The UNFPA Private-Sector Initiative

Exploring Ways to Facilitate Cooperation between Governments and the Commercial Sector to Expand Access to Reproductive Health Commodities

United Nations Population Fund
Technical and Policy Division
Technical Branch

A Project of the UNFPA Global Initiative on
Reproductive Health Commodity Management

TECHNICAL REPORT

THE UNFPA PRIVATE-SECTOR INITIATIVE: EXPLORING WAYS TO FACILITATE COOPERATION BETWEEN GOVERNMENTS AND THE COMMERCIAL SECTOR TO EXPAND ACCESS TO RH COMMODITIES

Technical Report is a periodic publication of UNFPA that covers important developments and discussions in the areas of population, family planning and reproductive health.

This technical report has been prepared by the Technical Branch of UNFPA's Technical and Policy Division (TPD). It presents some of the recent experience of UNFPA and others in expanding cooperation with the private sector for the provision of reproductive health services and commodities.

UNFPA also publishes reports in other series, including: **Evaluation Report** and **Programme Advisory Note.**

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FOREWORD

This report describes some of the recent efforts of various international agencies, including the United Nations Population Fund (UNFPA), to work with the commercial sector in support of the objectives of the International Conference on Population and Development (ICPD) Programme of Action. This report also reflects the results of two international consultations and six exploratory missions to developing countries. It is hoped that the report will provide a measure of guidance and inspiration to Governments, donors and representatives of the private sector who work in the area of reproductive health at both global and national levels. It is also hoped that this experience will serve as a basis for working together effectively to develop improved mechanisms for cooperation.

The intended main beneficiaries of this activity are the women and men, users of reproductive health services and commodities in developing countries, who will have expanded access to affordable products and services.

We would like to thank the Rockefeller Foundation, the David and Lucile Packard Foundation and the Department for International Development (DFID) of the United Kingdom for the funding they provided to this pilot activity. We are grateful for the financial support from these agencies and the support they and others in the Working Group of the Global Initiative on Reproductive Health Commodity Management have given so generously to this work.

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PREFACE

The number of women requiring reproductive health products and services in developing countries is increasing rapidly. This is the result of growing populations combined with expanding demand. Costs therefore are rising while available public resources to meet those needs are stagnating. For example, regarding family planning, there are 1.2 billion women of reproductive age living in developing countries, and this level is estimated to be increasing by approximately 2 per cent annually. Meanwhile, the proportion of couples who choose family planning is increasing. Currently, 49 per cent of married women in developing countries use a modern method. This rate is expected to increase to 62 per cent by the year 2015.

The Programme of Action adopted by 180 nations at the 1994 International Conference on Population and Development (ICPD) states that achieving the basic reproductive needs of men and women, including family planning, will cost an estimated $17 billion in the year 2000 and $22 billion by 2015. According to a 1998 UNFPA report, expenditures in 1996 for population and reproductive health were approximately $10 billion, of which international donors provided $2 billion, users $1 billion and developing country Governments $7 billion. Donor support for reproductive health is not expected to increase significantly, and developing-county Governments are facing increasingly tight budget constraints as the costs of providing reproductive health services continue to rise. Shortfalls are envisaged. Thus, agencies working in development need to identify ways to mobilize alternative sources of funding. Analysts propose several approaches including improving the efficiency of RH service delivery and charging fees for services. Increasing the appropriate role of the commercial sector, including through reduced prices, greater contributions by employers, private insurance and employer-based reproductive health programmes, is an approach that also deserves greater attention.

The ICPD and its recognition of the private sector's potential role provided a backdrop to the UNFPA decision to formally explore how it could work proactively and strategically with the private sector in the provision of reproductive health commodities in developing countries. In 1997, the Working Group of the Global Initiative on Contraceptive Requirements and Logistics Management Needs[1] encouraged UNFPA to explore ways to improve its collaboration with the private sector. In this way, the UNFPA Private Sector Initiative was established as a pilot project, within the Global Initiative, to examine whether UNFPA field offices could serve effectively as brokers between governments and the commercial private sector to expand the access of developing country couples to good quality, affordable hormonal contraceptives. The project is already developing promising ventures in several countries. As the pilot project progresses, UNFPA will explore other RH commodities and services.

[1] The Global Initiative Working Group was formed by the Consultative Group of the Governing Council of the UNFPA from among its members in 1991. Originally, it focused on estimating contraceptive commodities and costs. Recently, this UNFPA project has widened the scope of its work and has been renamed the Global Initiative on Reproductive Health Commodity Management.

This report outlines the experience of various agencies, including UNFPA, in expanding cooperation with the private sector for the provision of reproductive health services and commodities. While reviewing the conclusions of international consultations in 1997 and 1998 on the progress of the UNFPA private-sector initiative, it highlights various practical recommendations for Governments and donors as well as UNFPA. Brief case study reports of some of the important work, principally with family planning programmes carried out by other agencies, in Brazil, Mexico, Nigeria, Pakistan and Turkey appear in Annex A.

We would like to express our gratitude to the many individuals and organizations, public and private, whose knowledge and experience have contributed to this effort. In particular, we wish to acknowledge the assistance of two consultants: Ms. Susan Mitchell for her help in the preparation of the background section of the paper and Mr. Richard Pollard for his assistance in conducting six of the UNFPA country visits.

LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
BMZ	Bundesministerium fηr wirtschaftliche Zusammenarbeit und Entwicklung
CBD	Community-based distribution
CIDA	Canadian International Development Agency
CIMAS	Commercial and Industrial Medical Aid Society
CPR	Contraceptive prevalence rate
CSM	Contraceptive social marketing
DFID	Department for International Development, U.K.
DHS	Demographic and Health Survey
Enterprise	Family Planning Enterprise Project
FEI	Finishing Enterprises, Inc.
FEMAP	Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo, A.C.
GNP	Gross national product
ICSMP	International Contraceptive Social Marketing Project
IEC	Information, education and communication
IUD	Intra-uterine device
KfW	Kreditanstalt fηr Wiederaufbau
MEXFAM	Fundación Mexicana para la Planeación Familiar, A.C.
NGO	Non-governmental organization
OC	Oral contraceptive
OPTIONS	Options for Population Policy Project
PHR	Partnerships for Health Reform Project
PROFIT	Promoting Financial Investments and Transfers Project
PSI	Population Services International
PVO	Private voluntary organization
SFH	Society for Family Health
SOMARC	Social Marketing for Change Project
TFGI	The Futures Group International
TFR	Total fertility rate
TIPPS	Technical Information on Population for the Private Sector Project
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

1. EXPANDING PRIVATE-SECTOR INVOLVEMENT IN REPRODUCTIVE HEALTH

A. RATIONALE FOR EXPANDED PRIVATE-SECTOR ROLE IN PROVIDING REPRODUCTIVE HEALTH COMMODITIES AND SERVICES

The International Conference on Population and Development (ICPD), held in Cairo in 1994, established, *inter alia*, the goal of making high-quality reproductive health services universally available by 2015. The 180 nations that adopted the ICPD's Programme of Action recognized that achieving this ambitious goal would require the combined efforts of developed and developing countries, including the various sectors governmental, non-governmental and commercial. The objectives with respect to the latter two were addressed in Paragraph 15.15 of the Programme of Action:

> "To strengthen the partnership between Governments, international organizations and the private sector in identifying new areas of cooperation;
>
> "To promote the role of the private sector in service delivery and in the production and distribution, within each region of the world, of high-quality reproductive health and family-planning commodities and contraceptives, which are accessible and affordable to low-income sectors of the population."[2]

In addition, the Programme of Action calls upon Governments, non-governmental organizations (NGOs) and international organizations to "intensify their cooperation with the private, for-profit sector in matters pertaining to population and sustainable development" including "the production and delivery of quality contraceptive commodities and services . . . in a . . . cost-effective manner" (Paragraph 15.16). In 1986-1996, about 20 per cent of women who used a modern contraceptive in a developing country obtained their contraceptive method from commercial sources of supply.[3]

The recognition within the ICPD Programme of Action of the vital role already being played by the commercial private sector is historic. The need for a strategic and coordinated effort involving all sectors is now widely recognized. Family planning is an essential component

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[2] United Nations, *Population and Development, Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994,* Vol. 1 (United Nations publication Sales No. E.95.XIII.7).

[3] Paul Hopstock, Ann Sherpick and Carla Bricino, "Providers and Consumers of Commercial Family Planning Services in Developing Countries" (The PROFIT Project, September 1997). Information developed by Macro International from 55 Demographic and Health Surveys conducted between 1986 and 1996 was used to derive the source of supply of family planning products and services.

of reproductive health. Given that the demand for reproductive health services is increasing, and available public resources to meet this need are limited, continued access to quality contraceptives will require an active partnership of public and private sectors.

B. HIGHLIGHTS OF THE 1997 CONSULTATIVE MEETING

At the request of the Working Group of the Global Initiative on Contraceptive Requirements and Logistics Management Needs, UNFPA organized a "Consultative Meeting on Expanding Commercial Markets for Oral Contraceptives in Developing Countries". The meeting was held on 9 July 1997 at the offices of the Rockefeller Foundation in New York City. Representatives of developing countries, the development community and manufacturers of hormonal contraceptives attended the consultation. [4]

Participants in the consultation recognized that, in some countries, the large and growing role of the commercial sector -- that is, the commercial for-profit sector -- offers opportunities to improve the sustainability of the reproductive health commodity supply. They concluded that an expanded role for the private sector in meeting the demand of couples who can afford to pay would reduce the burden on governmental budgets by freeing scarce resources for couples who cannot afford to pay.

Several barriers exist, however, to improved access by consumers to high-quality, low-cost contraceptives. These barriers, relating to price, availability and acceptability, need to be addressed by the **interested parties** — Governments, donors and private-sector organizations, including technical agencies and market-oriented NGOs. Both Governments and manufacturers need to make concessions if the expansion of the private-sector role in selected countries and among appropriate target populations is to be achieved. Citing the benefits associated with wider commercial marketing of contraceptives, participants agreed that much could be accomplished by means of negotiated agreements among the main parties. They also agreed that UNFPA should take the lead in serving as a broker to help bring the interested parties into fruitful negotiations.

Achieving the goal of promoting greater sustainability of reproductive-health commodity-supply programmes while maintaining a high level of access by low-income consumers requires committed and innovative responses. Because each country situation is different, only broad indications of what negotiated agreements might contain are possible at this time. For now, it would appear that they could contain elements of the following:

[4] A full list of the participants can be found in the meeting report, UNFPA, *Consultative Meeting on Expanding Commercial Markets for Oral Contraceptives in Developing Countries,* Technical Report No. 41 (1998).

1. On the part of Governments

Governments would need to make commitments to take action on some or all of the following activities:

- Give preferential duties or tax conditions;
- Ease manufacturing or import regulations;
- Undertake tracking and evaluation studies;
- Support market segmentation research on consumer willingness and ability to pay for contraception; and
- Encourage the coordination of efforts.

2. On the part of pharmaceutical companies

Pharmaceutical companies would need to make commitments to take action on some or all of the following activities:

- Sell commercial products at prices that are affordable to as many people as possible;
- Handle all aspects of distribution as appropriate; and
- Implement market-building activities (advertising and promotion), to the extent possible.

3. On the part of donors

Donors would need to make commitments to take action on some or all of the following activities:

- Support market segmentation research on consumer willingness and ability to pay for contraception;
- Support tracking and evaluation studies; and
- Provide support for marketing and advertising costs.

4. Other useful actions

In addition, it may be useful for Governments, possibly with assistance from donors and manufacturers, to undertake the following:

- Carefully assess and, if necessary, take action to improve the policy environment for greater private-sector investment and security;
- Carry out or support action-related research on the impact of restrictive legislation on the importation, advertisement or sale of contraceptives;
- Facilitate the development of an extensive distribution system to reduce private-sector distribution costs; and

- Improve demand by working effectively with NGO and existing Contraceptive Social Marketing (CSM) programmes and invest in wider and more effective information, education and communication (IEC) efforts to educate users about the safety and efficacy of hormonal methods.

