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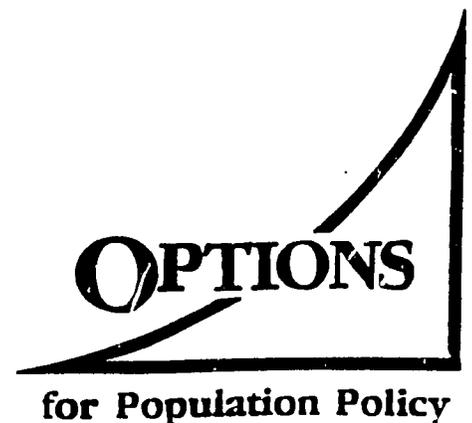
**TRENDS IN CONTRACEPTIVE SALES AND SOCIAL MARKETING IN INDONESIA**

by

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## **Executive Summary**

Indonesia's national family planning program faces important and evolving program directions in which critical policy decisions must be made. It is vital to support these with the fundamental analysis needed to ensure the best outcomes. The directions and decisions have to do with two aspects of the public sector program, 1) its provision of reduced price contraceptives and 2) the potential development of a new program, Gold Circle, for sales of government-procured contraceptives through community-based distribution (CBD) and private sector channels. As such, the policy decisions bear on a number of key aspects of the development of the Indonesia program, e.g. potential role of the private sector and contraceptive social marketing, public sector recurrent costs and cost recovery, optimal pricing of contraceptives with respect to usage, and segmentation of the market for contraceptive products.

The national family planning program is a holistic entity; any changes in one part are reflected in the operations of other parts. Thus it is not only legal and regulatory barriers which may impinge on private sector service delivery, but the actual operation of the public sector program--and its successes and failures--that affect the private sector's ability to be a full partner. The changes under consideration bring into high relief the implicit objectives of the Indonesia national program: the move to increase prevalence; the concern for broad-based resource support and private sector participation; and equity access of all Indonesian families.

Recently Indonesia has put increased emphasis on the private sector as a partner in development. Under the national family planning program, the Blue Circle commercial marketing program has been established to put affordable contraceptives in the marketplace. Another part of the social marketing effort has been to promote Blue Circle products and services through private sector providers. Blue Circle contraceptive sales have grown steadily, although more slowly than projected. Its efforts to develop the commercial market have also been successful in attracting additional manufacturers to introduce affordable products.

At the same time, public sector local promotion is having results. According to the 1991 DHS, of 47% modern method prevalence, public sector pill provision had the largest share, 13%, and private sector pill provision was eighth with 1.5%. In Indonesia, there is an informal but widespread practice of consumers paying for public sector contraceptives. Whether free or sold, public sector contraceptives cost the consumer less than Blue Circle products. The present situation, thus, is one of coincidental, but direct and unequal competition of one part of the national program with another.

Given the government's commitment to developing the private sector in Indonesia's economy, its interest in increasing family planning usage and its policy of encouraging families who can afford services to assume the costs, it is timely to look at how these objectives are being achieved in the national family planning program. Subsidized distribution may stimulate widespread use of affordably-priced contraceptives, but it also locks-in recurrent costs of procurement of subsidized contraceptives. Widespread availability of reduced-price contraceptives does not encourage consumers who could otherwise afford commercial products to use them, raising issues of targeting of subsidies. There will further be a continued need for free services to the poor to sustain their use of family planning, as well as mechanisms to insure use of effective methods by all families for whom they are appropriate.

The Indonesia national family planning program has been enormously successful. In the private sector, a commercial market exists where none existed before. The public sector has likewise demonstrated considerable capacity. Program planners and policy makers may now consider bringing market segmentation directly into the national system. This would involve analyzing the consumer market for products of all types at every price level, from the most expensive to free supplies. Ideally, a range of market niches would be identified, and products would be priced, packaged and actively marketed to their target audiences. The objective of the system would be appropriate use of family planning and maximal financial participation of families who can afford to pay. In the evolution of Indonesia's family planning program, all that is needed now is a hard look at the consumer market and a policy commitment to employ market segmentation and let it succeed. In a thriving program like Indonesia's, the necessary implementation mechanisms are in place for such a system to flourish.

### Introduction

National family planning programs seek to meet the needs of all families through a combination of public and private service delivery channels. Although countries may differ in how they define consumer groups, generally families fall into one of three particular groups: elite commercial consumers served by standard commercial products, a middle consumer group served by social marketing programs, and poor consumers more likely to seek public sector services.

The functioning of the family planning service delivery system, composed of public and private sector services, affects population growth and has implications for national budget allocation and equity. As a result, national programs have an interest in viewing the service delivery system as an integral whole and taking a strategic approach to it. This involves understanding and supporting what is deemed to be the most beneficial combination of delivery channels. National programs may define what is beneficial in particular ways, related to their view of fertility and population development, their own ability to provide services--in terms of policy and budgetary support and program development, and their orientation to equity considerations. However this is defined, a proactive stance, where

programs analyze the implications of programmatic choices and the process by which changes in one delivery channel affect operations in another, will give the program more focus and move it forward more quickly.

Indonesian policy makers and program managers have three objectives for the national family planning program: achieving a two-child family by the year 2005, developing a broad base of resource support and maintaining equity access of all families in Indonesia. The Government of Indonesia (GOI) is presently considering changes in its local promotion system. On the surface, these appear to be discrete changes in an isolated part of the service system. However, how local promotion operates bears directly on other parts of the system. Indeed policy decisions about its operations have serious implications for achievement of national fertility targets, recurrent cost burden to the government and equity needs of the poorest consumers. For this reason it is vital to understand the interface with the rest of the service delivery system, so that changes will serve to move the national program forward.

The GOI is examining adoption of a new program under the Gold Circle brand to expand distribution of supply methods (oral contraceptive pills, condoms, etc.) through CBD and private sector channels. Through CBD, this mechanism would formalize the present common practice where public sector village volunteers (and other health personnel) sell public sector contraceptives to consumers. The Indonesia national family planning program presently includes a commercial contraceptive social marketing (CSM) activity, the Blue Circle family of products, designed to put affordable, quality contraceptive products into the commercial market.

