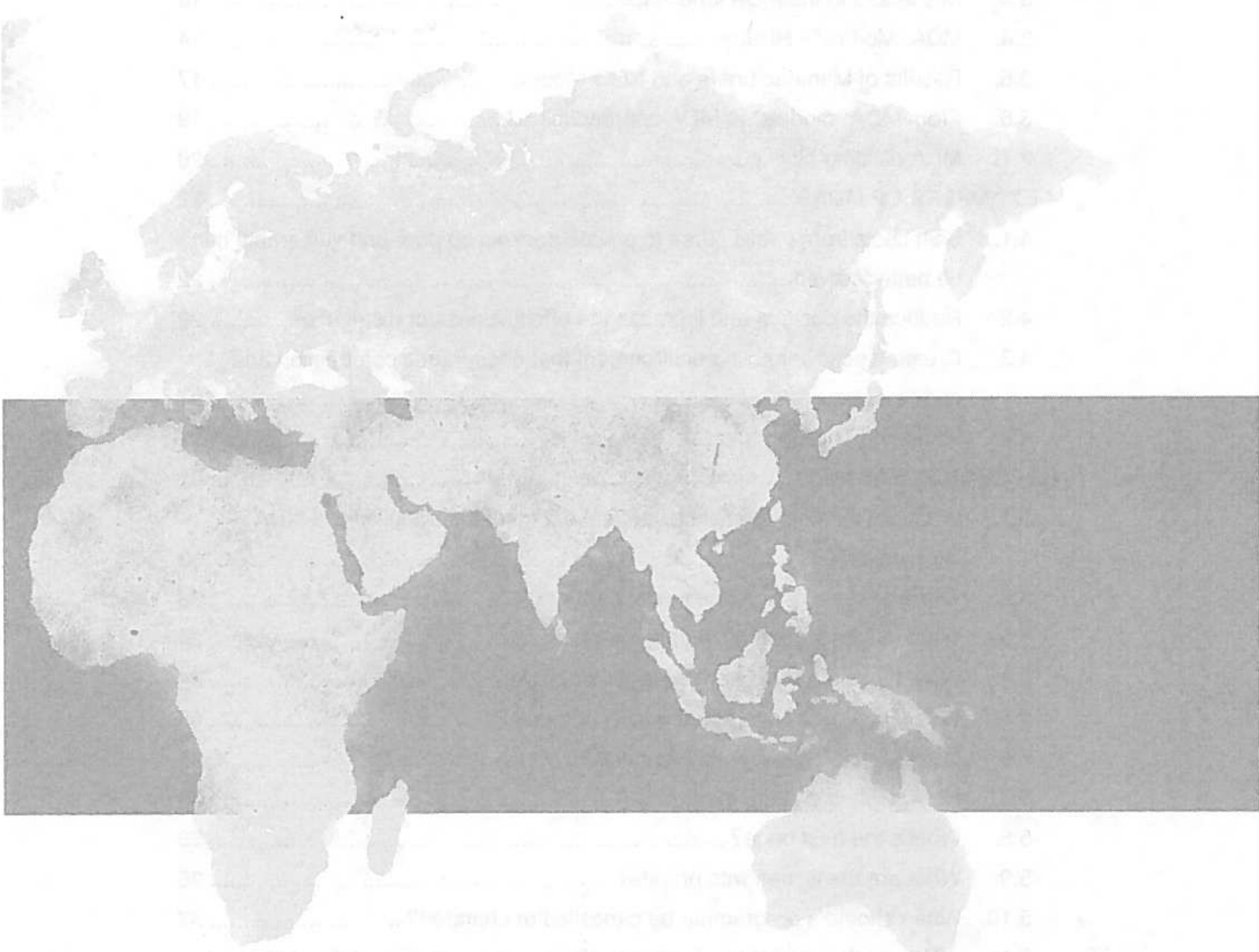




Market Development Approaches Scoping Report

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ACRONYMS

| | |
|---------|--|
| ARVs | Anti-Retrovirals |
| CMS | Commercial Market Strategies |
| CPR | Contraceptive Prevalence Rate |
| CYP | Couple Years of Protection |
| DFID | (UK) Department for International Development |
| DHS | Demographic and Health Survey |
| EMEA | European Agency for the Evaluation of Medicinal Products |
| EU | European Union |
| FDA | (US) Food and Drug Administration |
| FMCG | Fast Moving Consumer Goods |
| GDP | Gross Domestic Product |
| GNP | Gross National Product |
| IPPF | International Planned Parenthood Foundation |
| ITN | Insecticide-treated nets |
| IPR | Intellectual Property Right |
| IUD | Intra-uterine device |
| JSI | John Snow International |
| KfW | Kreditanstalt für Wiederaufbau (German Development Bank) |
| KSM | Key Social Marketing |
| LHW | Lady Health Worker |
| LSHTM | London School of Hygiene and Tropical Medicine |
| MDAs | Market Development Approaches |
| MIS | Management Information Systems |
| MSH | Management Sciences for Health |
| MSI | Marie Stopes International |
| NGO | Non-governmental organisation |
| OC | Oral contraceptive |
| OECD | Organisation for Economic Co-operation and Development |
| PSI | Population Services International |
| PSP-One | Private Sector Partnerships for Better Health |
| R&D | Research and Development |
| RH | Reproductive Health |
| RHSC | Reproductive Health Supplies Coalition |
| SFH | Society for Family Health |
| SOMARC | Social Marketing for Change |
| STIs | Sexually Transmitted Infections |
| TB | Tuberculosis |
| UNFPA | United Nations Fund for Population Activities |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counselling and Testing |
| WG | Working Group |
| WHO | World Health Organisation |
| WTP | Willingness to Pay |

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EXECUTIVE SUMMARY

This paper provides the Reproductive Health Supplies Coalition (RHSC) with an overview of Market Development Approaches (MDAs) and an analysis of lessons learned with key gaps and priorities identified. More broadly, this document is a tool for donors, Governments and implementers to learn about MDAs and begin thinking of options and issues to encourage, design, implement, manage and evaluate MDAs. Complementing the document is a web-based guide, which provides overview text and links to key documents, examples, tools and other resources.