C. UNFPA FOLLOW-UP TO THE 1997 CONSULTATIVE MEETING

With support from the Rockefeller Foundation, the David and Lucile Packard Foundation and the Department for International Development (DFID) of the United Kingdom, UNFPA embarked upon an exploratory exercise to systematically gather information from hormonal contraceptive manufacturers and donor organizations concerning priorities for expansion. Pharmaceutical companies indicated the countries they considered important marketing opportunities. A review of social marketing activities indicated where there were opportunities to initiate new programmes.

The criteria that guided the identification of countries where a mission could be warranted in the initial phase included the following:

- The existence of a sufficiently large segment of those who can afford to pay an "intermediate" private-sector price;
- Donor and manufacturer interest; and
- Market viability to maintain the interest of manufacturers.

Based on the information gathered, Egypt, India, Indonesia, South Africa, Thailand and Zimbabwe were selected as being especially promising for pursuing discussions (Table 1). Originally, a mission was to visit each of these countries by 1998. However, the Zimbabwe visit had to be postponed until February 1999. A mission was made in 1998 to Ghana, instead.

The team members, selected for their knowledge about negotiation opportunities, were responsible for facilitating discussions among the interested parties. In each case, the teams attempted to assess current market segmentation — i.e., consumer, provider and product market segments — and existing or planned donor and manufacturer projects that could affect these markets.

UNFPA Representatives took the lead in organizing and convening the in-country meetings and in coordinating arrangements. During this process, the Governments and pharmaceutical companies were asked to define what they perceived as the opportunities and constraints for developing the private sector in the particular country. Discussions focused on how to ensure that contraceptives would be made widely available through commercial channels to larger numbers of people at affordable commercial prices. Donors in each country were asked to define what they saw as the opportunities and constraints for expanding private-sector contraceptive sales and what they might be able to contribute to such an effort.

Table 1. Countries selected for initial exploration of potential market expansion, by interested manufacturers and donors

Country	Manufacturer	Donor
India	Cilag, Organon, Richter, Schering, Upjohn, Wyeth	DFID, KfW, USAID, World Bank
Indonesia	Cilag, Concept, Richter, Schering, Upjohn, Wyeth	KfW, World Bank
Thailand	Concept, Wyeth	
Egypt	Richter, Schering, Wyeth	CIDA, USAID
Zimbabwe*	Organon, Richter, Schering, Wyeth	CIDA, DFID, USAID, World Bank
South Africa	Schering, Upjohn	DFID

Notes:
*Postponed until 1999. Replaced by Ghana.
CIDA - Canadian International Development Agency
DFID - Department for International Development, U.K.
KfW - Kreditanstalt fηr Wiederaufbau
USAID - United States Agency for International Development

In this exploratory phase, UNFPA teams visited the countries to initiate dialogue. The expected outcome is a series of negotiated agreements among the interested parties in several of the identified countries. Eventually, model approaches will be developed permitting the expansion of the process to other countries, as appropriate. The results of UNFPA's missions and a review of commercial market-related efforts organized by other donors in the past decade were discussed at a meeting of the interested parties held in Bellagio, Italy, 16-20 November 1998 (see Chapter 3).

Trust is vital to any negotiation. UNFPA has a history of good working relations with developing country Governments, and its field offices demonstrated in this exploratory phase their capacity to facilitate valuable dialogue on these, sometimes, controversial matters. One of the most useful tools in promoting successful negotiations was the establishment of working groups, as in Egypt and Ghana, in which government and commercial (and, in Ghana, related NGO) representatives can share information and discuss issues.

D. TWO COUNTRY REPORTS: EGYPT AND INDIA

Two of the countries visited during 1998 were Egypt and India. In Egypt (see Box 1), UNFPA is in a unique position to play a role as broker between the Government and the private sector and to harness better cooperation and collaboration among donors. The ultimate goal is to forge a "win-win" partnership between the Government and the private sector in meeting the needs of the people for contraception and other reproductive health commodities.

Box 1. Egypt: Potential for expanding the private-sector role in supplying hormonal contraceptives

The market for hormonal contraceptives, including oral contraceptives (OCs), holds great promise for expanding the role of Egypt's private sector, which already plays an important role in the reproductive health programme. Fifty-four per cent of current users obtain their contraceptives from the private sector, and 9 per cent depend on NGOs. The Government's goal is to reach a CPR of 70 per cent by 2015, and it supports a cafeteria approach . Concerned about high discontinuation rates of contraceptive use (30 per cent overall, including 58 per cent for injectables and 46 per cent for OCs), the Government is committed to improving contraceptive efficacy and to educating users on side-effects, including those for hormonal contraceptives. It is believed that both urban and rural women in Upper Egypt, where contraceptive use was only 35 per cent, compared with 55 per cent overall, prefer hormonal contraceptives, especially injectables. The Government would like to see the role of NGOs and the private sector expand. A recently instituted Government/private-sector working group is addressing such issues as: a broadening of the method mix; better pricing system/approach; demand creation for hormonal products through information, education and communication (IEC)/media campaigns; information dissemination and utilization; market segmentation/pricing studies; and expanded social marketing in Upper Egypt.

Possible areas for further activity in Egypt have been identified as follows:

- ***The Government would undertake, with UNFPA assistance, a study of market segmentation, including the ability of various socio-economic groups to pay for quality products and services;***
- ***The Government would update the 1994 UNFPA study "Contraceptive Requirements and Logistics Management Needs in Egypt";***
- ***UNFPA would coordinate donor efforts in creating demand for hormonal and other contraceptives and in undertaking IEC aimed at improving the users' and providers' knowledge of safety, health benefits, correct use and side-effects of hormonal contraceptives while improving the image of the method;***
- ***All parties would encourage, through training, the concept of quality of care; and***
- ***All parties would support and encourage the role of NGOs and the private sector in making contraceptive and reproductive health services available in Upper Egypt.***

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***S**ource:* Discussion at Bellagio Meeting, 16-20 November 1998.

In India, similarly, UNFPA can play a significant role in encouraging cooperation between the private sector and the Government to increase the availability and accessibility of quality hormonal contraceptives to certain market segments of the population. In this way, public resources can be released to better serve the needs of the general population, including lower income groups (see Box 2). In May 1998, a UNFPA mission visited the Ministry of Health and Family Welfare, various commercial and social marketing programmes and donors. It was agreed that all stakeholders would participate in a UNFPA-organized meeting in 1999 to discuss concrete steps. As a result of the mission, some preliminary concepts were suggested as a framework for future discussions. These concepts were presented and discussed at the Bellagio meeting (see Chapter 3) and further suggestions were proposed.

E. RECENT EXPERIENCE OF OTHER ORGANIZATIONS IN PRIVATE-SECTOR INITIATIVES

Expanding the total market and making the effort more sustainable while, at the same time, supplying lower economic groups and rural areas require a concerted commitment from all sectors to understand their respective roles and responsibilities and how they might better support one another to accomplish their common goals. The four partners generally involved in most private-sector reproductive health commodity initiatives are as follows:

- International donor organizations that finance initiatives and organizations to oversee the implementation of programmes;
- Multinational contraceptive manufacturers that provide products and, in some cases, participate in project implementation;
- In-country commercial distributors of pharmaceutical products and local NGOs, including social marketing programmes; and
- Developing-country Governments.

1. Donors and international organizations

United States Agency for International Development. The United States Agency for International Development (USAID) has provided the most donor support, by far, to commercial-sector approaches for the provision of reproductive health products and services in developing countries. Before the 1980s, USAID worked mainly with the public sector and private NGOs. Realizing that Governments and NGOs could not, by themselves, meet the demand for family planning products and services, USAID funded three projects in the 1980s aimed at increasing the commercial sector's role in financing and the provision of commodities. These projects are known as the Family Planning Enterprise Project (Enterprise), the Technical Information on Population for the Private Sector Project (TIPPS) and the Social Marketing for Change Project (SOMARC).

Box 2. India: Potential for expanding the private-sector role in supplying spacing methods

The population of India, which is approaching one billion people, is growing by approximately 17 million persons annually. India supports 16 per cent of the world's population. India's Family Welfare Programme seeks to promote responsible parenthood through voluntary and free choice of contraceptive methods best suited to individual users. The mass media and interpersonal communication highlight the reproductive health benefits of small families and seek to eliminate socio-cultural barriers to the adoption of the small-family norm.

With a TFR of 3.5 children per couple and a CPR of 46.5 per cent, India is a promising market for OCs and injectables. Moreover, the Government's current strategy calls for a CPR of 60 per cent by the year 2011. Recently, there has been a notable shift among new acceptors away from permanent methods, such as sterilization, towards spacing methods, including OCs. For example, only 1.4 per cent of acceptors used OCs in 1980. By 1996, this percentage had grown to 15.1 per cent of acceptors.

Locally manufactured OCs are distributed free and under social marketing schemes. In the free distribution programme, OCs are distributed under the brand name Mala-N and through social marketing as Mala-D. The hormonal raw material for domestic production is donated to the Government by UNFPA. OCs are made available by the Government to qualified social marketing organizations to be sold at modest prices to the low-income public. OCs are also marketed under private brand names by the commercial sector through selected pharmaceutical companies, constituting about 13 per cent of the current total market for OCs.

Possible areas for further discussion are as follows:

- ***Develop a working group composed of the Government, hormonal contraceptive manufacturers, donors and social marketing organizations, as appropriate, to promote private-sector involvement in implementing the reproductive health/population aspects of the ICPD Programme of Action;***
- ***Undertake a study on the costs and benefits of the current programme of free provision of raw materials (hormonal base) for the national manufacture of OCs;***
- ***Follow up the findings and recommendations of the recent UNFPA-supported study on quality control of national OC manufacture, including independent quality assurance testing;***
- ***Reinforce, as appropriate, the Government's effort in four states to combine increased commercial-sector marketing of market-priced OCs with IEC and training activities on the part of the Government, building on an initiative supported by USAID;***
- ***Undertake social advertising and IEC aimed at improving the public perception of OCs;***
- ***Work towards allowing brand-specific advertising of OCs and improving commercial-sector access to mass media, possibly through donor-assisted generic advertising;***
- ***Initiate market segmentation studies and willingness-to-pay studies in various geographic markets;***
- ***Assist the Government's study of social-marketing activities to review issues related to geographic fragmentation, inter-programme competition and high costs;***
- ***Monitor product quality to ensure that it meets national or international standards; and***
- ***Play a useful "broker" role in the dialogue among the interested parties on the industry proposal, needing government approval, to introduce new-generation low-dose OCs in the commercial market.***

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Source: Discussion at Bellagio Meeting, 16-20 November 1998.

The Enterprise Project worked in three areas: (a) company-based, in which services were introduced to urban factories and plantation settings; (b) market-based, in which new approaches to private-sector service delivery were tried; and (c) private voluntary organization (PVO) sustainability, in which technical assistance in business practices was provided to PVOs.

The TIPPS Project worked to increase available private-sector resources by promoting, among private health and commercial systems, an understanding of the benefits of birth spacing. This entailed primarily using tools such as a cost-benefit model to convince companies and the insurance industry of the merits of offering reproductive health services to their workers or health insurance members.

The SOMARC Project was established to increase the availability and use of contraceptives among lower and middle-income groups, using commercial marketing techniques such as market research, strategic planning, advertising and public relations. The project implemented communications campaigns to increase the awareness and use of reproductive health products and services and created partnerships with contraceptive manufacturers and distributors to ensure that contraceptive products were widely available at an affordable price.

