marketing side to move contraceptives to them.

#### IV. Alternatives In Management and Finance

##### A. Financial Planning Issues

Table 8 represents an attempt to project CDC sales through 1989, and examines the revenue that would be generated at those levels of sales.

Table 8: Projections of CDC Sales and Revenue, 1985-1989

<u>Product Sales (units in 000's)</u>						
<u>Year</u>	<u>Pan.</u>	<u>Perle</u>	<u>Thin Con.</u>	<u>LD Pill</u>	<u>CYP's</u>	<u>Growth</u>
1985	1,450	440			48,300	
1986	1,566	484	50	20	54,900	13.7%
1987	1,691	532	60	25	60,400	10.0
1988	1,860	586	72	35	67,100	11.1
1989	2,046	644	88	70	76,300	13.7

##### NFPB Revenue From Sales (J\$ in 000's)

					<u>TOTALS</u>
1986	157	217	22	36	J\$432,000
1987	169	240	27	45	481,000
1988	186	264	32	63	545,000
1989	205	290	40	126	661,000

Source: Commercial Distribution of Contraceptives Marketing Plan, 1985/86, NFPB-CDC Department.

For reasons that are explained below, these projections are somewhat more conservative than those given in the Marketing Plan prepared by the NFPB in early 1985. Nevertheless, when the annual revenue totals are compared with past expenditures on the program (see Table 7), they seem quite lavish. On the other hand, as argued above, past expenditures have been only exigent and hardly adequate to

the more difficult tasks involved in launching new products (the thin condom and low dose pill) and in addressing increasingly difficult target markets. Moreover, the expenditures listed in Table 7 are incomplete: they do not include sizable establishment costs incurred by NFPB (warehousing, office space, equipment and supplies, utilities, clerical and administrative support, etc). Nor do they include the costs of the management input by the top level managers of NFPB or the costs of market research and consultancies. The apparent fact that the Board (or perhaps USAID) is prepared to make certain contributions to the operation of the project is quite apart from the fact that they are indeed very real costs.

As previously stated, the sales projections given in Table 8 are conservative, more so than those given in the Marketing Plan referred to above. Several factors suggest this more modest view of the near future: First, it seems likely that a good part of the switch from commercial pills to Perle brought about by devaluation and the removal of the subsidized exchange rate that pharmaceutical importers enjoyed has already taken place; much, probably most of the subsequent growth in Perle sales will have to represent new users. Second, the market for condoms will probably be increasingly difficult: constricted distribution channels and male attitudes towards family planning both seem to continue to represent serious constraints to condom sales. In particular, plans for a break-through in distribution with

small wholesalers appear to be less promising than they perhaps once were. Briefly, these wholesalers seem unsuited for the demanding task of introducing and encouraging the sales of new products; they deal almost exclusively in staples, the demand for which is not at issue; they work with severely limited capital and they do not commonly risk it; they seem to deliver, rather than sell. In short, their becoming a significant part of the CDC distribution system seems to be a difficult prospect. The new products face the usual difficulties of new products, and establishing a credible image for them in a niche between the established sociall marketed products (viz, Panther and Perle) and the established commercial brands may be more difficult than anticipated; in Bangladesh, roughly the same process proved less automatic than we had planned. I suspect the prospects for the low dose pill are better than for the condom.

#### B. Product Management Concerns

The first organizational question that arises concerns the low dose pill: it has been in the country too long, and it badly needs to be put into the market. How is it to be done? (While the Marketing Plan for 85/86 represents a significant advance in CDC management, it does not - perhaps could not - address this issue and several others; consequently, as a proposal for funding it seems to be inadequate.) At present it can only be handled as an ethical drug; it cannot be advertised in mass media. Therefore,

other than point-of-purchase materials, the only way it can be introduced is through doctors. It has been suggested that the Board itself hire a detailman to perform this function, perhaps through a subsidiary company wholly owned by the Board which would eventually generate more revenue by handling additional medical products such as diaphragms, disposable needles, and so forth. While this alternative is probably worth closer consideration, it does not seem to offer a proximate solution to the question of what to do with the low dose pill: establishing a company is complex and time consuming, less so from the technical, legal perspective, but from the political and administrative viewpoint: Whose approval would be necessary? How would it qualify to handle ethical drugs? Can it be non-profit and thereby enjoy tax-free status? Can the tax-free status of the Board devolve onto a separate legal entity? Such questions could probably be resolved satisfactorily, but in what time frame? And who would be able to spend the time to pursue their resolution?