The Blue Circle CSM program has had some notable successes. It has established a small commercial market for private sector supply methods, but the potential for this market to grow dramatically appears limited at present. This may be due to two related reasons: first, restrictions that limit the commercial distribution system, and second competition from sales of public sector contraceptives. The commercial distribution system in Indonesia is constrained; there are comparatively few pharmacies and other outlets for distribution of ethical pharmaceuticals like oral and injectable contraceptives<sup>1</sup>. As will be discussed below, legal and regulatory barriers to an expanded system have not yet been fully overcome. Recognizing the limitations of the commercial distribution system, the development of an effective system of community-based distribution became an important objective and achievement of the national family planning program.

Although the design is still in flux, the new Gold Circle program may incorporate public sector subsidies of various types. Thus, it is another step in the evolution of contraceptive sales in Indonesia designed to increase use of supply methods, tap private resources for

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<sup>1</sup>This may be partly due to legal and regulatory restrictions; a major restriction on distribution to doctors and midwives has been recently alleviated. Apparently it is still necessary to for a graduate pharmacist to work for 3 years in the MOH prior to receiving a license to open a pharmacy.

family planning and create a means to sustain the local promotion system permanently. The Indonesia national family planning program has been noted for its ability to conceive and test new approaches and then to implement nationally those which are successful. The program is seeking the right balance of a number of factors: high contraceptive prevalence/reduced fertility for the well-being of Indonesian families, maximum private purchase of services to create a broad base of financial support, and creation of a sustainable extended network of local promotion agents. The national program is seeking new approaches to optimize these factors.

The analysis in this paper has five parts:

- 1) review of the status of the present commercial CSM program,
- 2) description of Gold Circle and the rationale for adoption of the new approach (recognizing that the design is still in flux),
- 3) comparison to experiences in other countries, including Jamaica, Egypt, and particularly Thailand,
- 4) highlighting of aspects of subsidized programs where key design decisions can give the approach its best chances for long-term viability, and
- 5) identification of pragmatic, helpful ways A.I.D can support the continuing evolution of contraceptive sales and social marketing in Indonesia.

The present analysis is a think piece, to develop ideas and raise possibilities. But it is in no way definitive; the time to prepare it has been brief and the details of the Gold Circle program, not yet launched, remain to be clarified. As a follow on, a more comprehensive analysis of various quantitative aspects related to market segmentation, pricing and subsidies may be very useful, along with projected costs and benefits of the various approaches.

## 1. Status of Blue Circle Commercial CSM

### 1.1 Private Sector Context

To begin, it is important to situate private sector family planning activities in the larger context of Indonesia's efforts to open up the economy to private participation. Indonesia has recently created a fertile environment for economic reform, to enhance the private sector's role through de-regulation, de-monopolization, opening of markets and privatization initiatives. In terms of family planning, Indonesian families have used private

services proportionately less than they use private health care services<sup>2</sup>. Typically, users of private health care also seek private family planning services. Reliance on the private sector as a delivery channel has historically been limited in Indonesia when compared to other countries<sup>3</sup>. According to Kenney and Lewis' analysis, in recent data on 11 developing countries with contraceptive prevalence rates above 40%, Indonesia had the second lowest share of private sector services, after Sri Lanka<sup>4</sup>.

The Indonesia national family planning program has recognized the need to mobilize private resources to pay for services and has adopted an explicit strategy to increase reliance on private sector channels. Blue Circle commercial social marketing is one aspect of this. Other innovative approaches include but are not limited to the major initiatives to create a network of Blue Circle private providers, trained to provide quality services and distribute Blue Circle products, and adoption of the concept of KB Mandiri, self-reliant family planning, as an organizing principle to encourage families to assume responsibility for the costs of services.

The systematic push to involve the private sector is beginning to pay off: the 1991 IDHS indicates that 22% of services are now provided by private sources compared to 12% in the 1987 Indonesia Contraceptive Prevalence Survey (ICPS).

## 1.2 Blue Circle

Commercial CSM programs are founded on the over-arching principle that no donor or government funds subsidize costs (after an initial start-up phase). Thus these programs create no recurrent cost burden and are more independent of shifts in donor or government policy. Ideal commercial CSM programs have some significant traits. First, the contraceptives are sold at a commercial price<sup>5</sup>, and thus the contraceptives themselves are self financing. The price is considered affordable to the CSM target audience (primarily the C,D class consumer, in marketing terms) and usually lower than the commercial price structure, for products aimed at elite consumers, existing before the start of the CSM program. In Indonesia the manufacturers agreed to lower the price to

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<sup>2</sup>Meesock, Oey Astra. "Financing and Equity in the Social Sectors in Indonesia: Some Policy Options." World Bank Staff Working Paper No. 703, cited in Kenney, op. cit., p. 1.

<sup>3</sup>Kenney, Genevieve. The Economics of Private Sector Family Planning Service Provision in Indonesia. The Urban Institute, Washington, DC, November, 1989, p. 1.

<sup>4</sup>Kenney, Genevieve and Maureen Lewis. "Contraceptive Users' Sources of Supply. 1989. cited in Kenney, op. cit. p. 6.

<sup>5</sup>CSM projects typically underwrite the initial market development and marketing activities for CSM products; thus prices for these products do not at the outset have to include these costs. Thus, commercial CSM prices are below the minimum commercial prices which manufacturers would have to set independent of the CSM project.

participate in the program: other non-CSM commercial contraceptives continue in the market at higher prices.