The PROFIT Project, which was based primarily on the experience of TIPPS and Enterprise, supported a broad array of interventions ranging from employer-based and insurance-based activities to helping private providers, including doctors, midwives and pharmacists, through loans, training and improved access to commodities. PROFIT did not work in social marketing because the previously funded SOMARC I programme had received funding to continue its activities through SOMARC II and III.

The Commercial Markets Project, USAID□s latest initiative, began in October 1998 and combines the experience of both PROFIT and SOMARC into one large private-sector initiative. The project continues many activities initiated by PROFIT and has a substantial social marketing and legal and regulatory component.

USAID has made an effort to include the private sector in many of its projects. For example, USAID supports the OPTIONS/POLICY Project, which aims to foster a supportive policy environment for family planning and reproductive health programmes (including improving the environment for the private sector). USAID also supports various training projects such as those implemented by AVSC, Pathfinder International and others that train not only public-sector medical staff but also private providers. USAID's major private-sector family planning projects and their levels of funding are listed in Table 2.

Table 2. Major market-related family planning projects funded by USAID

Project Title	Years	Funding
TIPPS	1985-1991	$ 5.5 million
ENTERPRISE	1985-1991	$27 million
ICSMP*	1981-1984	$2.6 million
SOMARC I	1984-1988	$21 million
SOMARC II	1988-1992	$33 million
SOMARC III	1993-1998	$69 million
PROFIT	1991-1997	$36 million
COMMERCIAL MARKETS	1998-2003	$90 million

Note:
*ISCMP - International Contraceptive Social Marketing Project, a precursor to SOMARC.

Other bilateral support. Other bilateral donors are supporting private-sector initiatives through, for example, organizations such as Population Services International (PSI). A non-profit organization based in the United States of America, PSI develops and carries out health and population-oriented social marketing programmes around the world and has recently opened a European branch office in London. PSI's share of non-USAID funding has increased dramatically since 1990. As Table 3 shows, non-USAID funding accounted for almost half of the $144 million PSI received in 1998. PSI receives substantial funding from Kreditanstalt fηr Wiederaufbau (KfW), DFID and the Government of the Netherlands. PSI also receives funding from multilateral organizations such as the United Nations, including the World Bank and the World Health Organization (WHO), and host-country Governments, corporations and private foundations.

Table 3. Donor funding for Population Services International, 1990-1998

Year	USAID*	Non-USAID*	Total
1990	99%	1%	$ 58 million
1992	99%	1%	$ 97 million
1994	88%	12%	$102 million
1996	65%	35%	$145 million
1998**	54%	46%	$144 million

Source: PSI
Notes: *Percentages based on total value of contracts.
**1998 figures are through July 1998.

2. Contraceptive manufacturers

A number of contraceptive manufacturers have participated in commercial-sector initiatives supported by international donors. Most are multinational pharmaceutical companies, and some are worldwide leaders in the production of contraceptive products. A partial list would include: Aladan; Finishing Enterprises, Inc.; Gedeon Richter; Johnson & Johnson; Leiras; London International Group; N.V. Organon; Pharmacia-Upjohn; Schering A.G.; and Wyeth-Ayerst.

3. Local private sectors

In-country private-sector organizations are crucial to project implementation. These include commercial firms owned by private individuals or groups, operating on a for-profit basis, and NGOs that, although privately owned, have a social mandate and operate on a non-profit basis. Commercial organizations that participate in reproductive health initiatives include pharmaceutical distributors, health clinics, pharmacies, advertising agencies and research firms. NGOs in this field include family planning institutions, medical associations, universities and research firms.

4. Governments

Governments range in their level of participation from approving the in-country activity to financing initiatives, providing contraceptives and/or opening new avenues for product distribution or promotion through advocacy or changes in regulations.

2. IDENTIFYING KEY FEATURES OF COMMERCIAL PRIVATE-SECTOR ACTIVITIES

According to a recent study that analyzed data from 55 Demographic and Health Surveys (DHS) conducted between 1986 and 1996, pharmacies were by far the leading provider of supply-based methods in the commercial sector. Oral contraceptives and condoms were the leading methods provided, representing 69 per cent of the methods supplied by the commercial sector. Although clients of the commercial sector were more likely to be of higher socio-economic status, clients of all socio-economic categories used commercial providers. Consumers were motivated to use private providers because of the perceived quality of service, shorter waiting times and longer hours of operation.[5]

A. OPPORTUNITIES AND CONSTRAINTS

Population size and the levels of contraceptive prevalence and consumer income have direct effects on the level of demand for commodities. In addition to these contextual factors, a given society has other features that can act to constrain or motivate both the providers and the consumers of services and products. An understanding of the opportunities and constraints that affect the sources of products and services will enhance an understanding of opportunities for increasing the involvement of the commercial sector.

1. Motivating factors and constraints for providers

Motivating factors for private providers to offer family planning services include their concern for patients, awareness of the effects of rapid population growth and the potential for generating revenue. The constraints, according to one study, include policy and regulatory constraints on permissible types of services, access to contraceptives, restrictions on advertising, taxes, price controls and import/export restrictions. They also include limited revenue potential, which is, *inter alia,* the direct result of the availability of untargeted subsidized products and services; limited access to capital and cash flow problems; and weak commercial distribution channels. Another constraint is lack of training.[6]

[5] Hopstock, Sherpick and Bricino, "Providers and Consumers."

[6] Ibid.

2. Motivating factors and constraints for consumers

Factors influencing a consumer's choice of source of supply for family planning products and services include the following:

- Perceived quality of services, including competence and/or friendliness of staff, the quality and extent of the consultation, cleanliness and quality of the facility, reputation and trust;
- Convenience, especially waiting time and hours of operation;
- Privacy as defined by office conditions and the anonymity of the services;
- Price. Considered important in the decision on source of supply, price is often a factor in clients' decisions to use a public or non-profit facility over a commercial provider; and
- Lack of knowledge of an alternative source, particularly for those using public facilities.[7]

B. PRIMARY FOCUSES OF PRIVATE-SECTOR PROGRAMMES

Private-sector programmes have usually focused on one or more of six major areas:

- Reducing the price of contraceptives available through the commercial sector;
- Improving access by ensuring that contraceptives are available at a wide range of private-sector outlets;
- Improving the quality of products and services;
- Increasing demand through private-sector communications approaches;
- Improving consumer research to ensure that those who can afford to pay are contributing to the cost of products and services while those in need have access to those services on a subsidized or free basis; and
- Promoting commercial-sector financing of products and services by encouraging employers to cover such costs or by convincing health insurance companies to add family planning to their list of benefits.

Table 4 outlines approaches to achieving the goals in these six categories.

1. Price

Three main approaches have been employed and, in some cases, are used together, to reduce the prices of contraceptives and improve their affordability. The first is that of negotiating directly with manufacturers for a product price reduction in exchange for technical assistance, research, training, product advertising and promotion. This was the primary approach used by the USAID-funded SOMARC project.

[7] Ibid.

Example: In Brazil, the SOMARC Project was able to negotiate a 50 per cent reduction in the price of Depo-Provera in exchange for SOMARC support in the product launch and demand-creation activities (see Annex A).

Table 4. Means of increasing the role of the commercial sector in family planning

Reducing Prices

- Entering into social marketing partnerships with a price-reduction component;
- Permitting direct price subsidization by donors (typically through a social marketing initiative); and
- Removing duties, price controls and regulatory factors that increase price.

Improving Access

- Broadening the types of outlets where contraceptives are available (beyond pharmacies);
- Improving product distribution through social marketing initiatives;
- Removing regulatory barriers preventing certain practitioners from offering certain methods; and
- Introducing new methods.

Improving Quality

- Conducting training programmes; and
- Undertaking product testing.

Stimulating Demand

- Organizing communications campaigns; and
- Reducing restrictions on the use of mass media for family planning messages in general, and brand-specific messages, in particular.

Ascertaining Market Segmentation

- Researching the effect of untargeted government programmes on government budgets, on achieving overall impact and on commercial-sector participation; and
- Facilitating meetings with Government to determine how best to improve market segmentation.

Promoting Commercial-Sector Financing

- Encouraging employers to cover the cost and/or provide services to their employees; and
- Encouraging private health insurance plans to cover family planning as a benefit.

A second approach is that of directly subsidizing the price of contraceptives available in the commercial market. In some countries, the participation of commercial-sector manufacturers and importers/distributors is limited or non-existent, primarily where per capita incomes are low and prevalence is low. Hence, the market is small. In such cases, it has sometimes been found necessary to import and subsidize a contraceptive brand to have real impact on the market.

Example: In Nigeria, PSI took over after an unsuccessful attempt at a more traditional commercial-sector social marketing initiative. Nigeria has a low per-capita income and a low prevalence rate. PSI successfully introduced various contraceptive products at subsidized prices by focusing on increasing prevalence rather than programme sustainability (see Annex A).

A third approach is that of reducing or eliminating taxes to reduce the price of contraceptives. A study conducted by the USAID-funded Partnerships for Health Reform Project (PHR)[8] indicated that tax relief on public health commodities resulted in a reduction of consumer prices and an increase in the supply of these products. Further, the Ministry of Health's budgetary needs decreased because of the increased utilization of private sources of supply.

Example: According to the study, respondents noted successful USAID policy dialogues with government officials to reduce or eliminate taxes on condoms and vaccines. In Zimbabwe, the tariff on imported condoms was reduced from 10 per cent to 5 per cent. In Senegal, taxes were eliminated on condoms. In Morocco, taxes on vaccines, among other drugs, were reduced from 57 per cent to 10 per cent.

2. Access

Improving access to contraceptives is a critical component of all private-sector family planning initiatives. The four major categories of effort to improve access to contraceptives are: (a) increasing the number and types of outlets where contraceptives are available, (b) strengthening distribution, (c) removing regulatory barriers that prevent certain practitioners from offering certain methods, and (d) introducing new products where they had previously been unavailable (see Annex A).

Example: In Zimbabwe, pharmacists have the legal right to initiate women on the contraceptive pill; however, a study found that few actually sold contraceptive pills without a doctor's prescription. The Retail Pharmacists Association and the Zimbabwe National Family Planning Council collaborated in the implementation of a programme to train pharmacists in counseling skills, in the screening of contraceptive pill users and in general family planning so that they would feel sufficiently confident to initiate women on the contraceptive pill.

[8] "Survey of Tax Treatment of Public Health Commodities", prepared by Katherine Krasovec and Catherine Connor, Partnerships for Health Reform, Abt Associates, Inc., and Development Associates, Inc., January 1998.

Example: In Egypt, the law was changed to allow general practitioners to administer the Pharmacia-Upjohn product Depo-Provera. Previously, only obstetricians/gynecologists (Ob/Gyns) were allowed to do so. This legal change was the result of a study on constraints to the private provision of family planning conducted and disseminated by the USAID-supported OPTIONS project.

Example: In Indonesia, the Government's family planning ministry (BKKBN) trained and promoted the use of midwives for the provision of all methods except sterilization. Located in almost every village in the country, midwives were provided with loans through a project initiated by PROFIT to enable them to establish or expand their private practice.

Example: In Bolivia, PSI broadened the distribution of condoms exclusively from pharmacies to a variety of non-traditional outlets, including supermarkets, small shops, bars, discos, universities, liquor stores and brothels.

3. Quality

Improving the quality of products and services in the private sector typically involves improving provider training and establishing or improving product testing.

Example: As part of its programme to increase the utilization of the private sector in Zimbabwe, PROFIT conducted a survey among private doctors to determine why they provided such a small proportion of family planning services. According to the 1994 Demographic and Health Survey (DHS), less than 4 per cent of modern contraceptive method users received their services from private doctors. The study found that private doctors were limited to providing OCs, due to shortages in training and equipment. As a result, PROFIT staff and members of a working group of local doctors designed and implemented a training programme to meet the specific needs of private physicians. The programme took into consideration their particular training needs and their scheduling constraints. As a result, 60 private physicians were trained and are now providing a broad range of services.[9]

[9] Joanne Weinman, The PROFIT Project, "Private Sector Subproject Zimbabwe, Evaluation Report, Sept. 1995-January 1997" (14 March 1997).

