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West Africa Reproductive Health Commodity Security

Study Phase 1
Task Report: 3

Encouraging Greater Private Sector Participation

DELIVER
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Encouraging Greater Private Sector Participation

Paul Dowling

DELIVER
DELIVER, a six-year worldwide technical assistance support contract, is funded by the U.S. Agency for International Development (USAID).

Implemented by John Snow, Inc. (JSI) (contract no. HRN-C-00-00-00010-00), and subcontractors (Manoff Group, Program for Appropriate Technology in Health [PATH], and Social Sectors Development Strategies, Inc.), DELIVER strengthens the supply chains of health and family planning programs in developing countries to ensure the availability of critical health products for customers. DELIVER also provides technical support to USAID's central contraceptive procurement and management, and analysis of USAID's central commodity management information system (NEWVERN).

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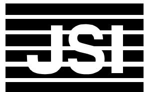
Recommended Citation
Dowling, Paul. 2005. *West Africa Reproductive Health Commodity Security.* "Encouraging Greater Private Sector Participation." Arlington, Va.: John Snow, Inc./DELIVER, for the U.S. Agency for International Development.



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Summary

Despite low overall contraceptive prevalence, the number of contraceptive users in West Africa, due to a fast growing population and increasing prevalence, is going to increase dramatically over the next few decades. Declining or constant donor funding means increasing pressure on governments to meet this growing demand.

Greater private sector participation in providing contraceptives can increase reproductive health commodity security in West Africa. Increased private sector participation can enable governments to conserve their resources to better serve those who cannot afford private sector charges and rural populations that are difficult for the private sector to reach. It also ensures a greater choice for consumers. Governments can, through regulations, tax policies, and pricing and promotion of subsidized services, directly influence the growth and impact of the private sector.

Currently, the true commercial sector, defined as non-subsidized products and services provided for profit through private sector sources, has a limited role in West African reproductive health markets. A benchmark income level of approximately U.S.$1,000 per capita is the level where low-end commercial contraceptives become affordable. In West Africa, only a small percentage of the population (around 10 percent or less, in most countries) has this income level. Given low purchasing power, low prevalence, and lack of economic development, it is unreasonable to expect that situation to change dramatically in the short term. Social marketing of subsidized products through private sector providers and outlets offers promise as a means of promoting contraceptive use, and switching current users from low cost public sector facilities to still-subsidized but higher priced private sector facilities. In this way, social marketing can play a role in facilitating the transition to a full commercial sector. To do this, however, social marketing must gradually work toward financial sustainability, increasing prices and cost recovery, and planning for an eventual exit from the market. Important components of a social marketing strategy that will ensure an eventual commercial market are not limited to product availability and promotion but also include development of sustainable distribution networks and training of providers and retailers in the private sector. Social marketing projects could also increase their efficiency through regional approaches to marketing, such as regional brands, advertising campaigns, product mixes, regional pricing, and others.

Government has an important role to play in regulating the private sector. It is important that government oversight maintains quality standards in the private sector. Regulations, taxation, and tariffs can all make the job of private sector easier or more difficult. Harmonized and standardized drug registration and regulations would make it easier for companies to register products, and to improve consumer choice and safety. A common regulatory framework and authority would also help conserve scarce resources. Tax policies that make it harder for providers to do business need to be reviewed. The number of medical providers needs to be increased, and regulations restricting providers ability to provide products and services needs to be reviewed on the basis of customer service and public health, not on the maintenance of professional monopolies.

Introduction

An important component of ensuring contraceptive security in West Africa—the concept that women are able to choose, obtain, and use reproductive health commodities whenever they need them—is to increase private sector participation in providing those products and services. There are three reasons for this (Smith 1998):

- Governments alone cannot meet the growing financial needs for reproductive health. As donors either cut back on their funding or maintain constant spending levels, the pressures mount on governments to increase funding to meet the growing demand from a expanding population. By stimulating the private sector, governments can help ensure that the growing demand is met.
- Many consumers prefer to get their products and services from the private sector. A healthy private sector, then, is an important part of consumer choice.
- Government services are best reserved for those consumers who cannot pay for private sector services. Without a healthy private sector, access of these underserved groups is restricted, because those that can pay use public facilities. If more of those who can afford to pay are directed to the private sector, governments can expand the quality and range of services they offer to the underserved.

While governments cannot order more private sector participation, policy decisions by governments can influence the private sector. Specifically, government regulations, and the prices that subsidized programs charge for their products and services, have implications for the private sector.

Outline

This paper looks at the general issues of increasing private sector participation in providing reproductive health products and services in the West Africa region. This is part of a general analysis of ways to improve reproductive health commodity security (RHCS) in the region. While RHCS includes a wide range of commodities—contraceptives, antibiotics for sexually transmitted illness (STI) treatment, and products for antenatal, neonatal, and obstetric care—this analysis examines the situation in detail only for contraceptives. Also, this analysis only considers three resupply methods (condoms, oral pills, and injections) in great detail. Intrauterine devices (IUDs) and implants are considered briefly, for two main reasons:

- Other RHCS commodities, like antibiotics, are used in a wide array of health programs; their use in reproductive health programs is only a small part of their overall use. Considering supply and demand for these commodities in reproductive health programs cannot be looked at in isolation from the overall supply and demand.
- The issues hindering private sector participation for contraceptive provision are general; therefore, policy decisions that will increase the private sector share for contraceptives will, by extension, apply to most other commodities.

Definitions

Our definition of private sector is best explained by what it the public sector is not, that is, the public sector. The private sector includes the true commercial sector, social marketing, and the nongovernmental organization (NGO) sector. The true commercial sector for reproductive health services can be defined as retailers, private medical providers and facilities, and health insurance organizations that provide or finance reproductive health products and/or services with the objective of making a profit.

Social marketing projects provide products and services that are subsidized by governments or donors. NGOs, such as faith-based providers and affiliates of the Planned Parenthood Federation, have a mission to provide services, and often provide them on a subsidized basis.

The distinctions between sectors are often blurred. Social marketing projects provide most of the products that are sold by commercial private sector retailers. In some West African countries, e.g., Mali and Burkina Faso, public sector facilities sell branded social marketing products. In some cases, NGOs run public sector facilities or receive public sector subsidies or products.

Private Sector Share in West Africa

It is difficult to reliably estimate the private sector share of family planning and reproductive health markets. We have seen that the lines delineating the various sectors are often blurred. In addition, surveys such as the Demographic and Health Surveys (DHS) do not always precisely capture sources of reproductive health products and services.

The true commercial market share is tiny in most West African countries, certainly less than 10 percent, and probably less than 5 percent. Social marketing is often the major source of contraceptive products in West Africa; this is particularly true for condoms, less so for hormonal methods. For longer term and clinical methods—IUDs, implants, and sterilization—public sector facilities are the main source of supply (see table 1).