Second, since prices cover real distribution costs, the distribution system is self sustaining. Third, since costs are paid by the consumer, private resources are mobilized in support of the service system. But since price has to cover costs and profit margin, the size of the consumer market which can pay a certain price will be related to actual costs and profit margins. This can be abstracted as follows:

### Commercial CSM

contraceptives  
distribution system  
mobil. of private resources

self financing  
self financing  
yes, but consumer participation (thus  
market share) varies with price

In Indonesia, the Blue Circle program is a strategic effort to involve private sector firms to create moderate-priced alternatives to the high-priced contraceptives which had previously comprised the commercial sector's product line. CSM programs are not intended to cover 100% of the market. Therefore their consumer population is limited by definition and depends on the project-specific design and strategy. By being the first to openly promote/advertise they have, in fact, opened the market to competing products that help to keep prices down and affordable.

Blue Circle has been very successful in this regard: it has itself put a group of affordable, quality supply methods on the market through commercial channels. These are supported exclusively by private firm sales to consumers, except for initial A.L.D. support of technical assistance, advertising and promotion, and market research. The establishment of a mid-priced market in Indonesia has also induced other manufacturers to offer products for this market. Two additional manufacturers have brought in contraceptives for these consumers and a third has recently announced plans to do so. This is an accomplishment of Blue Circle, to have opened up and developed the market for affordable contraceptives.

Social marketing in Indonesia has also been successful in other ways. Initially, social marketing was unfamiliar and not accepted in Indonesia. Since then, social marketing has been accepted; the GOI has strongly supported Blue Circle, so much so that the logo has become almost synonymous with the national program. This evolution reflects well on A.L.D.'s early support of CSM in Indonesia.

A major objective of social marketing is to increase demand for family planning among consumers (across all delivery channels). The National Family Planning Board (BKKBN) has been very successful in using communications in rural areas, particularly in Java, to increase demand. Since the commencement of social marketing in Indonesia there has been a moderate increase in contraceptive prevalence, and there has been a 200-300%

increase in unit sales in the private market. And A.I.D.'s investment has been minimal: in the period 1991-1992, the cost per couple-year of protection in the Blue Circle program has been under \$1.00<sup>6</sup>.

The prospects for Blue Circle CSM to play a role in stimulating total consumer demand for family planning remain to be determined. Despite growth in the private sector, the rate of growth of contraceptive use overall in Indonesia appears to have hit a plateau. Blue Circle CSM's relationship to this is unclear, that is, whether it had a neutral effect or in fact helped to sustain prevalence.

To date, Blue Circle sales create a mixed picture. The percentage increase per year has been spectacular, but sales have not yet achieved the level projected. For example, by the five-year mark in 1994, Blue Circle pill sales were expected to reach 4-5 million cycles annually. Projections during the design phase suggested this volume would be required to sustain the product at the offered price. Current estimates place 1994 sales in the range of 2-3 million cycles. Whether this is sufficient volume to sustain the products in the market at the present price will ultimately be determined by the manufacturers and the distributor as they evaluate their total sales pictures, including sales to the public sector program.

Blue Circle sales have not met projected targets due to a variety of factors, related to pricing, availability of competing products at non-market prices, legal and regulatory barriers, and lack of extended distribution networks. With respect to pricing, the Blue Circle line is aimed at lower-income consumers (B, C and D class consumers in marketing terms), estimated at 70% of the market but not at the poorest of the poor (E class, the lowest 20%). How the Blue Circle target market is defined (in terms of income, consumption, etc.) signals what consumers can be charged as a product price. The other factor determining price is cost and the need for commercial products to cover costs and profit margin to sustain their place in the market.

It is difficult to appraise prices set for Blue Circle products as affordable or too high for the target market. On the one hand the prices cover provision of a quality product/service, including support by the manufacturers of detailing to assure that correct information is given consumers about contraceptive use. Further, Blue Circle products are reaching into the target market and, particularly for the injectable, attracting users even from the poorest groups<sup>7</sup>.

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<sup>6</sup>This estimate includes costs for the following; Mecosin (distributor) operating budget; all promotion, advertising and market research; all fees; resident adviser time and overhead.

<sup>7</sup>SRL, Presentation of a Consumer Profile Study Among Blue Circle Users and Lapsed Users, Jakarta, April, 1992, Chart 40.

On the other hand, conflicting evidence suggests some Blue Circle products may be priced at the upper end of the consumer market for affordable methods. According to Kenney, retail prices (and service charges for clinical methods like IUDs or injectables) may put Blue Circle products out of reach of the 20% of the urban low-income group who may be in Blue Circle's market<sup>8</sup>. As discussed below, legal and regulatory barriers may still be restricting the development of the commercial market, and, as a result, adding to the costs of doing business.

The legal and regulatory climate continues to improve, but still reflects some barriers. The success of Blue Circle to date has been partially due to reforms in the legal and regulatory climate. Permitting doctors and midwives to purchase and dispense contraceptives, and allowing ethical Blue Circle products to be advertised, have had a great impact.

But other legal and regulatory barriers still inhibit the development of Blue Circle sales. To the extent that these restrict the market and add to the cost of doing business, such barriers tend to keep Blue Circle's price up. These include restrictions on the type of provider who can take delivery of consignments, restrictions on multinational manufacturers' latitude to sell directly to retail outlets, restrictions on the types of outlets which can sell contraceptives, etc.

It has further been difficult to develop private sector distribution networks. The number of distribution points has increased with inclusion of midwives as providers, although this was not easy to accomplish. In Indonesia only more densely populated, better-off areas have pharmacies, where sales of pills (an ethical pharmaceutical) are both legal and commercially viable. Income levels and consumption patterns in Indonesia mean that the lowest level of distribution for commercial products is essentially a micro enterprise, based on a small inventory, small volume of sales, and each consumer making a small purchase. Commercial distribution systems have difficulty supporting this type of retailer in terms of credit needs and resupply.

These problems have been compounded by the success of the public sector program. The Blue Circle product line did not have a chance to develop an open-ended mass market for its products, since free or reduced price products confined Blue Circle sales to a more limited group of consumers. Although the government initially adopted the policy of giving Blue Circle CSM unimpeded access to the social marketing consumer, this was not what happened in actuality. As will be discussed below, the public sector's progress in institutionalizing a local promotion network based on subsidized contraceptives has made the public sector a major alternative to Blue Circle commercial products.