4. Demand

Demand-creation activities are critical to attracting customers to private-sector brands and/or services and to creating sustainable markets. Yet, the promotional activities necessary to build viable markets are costly and time-consuming to implement, and few commercial firms are willing to make such an investment. Therefore, donors have supported demand-creation activities aimed at increasing overall contraceptive prevalence and building viable markets for the commercial sector. Such projects often use commercial-sector avenues for campaign development through advertising agencies and for dissemination through radio, television and print media. These campaigns are often complemented with point-of-purchase materials — informational and promotional materials available directly at the sales outlet — and public relations efforts such as special events.

Example: In Turkey, the SOMARC Project, in collaboration with Pharmacia-Upjohn and Schering A.G., launched two injectable contraceptives in 1998. The launching was supported by a mass media campaign that encouraged viewers to contact a hotline for information. The hotline represented an opportunity to educate consumers and providers about new reproductive health products on the market. In addition, a mass mailing with product information was sent to doctors, pharmacists and NGOs. Calls to the hotline before the campaign had averaged 583 per month. During the three weeks of the campaign, from 17 April to 10 May 1998, they reached 3,727. The number peaked in May, with 5,120 calls. Sales exceeded expectations. The manufacturers had anticipated sales for the launch period (February June 1998) at 80,000 vials; actual sales reached 151,496. In this effort, the combination of mass media and interpersonal counseling using an informational hotline had a significant impact on demand.[10]

Example: In the late 1980s, DKT International launched an AIDS awareness and condom social marketing campaign in Zaire. The campaign used both traditional media such as television spots and non-traditional media such as the release of an AIDS-prevention song written by a leading local musician that was broadcast widely on radio. As a result of this campaign, which ran for two and a half years, those who named condoms as their first mode of AIDS prevention increased from 5% to 13%. When asked how they changed their behavior in the face of AIDS, five times the number of people responded by using condoms (18.8% vs. 3.6% in the first survey). .[11] *Most important, sales of the project's social marketing condom brands increased from 900,000 in 1988 to 18 million in 1991.*

[10] "Getting from Awareness to Use: Lessons Learned from SOMARC III about Marketing Hormonal Contraceptives –Draft" (September 1998).

[11] Philip D. Harvey, "Advertising Affordable Contraceptives: The Social Marketing Experience" (Washington, DC, DKT International, N.D.), p. 166.

Example: In many countries in both the developed and developing world, the advertising of prescription drugs (including contraceptive pills) and reproductive health products is restricted either by law or by policy. This can severely limit demand-creation activities by restricting crucial avenues of communication. In 1993, the SOMARC Project launched two OCs in Morocco with Wyeth and Schering A.G. The advertising of ethical brands was not permitted in Morocco, but by marketing the two brands under an umbrella name, "Crescent Moon" , SOMARC was able to gain permission to advertise on both radio and television. Subsequently, the project launched an injectable in collaboration with Pharmacia-Upjohn and an IUD produced by Famy Care under the umbrella-advertising concept. The less explicit and non-brand-focused umbrella concept, combined with the support of the Moroccan Government, which had made family planning a national priority, allowed the project to break the advertising barrier. (Source: Houda Bel Hadj, SOMARC Morocco Country Manager.)

Example: In Jamaica, the SOMARC Project launched an OC and condom in the 1970s. The brand was built primarily through advertising in the mass media and through the over-the-counter status that was granted to the OC brand. Although advertising of ethical pharmaceuticals to consumers is prohibited in Jamaica, an exception was made for the social marketing pill. In 1993, the project "graduated" the brands, which were passed to a commercial partner. At the time, both brands were market leaders. However, when the project was passed to a commercial partner, the Government decided to deny the company the right to advertise the OC and revoked the over-the-counter status of the contraceptive pill. The rationale was that the social marketing project, which was viewed as a government programme, could bend the rules, but not a private enterprise. After substantial lobbying from the project (over a four-year period), permission was finally granted for brand advertising of the contraceptive pill, and pharmacies will again be permitted to sell OCs without a doctor s prescription, provided the pharmacists have been trained. (Source: Kathy Francis McClure, SOMARC/Jamaica.)

5. Consumer research

Market segmentation, particularly by socio-economic group, is important if private-sector initiatives are to succeed. Competition from untargeted free or low-priced products and services from the public sector is the most common obstacle cited by contraceptive manufacturers and organizations working in private-sector family planning. Market segmentation is especially important in countries with limited reproductive health budgets, which hope to shift those who can afford to pay to private sources of supply.

Example: In Turkey, the POLICY Project is working with the Ministry of Health to prioritize target groups for the receipt of government provided services to optimize the use of its resources and improve programme self-sufficiency. This action was undertaken in the light of USAID's intention to terminate donations of contraceptive commodities by 1999. As part of the process, the Ministry of Health developed a strategic plan for

Women's Health and Family Planning that takes into consideration all sectors, including the commercial sector. A segmentation analysis was conducted of the Turkish family planning market, a public-private partnership workshop was conducted and a contraceptive commodity budget for the public sector was developed. The Government is working with the POLICY Project to determine the size and location of groups that would benefit most from free government commodities and to develop a targeting system.[12]

6. Financing

Identifying a third party that can cover the cost of products and services is a mechanism by which the private sector can sometimes contribute to the cost of family planning provision, particularly if the consumer cannot afford to cover such costs. Two avenues have been utilized to encourage third-party payment. The first is employer-based programmes. Such programmes encourage employers to cover the cost and/or to provide services to their employers. The benefits to the employer are cost savings as a result of less staff turnover, sick leave and maternity costs and an improved corporate image.

The second avenue has been to encourage private health insurance companies to include family planning in their benefits packages. Private insurance is becoming increasingly prevalent in the developing world. In cases where insurance covers maternity benefits, the potential cost savings can motivate companies to reimburse and promote family planning benefits.

Example: In Zimbabwe, in 1989 the TIPPS Project worked with the Commercial and Industrial Medical Aid Society (CIMAS), the largest private health insurer in the country, to conduct a cost-benefit analysis of family planning and maternity and pediatric costs. The study convinced CIMAS to include family planning benefits as part of its health insurance package. In a follow-up study, the PROFIT Project found that subsequent to the intervention, nearly all of Zimbabwe s private health insurers had added family planning benefits which resulted in coverage for more than 700,000 beneficiaries.[13]

Example: The PROFIT Project conducted an assessment of 135 medium to large companies in Zimbabwe and found that 73 per cent offered some form of reproductive health products and/or services, with all offering condoms and 65 per cent offering at least one additional reproductive health product. The companies cited two main constraints to the increased provision of family planning: the ready availability of free products and services from the public sector and the lack of trained staff. Although PROFIT did not have the mandate to work with the Government in improving the targeting of services, it was able to focus on improving staff skills. It sent 35 company

[12] "Prioritization of Contraceptive Commodities Meeting Report: Draft", The Policy Project (Ankara, Turkey, August 1998).

[13] Susan Enea Adamchak, "Assessment of the Private Medical Sector in Zimbabwe", The PROFIT Project (February 1996).

nurses to a four-week clinical course and sponsored a one-day workshop on family planning at the Zimbabwe Occupational Health Nurses Association. [14]

C. PRELIMINARY CONCLUSIONS AND RECOMMENDATIONS

Projects aimed at increasing the role of the commercial sector in the provision and financing of reproductive health including family planning products and services have evolved significantly over the past 20 years. Initial projects such as TIPPS and Enterprise focused primarily on convincing employers and companies to finance the provision of services for their beneficiaries and employees. The SOMARC Project broke new ground by demonstrating that low- to middle-income consumers could afford to pay for some or all of the costs of family planning. Moreover, it showed that contraceptive manufacturers were willing to partner with donor-funded programmes to bring down costs, expand access and increase overall contraceptive utilization. More recent programmes, such as SOMARC III, PROFIT and the new Commercial Markets Project, have taken a broader approach, working simultaneously at many points in the chain of provision from distributors to providers and to those who finance services, such as health insurers, and to regulatory authorities.

Many models are being used to increase the commercial sector's participation in the provision and financing of reproductive health and family planning in developing countries. Commercial-sector initiatives have succeeded in increasing contraceptive prevalence, broadening the choice of methods available to consumers, increasing overall available resources and improving the quality of care. There is no one model that works in all cases. Designing an appropriate strategy requires understanding local circumstances, setting realistic objectives, identifying appropriate partners, finding a balance between social and business objectives and maintaining flexibility to respond to changing circumstances.

Notwithstanding many successes, obstacles persist. The main ones are listed in Box 3.

[14] Weinman, "Private Sector Subproject Zimbabwe Final Evaluation Report."

Box 3. Obstacles to expanded private-sector collaboration

Regulatory constraints

Regulatory obstacles include limits on advertising, which hamper demand-creation activities, and limits on the types of providers/retail outlets allowed to offer family planning services and, in particular, to sell OCs.

Insufficient Donor Coordination

There is a need for increased donor coordination to ensure that projects do not overlap. Furthermore, there is a need to consider the role of the commercial sector when contraceptives are donated to NGOs and Governments so as to ensure that clients are not simply shifting from commercial sources to subsidized NGO or government sources.

Competition from Untargeted Free/Subsidized Government Programmes

Creating viable markets for the commercial sector requires a government understanding of and commitment to increasing commercial-sector provision. An acknowledgement of the role of the commercial sector and efforts to ensure appropriate market segmentation are crucial so that a Government does not use its limited resources to serve those who could be served through commercial channels.

Lagging Demand

One of the most important contributions made by donors to expanding the role of the commercial sector has been to support demand-creation activities, both for family planning in general and for commercial-sector products and sources of supply in particular.

Product Leakage

Leakage of product from government programmes into commercial markets causes unnecessary competition with commercial providers.

There are five major areas on which Governments and donors, including UNFPA, may wish to focus:

1. Regulatory reform

Donors can play an important role in mobilizing the political will for regulatory reform. Continued efforts to remove burdensome regulatory barriers, including taxes and duties on commercially available contraceptives, limitations on the advertising of contraceptives in mass media and restrictions on the provision of OCs by pharmacies and, in some cases, by non-medical personnel in rural areas. In particular, UNFPA has credibility with government authorities and the long-term commitment necessary to make an impact in the much-needed area of regulatory reform.

2. Donor coordination

In 1997, USAID, DFID, BMZ/KfW and UNFPA together provided 79 per cent of total donations for contraceptive commodities.[15] With UNFPA taking the lead, an increased effort should be made to coordinate and work with local governments, social marketing organizations and representatives of the commercial sector to ensure that donated product is not simply shifting away from commercial markets and that resources are being utilized as effectively as possible. In addition, resources for project initiatives are limited, and increased efforts should be made to ensure that projects are not overlapping and are utilizing resources as effectively as possible.

3. Policy reform

One of the most important actions that can be taken by donors, including UNFPA, is to work with Governments to ensure that publicly subsidized resources are effectively targeted to those who cannot afford commercial prices. At the same time, those who are able to pay should be encouraged to use commercial sources of supply. A number of market segmentation studies show that a sizeable percentage of free or subsidized reproductive health services are being enjoyed by middle- and upper-income consumers who could otherwise afford to pay for their care. This discourages the growth of commercial markets. Much donor effort to date has focused on encouraging the private sector to become involved in the provision and financing of reproductive health products and services. More effort is needed to improve the viability of those markets through market segmentation.

[15] UNFPA, *Donor Support for Contraceptive Commodities 1997* . (1999).