Table 1 shows the market share for various methods in West African countries. Note that this is for source of methods and, in most cases, the products sold in the private sector will be subsidized social marketing products. For oral pills, public sector shares (excluding Liberia) range from a low of 29.1 percent in Nigeria, to 85.3 percent in Burkina Faso, with a mean public sector share (again excluding Liberia) of 53.2 percent. Low private sector share in Burkina Faso reflects the absence of pill social marketing in that country, at the time of the survey. A socially marketed pill was introduced in that country in 2001. Generally, because oral contraceptives are easier to dispense than injectables, private sector shares for these are higher than for injectables. For injectables, public sector shares range from 68.6 percent in Nigeria to 96.5 percent in Niger, with a mean share for the public sector of 84.2 percent. The private sector share for condoms is higher than for any other method; in general, clients prefer to receive condoms from private sector outlets even when they are available for free at public sector facilities. For condoms, the public sector share ranged from only 1 percent in Côte d'Ivoire to 36.3 percent in Niger, and the average public sector share is 15.6 percent. Note that Niger has very low overall condom prevalence, and the social marketing program there is relatively new. As social marketing becomes established, we can expect both the condom prevalence and private sector share to increase. Longer-term methods and clinical methods are generally not as readily available as resupply methods and are more likely to be found at public sector facilities. For IUDs, the average public sector share is 77.9 percent.

Table 1. Percentage of Market Shares for Contraceptive Methods in West Africa

Country/Survey Year	Oral Pill			Injectable			Condom			IUD		
	Public	***Private medical***	***Other private***	***Public***	***Private medical***	***Other private***	***Public***	***Private medical***	***Other private***	***Public***	***Private medical***	***Other private***
Benin	35.3	28.7	30.2	77.8	19.8	2.4	8.2	28.4	55.2	89.6	10.4	0
Burkina Faso 1998/1999	85.3	8	2.9	94.5	5.5	0	7.3	12.6	75.8	89.4	5.3	0
Côte d'Ivoire 1998/1999	45.4	42.7	11.9	75.3	24.7	0	1	34.5	54.1	67.6	32.4	0
Ghana 1998	33.3	60.1	1.2	88	10.9	1.1	15.9	68.1	13.4	91.7	8.3	0
Guinea 1998	49.6	23.9	22.6	82.4	12	5.7	12.6	27.1	38.9	66.7	33.3	0
Liberia 1986	21.3	60.2	17.9	40.8	50.1	9.1	31.5	1.7	26.7	49.8	50.2	0
Mali 2001	38.9	45.6	12.8	75.5	19.9	4	6.9	43.8	37	75.1	22.4	0
Mauritania 2000/2001	77.4	19.8	0.3	83.5	4.4	0	32.6	48.5	0	61.9	31.2	0
Niger 1998	79.8	12.3	8	96.5	2.8	0.8	36.3	17.4	46.3	90.2	9.8	0
Nigeria 1999	29.1	53.1	8.3	68.6	27	1.9	12.9	62.7	14.3	74.4	19.5	0.8
Senegal 1997	73.6	17.8	7.9	92.1	4.6	3.3	22.9	57.2	13	66.8	17.2	14.9
Togo 1998	37.6	15.4	42.3	91.6	7.4	0.5	14.9	18	66.3	82.9	17.1	0

Overall Market Size and Attractiveness

Markets in individual countries vary from tiny—and, therefore, commercially unattractive—to large and commercially attractive. Size may not be the most reliable predictor of private sector share, because smaller markets may be more attractive than larger ones for various reasons: public sector inaction, attractive regulatory environment, and others. Of course, if West Africa could be considered as one market, it would, all things being equal, become more attractive. The estimated population of the region in 2002 was 267 million people (World Bank 2002 includes 8.1 million for Chad but does not include Cape Verde); this is close to the population of the United States.

Given the current high fertility rates, the population of West Africa will grow at a faster rate than almost any other part of the world. In 2001, population growth for all the countries of the region was between 1.8 percent in Ghana to 3.1 percent in Niger. In Nigeria, with almost 50 percent of the region's population, population growth was 2.2 percent (WDI 2003). Current population growth rates, if maintained, suggest that the population in the region will double over the next 20 years or so.

While CPR in West Africa is low, several factors increase the attractiveness of the market. CPR rates (excluding Cape Verde) vary from a high of 10.7 percent in Ghana (DHS 1998) to a low of 2.7 percent in Senegal, (DHS 1997), and in almost all countries growth rates are in the single digits. However, unmet need in much higher, ranging from 16.6 percent in Niger (DHS 1998) to 34.8 percent in Senegal (DHS 1997). Typically, unmet need is between two and six times higher than satisfied demand, suggesting a large potential market. Most West African countries are increasingly emphasizing education, particularly girl's education, which is probably the greatest predictor of contraceptive use.

The number of women using modern contraceptive methods will increase from around 6 million in 2000 to over 16 million in 2010 (see table 2). This figure is based on population growth, numbers of women entering sexual maturity, and contraceptive prevalence growth rates. Of course, if there was a concerted effort by all parties to improve service provision and promote contraceptive use, the number of users could grow far beyond this.

Table 2. Numbers of Contraceptive Users (modern methods) for West Africa (2000–2010)

Country	2000	2005	2010
Benin	84	238	439
Burkina Faso	247	501	847
Côte d'Ivoire	509	899	1,400
Gambia	37	61	90
Ghana	658	1,128	1,720
Guinea	253	363	490
Guinea-Bissau	36	52	67
Liberia	123	181	258
Mali	212	399	667
Mauritania	20	43	83
Niger	153	315	545
Nigeria	3,193	5,572	8,693
Senegal	293	316	501
Sierra Leone	129	188	259
Togo	106	243	429
Total	**6,053**	**10,499**	**16,488**

Source: Profiles for Family Planning and Reproductive Health Programs, 116 Countries, TFGI.

For specific methods, the number of oral pill users will more than double from 4.2 million to over 10 million, injectable users from 1.3 million to 2.5 million, IUD users from 2.2 million to 4.8 million, and condom users (condoms from family planning programs) from 0.8 to 1.2 million. Given the large numbers of condoms used for STI prevention (including HIV), the number of condom users will be much higher.

Based on DELIVER estimates, the numbers of cycles of oral pills needed will more than double, from around 22 million in 2003 to almost 46 million in 2010. The required number of doses of injections will increase from 4.8 million to 9.7 million, IUDs from more than 0.3 million to more than 0.6 million, and condoms from 82 million to 162 million (see table 3). Again, this is commodity need for family planning programming only; condom requirements will be much higher because of dual promotion use.

Table 3. Projected Required Numbers of Commodities by Method

	Public	Private Medical	Other Private	Total
Condoms				
2002	9,157,667	39,832,832	24,883,955	73,777,045
2010	19,829,252	86,333,194	56,447,028	162,358,696
Pills				
2002	8,398,602	8,941,869	3,001,253	20,037,324
2010	19,442,127	20,024,389	6,937,606	45,620,441
Injectable				
2002	3,307,622	904,847	148,039	4,331,286
2010	7,381,858	2,019,247	336,478	9,662,350
Implants				
2002	31,535	11,801	7,577	50,913
2010	67,764	24,421	15,679	107,864
IUDs				
2002	228,223	57,263	16,781	301,562
2010	469,883	119,418	34,770	621,989

Based on the current breakdown of users by source, the total market size for various contraceptive commodities provided by the private sector (classified as obtained from private medical or other private) can be determined. For oral pills, the private sector market size was over 13 million cycles in 2003, predicted to grow to nearly 27 million in 2010. For injectables, growth is forecast from almost 1.2 million doses to nearly 2.4 million; and for IUDs, from over 80,000 to over 150,000. The private sector, through social marketing, provides most of the condoms used in West Africa. The condom market for women will increase from over 72 million in 2003 to nearly 143 million in 2010 (see table 3).