The lens through which market development approaches are viewed in this paper is primarily through the supply chain, given that the RHSC goal addressed by the MDA Working Group (WG) is “to improve access to and choice of RH supplies for low and moderate income consumers through public, private, and commercial sectors.”

While market development approaches can include a range of commercial approaches, the emphasis in this paper is on MDAs that have received public funding, rather than purely commercial models, as the team was asked to speak with donors and NGOs rather than the commercial sector. Consultations with the private sector would have been especially useful to understand what products are actually available in developing country markets; the team encourages the MDA WG to consider further analysis of product availability at the country level.

The key challenge was to find a clear way to synthesize so many different programmes in a useful manner. Equally challenging, the intended audience includes donors, implementers and Governments with varied familiarity with MDAs. Given the challenge of such a broad mandate, the team has opted to focus the discussion in five areas:

- **MDA Concepts and Frameworks**
- **Examples of MDA**
- **Lessons Learned: What Questions Should Be Asked**
- **Key Priorities and Gaps**
- **Recommendations**

One of our main conclusions is that Market Development Approach “models” have become less binary and more continuous and evolving. Therefore the traditional model labels (such as “manufacturer’s model”) have become less accurate and less useful. This paper focuses less on prescribing formulas or evaluating discrete ‘models’, but instead focuses on drawing attention to strategic and operational options, to important contextual influences, whilst raising questions and providing examples.

MDAs use or leverage commercial actors or tools as one or several components or “building blocks” to increase access to and choice of RH supplies. The frameworks and examples demonstrate some of the building blocks that are being tried. Many are truly innovative; more need to be found.