4. Demand creation

Donors should continue to support demand-creation activities by both the public and the private sectors, aimed at increasing overall contraceptive prevalence with specific emphasis on utilization of commercial sources of supply. Government support for growth of the overall market will stimulate interest in the commercial sector to make the necessary investments to increase its share.

5. Logistics management

Finally, the leakage of product from government programmes into commercial markets is a source of unfair competition with commercial sources of supply. More efforts should be made to ensure that Governments and NGOs have effective logistics systems so as to improve commodity management.

3. OUTLINING UNFPA'S FUTURE ROLE IN THE PRIVATE-SECTOR INITIATIVE

During 1998, UNFPA examined whether it could play a useful role in facilitating the process of expanding private-sector involvement through a series of missions, with full participation of UNFPA Representatives, in six countries (Egypt, Ghana, India, Indonesia, South Africa and Thailand). To review progress on the initiative, a meeting of representatives of the interested parties was held in the Rockefeller Study and Conference Center in Bellagio, Italy, 16-20 November 1998. The following section highlights the Bellagio meeting's conclusions and recommendations. A copy of the agenda and a list of participants appear in Annexes B and C.

Participants discussed key issues pertaining to the role of the private sector, including setting priorities and improving policy dialogue; minimizing trade barriers and maximizing entry into developing-country markets; and reducing leakage/systems loss.

A. HIGHLIGHTS OF THE 1998 MEETING IN BELLAGIO

The private sector makes a significant contribution to the delivery of reproductive health services, primarily where opportunities and the environment encourage their involvement. The meeting reviewed the constraints to a greater contribution from the private sector and identified the following issues:

- The interest of the private sector in entering or expanding markets for reproductive health services in the developing world is predicated on the following:
    - A large population base;
    - A sizeable middle class,
    - Significant unmet need that can be converted to usage;
    - The ability and willingness of the target market to pay an affordable commercial price for contraceptives;
    - The willingness of the public sector to accept and facilitate the role of the private sector in contributing to the development of the contraceptive market;
    - The presence in the market of low-priced, high-quality off-patent products;
    - Economic, social and political conditions that encourage private-sector activities; and
    - Potential for stable long-term growth in the contraceptive market;

- The private sector can best be mobilized if it is included at the concept development stage in dialogue with all other parties to address the development of the contraceptive market. To be effective, such multi-party dialogue must be country specific, engage decision-makers, recognize strategic opportunities for all participants and take a long-term approach to market expansion and market development;

- Dialogue needs to address barriers to market access for the private sector, including such constraints as legal and regulatory factors that impede commitment, regulations against contraceptive brand promotion, taxes, tariffs and price controls;

- Multi-party discussions should encourage a mutual understanding and approach to the development of the market which could be institutionalized through such measures as a Memorandum of Understanding among all participating parties;

- Such agreements should address demand creation as the primary vehicle to consumption and market expansion, and access to credit that would facilitate a consistent and adequate supply of contraceptives through the private sector. Potential finance and capital sources could be: The SUMMA Fund, The Development Credit Authority, International Finance Corporation (IFC), Commonwealth Development Corporation (CDC), PATH Fund for Development Technology, letters of credit from donors or public organizations and loan guarantees from the host Government; and

- It is evident that market development and expansion can be achieved only through a systematic, coordinated and cohesive approach to the total market. An understanding of the dynamics of the total market would be achieved through appropriate market intelligence, such as market segmentation analyses, research on the consumer's willingness and ability to pay for contraceptives, elasticity of demand, price sensitivity, and retail audits that monitor developments in the market. Such studies, which should be current, consistent and available to all parties, would form the basis for decision-making and the development of broad national marketing strategies to strengthen the hormonal contraceptive market.

Strengthening partnerships between the public and the commercial sector includes reducing trade barriers and maximizing the opportunities of the commercial sector to enter the contraceptive market. The general market conditions within a country should be favorable for the commercial sector to invest in creating and building a market for non-subsidized contraceptives. Among the conditions that should exist are: social and economic stability; a political environment supportive of reproductive health and family planning; reduction of import duties and export subsidies for contraceptives; a functioning infrastructure (e.g., roads, distribution systems and ports); and protection of a manufacturer□s proprietary information. In cases where proprietary information or trademarks are required to be registered, these must be respected. All these conditions are important factors in a manufacturer□s strategic decision on whether and how to enter a market.

The regulatory environment also affects a manufacturer□s strategic decision on whether and how to enter a market. The product registration process should not become a hurdle that significantly increases the effort involved in marketing products that are well established in the global market. Permitting product and brand advertising facilitates the willingness of the commercial sector to enter and expand its role in the commercial market for contraceptives. Finally, price controls for the sale of contraceptives in the private commercial market discourage greater market involvement by contraceptive suppliers.

Another area in which dialogue and action could help the private sector to fulfil its vital role in implementing the ICPD Programme of Action is in shaping various government policies that encourage private-sector participation. In principle, Governments have an obligation to ensure that adequate reproductive health services and a supply of contraceptives reach the lowest income groups as part of a "social safety net". By concentrating their efforts on the disadvantaged groups, Governments should, at the same time, ensure that higher income groups use products supplied by the private sector through normal market mechanisms. Usually, public policy supports the "cafeteria approach" for supplying contraceptive methods as well as ensuring informed choice of method. Government policy should recognize that subsidies for contraceptive production could lead to unfair competition among fully commercial producers.

Donors, Governments and manufacturers view the loss or diversion of donated or subsidized commodities as a serious matter. In some cases, products provided under public-sector and social marketing programmes are diverted in a way that deprives poor and needy individuals while possibly undermining the commercial market as well. This product diversion contributes to corrupt and fraudulent activities in society and undermines trust among Governments, donors, NGOs and manufacturers. Further mechanisms for monitoring product logistics systems to prevent leakage and diversion should be developed and/or strengthened, and Governments should ensure implementation and enforcement of these systems.

Finally, the meeting recommended that social marketing programmes for contraceptive commodities should, from the beginning, plan a strategy to cease using publicly subsidized commodities once the needs of targeted market segments can adequately and effectively be met by the commercial private sector. The role of social marketing programmes in helping low-income groups achieve their reproductive goals must continue to be included as a factor in the overall marketing strategy.

Acknowledging and affirming the private sector's role as a key stakeholder in the development of contraceptive markets, the meeting recommended that steps now be taken to encourage appropriate in-country dialogue and to set in motion a process to realize public-private partnerships. It urged the establishment of operational mechanisms, with UNFPA support, to facilitate and monitor the activities. It recognized the importance of identifying opportunities for successful public-private sector partnerships that will lead to the negotiation of mutually acceptable arrangements between the parties. It also affirmed

an active role for the Partners in Population and Development[16] to contribute to the process and act as a conduit for information exchange.

The meeting discussed countries that could match the market opportunities criteria discussed above. Participants suggested that consideration be given to private-sector engagement, in consultation with manufacturers, in Brazil, China, Mexico, Nigeria, Peru, the Philippines, Turkey, Viet Nam and Zimbabwe, in addition to Egypt and India and the other countries visited in 1998. (See Box 4 for highlights of case-studies reflecting private-sector activities supported by other agencies in some of these countries. A fuller discussion of each can be found in Annex A.)

[16] Partners in Population and Development has 14 member countries. Its aim is to expand and improve South-South collaboration in the fields of family planning and reproductive health. The Partners' Secretariat, located in Dhaka, provides a central point for networking and for identifying opportunities for South-South exchanges and sources of financial support.

Box 4. Highlights of private-sector initiatives in case-study countries

As the case-study examples below indicate, there is no single formula for successful private-sector initiatives. The requirements are to understand the market, to utilize sound research and analysis and to be responsive. More detailed descriptions of the projects appear in Annex A.

Brazil: Broadening the Method Mix

Contraceptive prevalence is high in Brazil, at 70 per cent for modern methods, but the method mix is skewed towards female sterilization and contraceptive pills. In 1997, Pharmacia-Upjohn had planned to launch Depo-Provera with a high-price niche market strategy focused on breast-feeding women. The Futures Group International (TFGI), viewing the launching of Depo-Provera as an important alternative to the OC and sterilization, proposed an alternative strategy. Its analysis showed that most Brazilian women paid $10 or less for a three-month cycle of pills. It proposed to Pharmacia-Upjohn to reduce the price of Depo-Provera by 50 per cent to $10, market the product to the medical community and set up a toll-free telephone number whereby consumers, physicians and pharmacists could receive detailed information on the product. In return, TFGI would launch a broad-based IEC campaign aimed at significantly increasing sales for the company. After three months of negotiations, Pharmacia-Upjohn agreed, and TFGI, with $1 million in USAID support, agreed to undertake a direct-to-consumer marketing campaign for the product. As a result of the project, Brazilian women now have access to a new contraceptive method that is widely available at an affordable price.

Mexico: Testing NGO-based Social Marketing to Peri-urban and Rural Communities

In 1996, a pilot project was launched to test the feasibility of using NGO community-based coordinators and promoters to increase the use of OCs in the peri-urban and rural areas of Mexico. The project was a collaborative effort between SOMARC, Mexico s National Population Council, two of Mexico s leading family planning associations and the pharmaceutical company Schering A.G. The project planned to reach 240 communities, 764 pharmacies and 1,850 small stores. Although the programme successfully distributed the product to the target number of pharmacies, the use of community distribution networks for the sole objective of targeting hard-to-reach areas proved to be unrealistic. Community-based networks are not the best mechanism for training pharmacists. In some areas, the cost of distribution was higher than the revenues generated by product sales. It also became clear that it is not possible to have a mass media campaign that emphasizes price when two identical products exist in the market at different price points, and the low-priced product is not available in all areas covered by the mass media message.

Nigeria: Subsidizing Prices for Social Marketing in Low-income Countries

PSI was invited by USAID to enter the market following an earlier failed attempt at a social marketing programme based on a traditional manufacturer's model. PSI maintains that the manufacturer's model was not viable in the Nigerian market because Nigerians did not have sufficient purchasing power to create a viable commercial market. Rather than working exclusively with a local pharmaceutical manufacturer, the project joined with a local NGO, the Society for Family Health (SFH), which became responsible for managing the social marketing programme. SFH handles imports and sales to doctors, hospitals, NGOs and wholesalers. SFH's sales representatives are responsible for product promotion. The project, which had USAID and, later, DFID support, succeeded in achieving national distribution of its products in both urban and rural areas, including low-income communities. By 1997, SFH was supplying 80 per cent of all contraceptives used in Nigeria. In 1998, it was the largest social marketing programme in sub-Saharan Africa. The project shows that strict manufacturer models can be problematic in low-income/low-prevalence countries and that a capable and focused NGO can successfully mass distribute and promote social marketing brands.

Pakistan: Recognizing the Importance of Market Segmentation

In Pakistan, contraceptive prevalence among married women of reproductive age remains low (17-25 per cent), and the usage of hormonal contraceptives accounts for only 3 per cent. Both The Futures Group International (TFGI) and PSI launched social marketing programmes in Pakistan in 1997. TFGI joined with two pharmaceutical companies to market their oral and injectable brands under a social marketing logo at a (non-subsidized) commercial price. PSI set up a non-profit organization to manage importing, packaging and marketing a subsidized social marketing brand. Both projects had similar aims to increase consumer confidence and hormonal contraceptive usage. Products from both organizations were similarly priced.

As a result of the social marketing programmes, the market for OCs has increased by 23 per cent and the market for injectables by 15 per cent. However, it was inefficient to have two organizations targeting the same market, particularly in a country with as much need as Pakistan: neither social marketing organization reached its initial sales goals for hormonal contraceptives. Moreover, competition from untargeted government programmes affected the success of the social marketing initiatives. In 1998, the Government accounted for 50 per cent of OC provision and more than 90 per cent of injectable provision. There is an opportunity in Pakistan for market segmentation, with the Government focusing on rural areas and those with the greatest need, while social marketing programmes reach low- and middle-income consumers in urban areas.