Clients Served and Purchasing Power

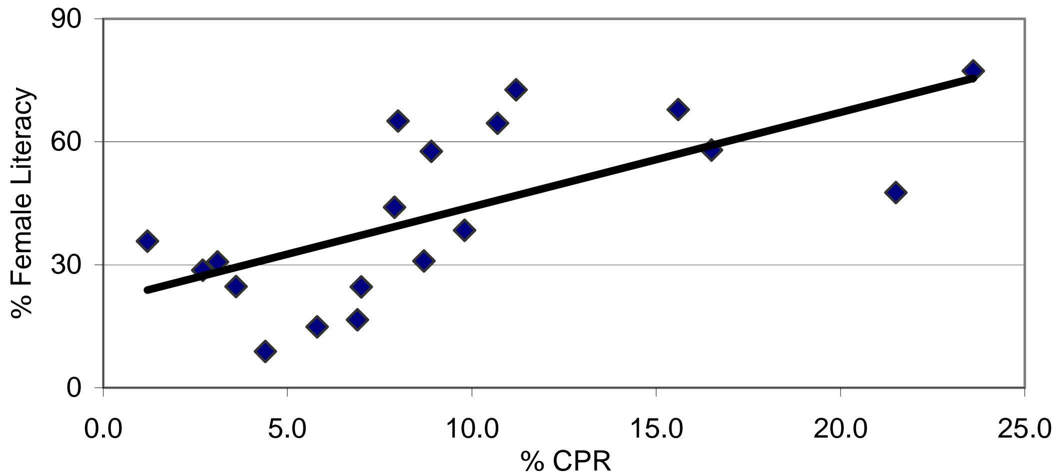
Two important questions to be asked are (1) who are the clients being served by various sectors and (2) could some of the clients currently being served by the public sector afford to pay for services in the private sector? To answer these questions, we examined the use of family planning by income quintile based on the work of Gwatkin (Gwatkin et al. 2000). Gwatkin used wealth status to divide a population into five equal-sized quintiles; then, through secondary analysis of DHS data, determined contraceptive prevalence for each quintile. Wealth (measured by household possessions) is taken as directly linked to income. Prevalence is much higher for higher income quintiles than for lower income ones (see table 4 and figure 2). For example, in Senegal in 1997, overall prevalence was 8.1 percent; for the highest wealth quintile, the figure was 23.6 percent, and for the lowest it was 1 percent. In Nigeria, overall prevalence in 1990 was 3.4 percent; for the highest wealth quintile prevalence was 11.6 percent and for the lowest it was 0.5 percent. Of course, wealth alone does not determine prevalence. Many factors are linked to wealth, such as education; wealthier people are more likely to be educated, which is an important indicator of prevalence (see figure 1). They are also more likely to live in urban areas with greater access to contraceptive services. What is important, is to look at the income levels of these groups to determine if they could pay for products and services.

Table 4. CPR by Income Quintile for Various West African Countries

Country	Year of Analysis	Total CPR (%)	Rich (%)	Fourth (%)	Middle (%)	Second (%)	Poor (%)	Current CPR (%)	Year
Benin	1996	3.4	9.0	4.6	1.7	1.4	1.3	7.2	2001
Burkina Faso	1992/ 1993	4.2	16.4	2.5	0.8	0.5	0.7	4.8	1998/ 1999
Cameroon	1991	4.3	12.5	4.4	2.8	1.2	0.7	8.0	1998
Chad	1996/ 1997	1.2	4.8	1.0	0.1	0.2	0.1	1.2	1996/ 1997
Côte d'Ivoire	1994	4.3	12.5	5.3	2.0	2.1	1.1	7.3	1998/ 1999
Ghana	1993	10.1	19.1	12.1	7.7	5.3	5.4	13.3	1998
Mali	1995/ 1996	4.5	15.3	4.2	2.0	1.4	0.5	7.0	2001
Niger	1998	4.6	18.1	2.9	2.2	1.6	0.8	4.6	1998
Nigeria	1990	3.4	11.6	3.3	1.7	1.7	0.5	8.6	1999
Senegal	1997	8.1	23.6	11.6	4.8	1.6	1.0	8.1	1997
Togo	1998	7.0	12.5	7.5	7.0	4.9	3.3	7.0	1998

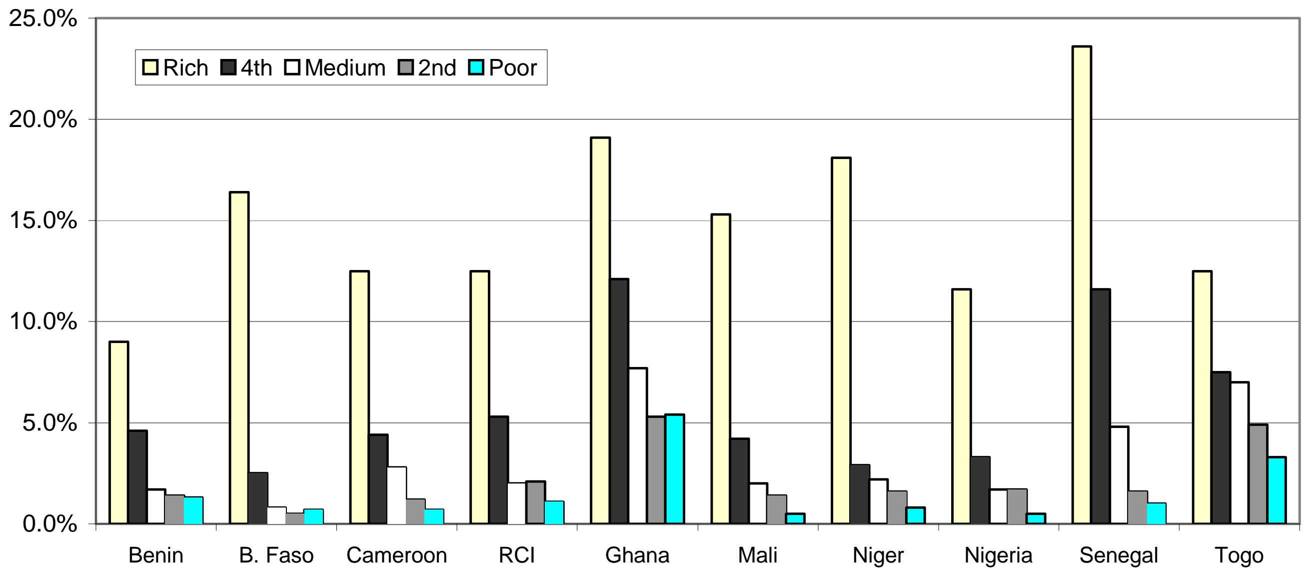
Source: Secondary analysis of DHS by Gwatkin et al. 2000.

Figure 1. CPR (Modern Methods) versus Percentage Female Literacy for Various West African and African Countries



Note: Correlation factor between CPR and female literacy = 0.67, indicating a strong positive correlation between female literacy and use of modern contraceptives.