This paper outlines some tools and questions to guide donors, Governments and implementers to understand reproductive health markets and develop strategies. Markets are dynamic and need to be better understood. Those involved in MDAs need to know how given markets are segmented and how the variety of interventions

interact to influence contraceptive usage. Donors and Governments need to develop responsive strategies, make expectations clear and remain committed to the strategies and have planned exit strategies as appropriate. At the same time, paradoxically, Governments, donors and implementers also need to be flexible and responsive to changes in the market.

Given the short timeframe for the assignment, we undoubtedly have passed over many programme examples; we have focused on MDA approaches that illustrate fresh thinking as well as those which are fundamental to our analysis and lessons learned. Reviews found elsewhere may be relied on for a more comprehensive description of programmes.¹ We believe that solid evaluations of MDAs and exchange of information about programmes as they are happening will contribute to the expansion of MDAs. We have highlighted some past experiences and challenges with evaluation.

This paper was commissioned by the Gates Foundation for the RHSC's Working Group on Market Development Approaches. In December 2005 and January 2006 the team interviewed 28 people from within the WG and outside of it and prepared an initial draft of this paper. We were particularly impressed by and grateful for the responsiveness of the respondents. They kindly shared their time, expertise, insights and even their trade secrets.

¹ For example, "Review of DFID Approach to Social Marketing" 2003 and "Private Sector Participation in Health," KfW, February 2004.

1. METHODOLOGY

HLSP's Global Division was contracted by the Gates Foundation to manage and deliver the MDA scoping exercise and MDA Information Resource. The team included Elizabeth Gardiner, Ditlev Schwanenflugel and Cheri Grace, with input from James Macintyre Brown.

To produce an initial draft of this report in time for the January 26, 2006 meeting of the Reproductive Health Supplies Coalition (RHSC), the project team undertook a series of interviews in December 2005 and January 2006 with 28 stakeholders involved in Market Development Approaches. Members of the Working Group on MDAs of the RHSC formed the core group of interviewees. Additional interviews were conducted with experts in social marketing, health economics and contraceptive security drawn from suggestions by Working Group members and the project team's own network of contacts.

The team interviewed the primary implementers of MDAs: Chemonics International, Futures Group, PSI, MSI, IPPF/ICON, DKT, Concept Foundation, JSI and Abt/PSP One, including some field staff. Former CMS and SOMARC staff were also interviewed. The team spoke with donors including USAID, DFID, EU, KfW, UNFPA, Gates and the UN Foundation. Representatives from two Governments were interviewed as well as two specialists from the London School of Hygiene and Tropical Medicine. One manufacturer was consulted directly and the team also spoke with ICON about the preliminary results of their emerging market supplier consultation exercise.

The interviews were by no means intended to be exhaustive, but rather to contribute to the overview of existing MDAs and provide some insights on the lessons learned. A balance between practitioners and other stakeholders was sought, though inevitably too few Governments and field staff were able to be interviewed. More interviews with commercial entities might also have enhanced the report to bring more exclusively commercial examples into the mix. Consultations with the private sector at country level combined with import data as well as producer country export data would have been especially useful to understand what products are actually available in developing country markets.

Further data was collected through a review of literature. The literature review was expanded upon during the second phase of the activity – development of the MDA Resource (<http://www.eldis.org/healthsystems/mda/>) where links to and abstracts of key documents, tools, examples and other resources on MDAs are housed within a text synthesizing key points from this report.

2. PROJECT CONTEXT

A number of circumstances have arisen that are changing the environment and increasing interest in MDAs. The decrease in funding from USAID and other donors in many countries is creating a funding gap while demand for reproductive health services continues to grow. UNFPA, a long-term supplier of contraceptives, has regular annual budget fluctuations that can disrupt supplies. Similarly, lack of predictability at national level results from funding fluctuations, weak policies and systems of donors, governments and implementers, and particularly lack of co-ordination between these actors.

Donors are increasingly focused on sustainability. Some view that the 2005 Paris Declaration on Aid Effectiveness as a mandate to shift control more to local governments who will need a range of options for ensuring contraceptive security. Some donors are looking for ways to co-finance programmes and make them more cost-effective.