An alternative which developed in my conversations with the director of Pharmaceutical Services Division, Ministry of Health, was to negotiate an arrangement with Grace-Kennedy in which G-K's own detailman (or men) would detail the CDC low-dose for the consideration of a higher margin of its retail price. Such an arrangement has several immediate advantages: First, it would permit the launch of the new product to be undertaken as soon as the negotiations

were complete: since no advertising would be needed (or allowed), only a relatively small sum for detailing and POP materials would be required. Second, the recruitment, training, and financial arrangements for a new person hired by the Board (or its subsidiary) would not be necessary. And such a step would not necessarily preclude the NFPB from attempting to sell other products in order to generate additional funds for the CDC operation (or for whatever purpose): it could handle additional products in the same manner, turning them over to G-K for promotion as well as for the customary distribution.

I find this alternative particularly well suited to the conditions that I perceive, perhaps imperfectly, in Jamaica. The disadvantage of engaging a large corporation in the marketing of subsidized products is that they (the products) by definition are not profitable to handle. One sees this factor acting as a constraint in the Indian social marketing program, and I have argued (unsuccessfully) against such an arrangement in Pakistan. But the conditions here seem to urge the use of established commercial marketing structures: the fact of the matter is that the market for the social products and the income they generate are so small that virtually any structure created solely to handle them will fail on economic viability. If Grace-Kennedy were to agree to detail the new low dose pill for a portion (even a large portion) of its retail price, the mitigation of the problems the new product presents for the Board seems substantial.

In fact, this approach to the low dose pill seems to suggest in a persuasive way a viable resolution to a larger policy issue that the Board faces. I trust that the discussion above concerning the marketing challenges the CDC operation will face in the coming years indicates how badly professional marketing management will be needed. And if the Chairman acknowledges the difficulty the Board has in paying for such management directly - even if the salary of a marketing manager were supplemented by a donor, the problem of continuing such a supplement when donor involvement ended would arise; and such a supplement could itself create difficulties with other officers of the Board - e.g., who will provide such broad marketing professionalism, and how can it be financed?

### C. Organizational Considerations

I recommend exploring the possibility of contracting with Grace-Kennedy for their assuming the marketing responsibility for all the CDC products; that is, a responsibility over and above that of detailing the low-dose. Again, low price, low volume is the financial problem represented by social marketing in Jamaica. In Pakistan I argued for establishing a separate marketing unit that would be responsible for all major marketing decisions that would then be implemented by distribution, advertising, and research sub-contractors; but the market is vastly larger there and the justification for the cost of such a unit is found in the sales projections in a market of such size. Similarly,

while a multi-national corporation might attempt to establish its own office to market products in a country the size of India, it would be much more likely to approach a company like G-K to perform this primary marketing function on its behalf in a small country like Jamaica. I am recommending such an approach be followed with G-K for all the social marketing products in Jamaica.

The general marketing functions that G-K would perform under such an arrangement would include the development of channel and promotional strategies, the definition of issues for market research, the determination of educational requirements among the trade and consumers, and so forth. . The NFPB (or perhaps a subcommittee of it) would remain involved with the operation on a policy level, retaining for itself the authority to review or approve virtually any of its elements. (Although the degree to which the Board allowed G-K autonomy in making specifically marketing decisions is precisely the degree to which it would take advantage of G-K's expertise.) Such policy matters reserved for Board approval might include pricing, product mix, target market definition, and other matters the Board would consider within its mandate from Government. The Board would also probably review and approve annual marketing plans (which would include budgets) and retain audit rights over the disposition of public funds. The Assistant Marketing Officers presently employed by the Board would continue to perform usefully on behalf of the Board, since their func-

tion even now transcends that of conventional salesmen; not only could they continue to generate demand in particularly difficult areas, they would also provide independent market intelligence to the Board.