Figure 2. CPR versus Wealth Quintile for Various West African Countries



Various attempts have been made to quantify the level of income needed to pay for family planning products. A common gauge used by social marketers (Harvey 1994) is that families should pay no more than 1 percent of their incomes on family planning. It has also been suggested that individuals with a per capita GDP of $750 can afford low-end commercial pills (Fleischmann Foreit 2002). We calculated theoretical required minimum income levels using the best available prices for condoms, pills, and injectables. Prices quoted include transport. A 100 percent nominal markup is added to cover distribution, packaging, marketing, and profit margins. Prices for a couple-years of protection (CYP) are based on standard CYP

factors (120 condoms, 15 pill cycles, and 4 injections for one CYP, and 3.5 CYPs both for 1 IUD insertion and 1 implant). The calculated minimum income level needed to pay minimal commercial prices for pills is approximately $1,000 per annum, for injectables is $700, and for condoms is $625. The figure for oral pills is further validated by looking at prices for low-end commercial products in developing country markets. In December 1998, Wyeth oral contraceptives were retailing at $0.86 per cycle and Schering at $0.67 per cycle (IMS Global services cited in Fleischmann Foreit 2002). With inflation, a benchmark price of $1 per oral cycle is reasonable. Because injectables have a higher service cost (cost per injection), and condoms are likely to require higher markups because commodity cost is likely to be a smaller proportion of the total cost, a figure of $1,000 per capita income for all methods is a useful benchmark. Note that these figures are general estimates to guide pricing discussions and are not intended to be pricing recommendations.

Looking at income levels for the different wealth quintiles, we can determine if those quintiles could pay for low-end commercial products (see table 5). Based on this analysis, we can see that, in several countries, the top wealth decile (top 10 percent) could pay commercial, but in only in four countries—Benin, Cameroon, Côte d'Ivôire, and Senegal—do income levels of the top quintile exceed our benchmark. This suggests that while there are some who can pay commercial prices, greater public policy effort should be expanded to promote subsidized products via social marketing and encouraging public sector clients to pay more, rather than pay commercial prices. At the same time, social marketing projects should be set up to ensure that the sector does not, either now or in the future, crowd out the emergence of a commercial sector. This is not to say that the goal of switching higher income users to commercial products is not worthy; rather that, given the current market situation and income levels in West Africa, more effort should be expended on promoting both overall use and social marketing than on developing commercial markets.

Table 5. Per Capita Income per Wealth Quintile and Top Decile for Various West African Countries

Country	Top 10 % ($)	Rich ($)	4th ($)	Middle ($)	2nd ($)	Poor ($)
Benin	**1,379.23**	**1,001.33**	398.61	250.48	157.90	87.19
Burkina Faso	**1,033.15**	677.24	186.32	118.27	82.56	50.21
Cameroon	**2,056.49**	**1,493.07**	591.59	366.22	233.82	129.59
Chad	785.41	478.14	236.37	168.37	120.88	76.63
Côte d'Ivoire	**1,762.17**	**1,355.28**	669.99	477.25	342.64	217.21
Gambia	**1,082.56**	786.28	296.28	175.20	108.26	56.98
Ghana	813.86	632.10	309.27	202.11	137.00	75.96
Guinea	**1,296.28**	956.01	429.39	299.76	210.65	129.63
Guinea-Bissau	605.34	453.62	158.65	92.42	50.06	16.17
Liberia	539.97	392.02	156.06	98.06	61.82	34.13
Mali	986.32	686.03	235.59	145.26	97.66	56.15
Mauritania	**1,167.93**	906.79	460.59	329.00	230.30	131.60
Niger	617.40	472.82	204.92	123.31	62.98	23.06
Nigeria	**1,188.50**	811.26	281.10	182.06	119.43	64.09
Senegal	**1,568.04**	**1,128.05**	482.11	339.35	241.06	149.78
Sierra Leone	603.82	439.02	164.11	67.86	13.85	7.62
Togo	976.21	708.73	282.13	177.29	111.76	61.71

Note: Highlighted are quintiles or deciles that exceed the $1,000 per capita benchmark.

Social Marketing

Definition and Role

Social marketing is the application of modern marketing techniques for a social cause. In a reproductive health context, social marketing is the provision of products and behavior change communication messages that improve maternal and child health. Social marketing creates demand for family planning and reproductive health services through mass media advertising and interpersonal communications, and then supplies the products needed to satisfy that demand. Social marketing provides services that the commercial sector is either unable or unwilling to provide and complements the work of the public sector. By using private sector distribution channels and outlets, social marketing helps develop a commercial sector in situations where purchasing power is not yet sufficiently high.

There are two basic social marketing models (Armand 2003). In the manufacturer's model, a social marketing organization partners with existing commercial organizations to provide products and then helps them increase their product availability and accessibility through demand creation activities. In the nongovernmental (NGO) model, a social marketing organization launches its own products and takes responsibility for marketing and distribution, either directly or through commercial partners. There are, of course, several variations of these two models.

In West Africa, social marketing mostly follows the NGO model, with social marketing organizations directly managing most aspects of the business. This is often out of necessity because commercial manufacturers have little immediate financial incentive in marketing contraceptives in West Africa. Where they do market products, they target only a tiny percentage of the population who can pay commercial prices and they are based in the main population centers. There is almost no advertising, marketing, or demand generation activity. In that situation, social marketing organizations have entered with their own brands, created their own distribution systems (or adapted existing channels), and devised and executed their own marketing and advertising campaigns; all with the goal of creating a market for their products.

The manufacturer's model is, by its nature, a more sustainable model. Social marketing plays a role in increasing demand for existing entities and, when the market has been developed to a point that it does not need external assistance, the social marketing organization exits (at least theoretically). While an NGO model has, in principle, the same goal of exiting and leaving the market to a commercial entity, in practice, this is harder to achieve. The very presence of the social marketing organization, with its own trusted brands, may become an impediment to commercial products.

In general, however, research has shown that social marketing, probably through its promotional activities, increase commercial market share (Rodolfo 2002). This is known as *crowding in* and occurs in situations where CPR is low due to a lack of promotion and education (Hanson 2001). Socials marketing-sponsored promotional activities attract new users and help grow a market.

Organizations

Population Services International (PSI) is, by far, the most significant NGO involved in social marketing of reproductive health products in West Africa. PSI is a Washington, D.C.-based, not-for-profit organization that manages and provides technical assistance for social marketing for health in around 70, mainly

developing countries and in the United States. PSI is presently, either by itself, or in partnership with local entities, active in eight West African countries: Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Guinea, Mali, Nigeria, and Togo. Local NGOs manage programs in two countries: Ghana, and Senegal (with technical assistance from Commercial Market Strategies). GFA Medica of Germany manages programs in Chad and Niger, with The Futures Group providing technical assistance in the latter. Sierra Leone, Liberia, Mauritania, The Gambia and, possibly, Guinea-Bissau, have apparently no large-scale social marketing programs, although Guinea-Bissau had, until 2002, an active PSI-managed program. See table 6 for a summary of West African social marketing programs.

Table 6. Social Marketing Programs in West Africa[1]

Country	Name of Program	Operating Organization	Reproductive Health Products
Benin	PSI-Benin	PSI	Condoms, pills, injections
Burkina Faso	PROMACO PSI Burkina	PROMACO and PSI PSI	Condoms, female condoms, pill
Cameroon	PSI Cameroon	PSI	Condoms, pills, injections (also health services franchise)
Chad	–	MASOCOT and GFA Medica	Condoms
Cape Verde	–	–	–
Côte d'Ivoire	Côte d'Ivoire Social Marketing Program	PSI	Condoms, pills
Gambia	–	–	–
Ghana	Ghana Social Marketing Foundation (GSMF)	GSMF	Condoms, pills, injections
Guinea	PSI-Guinea	PSI	Condoms, pills, injection
Guinea-Bissau[2]	AGMS	AGMS (Local NGO)	Condoms
Liberia	–	–	–
Mali	PSI-Mali	PSI	Condoms, female condoms, pills, injections
Mauritania	–	–	–
Niger	–	GFA Medica and Futures Group	Condoms
Nigeria	Society for Family Health (SFH)	SFH & PSI	Condoms, female condoms, pills, injectables, IUDs, emergency contraceptives
Senegal	ADEMAS	Formerly TA from CMS	Condoms, pills
Sierra Leone	–	–	–
Togo	PSI –Togo	PSI	Condom, female condom, pills, injectables, STI kit

[1] Note: Blank entry means either no information available or no social marketing program with national reach.