Turkey: Using Commercial-Sector Partnerships

The SOMARC Project has been working in Turkey since 1990 with support from USAID. The project has launched and successfully graduated two contraceptive products, the condom and a low-dose contraceptive pill. Before the project initiative, the commercial sector had seen its sales erode, primarily as a result of the large influx of USAID-donated product to the public sector and the negative side effects of high-dose OCs. The social marketing of the products did not rely on reducing prices compared with those of competing products. The project used well-established private infrastructures to administer the project, undertake distribution and cover detailing costs. The project partnered with the leading pharmaceutical manufacturer in Turkey, Eczacibasi, which took responsibility for procuring and importing condoms, project administration, distribution, product cost and a portion of promotion costs. It also teamed up with three OC manufacturers, Schering, Wyeth and Organon. All together they represented approximately 90 per cent of the commercial OC market in Turkey.

The project significantly exceeded its original projections for both products. Price subsidization was not necessary for success in the Turkish market. The project also confirmed that support for free distribution of contraceptives in the public sector is not always a good strategy, especially in a relatively affluent country with a well-established private sector and a weak public sector. Product donated to the Government resulted only in a decrease in the commercial sector's share of the market.

B. RECOMMENDATIONS OF THE BELLAGIO MEETING PARTICIPANTS

The public, non-governmental and private sectors play complementary roles in product and service delivery to meet the needs of individuals and couples. To explore and further develop coordinated and strategic marketing approaches to the delivery of contraceptive commodities, discussions among all interested parties need to be initiated at country level. UNFPA has a central role to play in facilitating such discussions.

An expanded role for the for-profit private sector is desirable. It is a long-term process requiring an approach tailored to the needs of consumers and the context of a given country, including its market situation. It requires actions by all concerned parties (Governments, the private sector and donors) in order to foster progress.

The Bellagio meeting recommended that UNFPA continue to pursue this private-sector initiative, within the context of the Working Group, along the following lines. UNFPA should:

- Undertake follow-up to support the important progress made so far in Egypt and India;

- Continue to support exploration of the initiative in Egypt and India and the other countries visited in 1998;

- Identify, in consultation with all interested parties, additional prospective countries for this initiative during 1999. Brazil, China, Mexico, Nigeria, Peru, the Philippines, Turkey, Viet Nam and Zimbabwe were suggested for consideration;

- Ensure that all interested parties, including the private sector, are involved from the outset in the development of this initiative at the country level;

- Promote the undertaking of market segmentation/price elasticity studies in prospective countries for the private-sector initiative;

- Arrange for the convening of a meeting in about one year□s time to assess the progress of the initiative in terms of the above priorities.

To carry out its important role in moving the private-sector initiative forward, the meeting recommended that UNFPA□s organizational capacity be strengthened and that UNFPA consider the institutionalization of this initiative in its programme development process.

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ANNEX A

FIVE CASE STUDIES: BRAZIL, MEXICO, NIGERIA, PAKISTAN AND TURKEY

THE BRAZIL CASE

USING A COMMERCIAL-SECTOR PARTNERSHIP TO BROADEN THE METHOD MIX AND IMPROVE QUALITY OF CARE

A. BACKGROUND

With a population of more than 160 million, Brazil is the most populous country in Latin America. Contraceptive prevalence is high: 77 per cent for all methods and 70 per cent for modern methods. However, the method mix is skewed towards female sterilization and contraceptive pills (52 per cent and 27 per cent of total contraceptive users). The injectable contraceptive accounts for only 2 per cent of total usage.

In 1997, following the registration of the three-month injectable contraceptive, Depo-Provera, the manufacturer, Pharmacia-Upjohn, had plans to launch the product with a high-price niche market strategy focused on breast-feeding women. The company planned to provide information on the product exclusively through doctors.

The Futures Group International (TFGI) viewed the launching of Depo-Provera as an important alternative to the OC and sterilization, and, with the support of USAID, proposed an alternative strategy. Based on available market data, TFGI concluded that Depo-Provera could be marketed as an alternative to the contraceptive pill, if priced appropriately; marketed directly to consumers; and made widely available through commercial outlets. Its analysis showed that 78 per cent of Brazilian women paid $10 or less for a three-month cycle of pills. Therefore, it concluded that if Depo-Provera could be introduced at a similar price, the potential market for the product was significant. Pharmacia and Upjohn□s strategy aimed at selling 100,000 units a year by 2001; TFGI predicted that with a lower price and sufficient marketing aimed at middle- and lower-income consumers, 350,000 units could be sold. Based on this information, it made a proposal to Pharmacia and Upjohn to reduce the price by 50 per cent to $10, include a syringe and date card, market the product to the medical community and set up a toll-free telephone number whereby consumers, physicians and pharmacists could receive detailed information on the product. In return, TFGI, with support from USAID, would launch a broad-based IEC campaign aimed at significantly increasing sales, and profits, for the company.

B. THE PROJECT

After three months of negotiations, TFGI and Pharmacia-Upjohn came to an agreement. The company agreed to the proposed conditions and TFGI, with $1 million in USAID support, agreed to undertake a focused direct-to-consumer marketing campaign in support of the product launch. The TFGI campaign included:

- Efforts to gain the support of opinion leaders, including representatives of the Government and the medical community;

- A large-scale consumer marketing campaign that included celebrity endorsements and radio and television advertisements;
- An informational programme directed to pharmacists; and
- Strategic alliances with local family planning associations.

In addition, a public-sector price was negotiated, and training and information were provided to public-sector doctors in an effort to ensure that consumers who could not afford private-sector sources would also have a channel to obtain the product.

C. RESULTS

Brazilian women have access to a new contraceptive method that is widely available at an affordable price. The Brazilian Federation of Obstetrics and Gynecology has endorsed the product. The Ministry of Health and 30 leaders of the Brazilian medical community issued a joint report on the acceptability of Depo-Provera. Sales in 1997 exceeded projections by 30 per cent, prompting a revision of the sales projections for 2001 to 520,000 units.

D. LESSONS LEARNED

- Donor support for promotional and IEC activities, particularly for new product launches with commercial-sector manufacturers, can result in a "win-win" situation with increased sales and profits for the manufacturer and increased consumer access to new contraceptive options;

- A new initiative in the ethical pharmaceutical industry, direct-to-consumer advertising marketing is a powerful tool. Pharmacia-Upjohn□s recent positive experience with direct-to-consumer advertising in the launch of Depo-Provera in the United States of America made it more receptive to testing the concept in another setting;

- Trust is a key factor in partnerships. TFGI□s long-term relationship with both USAID and Pharmacia-Upjohn, in addition to its business expertise, provided credibility at the negotiating table;

- USAID□s willingness to invest significant resources in demand creation was also key in the negotiation. In this case, although USAID is phasing-out its programme in Brazil, it was willing to support this initiative because of its limited time-frame (two years) and strong potential for sustainability; and

- There is no single formula for success. The requirements are to understand the market, to utilize sound research and analysis and to be responsive.

E. OUTSTANDING ISSUES

Without government approval, the project sells Depo-Provera in a vial rather than in the proposed social marketing packaging, which includes a syringe and date card. The revised package was proposed to ensure proper application and to ensure continuity using a date card to remind the client of the date of her follow-up visit. The date card also provides information on common side effects and a toll-free telephone number.

Sources: 1. □Marketing Social Marketing to Commercial Partners: What□s in It for Them? Brazil□, Pamphlet from The Futures Group International, September 1997; 2. Presentation by Patricia Allman, □Lessons Learned Contraceptive Social Marketing □ The SOMARC Project□, The Futures Group International, 22 September 1998.

THE MEXICO CASE

TESTING NGO-BASED SOCIAL MARKETING TO PERI-URBAN AND RURAL COMMUNITIES

A. BACKGROUND

In 1996, the SOMARC Project launched a pilot project to test the feasibility of using NGO community-based coordinators and promoters to increase the use of OCs in the peri-urban and rural areas of Mexico. The project was a collaborative effort between SOMARC, Mexico's National Population Council, two of Mexico's leading family planning associations, Fundación Mexicana para la Planeación Familiar, A.C. (MEXFAM) and Federación Mexicana de Asociaciones Privadas de Salud y Desarrollo, A.C. (FEMAP), and the pharmaceutical company Schering A.G. Designed to meet USAID's strategic objective of targeting support to Mexican states with the lowest overall prevalence and highest indices of poverty, the project had multiple objectives, including the following:

- Promoting the use of OCs among young people living in peri-urban and rural areas (towns with populations of 7,000 or less);
- Obtaining widespread distribution of affordable contraceptives in these areas;
- Strengthening the ability of the CBD networks of both MEXFAM and FEMAP to serve these areas;
- Guaranteeing the continuing availability of OCs at an affordable price; and
- Improving the knowledge and use of OCs through a comprehensive IEC programme.

Although not explicitly stated, one objective of the project was to enable MEXFAM and FEMAP, two organizations that depended on donated product, to make the transition to the purchase and sale of commercial brands.

A key opportunity was presented by the approval in Mexico of Schering's Microgynon, a low-dose combined OC, as an over-the-counter product. Therefore, both pharmacies and small stores could sell the product directly to consumers without a doctor's prescription. Microgynon was the only OC product that benefited from this status. To ensure affordability, Schering agreed to provide the product to MEXFAM and FEMAP at a reduced price so that consumers could purchase a cycle for 10 pesos ($1.10), half the standard retail price. The price represented 1.2 per cent of Mexico's monthly minimum wage, a price considered affordable to the target C and D socio-economic groups. Mexico's distribution system is well developed, and most pharmacies, even in peri-urban and rural areas, carried Microgynon, but at double the social marketing price. In short, the project was attempting to establish a parallel distribution system for an identical product to one existing in most pharmacies, but at half the price.

B. THE PROJECT

The project had three main components: distribution and sales, training, and an IEC campaign aimed at increasing the use of OCs. Relying on 396 existing NGO coordinators and promoters, the project planned to reach 240 communities, 764 pharmacies and 1,850 small stores. The coordinators were to train at least one representative from each retail outlet and to convince the pharmacist that the less expensive Microgynon would sell more quickly even if the pharmacist's margin was lower. The project projected sales of 38,000 cycles during the pilot period (March 1997–September 1998). Training was considered a key component since pharmacists were seen as an important source of information for first-time pill users. Both coordinators, who travelled and sold directly to retail outlets, and promoters, who were based in their communities selling product directly to consumers and retailers, worked on a volunteer basis but received a margin on the product sold. The project's IEC campaign aimed at increasing awareness of the lower-priced product and included point-of-purchase materials, including signs, posters and informational brochures. In addition, a 30-second radio spot was to be aired in target areas. Although pharmaceutical brand advertising is not permitted in Mexico, Schering succeeded in getting special approval for the airing of brand-specific spots due to the project's social nature. The campaign was to be designed and implemented by the Mexican National Population Council.

C. RESULTS

The programme's early logistical difficulties were generally remedied. However, some larger issues emerged. A project review revealed that the number of promoters distributing the product was less than anticipated, which limited the number of target communities reached. Promoters lacked experience in selling to retail outlets and focused, therefore, on selling to individual consumers. In addition, fewer pharmacists had been trained than originally anticipated. The organizations had difficulty in bringing together pharmacy staff for training, and the strategy had to be changed to one-on-one training. This had to be conducted by coordinators because promoters were uncomfortable approaching retailers. Moreover, pharmacists were willing to provide only limited time for in-store training. In response, SOMARC developed print materials, including a consumer brochure and a reference sheet for pharmacists reminding them of protocol for new users. Finally, during the initial training, the over-the-counter status of Microgynon was revoked. The project then had to be modified to target only pharmacies and not small stores.