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<sup>8</sup>Kenney, op. cit. p. 59.

## 2. Subsidized Sales

### 2.1 Public Sector Program in Supply Methods

The success of the public sector in creating a functional, extended local promotion network for supply methods has set up an important alternative to Blue Circle commercial sales. As shown in Figure 1 (see next page), according to the 1991 IDHS, the single largest method distribution channel is the pill through the public sector<sup>9</sup>. Of married women of reproductive age (MWRA), 47% are using modern methods of contraception in Indonesia, including 13% who use public sector pills. For comparison, the next largest is the IUD through the public sector (10%) and public sector injectables (7%). Private sector methods only come in fourth place, with injectables accounting for 4.6%. The pill through the private sector is in eighth place, with 1.5%, notwithstanding the fact that the pill is a very good method to supply through commercial channels (since clinical services are not required). The following section of this analysis will put these patterns into an international context.

The history of the development of the extended local promotion network has been clearly documented elsewhere<sup>10</sup>. A key facet, however, has been the evolutionary character of its development. In the interests of increasing prevalence, various mechanisms have been tried, and where successful, later institutionalized. For example, to increase consumers' use of private service providers, these providers were initially provided with public sector contraceptives.

Another aspect of the evolution has been a growing practice of public sector service providers (clinics and village volunteers) charging for public sector contraceptives. There is little quantitative information on this -- e.g. regarding frequency, type of provider, amount charged by method, etc. -- but considerable anecdotal evidence. To give an indication of the magnitude of this practice, volume of commercial sales can be related to reported sources. Although the 1991 IDHS shows that private sector sources account for 22% of services, commercial sales -- which would presumably underlie these private sector

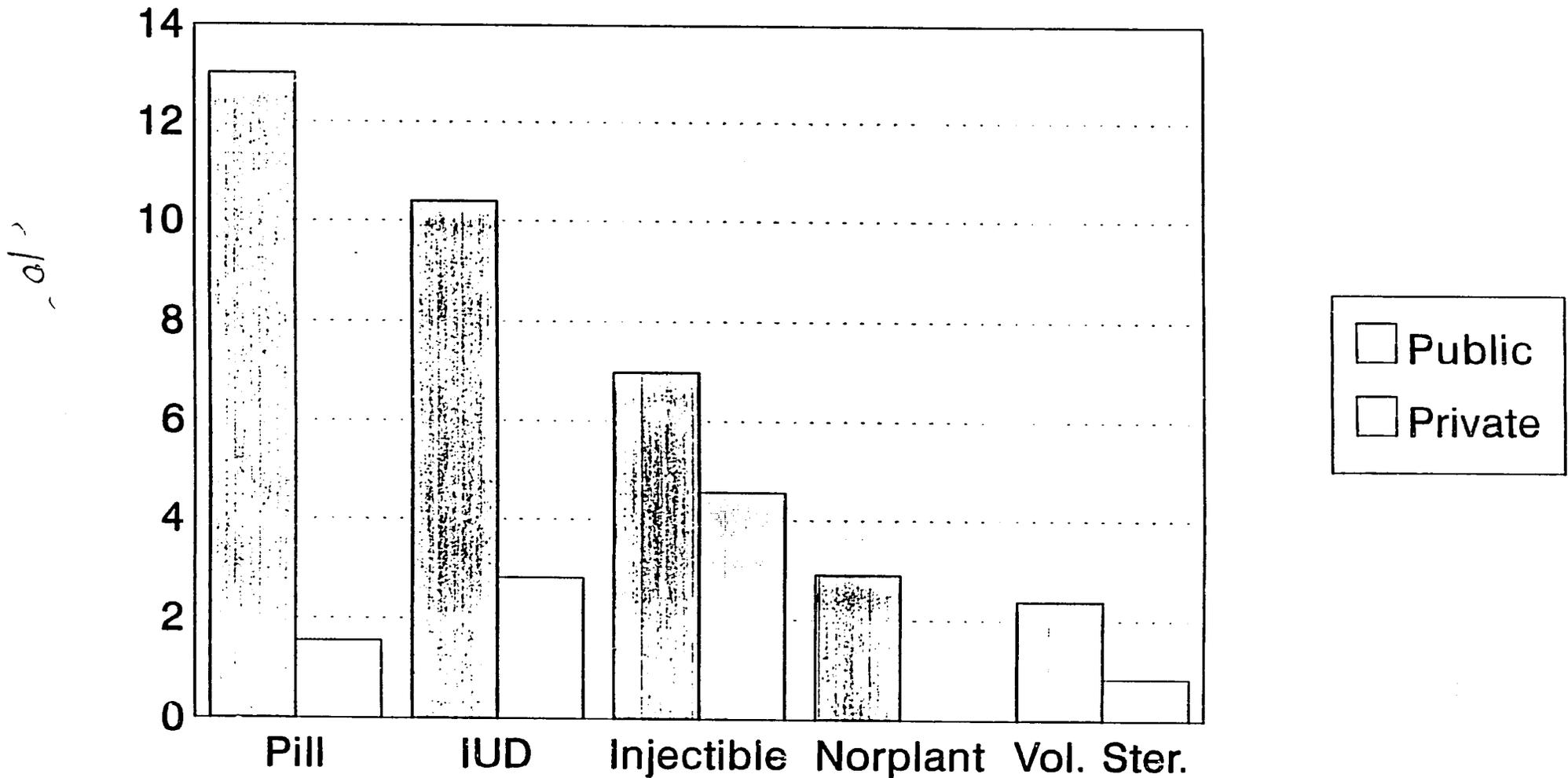
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<sup>9</sup>Indonesia Demographic and Health Survey 1991. Preliminary Report. Central Bureau of Statistics, BKKBN, MOH, IRD/Macro International, November, 1991. When the 1987 ICPS and the 1991 IDHS are compared, it is evident that the public sector has increased its role in providing supply methods, while the private sector has increased its provision of injectables and IUDs. Typically, the private sector (and pharmacies in particular) has an important role in distributing supply methods. This does not appear to be the case in Indonesia. A.L.D. with its emphasis on more effective methods may wish to reinforce the private sector's comparative successes in supporting IUDs and injectables.