[2] PSI active in Guinea-Bissau marketing condoms until 2003.

Products

For the most part, social marketing programs restrict themselves to condoms, oral pills (usually the more popular combination pill), and an injectable (Depo-Provera® or equivalent). Certain programs may have more products, e.g., in Nigeria, the Society for Family Health/PSI markets the IUD and emergency contraceptive pills. While the basic products are the same or, in some cases, identical, there are many brand names found (see table 7). Even PSI, which manages eight projects in the region, has three different major condom brands: Protector, Prudence, and Gold Circle. And, even within these *major* brands, each country brand is slightly different (e.g., Prudence in Benin, Prudence Nouveau in Burkina Faso, Prudence Plus in Cameroon have different logos in each country). Oral combination pills are marketed by PSI as Confiance in Burkina Faso, Côte d'Ivoire, and Togo; and as Confidence in Nigeria. In Mali, they are known as Pil-Plan, in Guinea as Planyl, in Benin as Harmonie, and in Cameroon as Nouvelle Duo. Then in Mali, Depo-Provera® is marketed as Confiance.

Obvious advantages to having regional brands for social marketing commodities are reduced packaging costs, and reduced marketing and advertising costs because standard marketing campaigns with differences in execution in each country can be used. While each country is different, there are similarities across countries, and brand names can be invested with slightly different meanings in each country. Many consumer goods have regional brands, whether they are beverages, foodstuffs, or toiletries. Advertising campaigns and strategies are similar for Coca-Cola in different countries, with country management responsible only for fine-tuning campaigns based on their particular country situation. Social marketing commodities would benefit from a similar level of regional branding. It may be difficult now to change successful brands with loyal customers. However, in some countries, this could be done because prevalence is still quite low. Certainly for new products, like the female condom, regional brands and strategies should be developed.

Table 7. Social Marketing Products and Brands

Country	Condoms	Pills		Injectable	
	Brands	***Type***	***Brand***	***Type***	***Brand***
Benin	Prudence	Wyeth combination	Harmonie	Depo-Provera®	Equilibire
Burkina Faso	Prudence Nouveau	Generic combination	Confiance	–	–
Cameroon	Prudence Plus		Nouvelle Duo	Depo-Provera	Depo-Provera
Cape Verde	–	–	–	–	–
Chad	–	–	–	–	–
Côte d'Ivoire	Protector	Generic combination	Confiance		–
Gambia	–	–	–	–	–
Ghana	Protector, Panther, Bazooka, Champion, Aganzi,		Secure		Famplan
Guinea	Prudence Plus		Planyl		Depo-Provera
Guinea-Bissau	Panté	–	–	–	–
Liberia	–	–	–	–	–

(continued)

Country	Condoms	Pills		Injectable	
	Brands	***Type***	***Brand***	***Type***	***Brand***
Mali	Protector Plus	Wyeth Combination	Pil-Plan	Depo-Provera	Confiance
Mauritania	–	–	–	–	–
Niger	Unknown	–	–	–	–
Nigeria	Gold Circle	–	Confidence	Noristerat (Schering)	Depo-Provera
Senegal	Protec	Wyeth Combination	Securil	Depo-Provera	–
Sierra Leone	–	–	–	–	–
Togo	Protector, Rebel	Wyeth Combination	Confiance	Depo-Provera	Depo-Provera

Source: DHS.

Social marketing projects should also broaden the range of products they offer. All projects should offer condoms, oral pills, and injections. Private sector medical capacity for IUD insertion and the cost of implants will probably restrict those methods, but the three most popular resupply methods should be available in every country.

Pricing

Prices charged for social marketing products vary depending on—

- customer ability and willingness to pay
- historical pricing
- donor and government policy, especially cost recovery and access.

As shown in table 8, prices vary across countries. While differences in local conditions mean that standard pricing across the region may not be possible, pricing decisions made in one country can impact another. If the price of commodities in neighboring countries show wide variations, this can lead to parallel importing[3] of those commodities from one country to another. This, and equity considerations mean social marketing projects should, taking into account local purchasing power, work to harmonize pricing across countries.

[3] Parallel importing occurs when goods produced or sold in one country are imported into another country without the knowledge or consent of the manufacturer or distributor of those goods.

Table 8. Retail Prices for Contraceptive Commodities

Country	Condom (piece) U.S.$		Pill (cycle) U.S.$		Injectable (3-month cycle)	
	Public sector	***Social marketing***	***Public sector***	***Social marketing***	***Public sector***	***Social marketing***
Benin						
Burkina Faso	0.023	0.023	0.19	0.93	0.57	NA
Cameroon		0.012		0.37		1.11
Chad						
Côte d'Ivoire		0.046		0.28		NA
The Gambia						
Ghana						
Guinea		0.025		0.16		0.49
Guinea-Bissau						
Liberia						
Mali[4]	0.031	0.046	0.19	0.19	0.56	0.56
Mauritania						
Niger						
Nigeria		0.027		0.15		0.55
Senegal		0.093		0.56		NA
Sierra Leone						
Togo		0.023		0.19		0.56

Note: Dollar equivalents calculated at following exchange rates: U.S.$1 = FCFA 525, Cedi (Ghana) 9002; Guinean Francs 2060; Naira (Nigeria) 137.

Donors

By their nature, social marketing programs are not financially sustainable; products are sold at a loss so that they can remain financially accessible to a significant portion of the population. The difference between program costs and sales revenues comes from donor and host country governments. Donor financial support either for commodities or for marketing and other activities is indispensable for social marketing programs, especially in West Africa where consumer purchasing power limits cost recovery on products. The main donors are USAID, British Department for International Development (DFID), and Germany's KfW, with some support from private foundations like Gates, Hewlett and Packard, and multilateral organizations like UNFPA. In some countries, World Bank loans may be used to finance the purchase of social marketing commodities. West African governments give some support, usually in the form of tax exemptions and, occasionally, commodities. USAID supplies commodities directly to social marketing programs in Ghana, Mali, Nigeria, and Senegal. Programs in Togo, Cameroon, and Burkina Faso have received commodity support in the past, but that support is now either limited or being phased out. DFID and KfW fund commodity procurement, with DFID supporting procurement in Ghana and Nigeria, and KfW doing likewise in Benin, Burkina Faso, Cameroon, Chad, Guinea, and Niger. In addition, donors support other activities like marketing campaigns, research, and training.

[4] Mali social marketing soon to increase price from FCFA 50/3 to FCFA 100/4. Not clear if public sector will keep old price or also increase prices.

Market Share

It is difficult to obtain reliable estimates of market share for various sectors in the West African contraceptive markets. Reliability of social marketing programs sales figures vary greatly, because most programs do not track actual sales. Instead, they track numbers of commodities that enter the supply chain. While, in theory, this will reflect sales; in practice, it often does not, as commodities may be stockpiling in different levels of the supply chain. It is also very difficult to obtain sales or dispensed-to-user data for other programs: commercial, NGOs, and public sector. Commercial organizations will not disclose their sales information. DHSs give data for the source of contraceptives but this data is aggregated for public sector, private medical, and other private groups, and it is impossible to disaggregate the data any further. The self-reported market shares displayed in table 9 are guesses by social marketing projects and should be interpreted cautiously. Because commercial products have a market share of, at best, a few percentage points, a more reliable estimate for market share can be taken as the private sector share, as shown in table 1, less a few percentage points. This may be an over-estimation for condoms because commercial condoms are more likely to be affordable and available.