The global market is expanding. More suppliers in developing countries have emerged as national players with potential to gain a foothold in international markets as intellectual property and technology barriers decline with some of the older contraceptives. With the expansion of markets, donors are gradually untying aid to their home-country manufacturers in search of more cost-effective supplies.

New donors and implementers with a potentially more market-oriented view on solutions are increasingly involved in reproductive health supply security issues.

Market Development Approaches can respond to these circumstances by addressing sustainability, access and choice through greater involvement of the commercial sector.

3. OVERVIEW OF MDAS:

The overview of MDAs includes two components: some basic concepts and frameworks and a discussion of MDA examples. The aim of this section is to provide readers with background on MDAs as well as some historical perspective on their evolution

3.1. *Concepts and Frameworks*

A common piece of feedback from the interviews was the need to establish a shared language and common understanding, thereby providing a stronger foundation for developing improved, joint approaches. Others expressed an interest in moving away from the discussion of terminology and concepts.

Given the diversity of perspective, experiences and terminology among members of the Working Group, we have opted to explore some of the definitions of MDAs and the basic concepts. The purpose of this is to ensure that there is enough common language and understanding within the group to move the discussion forward.

The following topics will be covered:

- Definition of MDAs
- Key actors in the MDA landscape
- MDA "Models"
- MDA building blocks

We present frameworks to be descriptive, not prescriptive, and recognize that there is no one "best practice" approach.

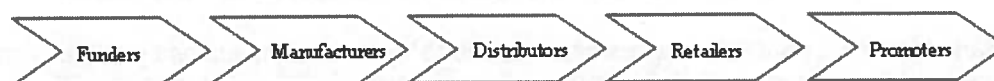
3.2. *Definition of MDAs*

Clearly there are many ways of defining what a "Market Development Approach" actually means. In even the poorest countries, the commercial sector makes

products and services available to consumers around the world.² These are market development approaches in their purest form. Donor and government support to the commercial sector can enhance its ability to reach consumers across social, economic and geographic groups.

Virtually all health approaches have some degree of commercial involvement. Even the most public sector-based approach generally has some minimum level of commercial involvement: for example, there are very few approaches involve manufacturing products within the public sector.

Commercial entities may be involved in all steps of the value chain to deliver reproductive health to consumers including financial support, manufacturing, distribution, retail and promotion. In other words, commercial companies take part at all stages that lead to product and service delivery to the consumer.

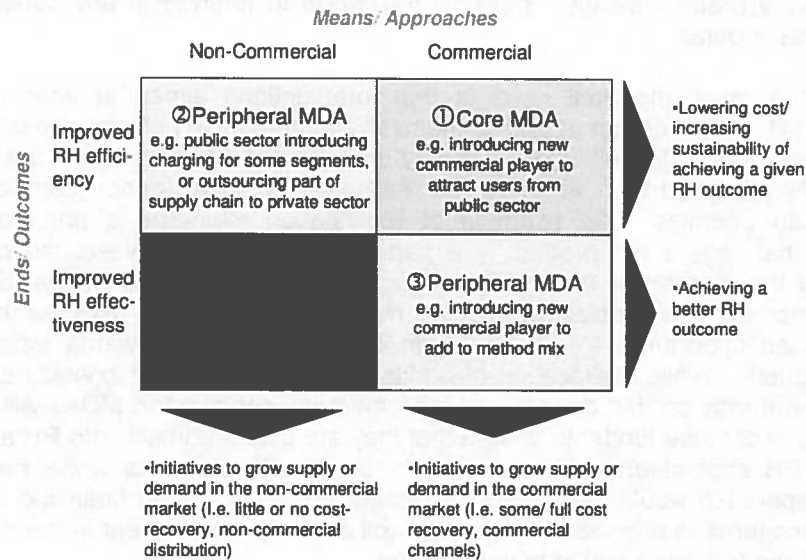


According to the Terms of Reference (ToRs) for this work, Market Development Approaches (MDA) are defined as “any intervention undertaken by donors or implementing agencies that has led, or would lead, to an improved level of financial sustainability for a given market.” The MDA Working Group sees its mandate to “improve access to and choice of reproductive health supplies for low and moderate income consumers through public, private and commercial sectors.” Thus, MDAs can be seen as initiatives which work towards the outcomes of improved financial sustainability, improved access and improved choice. These outcomes can be achieved via a variety of means and approaches.