<sup>10</sup>Curtin, Leslie B. et al. Indonesia's National Family Planning Program: The Impact on National Development 1968-1992, POPTECH, Arlington, May, 1992.

FIGURE 1

# Public vs. Private Distribution Indonesia



Percent of MWRA; Source 1991 IDHS

services -- are only the equivalent of 10%<sup>11</sup>. A significant portion of the gap may be consumers who are getting public sector contraceptives through gray market private sources or who are paying for contraceptives. This illustrates the blurring of the line between public and private service provision, and the difficulty of defining where one sector ends and the other begins<sup>12</sup>.

Public sector contraceptives, whether free or sold, cost the consumer less than Blue Circle products. The present situation, thus, is one of coincidental, but direct and unequal competition of one part of the program with another.

## 2.2 Gold Circle

The GOI is considering developing a subsidized program, termed Gold Circle, which will formalize the present practice of charging for public sector contraceptives. Full details of how the new activity will operate are not yet available. But according to the best information available in early May 1992, one of the key objectives appears to be to provide incentives for the volunteers to insure their long-term involvement<sup>13</sup>. Based on the Dualima and NORPLANT models, the National Family Planning Board (BKKBN) will apparently purchase contraceptives and hand them out to groups to sell under certain specified conditions (like price).

Programs of subsidized sales differ in certain key ways from commercial CSM. The Gold Circle idea would "privatize" the sale of public sector products to the consumer; revenues from sales would help cover costs in the distribution system (partial cost recovery); but government support would still be required for procurement of the contraceptives themselves. Price to the consumer does not have to reflect market conditions, therefore a highly affordable price might be able to attract a bigger clientele. However, an intermediate factor, quality, affects the degree to which price is related to market size. As long as the perception of quality products is maintained, low prices do not necessarily

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<sup>11</sup>The full version of the 1991 IDHS, not yet available, will report information on who is paying, how much they are paying and to whom. Further evidence is provided by a recent URC study of injectable service delivery, which found that the average price for the injectable (for the service alone) was 1341 rupiah (add citation). For the average to be this high, sales in the public sector are likely to be very frequent.

<sup>12</sup>Related to this is the recent history of the Blue Circle logo. The logo has become so popular, that it has become synonymous with the national family planning program.

<sup>13</sup>For workers to keep the money, changes in government regulations will be necessary. At present regulations require that all funds generated by the village distribution system be turned over to the national treasury (Guidelines for Implementation of a Self-Sufficiency Pilot Project in Family Planning In Selected Districts). This is a problem commonly faced when cost recovery systems are proposed and may or may not be insurmountable depending on the policy climate in country. Other documentation of this pilot activity includes: Mitchell, Marc. Indonesia Pilot Project Activities KB-Mandiri Pedesaan. Final Report, MSH, Boston, Sept. 1990. and Mitchell, Marc. KB-Mandiri Proposed Implementation Strategy, MSH, Boston, Aug. 1990.

increase sales. This can be abstracted as follows:

Gold Circle

contraceptives  
distribution system  
mobil. of private resources

subsidized  
partial cost recovery  
yes, lower price=bigger market??

The idea of introducing cost recovery into the community-based distribution (CBD) system has long been considered in Indonesia, and preliminary operations research has been conducted to look at implementation and impacts on service utilization. The design of A.I.D.'s Private Sector Family Planning Project (497-0355) includes an activity to introduce cost recovery into the CBD program in selected provinces, and calls for revenues to defray some or all program costs and for safeguards for access of the poor to free services. Operations research to test how the activity would work has been performed; these tests were based on use of Blue Circle products, and use of Blue Circle would further expand its market. Analyses of price elasticity of demand have also been performed, showing that in Indonesia poor consumers are sensitive to price levels<sup>14</sup>. Thus the needs of this group must be addressed as part of the ongoing effort to introduce cost recovery and maintain high levels of use.

Previous ideas about the evolution of the CBD program did not anticipate the recent experience with public sector mass distribution and with Blue Circle sales. Actual, on-the-ground experience has shaped interest in Gold Circle subsidized sales, even in the face of recurrent costs and division of the Blue Circle target market.

Now the national program is taking steps to institutionalize a new program. Institutionalization in any area of public policy implies "locking-in" implementation until procedures are formally changed again. Given this, it is vital that the design of the new activity carefully consider how best to serve the future needs of the national program. The key design elements have to do with:

- o recurrent cost burden,
- o targeting of subsidies,
- o access of the poor to services,
- o appropriate use of effective methods, and
- o market segmentation and Blue Circle commercial CSM.

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<sup>14</sup>Two studies have concluded that in certain groups of users, a move to price CBD contraceptives closer to commercial levels would affect usage to a degree that would be significant to the national program. Jensen, Eric. "The Economic Effects of KB Mandiri", URC, Washington, DC, Sept. 1990 (Draft). Molyneaux, John W. and Tohir Diman. "The Impact of Contraceptive Price on Contraceptive Choice", Lembaga Demografi/BKKBN, Jakarta, April, 1991.

In the section entitled "Design Decisions and Data for Strategic Planning", these are briefly discussed.