Table 9. Social Marketing Market Shares

Country	Product	Market Share	Comment
Benin	Condoms		
	Pills	50%	
	Injections	95% of private sector	
Burkina Faso	Condoms	No data but probably >90%	
	Pills	NA	
Cameroon	NA		
Cape Verde	NA		
Chad	NA		
Côte d'Ivoire	Condoms	24% of total market	PSI estimate
Gambia	NA		
Ghana	Condoms		
	Pills	57%	Source: Foreit 2002
Guinea	Condoms	c. 85%	Most of rest is other private
Guinea-Bissau	NA		
Liberia	NA		
Mali	Condoms	95%	All PSI estimates
	Pills	50%	
	Injections	58%	
Mauritania	NA		
Niger	NA		
Nigeria	Condoms	80%	Most of rest is private sector
	Pills	40%	Estimate 50% public sector, 10% other private for these products. All estimates from PSI
	Injections	40%	
	IUDs	40%	
Senegal	Condoms	95% of private sector	ADEMAS estimate
	Pills	NA	
Sierra Leone	NA		
Togo	Condoms	72%	PSI estimates for two condom brands

NGO Sector

Role

The NGO sector plays an important role in complementing the public sector in reproductive health service provision. The NGO sector includes faith-based organization hospitals and clinics, international NGOs like *Médecins Sans Frontières* (MSF), International Planned Parenthood Federation (IPPF) affiliates, and others.

Organizations

Major NGOs are active in reproductive health service provision in West Africa:

IPPF has affiliates in Benin, Burkina Faso, Cameroon, Cape Verde, Chad, Côte d'Ivoire, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, and Togo. In Ghana, for example, the IPPF affiliate, PPAG operates 15 clinics.

There are many faith-based organizations (FBOs) active in reproductive health. For instance, in Ghana an estimated 9 percent of health facilities are operated by FBOs and 52 percent of those facilities offer temporary methods of contraception (Ghana SPA 2002).

Market Share

The importance of the NGO sector varies from country to country and it is difficult to assess. Table 10 shows the NGO share for oral contraceptives. Shares vary from almost 8 percent in Senegal to zero in Niger. NGOs like Planned Parenthood often play a role more important than their actual market share in promoting family planning, advocacy, and as role models in service delivery.

Table 10. Oral Contraceptive Market Shares for NGOs

Country/Year of Survey	NGO Share
Burkina Faso 1998/1999	1.0
Ghana 1998	3.1
Niger 1998	0
Senegal 1997	7.9
Togo 1998	4.1

Source: Secondary Analysis of DHS data by Fleischmann Foreit 2002.

Commercial Market

The true commercial sector, with private service providers and retailers selling commercial products at a profit, is tiny in West Africa. A large percentage of DHS estimates of the commercial sector include private providers distributing subsidized social marketing products and they are not truly *commercial*. Commercial manufacturers like Wyeth and Pfizer, selling their products at full retail price, have small niche markets in some of the larger countries like Nigeria, Ghana, Côte d'Ivoire, and Cameroon. Social marketing projects are beginning to source cheaper generic versions of products from manufacturers in developing countries, like India (e.g., PSI in Côte d'Ivoire, and Burkina Faso). Currently, it is not known if those same manufacturers have developed commercial markets for their products in West Africa.

Generally, contraceptives make up only a small share—at best 1 or 2 percent—of pharmaceutical companies' turnover, and therefore profit (Bulato 2002). From a business perspective, they are not a very important part of a product portfolio. Commercial manufacturers cite a lack of consumer purchasing power as the major factor hampering their ability to do business in West Africa, followed by inadequate capacity in private sector service provision, competition from free or heavily subsidized public sector products, and economic uncertainty.

Employer-Based Services

Employer-based family planning programs are not a major source of reproductive health services in West Africa. The small size of the formal employment sector, the limited number of companies large enough to provide cost-effective services, and the small percentage of women employed by the sector, all limit the potential of the sectors. Nevertheless, is some African countries, e.g., Madagascar, this sector plays an important role both in providing services and making family planning more popular. It is likely that employer-based services, with encouragement, could play a significant role in providing reproductive health products and services in countries like Cameroon, Côte d'Ivoire, Ghana, Nigeria, and Senegal.

Structural Barriers

Purchasing Power

This is probably the most significant obstacle for development of commercial sector drug activities. Average per capita incomes in West African countries vary from $140 in Sierra Leone to $610 in Côte d'Ivoire (World Bank 2001). Clearly, these averages would not support a commercial market for contraceptives. However, these averages conceal large disparities in income levels. In Burkina Faso, with an average per capita income of $220 (2001), the richest 20 percent of the population (quintile) earn almost 61 percent of income. Even allowing for this unequal distribution, per capita income for this quintile is still quite low at less than $700 (see table 5).

Per capita health expenditure in these countries is also small. Niger spends only $5 per person; Cameroon spends the most, yet it only spends $24 per capita. This is total per capita spending; it includes public and private (out of pocket) spending. Family planning is likely to be given a lower priority in health care spending because it is not likely to be a matter of life or death, and it will be a recurring expense not a on-off (for the more popular resupply methods).

Without substantial economic development in West Africa, it is unreasonable to expect significant growth in the size of the commercial market.

Market Size

With low prevalence, low purchasing power, and small populations, market size is a restriction to greater private sector provision of reproductive health products and services. Many West African countries have small markets; Togo has only around 12,000 users of oral contraceptives, Benin has only around 23,000. One market, Nigeria, is as large as all the others put together. Obviously, if the individual country markets could be considered as one, the market size would be considerably more attractive from a commercial viewpoint.

Tax and Duty

An array of taxes and duties can make the provision of contraceptives unattractive. For instance, the countries of the West African Monetary zone (Benin, Burkina Faso, Côte d'Ivoire, Mali, Niger, Senegal, and Togo) charge a 2.5 percent duty on all drug imports, including contraceptives. In Burkina Faso, drug wholesalers complain that excessive taxes are hampering their ability to do business.

Regulatory

Drug Registration

Drugs must be registered in a country before they can be legally sold or dispensed in that country. In order to register a product, the manufacturer must file a dossier including information on the dosage form, manufacturing process, specifications, quality control, drug stability, pharmacology, etc. Most countries have either a department of the Ministry of Health, e.g., DGPLM in Burkina Faso or a parastatal organization,

e.g., NFDAC in Nigeria, responsible for drug registration. In almost all instances, drug registration in West African countries for international manufacturers involves preparing a dossier with already available data generated for registration elsewhere. Nevertheless, the process takes time (it can take up to one year to register a product in West Africa), can be expensive as fees must be paid, and the paperwork can be onerous.

The global trend in drug registration is a move toward harmonization and standardization between standards. The countries of the European Union have a standardized system with drug registration in one country being valid in all others. At the same time, there is an effort to harmonize the drug standards of the European Union, the United States, Japan, and other developed countries and to eliminate inconsistencies between them.