The advantages that would accrue to the Board in such an arrangement would be considerable. First, the definition, examination, and resolution of marketing issues would be in the hands of those whose experience and training have prepared them for such tasks. The top officers of the Board could concentrate their time and energy on the population policy ramifications for which they alone have the responsibility. By way of example, I see little reason for the Board to become closely involved with the design of a package or the name of a product. On the other hand, pricing directly affects both the financial viability of the project and its success in delivering contraception to the poor, and the Board would naturally be concerned with decisions in this area. More generally, I can imagine a firm charged with marketing for the Board preparing a complete presentation on the introduction of a new product. The plans for the new product would necessarily be based on a brief from the Board on the objectives of including the new product, but the firm on its own would define the issues involved, carry out any research required, and come to the Board with a series of recommendations regarding product platform, price, name, package, channel strategy, promotional strategy, budget requirements, and sales and revenue projec-

tions. Some elements of this plan would obviously be of more interest to NFPB than others, but the Board, particularly in its IEC and Research Departments, is quite capable of evaluating such a plan for its consistency with national population policy and program needs. Approval by the Board would allow the marketing firm to implement the plan, but the implementation would itself be subject to the Board's review. Certainly the Board would require monthly sales and inventory reports, and financial reports on perhaps a quarterly basis. Also subject to Board review and approval would be the major sub-contracts for packaging, advertising, and printing that the firm would execute and administer. But what is most important is that while the Board would retain critical control functions, it is the firm that would be charged with doing the work, work of the sort that is part of the routine business of the firm.

#### D. Funding Implications

It is difficult to be helpful on the probable costs of such an arrangement. The revenue projections in Table 8 seem very encouraging when compared with previous income (Table 6) and with previous program costs (Table 7). But this report is recommending substantially heavier expenditures in the coming years, particularly in advertising and promotion. And packaging as a direct cost will rise with sales increases as well as with those of inflation. The cost of an arrangement such as that described above with

Grace-Kennedy can be expected to require a portion, perhaps substantial, of that projected income. In Pakistan where a contract of this type has been executed by the Government, a net payment to the firm is required; of course, the retail price that can be charged is much lower there than in Jamaica, and Grace-Kennedy's costs can probably be covered adequately within the retail price. But costs will continue to represent problems to the CDC operation.

## V. Donor Assistance

The arguments outlined above lead compellingly to the conclusion that greater levels of expenditures on the social marketing program are required. It should be emphasized that the sales projections that are made in Table 8 and which lead to higher revenue projections are based on the assumption that adequate advertising support would be undertaken in 1986. Without this initial and continuing support, such sustained growth in sales would be problematic. Further, it does not seem that the Board presently has the resources to invest in an initial campaign required to launch a new brand of condoms. (As suggested above, advertising would not be required to introduce the low dose pill as an ethical product, provided it can be adequately detailed; but if efforts to gain its approval as an OTC product were successful, substantial advertising costs would follow.)

Moreover, levels of expenditure such as these would seem bound to keep the Board's capacity to support the program at a hand-to-mouth, exigent level: Whatever plans there might be to put the CDC project on a sounder financial basis would be very likely to remain in the planning stage without resources to invest in them. The other cost that can be expected to continue to demand a sizable share of the resources available for the project is that for packaging. If USAID were able to meet these costs i.e., for advertising

and packaging, for a limited period, however, the Board might well be able to build adequate capital which, if prudently invested, could form the basis of a more promising financial prospect for the CDC operation.