The diagram below categorizes RH interventions into four distinct groups, based on whether the outcomes are primarily improved RH efficiency or effectiveness and whether the means are primarily via the commercial market versus the non-commercial sector.

² The “commercial” sector refers to for-profit entities, while “private” sector may also include any non-government organisation, such as non-profit organisations as well as for-profit entities.

Market Development Approaches – Ends and means



It is clear that there are no hard and fast boundaries between the four quadrants, and that most interventions will span more than one quadrant.

Nevertheless, we believe the diagram is useful for drawing out a number of key implications:

- The core of the MDA concept is to use the commercial market to improve RH efficiency, i.e. to lower the public cost of product delivery (though costs to the consumer may increase) or increase the sustainability of achieving a given RH outcome. [top right hand quadrant #1, coloured green]. Note that this quadrant could include also government initiatives to expand commercial supply [e.g. through streamlining the regulatory process or otherwise improving the commercial enabling environment].
- Some would also see any intervention to improve RH efficiency as an MDA, even if entirely played out within the public sector (e.g. the public sector starting to charge fees) [yellow top left quadrant #2]
- Others would include interventions using the commercial sector that aimed to improve RH effectiveness (outcomes), without actually saving any money, e.g. by trying to add to the mix, or by drawing in new audiences e.g. through more exciting brands, packaging or marketing [yellow bottom right hand quadrant #3]
- A “classical” social marketing intervention program would generally span both quadrants 1 and 3, i.e. aiming to expand commercial supply and demand, to improve both RH efficiency and effectiveness.
- A commercial company that makes a product available on its own, i.e. primarily aimed at improving efficiency but not necessarily effectiveness, would be in quadrant 1.
- Most would agree that interventions within the public sector aimed purely at improving RH effectiveness/ RH outcomes [bottom left red quadrant #4] would not be covered by the MDA term – if indeed it was, the MDA term would be meaningless, as it would encompass the entire range of RH interventions.

-
- It is clear that if one includes also the peripheral quadrants, MDAs are already a very broad concept – possibly too broad to analyze in any considerable level of detail

Perhaps the most important point is that interventions aimed at improving RH efficiency [#1 and #2] do not in and of themselves improve RH effectiveness as well. Any improvement in RH efficiency will only improve RH effectiveness if the savings are actually ploughed back into RH, not reallocated to other (donor, commercial or government) priorities. An example of reallocation might be a pharmaceutical company that sells a RH product in a particular market and invests the profits in expanding the market for a non-RH product or simply takes the profits. Similarly, public sector (or grant recipient) savings may be perceived by a Government (or donor) as an opportunity to cut their own contribution/share towards reproductive health budgets. While reallocation of profits or savings might be considered highly acceptable, it may be that donors and implementers who support MDAs will want to track the use of these funds³ to ensure that they are ploughed back into RH and used to target RH expenditures more directly to those with unmet or under-met need. Such an approach would require an understanding of the overall financing of health care expenditures in a broader context as well as early involvement in the allocation of the savings to ensure buy-in to the concept.