Currently in West Africa, manufacturers must register their products separately in each of the countries. Given the small size of some of the markets, this can be an obstacle for the commercial sector. Greater standardization and harmonization between standards, with the ultimate goal of a standard drug registration process valid for all the countries of the region, would make doing business in the region easier for drug manufacturers and distributors. At the same time, a regional drug registration authority, by consolidating resources, would probably contribute to better quality assurance and consumer safety as well as being more cost efficient.

Prescribing Restrictions

In most West African countries, only doctors can prescribe hormonal contraceptives in the private sector and only pharmacists can dispense them. The shortage of qualified pharmacists, the small numbers of pharmacies, and their restriction to urban areas limits the ability of the private sector to grow. Madagascar recently tried to alleviate this problem by changing its prescribing laws so that doctors cannot only prescribe but also dispense hormonal contraceptives. In most developed countries, hormonal contraceptives are available at pharmacies without a doctor's prescription. It should be noted that while many West African countries have strict regulations on their statute books, in many instances there are not enforced.

Advertising Restrictions

Many countries in West Africa have formal bans on advertising specific contraceptive brands, e.g., Burkina Faso. In many cases, these bans are weakly enforced or not enforced at all. Nevertheless, the presence of these bans undermines official policies that encourage the use of contraceptives. Exceptions to laws against advertising ethical products should be made for contraceptives, with the goal of encouraging greater uptake.

Service Provision

The small numbers of licensed medical practitioners and pharmacists offering reproductive health products and services limits private sector participation. The total number of doctors in West African countries varies from a high of 19.2 per 100,000 people in Nigeria, to only 1.6 in The Gambia. The average for sub Saharan Africa is only 16.1, compared to 106.1 for North Africa, and 303 for industrialized countries (see table 13). Most of the doctors in West African countries work in the public sector and a large number of those are in administrative functions. The situation for pharmacists is even worse. There are no reliable figures for individual West African countries but WHO estimates that, on average, there are 1.1 pharmacists per 100,000 people in sub-Saharan Africa, compared to 26.8 in North Africa and 64.8 in industrialized countries. Again, most of the pharmacists in West Africa are likely to be employed in the public sector.

Even for the small number of providers in practice, lack of training is also a major obstacle. Providers may be interested in providing reproductive health services but may lack the training needed to do so. Some social marketing projects have added provider training to their activities but these programs have been

limited. Retailers (condoms) also require basic training to help them better serve their clients. Commercial companies report that they provide training for their sales representatives but not for providers.

West African countries need to produce more trained medical staff for many health reasons. Increasing capacity in the private sector is just one reason. Even if countries dramatically increase staff numbers, they are still likely to be faced with chronic shortages. There is a necessity to look at alternative service delivery mechanisms. For instance, staff can probably dispense oral contraceptive pills with minimal training. This is already done in many countries, either as part of a policy or as an accepted practice.

Distribution/Supply Chain

In many West African countries, there are limitations to the existing distribution systems, particularly in reaching rural areas. Social marketing programs in many countries carry out their own distribution system (e.g., Burkina Faso) in addition to using existing distributors and wholesalers. This may not be the most cost-effective solution but the main goal of social marketing is to improve access to products, not necessarily to do so in a cost-efficient way. In other countries, e.g., Mali, parastatal central medical stores, established to serve the public sector, also distribute drugs to private sector. Due to their state subsidy, they may be able to provide greater coverage) than private sector distributors. However, this may ultimately impede the development of effective private-sector supply chains, because the private sector will find it difficult to compete with a subsidized service. Distribution of reproductive health products by public sector/parastatals may be desirable to improve access to products. However, it should not be subsidized at the expense of the private sector, if private sector distributors have the capacity to provide the same service.

Counterfeit Drugs and Unlawful Dispensing

Sales of illegal or counterfeit drugs and sales of approved drugs through unapproved channels are a major problem in West Africa.

Most countries have a thriving black market in drugs, although it is not clear if this is the same for contraceptives and other RH commodities. These drugs may be illegally imported or, in a few countries, manufactured locally. Counterfeit drugs may be sold legally (through licensed pharmacists, for example), while legal drugs may be sold unlawfully. They may be adulterated, sub-potent (contain less of active ingredient than required), or fake (contain no active ingredient).

The gray market—legal drugs sold through unapproved channels (for example, on the street)—is probably of more concern for RH commodities than parallel trading, with price differentials allowing commodities to be profitably imported from one country to be sold in a second country (e.g., social marketing condoms from Guinea found on sale in Mali).

The size of the problem is almost impossible to quantify. Global estimates are that 10 percent of drugs are counterfeit, but there have been no formal studies. In Nigeria, estimates have been made that fake drugs account for 35 percent of the total drug market.

In addition to public health concerns, counterfeit drugs impact the ability of the private sector to function profitably. In Nigeria, many MNEs moved out of the country partly because of cheap counterfeit drugs that undercut their profits (Naik, WSJ 28 May 2004). Nigeria is making strides to combat counterfeit drugs and this is the most effort in the region because many of these drugs either originate in Nigeria or are brought into the region via Nigeria. With the support of WHO and other partners, there are campaigns against counterfeit drugs, mainly by trying to raise awareness in consumers about the problem and the negative health effects of buying drugs through unofficial channels.

Sources of Competitive Advantage for Private Sector

- Perception by the public is that the private sector can provide better quality service. Of course, this may not be true, particularly if public sector services are of a reasonable quality and services are available free-of-charge or at a low cost. Most countries in West Africa follow the Bamako Initiative for cost recovery, where clinics charge for services, and funds recovered are allocated to the clinic operating costs, including a revolving drug fund. Services are offered at a subsidized cost however, and, in the case of contraceptives, commodities are also offered at a heavily subsidized cost (see table 8). Free or extremely low cost service provision in the public sector is the major determinant of private sector market share.

- Branded social marketing products available to private sector service providers in most countries are perceived as being of higher quality than *generic* public sector products.

- Urbanization, which means more concentrated and easier to reach populations, is increasing in West Africa. The urban populations in West Africa vary from 16 percent in Burkina Faso to 59 percent in Mauritania, with a regional average of about 38 percent (WDI 2003). And, urban population growth rates in the region are averaging around 4.4 percent versus overall population growth of 2.4 percent. Urban populations are the mainstays of the private sector, providing a large enough pool of easy to reach clients that makes service provision profitable.

Recommendations

- Given that family planning/reproductive health services are not widely used and are probably perceived as being less important than other health interventions by the public. The primary focus of government policy should be on increasing prevalence. After people have become users, and perceive the benefits of use, it will be easier to reorient them toward private sector products and services.

- While some clients that can pay more are currently receiving low-cost public sector products, the numbers of clients in West Africa who can pay commercial prices is limited. This, combined with overall low contraceptive prevalence in the region, suggests that the priority policy goals in West Africa should be to promote utilization through subsidized programs, both public sector for lower income and rural populations, and social marketing for middle income groups.

- The private sector cannot grow when the public sector provides free of close-to-free services and products to all. At the same time, without the public sector providing reproductive health service, the overall market will not grow. Governments should continue to charge fees for public sector services, with money raised used to improve service quality, and with exemptions for low-income populations.

- Governments should ease restrictions on the ability of pharmacists to dispense hormonal contraceptives without a doctor's prescription and on doctors to dispense them. This would improve access of clients to these products. Standard regulations across West African countries would be the ultimate goal.

- Laws restricting advertising of branded contraceptives should be removed. In general, regulations restricting and regulating activities of NGOs and the commercial sector should be limited to those necessary to ensure public health and safety.