Delays were encountered in the launching of the IEC campaign. The project was limited to selected communities with populations of less than 7,000, but it was difficult to design an effective mass media campaign, since it would be heard and seen in communities that did not have access to the 10-peso product. In addition, the National Family Planning Council, which was responsible for the design and implementation of the campaign, was concerned about launching the campaign without verification of the actual pharmacies where training had been conducted and about the quality of the training. Training was especially important to the Government. The Government agreed

that, although Microgynon would no longer have over-the-counter status, a "trained" pharmacist could dispense the product. The campaign was not launched, but MEXFAM and FEMAP continued to try to sell the product without mass media support. Nevertheless, the programme successfully distributed the product to the target number of pharmacies, trained the correct number of CBD workers, trained staff at 445 pharmacies and sold 69 per cent of the target number of cycles (24,262). Moreover, the project provided both organizations with valuable experience for their transition from donated to commercial product, and both intend to continue to purchase the product and distribute it through their local networks.

D. LESSONS LEARNED

- The use of community distribution networks for the sole objective of targeting hard-to-reach areas proved to be unrealistic and incompatible with the organizations' own self-sufficiency objectives. This was especially the case when the cost of distribution to certain areas was higher than the revenues to be generated by product sales;

- Community-based networks are not the best mechanism for training pharmacists. MEXFAM's and FEMAP□s prior experience in training coordinators and promoters in family planning was not applicable to the training of pharmacy personnel. Moreover, it was sufficiently challenging for the organizations to undergo the transition of their networks to commercial product without the additional burden of the training programme;

- Changes in government regulations and vague definitions by government officials regarding the requirement for sales of contraceptive pills by pharmacists unnecessarily complicated the initiative; and

- It is not possible to have a mass media campaign that emphasizes price when two identical products exist in the market at different price points, and the low-priced product is not available in all areas covered by the mass media message.

E. OUTSTANDING ISSUES/OPPORTUNITIES

An opportunity apparently exists for a broad-based, urban- and rural-focused contraceptive pill social marketing campaign, if donor funding can be identified. Schering A.G. is a willing and able partner, the use of contraceptive pills is relatively low and the use of the public sector as a source of supply is declining. However, the project would have fewer obstacles if commercial rather than NGO distribution systems were utilized. There remains a need to better define training requirements for pharmacists to allow direct pharmacy sales of contraceptive pills.

Source: Adapted from Cindi Cisek, Senior Technical Officer, SOMARC, □The Microgynon Project: A Pilot Project to Improve Use and Access to Oral Contraceptives in Peri-Urban and Rural Areas□, The Futures Group International, Draft, September 1998.

THE NIGERIA CASE

SUBSIDIZING PRICES FOR SOCIAL MARKETING IN LOW-INCOME COUNTRIES

A. BACKGROUND

Nigeria, with a population of 103 million, is the 10th largest country in the world. The most recent DHS for Nigeria (1990) shows a total contraceptive prevalence of 6 per cent and 3.5 per cent for modern methods; only 2 per cent of currently married women had ever used a condom. The TFR in 1990 was 6. Three fourths (75 per cent) of Nigerians live in rural areas, and more than 80 per cent of the people are in the C-D-E socio-economic categories. The Government has few resources to devote to reproductive health, and little donor support is provided, although UNFPA provides some contraceptives to the Government. Stock-outs are common.

PSI launched a multi-product social marketing campaign in Nigeria in 1993. Products included condoms, pills, IUDs and injectables. PSI was invited by USAID to enter the market following an earlier failed attempt at a social marketing programme based on the more traditional manufacturer's model. Rather than working exclusively with a local pharmaceutical manufacturer, the project joined with a local NGO, the Society for Family Health (SFH), the sole mission of which was the management of the social marketing programme. In addition to USAID support, the programme, in 1995, was provided additional funds by DFID to focus on initiatives targeted at youth.

PSI maintains that the manufacturer's model was not viable in the Nigerian market for several reasons:

- The market was too small to attract the attention of commercial manufacturers;
- Since the public sector was not providing sufficient quantities of products and services, there was no safety net for those who could not afford full commercial prices;
- Nigerians were poor (per capita income $280) and did not have sufficient purchasing power to create a viable commercial market. As an example, in the early 1990s, condoms were marketed in Nigeria on both a break-even and a for-profit basis. Both attempts failed, primarily because organizations could not make money on the products. SFH argues that this is because commercial manufacturers were being asked to build a market, not to supply an existing market, and the costs required to build the brands were too high to recuperate costs from sales alone.

In 1996, USAID withdrew support to SFH as part of a general withdrawal of aid to Nigeria. As a result, SFH could not maintain the scale of its activities. DFID stepped in to support the full continuation of the programme.

B. THE PROJECT

The social marketing product line is distributed nationally to pharmacies and patent medical stores, which are widespread throughout the country, including rural areas. SFH handles imports and sales to doctors, hospitals, NGOs and wholesalers. SFH's sales representatives are responsible for product promotion.

The project engages in both trade and consumer marketing activities, including the production and placement of articles in magazines. Other activities include a radio phone-in programme and radio drama and television programming; point-of-purchase materials such as pamphlets, posters, stickers; shelf markets; and a to-be-introduced product insert in OC packages addressing misinformation and erroneous ideas.

C. RESULTS

The project has succeeded in achieving national distribution of its products in both urban and rural areas, including low-income communities. In the first year, the programme more than tripled couple-years of protection compared to previous social marketing efforts. In the second year, the project again doubled sales. By 1997, SFH was supplying 80 per cent of all contraceptives used in Nigeria. In 1998, it was the largest social marketing programme in sub-Saharan Africa. Table A provides sales data for the condom and contraceptive pill since the initiation of the project. Condom sales grew steadily until 1996, when the retail price of the condom was doubled in an effort to try to improve project sustainability in the face of a USAID pull-out. Sales have since continued on an upward trend. Contraceptive pill sales have been less dramatic. The project has not conducted significant IEC activities for this product, and it is believed that sales are meeting previously unmet demand. The USAID pull-out of the programme, which limited product supply, greatly affected pill sales in 1996.

Table A. Sales data, 1993-1998
(In thousands)

	Condoms	Pills
1993	20,757	3,250
1994	44,006	3,558
1995	55,044	3,266
1996	29,587	1,675
1997	32,752	2,280
1998 *	50,000	2,690

*Projection based on six months of sales

Condom sales account for 80 per cent of total sales. This is related to limitations on the distribution of OCs to pharmacies and injectables to trained providers. Other factors include the limited ability of the project to promote these products due to a

prohibition on the promotion of ethical pharmaceuticals, the lack of trained providers and, for the IUD, leakage of the product from the public sector. Moreover, SFH has focused more of its promotional activities on STD/AIDS prevention and youth, who are more inclined to purchase condoms.

Although no large-scale studies have been undertaken to evaluate project impact, □...the 1997 Nigerbus Survey reports that 17.5 per cent of women of reproductive age (compared to 14 per cent in December 1995) and that 19.1 per cent of youth (compared with 16.1 per cent in 1995) were condom users. This is also a significant increase over the 1990 DHS, although using the different surveys for comparative purposes is not advised.□ [17]

D. LESSONS LEARNED

- Making products affordable in poor countries sometimes requires subsidies;
- Strict manufacturer models can be problematic in low-income/low-prevalence countries;
- The lack of a large network of trained counselors and service providers and limitations on the use of mass media have constrained the ability of the project to combat erroneous notions regarding many methods and, hence, to have a large-scale impact on contraceptive prevalence;
- A capable and focused NGO can successfully mass distribute and promote social marketing brands; and
- Research is essential; yet, in Nigeria, research is limited. This has hampered the project□s ability to design a focused and effective IEC campaign and to assess project impact.

E. OBSTACLES/OPPORTUNITIES

- Project evaluators conclude that it would be difficult to raise product prices without affecting demand. This leaves the project, and by virtue of the project□s success, the mainstay of the family planning market in Nigeria, completely dependent on donor support. This is a vulnerable position for any programme;
- Patent medical stores were an important outlet for reaching rural areas. Yet, in 1995, patent medical stores were decertified from the distribution of OCs, a legal barrier that has had an impact on access to OCs;
- Weak government systems have caused product to leak into the private market, which has had an impact on SFH sales; and
- Regulatory obstacles have prevented the project from launching a campaign to promote injectables and pills through the mass media.

[17] OPTIONS Consulting Services Limited Report, p. 25.

Sources: 1. □Revitalizing Social Marketing Programmes,□ *PSI Profile,* March 1997; 2. Richard Pollard *et al.*, □Nigeria Contraceptive Social Marketing Project Output to Purpose Review□, OPTIONS Consulting Services Limited, February 1998. 3. □Social Marketing and the Commercial Sector□, The Society for Family Health, June 1996.

THE PAKISTAN CASE

RECOGNIZING THE IMPORTANCE OF MARKET SEGMENTATION

A. BACKGROUND

Pakistan, with a population of 140 million, is the world□s seventh largest country. It is the third largest contributor to population growth, following India and China, with a TFR of 5.5. Despite many years of family planning programming, contraceptive prevalence among married women of reproductive age remains low. The CPR is estimated to be between 17 per cent and 25 per cent. Traditional methods are estimated to account for 7 per cent of CPR, whereas the use of hormonal contraceptives accounts for only 3 per cent. Barriers to the increased use of hormonal contraceptives seem to be lack of awareness, lack of correct information, the objection of family members to contraception in general, and inadequate access to trained female providers. In addition, female literacy is only 24 per cent, which makes educating women about family planning options an additional challenge.

In general, consumers rely heavily on the private sector to meet their health needs. More than 70 per cent of health-care interventions are delivered in the private sector, and the commercial pharmaceutical sector is well developed. Although the commercial pharmaceutical sector has been active in the market for over two decades, interest in contraceptives has been limited by weak acceptance of family planning overall and by low incomes (per capita income in 1994 was $430).

B. THE PROJECTS

Both TFGI and PSI launched social marketing programmes in Pakistan in 1997. TFGI received funds from DFID, whereas PSI received funds from KfW. TFGI took a traditional approach, joining with two pharmaceutical companies to market their existing oral and injectable brands under a social marketing logo at a (non-subsidized) commercial price. PSI was of the opinion that prevalence and incomes were too low to justify such an approach. Therefore, it established a non-profit organization to be responsible for importing, packaging and marketing a subsidized social marketing brand. The PSI line consists of condoms, oral and injectable contraceptives, IUDs and oral rehydration salts (ORS) packets.

PSI had worked in Pakistan before 1997. With funds from KfW, it launched the □Green Star□ clinic-franchising project, which promotes affiliate clinics that offer a full range of family planning services. As part of the programme, participating clinics are provided with a two-week training course in service delivery, including IUD insertion. A green star is placed on the clinic to identify it as a place where couples can find affordable high-quality services. The Green Star concept is then promoted on television and radio. Participating clinics are also provided with access to social marketing products. To participate, the clinic must make a commitment to keep prices at an agreed-

upon level that is affordable to low-income women. There are nearly 4,600 Green Star clinics and nearly 2,000 Green Star-affiliated pharmacies. PSI was also already engaged in social marketing its condom and IUD brands through its clinic network and pharmacies prior to the launch of the hormonal contraceptive initiative.

Both projects had similar aims to increase overall consumer confidence and the usage of hormonal contraceptives. Both organizations target low-income urban married women with an unmet need for birth-spacing, and both distribute product to pharmacies, NGO clinics and private doctors on a national basis and engage in provider training.

As of 1998, products from both organizations were priced similarly. The PSI two-month injectable was sold for Rs.35.00 ($US1.00 = Rs.55.00). TFGI's three-month injectable was sold for Rs.55.00. PSI was selling its OC at a retail price of Rs.10.00. TFGI was selling its OC at Rs.12.00. Commercial brands ranged in price from Rs.12.88 to Rs.290. PSI originally intended to offer its products at subsidized prices but after protests from DFID and TFGI agreed not to. A study on pricing funded by DFID in 1998 concluded that there was an opportunity for greater market segmentation.[18] It recommended a reduction in the price of PSI s injectable from Rs.35.00 to Rs.20.00 while maintaining the price of the TFGI product. Although a price reduction was not recommended for the OC, the evaluators concluded that a price reduction to Rs.7.00 could grow the market by 4 per cent. PSI would like to see its OC price reduced to Rs.8.00 or 9.00.