I have been unable to develop the background to make useful comments on the financial requirements presented in the 85/86 Marketing Plan. On the other hand, the figures given in that document will serve to develop rough cost estimates for these two line items: While the Plan gives no details of its figures for advertising, the estimates were evidently prepared in collaboration with Dunlop, Corbin, Compton, the advertising agency, so it is safe to assume that they represent reasonable levels of reach and frequency. Similarly, the estimates given for packaging costs are not disaggregated by product, so that it is difficult to project these costs into subsequent years; but they are also based on known parameters and will therefore serve for very rough projections. The figure given for advertising is J\$638,800 (about US\$116,100), and that for packaging J205,423 (about US\$37,300). Projecting packaging according to percentage increases in CYP's projected in Table 8, and allowing a 10 percent increase for inflation in advertising, Table 9 is an attempt to estimate the costs of these two program elements over the four years dealt with in Table 8.

Table 9: Projected Costs of Advertising and Packaging, 1986-1989 (U.S. \$)

<u>Year</u>	<u>Packaging</u>	<u>Advertising</u>	<u>TOTAL</u>
1986	\$37,300	\$116,100	\$153,400
1987	42,400	127,600	170,000
1988	46,600	140,400	187,000
1989	<u>51,800</u>	<u>154,400</u>	<u>206,200</u>
TOTAL	\$178,100	\$538,500	\$716,600

It should be clear that in making these projections on the basis of the Marketing Plan does not constitute an endorsement of that Plan or imply an acceptance of the soundness of those figures. On the other hand, they do suggest the magnitude of at least one estimate of the costs involved in bringing advertising up to a level at which real impact could be expected and in continuing to meet packaging costs. Comparing projected revenue from Table 8 with these projected costs in Table 10 strongly suggests that revenues will not be able to cover these costs in the near future.

Table 10: Project Advertising and Packaging Costs vs. Projected Revenue (U.S. \$)

<u>Year</u>	<u>Costs</u>	<u>Revenue</u>
1986	\$153,400	\$ 78,500
1987	170,000	87,400
1988	187,000	99,100
1989	<u>206,200</u>	<u>120,200</u>
TOTAL	\$716,600	\$385,200

It will be remembered that revenue is also expected to meet other costs as well as those of packaging and advertising. Thus, it is clear that the Board would not have

income sufficient to cover expenditures at this level. It may well be that part of resolving this problem would be to decide that expenditures at this level are not possible. But to cut back very far would be in opposition to the argument developed earlier in this paper: That more contraceptives must be delivered, and the CDC distribution system has in recent years not received adequate resources.

By way of illustrating the possibilities that arise if USAID were to absorb the cost of these two program elements (i.e., advertising and packaging) and the Board were able to invest the savings, Table 11 projects the capitalization of the project if the Board were able to meet the other program obligations with one-third of the revenue and place the remainder in savings at the current 22 percent.

Table 11: Projected Capital, Saving Two-Thirds Revenue at 22% Per Annum (U.S. \$)

<u>Year</u>	<u>Revenue</u>	<u>Savings</u>	<u>Interest</u>	<u>Capital</u>
1986	\$ 78,500	\$52,400	\$11,500	\$ 63,900
1987	87,400	58,300	26,900	149,100
1988	99,100	66,100	47,300	262,500
1989	120,200	80,200	75,400	418,100

At that rate, the Board would accumulate \$418,100 in capital (about J\$2,299,500 at current rates) - virtually without risk. Even with prospects of a 30 percent return with investments in products brought in without duty and sold commercially, it would be difficult to resist the security of a bank deposit. The income from this capital at

current rates would be some J\$506,000 per annum, or about the same effect as doubling sales revenue. Perhaps at that point the Board would not opt to continue advertising at the level contemplated here for USAID funding, but the resources would be there if needed.

It should be painfully obvious that many of the numbers used in this discussion are far from being firm. There would be considerable work involved in preparing an adequate proposal along these lines with credible cost and sales projections. At the same time, the approach demands serious consideration, even though variations on this general theme may prove to be more promising. If the alternative were to continue along current low levels of investment in the marketing effort, I believe the prospects for future progress in sales and for a firmer financial foundation for the operation would be dim.