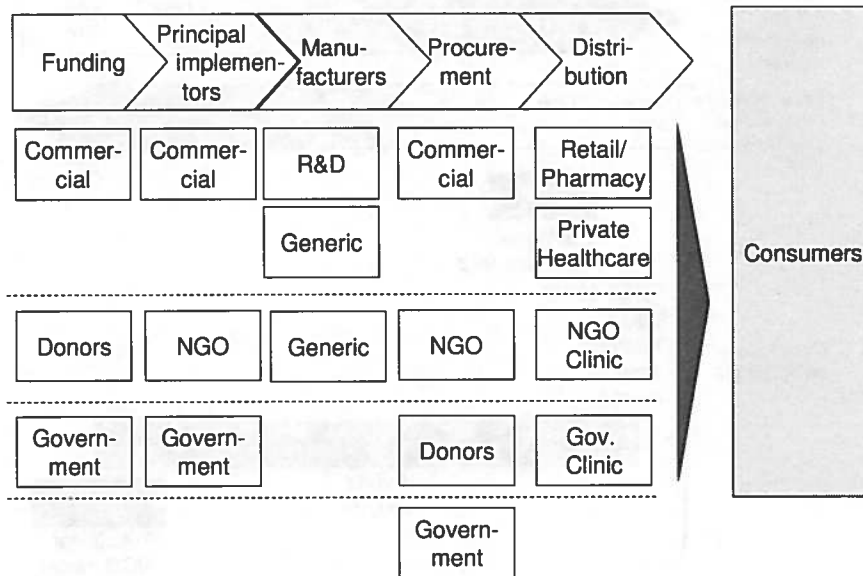
This efficiency/effectiveness distinction is worth emphasizing – a considerable part of latent scepticism towards MDAs applies not so much to the uncontested efficiency benefits of using the commercial sector but more to the fear that the savings will be reinvested elsewhere, outside RH.

³ However, this requires an infrastructure that enables such 'tracking', and this is non-existent in many developing countries.

3.3. Key actors in the MDA landscape

It is clear that there is a very considerable set of RH actors across the supply chain for any particular country, as set out schematically in the following diagram:

Market Development Approaches – key actors



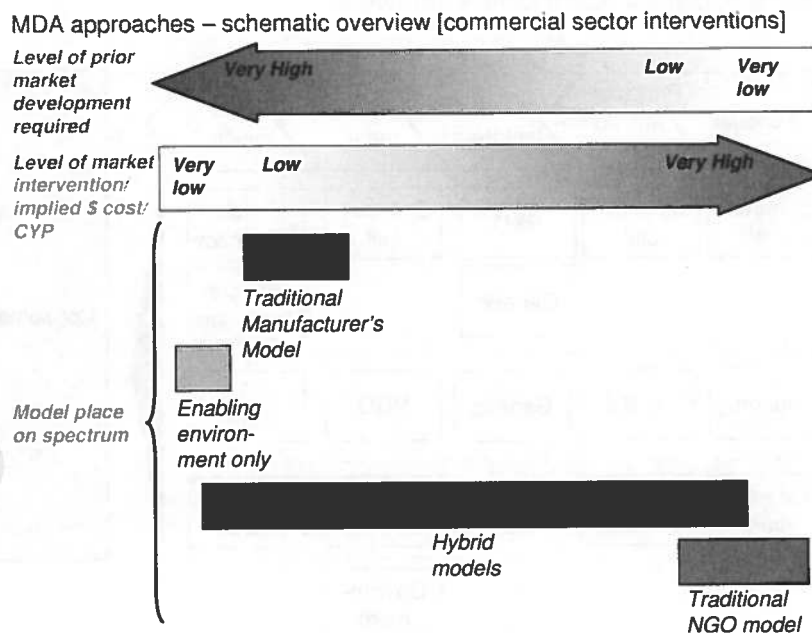
Moving left to right, the diagram shows the various key stages of the supply chain, moving towards the consumer. Moving top to bottom, it shows the various actors by type within each of the stages – there may of course be several actors of the same type acting in the same system, e.g. several donors, or several different NGO principals [implementing agencies]. There can also be fluidity horizontally in the diagram – i.e. a donor funded programme may rely on commercial, NGO or government implementers and can source either branded product from originators (R&D based industry) or from generic suppliers, and so on with the variety of choices as one moves towards the right of the diagram.

The diagram underlines the following points:

- RH supply systems are highly complex and involve a broad set of stakeholders. MDAs – by adding additional actors – may well increase complexity.
- Interventions do not happen in a vacuum. Any intervention needs to consider its impact on the rest of the system – and the impact that actions by the rest of the system can have on itself [e.g. expansions of government free handout programs can be detrimental to commercial players].