PSI buys its injectables and OCs from Schering A.G. An active participant in the programme, Schering designed and implemented the training programme for the project s sales force and advised the project on sales force management. Schering is actively involved in the production of promotional and detailing materials and has designated a department, including a product manager, for the programme. Schering s sales force of 90, which travels throughout the country, is actively promoting the social marketing brands. The project also has its own sales promoters who sell the product directly to doctors and pharmacies. The project marketing strategy builds heavily on the Green Star concept. PSI sponsors community events and mothers' meetings and has door-to-door motivators working in Green Star neighborhoods. PSI also collaborates with NGOs and their CBD networks to promote generic messages. Mass media efforts, such as television advertising, are also built around the Green Star concept and around generic messages rather than brand-specific messages.

TFGI is using the manufacturers' model, partnering with Wyeth for the contraceptive pill and Pharmacia-Upjohn for the injectable. Both companies agreed to introduce a reduced-price product into the market as part of the social marketing programme. The company sales forces take responsibility for promoting the product to doctors, and the companies themselves take responsibility for product distribution and sales. Both products are sold under the Key brand name. TFGI provides mass

[18] Alan Handyside and Sarah Javeed, Report on the Study to Review Pricing of Hormonal Contraceptives in Pakistan Social Marketing Programmes (Options Consultancy Services, June 1998).

marketing support for the two brands, including television advertising, banners, a newsletter and point-of-purchase promotional products. Person-to-person educational efforts are also conducted through small group discussions in the home and the use of informational tapes and cassettes. Emphasis is placed on provider education and communication skills. TFGI has an active public-relations programme for the project, which includes obtaining product endorsements from the Pakistan Chemists and Druggists Association, the Pakistan Medical Association and local community leaders and spokespersons.

C. RESULTS

Neither social marketing organization reached its initial sales goals for hormonal contraceptives. Nevertheless, the OPTIONS Report estimates that as a result of the social marketing programmes, the market for OCs has increased by 23 per cent and the market for injectables by 15 per cent.

E. LESSONS LEARNED

Donor coordination and market segmentation are key. It is inefficient to have two organizations targeting the same market, particularly in a country with as much need as Pakistan; and

- Competition from untargeted government programmes affects the success of social marketing initiatives. Currently, the Government accounts for 50 per cent of OC provision and more than 90 per cent of injectable provision. Again, there is an opportunity for market segmentation, with the Government focusing on rural areas and those with the greatest need, while social marketing programmes reach low- and middle-income consumers in urban areas.

E. OBSTACLES/OPPORTUNITIES

In 1997, the Government decided to pull all television advertisements related to family planning. Since that time, television promotion has been intermittent, depending on the political situation of the moment.

Due to logistics management problems in the public sector, there is some indication that the leakage of free product from government programmes is affecting social marketing efforts. PSI learned that some staff in the Green Star clinic network purchase government-supplied product for below the social marketing price. This same product, Lo-Femenol, has been found at pharmacies selling at Rs. 3.00. PSI is studying the extent of the problem.

Sources: 1. Discussions with Imran Zafar, Population Services International; 2. General information provided by DFID on the TFGI programme; 3. Alan Handyside and Sarah Javeed, "Report on the Study to Review Pricing of Hormonal Contraceptives in Pakistan Social Marketing Programmes", OPTIONS Consultancy Services, June 1998.

THE TURKEY CASE

USING COMMERCIAL-SECTOR PARTNERSHIPS TO ACHIEVE A SUSTAINABLE REPRODUCTIVE HEALTH IMPACT

A. BACKGROUND

Turkey, with a per capita GNP of $2,500, is considered to be a middle-income country. The Turkish Government has been actively supporting reproductive choice since 1983, and there is a well-developed pharmaceutical industry selling a wide range of contraceptive brands.

Turkey has a population of 65 million. Although fertility rates dropped significantly, from 4.3 in 1978 to 2.7 in 1993, there remains a large unmet need for family planning. The most widely used method is withdrawal (26 per cent) and, although "ever use" of modern contraception is high (61.8 per cent), there is a large problem of discontinuation.

The TFGI SOMARC Project has been working in Turkey since 1990 with support of USAID. The project has launched and successfully cgraduated two contraceptive products, the condom and the contraceptive pill. Because of Turkeys relatively high level of development, the products were launched with the intention of achieving self-sufficiency. At the time of the project launch, the condom market represented 11 per cent of prevalence and advertising of condoms was not permitted. Condoms were available only in pharmacies and were not openly displayed.

Oral contraceptives represented only 9 per cent of prevalence, and 68 per cent of consumers indicated that they had health concerns related to the contraceptive pill. The commercial sector played an important role in OC sales, representing 80 per cent of total product provision. However, prior to the project initiative, the commercial sector had seen its sales erode, primarily as a result of the large influx of USAID-donated product to the public sector and because the available high-dose OCs had negative side-effects. As in most countries, the promotion of ethical pharmaceuticals, including the OC, was not permitted.

B. THE PROJECT

In 1991, the SOMARC project launched the Okey condom, the first nationally advertised condom brand, and a low-dose OC that promoted a range of low-dose brands. The social marketing of these products did not rely on reducing prices compared with those of competing products. Rather, for condoms, the programme objectives were to desensitize the issue of condom promotion, to increase the distribution and availability of condoms and to sell 3.5 million condoms in the first year. For the contraceptive pill, the objectives were to increase overall pill use, to shift the largely high-dose pill market to

low-dose products and to sell 1.6 million low-dose cycles in the first year. For both products, the project used well-established private infrastructures to administer the project, undertake distribution and cover detailing costs. For the condom, the project partnered with the leading pharmaceutical manufacturer in Turkey, Eczacibasi, which took responsibility for procuring and importing condoms, project administration, distribution, product cost and a portion of promotion costs. For OCs, the project partnered with three manufacturers, Schering, Wyeth and Organon, that together represented approximately 90 per cent of the commercial OC market in Turkey. Both Eczacibasi and the OC manufacturers had strong marketing skills, which allowed them to take the lead in promotional efforts.

Overall, the project aimed at achieving self-sufficiency within three years by working directly with the private sector and having the private sector cover commodity costs and, in the long-term, promotional activities. The SOMARC project, with support from USAID, helped to fund method-specific advertising for the low-dose contraceptive pill on television, consumer brochures addressing women's specific concerns about the pill and a low-literacy insert for inclusion in product packaging to improve correct use. In addition, the project developed consumer and pharmacists' brochures to increase awareness of the condom. It also undertook extensive promotion to consumers on both television and radio.

C. RESULTS

The project sold 6.3 million condoms in its first year of operation (1993), significantly exceeding its original projections, and graduated the condom in two and a half years. In subsequent years, the project condom brand continued to increase in sales to 7.7 million units in 1994, 9.6 million in 1995, 15 million in 1996, and 17 million in 1997. Moreover, the project succeeded in desensitizing the issue of the promotion of condoms by obtaining the support of the Turkish Family Health and Planning Foundation to facilitate the arrangement between the partner manufacturer, Eczacibasi, and the Government to allow the use of mass media to advertise the Okey condom. Condom advertisements on television and radio achieved an approval rating of 74 per cent. The project also succeeded in expanding the distribution of condoms to non-pharmaceutical outlets such as grocery and convenience stores, and in expanding the overall commercial market for condoms. As a result of the success of Okey sales, Eczacibasi introduced Okey Extra, with company financing.

The project significantly exceeded its first-year low-dose pill projections with sales of 3.2 million cycles. As a result, the low-dose share of the pill market reached 73 per cent in 1994. The total market for OCs increased by 18 per cent. The Turkish Family Health and Planning Foundation, in collaboration with the manufacturers and SOMARC, also succeeded in opening the market for contraceptive pill advertising.

D. LESSONS LEARNED

- The project's success in convincing three competing OC manufacturers to work collaboratively to market the low-dose OC was key in the success of the OC project component;
- The Turkish Family Health and Planning Foundation, a reputable local institution, was critically important in working with the Government to open up mass media to promote both condoms and OCs;
- Price subsidization was not necessary for success in the Turkish market. For both condoms and contraceptive pills, the lowest priced products on the market were not the most popular brands; in fact, in the case of the OC, Organon□s low-dose pill, the highest priced product, represented 50 per cent of the growth in the low-dose pill market; and
- Support for free distribution of contraceptives in the public sector is not always a good strategy, especially in a relatively affluent country with a well-established private sector and a weak public sector. Product donated to the Government resulted only in a decrease in the commercial sector□s share of the market.

Sources: 1. Maggie Huff-Rouselle, Cindi Cisek and Dr. Roy Jacobstein, □Success Stories and Unintended Consequences: The Private Commercial Sector and Contraceptive Social Marketing in Turkey□, 21st Annual National Council for International Health (NCIH) International Health Conference, June 1994; 2. Discussions with Gretchen Bachman, The TFGI SOMARC Project, September 1998.

ANNEX B

AGENDA
UNFPA PRIVATE-SECTOR INITIATIVE
BELLAGIO, 16-20 November 1998

Schedule	Presentation/Event	Responsible
6 P.M. **Monday**	• Welcome and Opening Statement by Meeting Facilitator • Introduction of Participants • Review and Approval of Agenda and Process • Background of UNFPA Involvement including the Roles of the Interested Parties	Dr. Steven W. Sinding Dr. Nicholas Dodd
0900-1230 1230-1400 1400-1730 **Tuesday**	• Review of missions in Six Countries • Five Case Studies: Lessons Learned from Brazil, Mexico, Nigeria, Pakistan, Turkey • LUNCH • Panel Discussions: (Proposed Topics) • Constraints to Expansion of the Commercial Sector • Commercial Sector Partnerships with Government and NGO Sectors • Working Groups: (Proposed Topics) • Setting Priorities and Improving Policy Dialogue • Minimizing Trade Barriers • Reducing Leakage/Systems Loss	Mr. P. Friel/Mr. R. Pollard Concerned Manufacturers, Donors and Tech. Agencies Panel: Mr. Abu Nuwar, Dr. El Shafei, Mr. Loohuys, Mr. Crowley Three groups chaired by Messrs. Draeger, Stoneburner, and Chambers, respectively
0900-1030 1230-1400 1400-1730 **Wednesday**	• Continue Working Groups, with Reports • LUNCH, PHOTO AND BOAT RIDE • Panel discussion: India, moderated by Mr. K.N. Shrivastava, the UNFPA Representative, assisted by Mr. Pollard, et al. Discussion points for Panels include: • Policy dialogue among donors and key institutions • Privatization of public/parastatal industries • Pricing policies • Donor coordination • Trade barriers that may need to be lowered • Market segmentation, price elasticity studies	Working Groups Panel Discussions

	• Improved IEC, advertising, counseling	
0900-1030 1230-1400 1400-1730 **Thursday**	• Reproductive Health Commodity Needs, 1998-2005 • Lessons Learned in Social Marketing • Social Marketing: Different Models for Different Settings • LUNCH • Contraceptive Markets: Trends, Opportunities • Review of Findings, Conclusions, Next Steps • Closing Ceremony	Dr. Nicholas Dodd Mr. Don Levy, TFGI Ms. Michele Cato, PSI Ms. Margaret Morrow, PATH Participants Dr. Steven W. Sinding
Friday	Depart in the morning	

ANNEX C

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UNFPA PRIVATE-SECTOR INITIATIVE
BELLAGIO, 16-20 November 1998

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