### 3. International Experience

Table 1 (see next page) includes the method mix and delivery channels for Indonesia and three other countries, Thailand, Egypt and Jamaica. These countries all have relatively high prevalence, well-developed service delivery systems and past histories of donor support and thus are useful to illustrate various points about the Indonesia program<sup>15</sup>. According to the 1991 Indonesia Demographic and Health Surveys (IDHS), 75% of family planning services in Indonesia were provided by the public sector. This was close to the percentage in Thailand, a country which made a policy decision not to make the private sector a full partner in service delivery<sup>16</sup>. In Jamaica, the public sector share is also high (60%), and reducing the burden on the public sector is one of two major objectives of the present phase-out program of A.I.D. assistance in Jamaica. By contrast, in Egypt, the program is 29% public sector.<sup>17</sup>

The national program in Jamaica has a total of 19% of MWRA using the pill from either the public or private sectors. The over-reliance on the pill is costly; costs per couple-year of protection for supply methods are higher than for more effective methods. Further, supply methods are comparatively less effective since they depend on correct use (through use failure, they bring less fertility reduction). In consequence, the Jamaica A.I.D. phase-out program has two goals: as already cited, increased private participation to reduce the burden on the public sector and increased use of effective methods.

Jamaica has 11% of MWRA relying on private sector pills and condoms. It appears at first glance that the private sector is playing an important role in distributing supply methods. However, the majority of private sector pills and condoms are donated by A.I.D. for distribution through the subsidized CSM program, Perle pills and Panther condoms. A.I.D. is seeking to reduce its recurrent cost burden of these contraceptives. Whether to transfer this responsibility to the GOJ or to the private sector is a serious issue. The GOJ has

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<sup>15</sup>Prevalence of tubectomy in Indonesia and Thailand is illustrative, although not the subject of this paper. Indonesia could attain the same level of prevalence as Thailand (and by implication replacement-level fertility simply by expanding tubectomy to the levels of Thailand. Typically developing countries with replacement-level fertility have from 15 to 30% voluntary sterilization in the method mix. A.I.D. has developed around the world a comparative advantage for investments in voluntary sterilization; this may be a very appropriate area for further A.I.D. work in view of the national program's slow progress in this area.

<sup>16</sup>Bennett, Anthony, et al. How Thailand's Family Planning Program Reached Replacement Level Fertility: Lessons Learned, POPTECH Occasional Papers No. 4. Arlington, 1990.

<sup>17</sup>Other high prevalence countries (more than 50% prevalence) with important private sector participation include: Brazil 73% private sector (1986); Colombia 77% (1986); and Turkey 81% (1988). Source: Population Council Data Bank, 1991.

TABLE 1

<b>DISTRIBUTION CHANNELS FOR METHODS</b>				
	<b>Indonesia</b>	<b>Thailand</b>	<b>Egypt</b>	<b>Jamaica</b>
<b>PUBLIC SECTOR</b>				
pill	13	13	2	13
IUD	10	7	11	1
injectible	7	7		7
NORPLANT	3	0		
tubectomy	2	21	1	12
vasectomy	0	4		
Subt. major public	35	51	14	32
% of Total	1	1	0	1
<b>PRIVATE SECTOR</b>				
injectible	5	1		1
IUD	3	0	13	1
pill	2	5	14	7
sterilization	1	3	1	2
other priv. (condom?)	0	1	5	5
Subt. major priv.	10	10	32	14
% of Total	0	0	1	0
<b>OTHER</b>				
other pub./priv.	1	2	1	8
other source	1	3	1	
<b>Total Modern Methods</b>	<b>47</b>	<b>67 *</b>	<b>48</b>	<b>54</b>
	Src: 1991 IDHS	Src: 1987 TDHS * 1% Rndg. Error	Src: 1990 PAPCHILD	Src: 1989 JCPS

never previously allocated funds for the national program's contraceptive needs; if and when it does, the funds may have to be in hard currency due to the lack of local production.

Egypt has substantial private sector involvement, with 67% of all services provided privately. The public sector program serves few pill users, preferring that these couples be served in the private sector. However, again, A.I.D.-donated commodities have played a significant role. The GOE has, like Jamaica, not historically allocated funds for the program's contraceptive requirements. Egypt produces pills and its market is sufficiently large to warrant local production of IUDs. The next phase of A.I.D. assistance to Egypt seeks to transfer the cost responsibility for private sector contraceptives to the consumer; given the high stakes in terms of Egypt's population growth, the situation will be monitored very carefully to assure that this transfer does not result in declines in prevalence or unwanted shifts to the public sector.

The Thai case is also very relevant to Indonesia. This neighboring Asian country may be an influential model for Indonesia. As mentioned earlier, the Thai government made an explicit decision not to depend on the private sector. The method mix/delivery channel picture reflects this; only 15% of all services are through the private sector, and the largest private sector contribution is the pill in the private sector with 5% of MWRA.

Bennett et al's review of the Thai program's success and lessons learned summarizes the government's decision to emphasize accessibility over private participation.

The Thai government's strong commitment to providing family planning services meant that it could reject solutions for new revenues offered in other settings. Specifically the National Family Planning Program turned neither to the private sector to increase its role ... nor to cost recovery schemes to help support its own activities. Rather it remains the policy of the NFPP not to charge for contraceptives, except for injectables and implants. Although there is some evidence that couples are paying a small charge for contraceptive pills at some government outlets, the Thai program has eliminated any financial barrier to couples to accept family planning.<sup>18</sup>

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<sup>18</sup>Bennett et al, op. cit., p. 79.

The Thai program as a sovereign policy matter decided to subsidize family planning from government revenues as a public good. The Thai program is highly touted for its success in reaching replacement-level fertility and its independence from donor support. The government of Thailand's assumption of program costs from the donors gave the program the latitude to decide itself about the role of the private sector. In the cases of Jamaica and Egypt, A.I.D. is reducing its support for contraceptives. This puts pressure on the governments involved either to allocate domestic (or other donor) resources to continue subsidized CSM programs, or convert the CSM programs to a more commercial approach.

#### 4. Design Decisions and Data for Strategic Planning

As in Thailand, Indonesian policy makers could decide that it is appropriate for government to play a significant role in family planning finance. But even so, policy makers may want to proceed with implementation strategies designed to keep government's role at a manageable level, to maximize effective use of family planning, and to address equity concerns for the poor. In Indonesia, interest in such implementation strategies raises four key questions:

1) What will be the recurrent cost burden to the GOI, given population and expected program growth, if institutionalization of subsidized sales succeed? If this is too high, how can the program maximize sustainability? Could volunteer distributors share the cost of the contraceptives with the GOI?