- The numbers of providers in private practice is a huge constraint on private sector development. There are not enough doctors, nurses and pharmacists in West Africa, and too few of those are in private practice. There is a need to train more providers, and to make it easier for those who want to start private practice to do so. There is also a need to create alternative service delivery mechanisms.

- Greater harmonization and ultimately standardization of drug registration in West Africa would bring benefits to private sector manufacturers and distributors, and consumers. The ultimate goal should be to create a regional drug registration board with regional drug approval. Consolidating limited resources countries could improve their overall drug registration process. Speeding up the process and eliminating duplication drug manufacturers and distributors would be more likely to bring products to West African markets. A strong regional drug registration authority would lead to better monitoring and control of all aspects of drug registration and marketing and, ultimately, better consumer safety.

- Social marketing projects need to plan more for an eventual transition to commercial service provision. While prevalence must be a priority, this is not incompatible with incremental increases in prices and greater cost recovery.

- Social marketing projects should market the three most widely used methods in each country: in almost all cases, condoms, oral pills, and injections. The IUD could be marketed in countries where there is sufficient capacity in the private sector for IUD service provision (insertion and removal).

- Donors, governments, and social marketing organizations should work together to develop regional brands for contraceptive commodities, thus achieving economies of scale in packaging and advertising. This should be an immediate priority for newer commodities like the female condom and a longer-term goal for more established brands.

- Better market segmentation is needed in contraceptive markets in West Africa. Governments need to expand services to ensure low income people have access to low cost products and services. Where necessary, those services should be available free-of-charge for the most disadvantaged groups. Social marketing projects need to target middle income groups.

- While it is not likely to be a major source of reproductive health services, some research on the capacity of employers to provide more services may be warranted. Given the low prevalence and high-unmet need in all sectors of the population, there are opportunities for advocacy with employers; the focus should be on the cost/benefit analysis of providing these services to female employees. Only larger, more economically developed countries are likely to benefit from this.

- Governments have an important role to play in regulating the private sector provision of services. With this regulatory oversight comes a responsibility to ensure that providers can receive training in the providing reproductive health services.

Conclusion

Current low uptake of contraception in West Africa, combined with low purchasing power, points to the social marketing sector as the main focus of efforts to boost private sector participation in service provision and, eventually, the creation of a thriving commercial sector. This will allow the public sector to concentrate its efforts on low-income groups and rural populations. Governments, donors, and social marketing organizations should work together to provide more training for private sector providers. Governments should work to ensure that there are more trained medical personnel and remove obstacles—regulatory, tax etc.—to providers entering private practice. There should be harmonized and, eventually, standardized drug registration in the region. Social marketing projects should work together to ensure more regional branding of commodities, allowing for cost efficiencies on packaging and advertising, and on harmonized pricing.

Tables 11–14

Table 11. Cost per CYP for Contraceptive Methods

Method	Unit Cost	Procurement Cost per CYP ($)	Total Cost per CYP (100 percent markup) ($)	Per Capita Income Required ($)
Oral	0.347	5.205	10.410	1,041.00
Injectable	0.893	3.572	7.144	714.40
Condom	0.026	3.120	6.240	624.00
IUD	0.404	0.115	0.231	23.09
Norplant	26.565	7.590	15.180	1,518.00

Table 12. Prices Paid for Oral Contraceptives

Country	Median Price Paid (U.S.$ at time of survey)	
	Public	***Pharmacy***
Burkina Faso	0.19	*
Ghana	0.22	0.22
Niger	0.00	0.45
Togo	0.34	0.54

Source: DHS secondary analysis by Fleischmann Foreit 2002.

* Too few cases to analyze.

Note: Pharmacy prices include social marketing products.

Table 13. Numbers of Medical Staff per 100,000 People

Country	# Physicians	# Nurses	# Midwives	# Pharmacists
Benin 1995	5.7	20.4	7.9	NA
Burkina Faso 1997	3.8	19.6	3.4	NA
Cameroon 1996	7.4	36.7	0.5	NA
Cape Verde 1996	17.1	55.6	2.3	NA
Chad 1994	3.3	14.7	15	NA
Côte d'Ivoire 1996	9	31.2	8.2	NA
Gambia 1997	3.5	12.5	NA	NA
Ghana 1996	6.2	72	53.2	NA
Guinea 1995	13	55.7	5.2	NA
Guinea-Bissau 1996	16.6	109.4	8.7	NA
Liberia 1997	2.3	5.9	4.3	NA
Mali 1996	6.3	13.1	3	NA
Mauritania 1995	13.8	62.4	10.1	NA
Niger 1998	3.3	22.9	5.5	NA
Nigeria 1993	19.2	66.1	52.4	NA
Senegal 1998	9.5	22.1	6.6	NA
Sierra Leone 1996	7.3	33.0	4.7	NA
Togo 1995	7.6	29.7	10.4	NA
Sub-Saharan Africa average	17.1	87.4	30.9	1.1
North Africa average	106.1	256.4	NA	26.8
Industrialized countries average	303.7	703.6	32.4	64.8

Source: WHO. Available at http://www3.who.int/whosis

Table 14. Socioeconomic Indicators in West Africa and Other African Countries

Selected Reproductive Health Indicators for West Africa

Country	DHS/MICS Survey Year (1)	TFR	CPR (modern methods)	GDP per Capita (PPP US$)	GDP (U.S.$ b.) 2001	% of Pop Earning <$2/day	Gini Index	Adult Illiteracy	Female Literacy	Primary Enrollment	*Public Exp. On Health (% of GDP)*
Benin	2001	5.6	7.0	980	2.4	N.A.	N.A.	61.4	24.6	70	1.6
Burkina Faso	1998/1999	6.4	5.8	1120	2.5	85.8	48.2	75.2	14.9	36	3
Cameroon	1998	4.8	8.0	1680	8.5	64.4	47.7	27.6	65.1	N.A.	1.1
Chad	1996/1997	6.4	1.2	1070	1.6	N.A.	N.A.	55.8	35.8	58	2.5
RCI	1998/1999	5.2	9.8	1490	10.4	49.4	36.7	50.3	38.4	64	1
Gambia	2000	5.8	8.7	2050	0.4	82.9	47.8	62.2	30.9	69	3.4
Ghana	1998	4.4	10.7	2250	5.3	78.5	39.6	27.3	64.5	58	2.2
Guinea	1999	5.5	4.9	1960	3	N.A.	40.3	N.A.	N.A.	47	1.9
Guinea-B	2000	6.0	3.6	970	0.2	N.A.	47	60.4	24.7	54	2.6
Lib.	1986	6.7	7.0	N.A.		N.A.	N.A.	45.2		N.A.	N.A.
Mali	2001	6.8	6.9	810	2.6	90.6	50.5	73.6	16.6	43	2.2
Mauritania	2000/2001	4.5	3.1	1990	1	68.7	37.3	59.3	30.7	64	3.4
Niger	1998	7.2	4.4	890	2	85.3	50.5	83.5	8.9	30	1.8
Nigeria	1999	4.7	8.9	850	41.4	90.8	50.6	34.6	57.7	N.A.	0.5
Senegal	1997	5.7	2.7	1500	4.6	67.8	41.3	61.7	28.7	63	2.6
Sierra Leone	2000	6.2	3.9	470	0.7	74.5	62.9	N.A.		N.A.	2.6
Togo	1998	5.2	7.9	1650	1.3	N.A.	N.A.	41.6	44	92	1.5
Kenya	1998	4.7	23.6	980		58.6	44.5	16.7	77.3	69	1.8

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