2) How should prices be set to best target GOI subsidies on different groups of consumers? With incentives for promoters based on sales, what mechanism will assure access of the poor to free services?

3) With incentives related to sales of supply methods, what mechanism will assure increasing use of effective methods as families' needs change?

4) Could a strategy of market segmentation be employed with market niches to maximize the role of Blue Circle commercial CSM for consumers who can afford to pay a commercial price and meet the needs of other consumers through other mechanisms?

##### 4.1 Recurrent Costs and Maximizing Sustainability

In contrast to commercial CSM, subsidized programs create recurrent cost burdens. The provision of sales incentives to local promoters will increase the chance of success of Gold Circle; by implication, the success of the program escalates recurrent costs. To meet its new performance target of replacement-level fertility, the national program will have to

increase prevalence to the range of 63-70%<sup>19</sup>. This implies an increase in the number of families served of 64-81% by 2005 both to keep pace with population momentum and to increase from the present 47% level of modern method prevalence. In 1991, the GOI's contraceptive bill was \$27 million; this can be expected to expand by population momentum, program growth and by the impetus of a potentially successful Gold Circle program.

Can the Gold Circle activity be designed to alleviate some or all of this recurrent cost burden? The national program may want to set Gold Circle up on the basis of a revolving drug fund, where sales pay for purchases. The program may want to look at the feasibility of establishing local promoters as micro-entrepreneurs who buy products for resale and thus provide some return to the program. This would make the activity more sustainable; the practical aspects of this are discussed below under Blue Circle. (Decisions about these approaches will ultimately grow out of the policy aims of this channel of the program: if the aim is to offer a highly affordable price to increase availability, then a revolving fund might not produce much revenue; if it is to provide incentives to the local distribution network, then there may not be sufficient margin to cover both the incentive and the purchase price.)

#### 4.2 Targeting Subsidies/Assuring Access for Poor

Another way to decrease recurring costs is to target subsidies to those consumers for whom the subsidy represents a public good. If prices are set in relation to what groups of consumers can afford to pay and consumers who cannot afford to pay receive the largest subsidies, the overall cost of the program is less, and the actual subsidies are targeted to the consumer groups (the poor) for whom equitable access is a concern. To address targeting of subsidies and access for the poor, it may be useful to look at pricing issues, criteria for eligibility for free service, incentives for provision of free services, etc. The latter issue of incentives again relates to foreseeable success of Gold Circle: if paid services take off, what will be the incentive to the promoter or provider to provide free services?

#### 4.3 Assuring Appropriate Use of Long-term Methods

It is also vital to consider ways to compensate promoters to help develop appropriate use of effective methods. Because of high reliability and long period of effectiveness, these methods are both cost- and use-effective compared to supply methods. Therefore it is in the interest of the national program to consider ways to stimulate usage so that families do not stay with supply methods longer than is warranted. Consideration should be given to how to foster referrals to more effective methods (given consumer preference, age, and

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<sup>19</sup>Curtin et al, op. cit. p. 32 draft of May 8, 1992. Ranges have been used because of technical questions about the 1991 IDHS results. The survey estimates Indonesia's present total fertility (average number of children born per woman) at 3; this may be an underestimate, and, if it is, the contraceptive prevalence rate required to reach replacement-level fertility would then be the upper boundaries of the range.

parity). Anecdotal evidence suggests that the payment to providers to partially reimburse their costs for delivering voluntary sterilization services is shared with the local recruiter. This might be a start on developing ways to insure appropriate use of a range of effective methods. In many countries, A.L.D. has developed a comparative advantage in investing in long-term methods; it may be appropriate for A.L.D. to continue to play this role in Indonesia.

#### 4.4 Market Segmentation and Optimal Role for Blue Circle

Careful consideration should be given in advance to the optimal role for Blue Circle in an environment where Gold Circle is operating. The Gold Circle initiative has the potential to take the mass market for affordable contraceptives, with Blue Circle evolving into a higher-priced, smaller volume product that is commercially sustainable. This raises all the issues of public sector recurrent costs, subsidies, method mix and equitable access described above.

A strategy of market segmentation, as a matter of policy and practice, could go far in rationalizing how programs of different types interface. Market segmentation would start with analyses of the Indonesian consumers' needs, preferences and ability/willingness to pay for contraceptives. From this, a range of market niches would be identified, and products would be priced, packaged and actively marketed to their target audiences. The objective of this process would be to maximize usage and financial participation of consumers who can afford to pay, be it the full price or something less.

Effective use of market segmentation requires both policy commitment and supportive implementation plans. The next few examples with respect to Blue Circle illustrate this. Product image is important. Blue Circle's image should be commensurate with its price and target market, so that it can secure the portion of the consumer market that can ultimately sustain the products. Typical connotations about perceptions of blue and gold suggest that there is a potential for Gold Circle being positioned as a more prestigious product than Blue Circle. As a marketing issue, if higher-cost Blue Circle products were to be positioned as a less valuable product, this would be a tough sale.

Another aspect of policy commitment relates to removal of legal and regulatory barriers. Although there have been successes in this area, there is still more to be done, so that Blue Circle products can be offered at the lowest possible price. Legal and regulatory barriers add to the cost of doing business and are reflected in the consumer price. These include that multinational manufacturers are not permitted to distribute their own products; orals are not permitted for sale in toko obat, the numerous but tiny patent medicine shops; advertising is restricted for ethical pharmaceuticals; the addition of value added taxes; and deterrents to private practice and laws regulating full-time private practice<sup>20</sup>.

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<sup>20</sup>Kenney, op. cit. p. 3, p. 16-17.

Further, it may be possible to develop village volunteers as micro-entrepreneurs to sell Blue Circle products. This would have the advantage of being commercial (no recurrent costs to the GOI), but would include incentives to the village promoters to motivate sales and continue participation. At present establishing these local entrepreneurs is difficult for a variety of reasons--Blue Circle's price may be high for their market, regulations limit who can take delivery of contraceptives, and there are issues of credit for the micro-entrepreneur. For the commercial sector, the need to offer credit to this group adds to the cost of doing business with them which again would be reflected in the price to the consumer.

It may be possible to identify an entity which could develop procedures and provide seed capital/credit, so this type of initiative could go forward. This would be an ideal resolution, permitting sales of Blue Circle commercial CSM products at the most local levels. (Depending on all factors motivating the Gold Circle campaign, which are not fully clear at present, Gold Circle could also adopt the micro-enterprise approach.)

#### 5. How A.I.D. Can Help

A.I.D. can support the continuing evolution of the Indonesia national family planning program and Blue Circle commercial CSM in a few simple, practical ways.

o Strategic planning. The new DHS is an excellent resource for developing an in-depth understanding of the consumer market in Indonesia. Existing consumption data and retail sales information reinforce what the DHS has to offer. These data should be examined on a sub-national basis to understand the supply of services: where public sector local promotion is working, where commercial sales are working, where additional effort is needed to increase prevalence, and how the sectors can best respond to that need. Also of concern is where private providers are active and the products they are offering. Re-examination of DHS data also will clarify demand: what types of consumers are using which method/sector delivery channels, the patterns of fertility preference, patterns of reproductive risk, etc. Exploitation of existing data will not only support market segmentation and programming in social marketing, but will also help to address expansion of effective methods and help the national program plan how to achieve the next jump in prevalence.

The process of exploiting DHS results to answer particular questions for program planning will be much more useful if staff of the local program are heavily involved. In a participatory planning process, information which is coming out of the analysis is immediately applied to thinking about program implementation itself. Further, not only will the specific strategic planning exercise benefit the program now, but program staff will grow in skills and strategic thinking as a result. When one considers that Indonesia is an active training site for staff from other countries, it is clear that investments in methodologies that foster strategic thinking may pay off richly in lateral transfer of technology.

- o Analytic Support. Analytic studies are needed in two areas:

Resource allocation:

- o how much will it cost and who will benefit from the subsidies in programs of subsidized sales, for NORPLANT if subsidized implants are made available to the private sector<sup>21</sup>, and for voluntary sterilization;
- o how much would it cost and how best to implement mechanisms for village promoters to refer for effective methods; assessment of alternatives for sustainability of local distribution system;
- o eligibility criteria for free services particularly in urban areas; potential utility and mechanisms to implement a reimbursement system for private services to poor consumers.

Legal and Regulatory Barriers: Beyond the significant reforms thus far, additional barriers exist:

- o the costs to consumers; the social, sectoral or corporate benefits of maintaining regulations; the social, sectoral or corporate benefits of changes in the following operational policies:
  - prohibitions on multinational manufacturers from distributing their own products;
  - orals restricted from sale in toko obat, tiny patent medicine shops;
  - restrictions on advertising of ethical pharmaceuticals;
  - value added taxes; and
  - deterrents to private practice and laws regulating full-time private practice.

o Implementation Tests. A.I.D. could support implementation pilot tests (continuing its earlier role of supporting new approaches which were then later implemented broadly through other donor or GOI support). Among these would be: test market activities to try out price levels, incentive schemes to assure that poor consumers receive free services or that families are referred for effective methods, and business practices/capitalization/credit for micro-entrepreneurs.

o Monitoring and Evaluation. In Indonesia's situation, where a concerted effort is being made to increase prevalence after program growth has levelled off, a variety of new

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<sup>21</sup>With respect to the amount and targeting of subsidies in Indonesia, the same type of strategic thinking pertinent to social marketing of supply methods applies to the national family program's large NORPLANT component, in terms of how long the GOI can support the recurrent costs of growing reliance on this method, presently costing \$23/set.

initiatives will be explored. It is vital that there be continuous flows of data to monitor program performance. This will include prevalence, method mix, source of service, amount of payment, non-use, all broken down by geographic area and type of consumer (age, parity, socioeconomic characteristics). Service statistics will be very helpful in this regard, because they paint a picture of what the program is doing and who it is reaching. But service statistics must be supplemented by community data, to get the other part of the picture--consumers who are not using services at all, who are getting them from other sources, etc.

A creative mix of data collection methods should be used. Of course, large-scale household surveys (like the DHS) will be needed periodically, in order to calculate fertility rates. But smaller, quick response types of studies should also be done, using smaller samples, signal geographic areas, directed at having a continuous flow of data to answer questions about changes in consumer usage in relation to changes in the program or its new initiatives. Techniques from market research (panel studies, marketing studies, placing questions in consumer omnibus market surveys) and operations research (pre-post studies of paying for services), etc. may be useful in generating the data needed for program development.

o Flexible Programming Mechanism. A flexible mechanism like sector support or non-project assistance (NPA) may be very useful in the Indonesia context. The national program has a high level of development, thus it has considerable capacity to implement new initiatives without major program development support on the part of A.I.D. Further, it has the managerial controls in place which are a pre-requisite to use of NPA. Use of NPA to develop performance targets and apply performance-based disbursement might energize the US/GOI bilateral program. Recent changes in A.I.D. procedures for implementation of project assistance are viewed by the GOI as overly bureaucratic; these changes seem to have eliminated the flexible support of innovation which has been the hallmark of US assistance in family planning to date.

Sector assistance has some great advantages in working with a mature program: the serious effort to jointly develop program targets increases the program's ownership of goals; based on this ownership, the program then works toward accomplishing those goals; lastly the program has more latitude to decide how assistance support is applied. NPA may include technical assistance or supplementary technical assistance could be provided through other mechanisms. With respect to the private sector, given that there remain legal and regulatory constraints to its maximum participation, NPA would be well suited as a vehicle to negotiate policy changes. Likewise for operational policy issues underlying market segmentation, NPA would also be well suited to demonstrate policy commitment.

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