3.4. MDA "Models" - History

In trying to provide an overview of MDA "models", our primary focus has been on interventions using commercial markets, i.e. quadrants #1 and #3 in the Ends and Means / Outcomes and Approaches diagram (above). Within these categories, interviews indicate that the level of market intervention is seen as a key defining variable, as set out in the diagram below:



Overall, the assumption (based on some degree of empirical evidence) was that commercial entities (i.e. condom, injectable and pill manufacturers) would not enter developing country markets without added incentives. The notion was that assistance to commercial entities would kick-start what was hoped to become a purely commercial endeavour, or, in other words, creating a process of moving from partially-commercial to fully-commercial entities. Recognising the failure of the markets to meet contraceptive needs, social marketing was employed as a means to market development.

Traditionally, there have been two relatively polar opposites: the "Manufacturer's Model" and the "NGO Model". While both terms are now outdated and few, if any, interventions fall squarely into one or the other box any more, it is worth using these terms as a starting point to explore the dimensions of MDAs in some more detail. In the initial paragraphs, we set out the generalisations about the models and then in subsequent sections we provide details to render the generalisations inaccurate. We have done our best to be objective, but recognise that not everyone may agree.

The Manufacturer's Model has relied to a large extent on an established commercial partner (or supplier), who is provided with incentives [e.g. marketing support] to enter a new market, but who continues to operate as an independent, commercial, for-profit player. The manufacturer maintains control over the brand, and is usually (though not always exclusively— see Pakistan case study) responsible for sales and distribution. A manufacturer's model can also have varying degrees of market intervention, for example large subsidies may be employed to support brand building, distribution, product price reduction, etc, over a long period of time or a 'lighter touch'

of temporary brand building and market support with quick transition to independence and subsidy withdrawal.

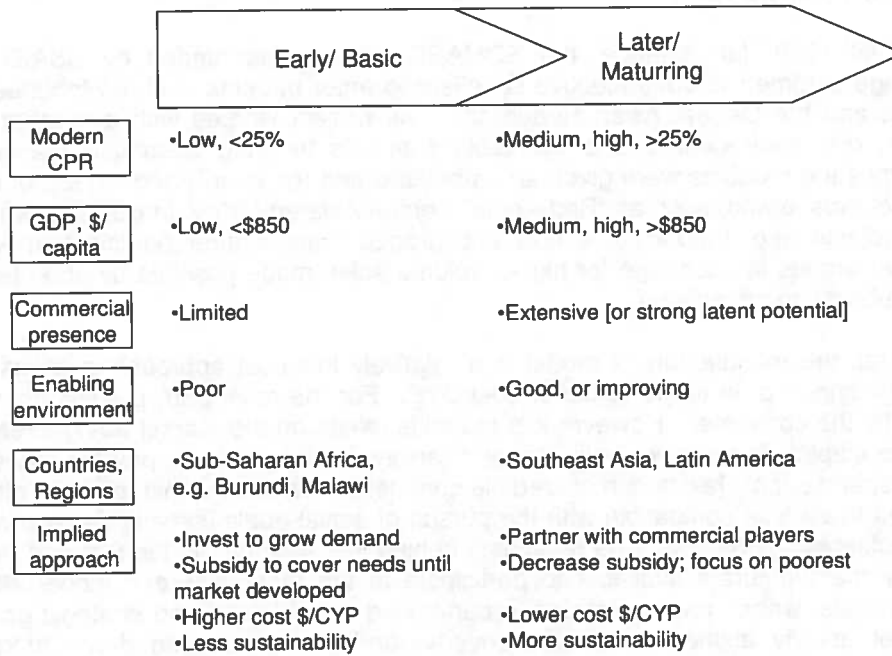
From 1980-1998, for instance, the SOMARC project was funded by USAID to encourage commercial contraceptive suppliers to enter markets such as Indonesia, Jamaica and the Central Asian Republics. The project worked with a number of condom, oral contraceptive and injectable suppliers to bring them into markets. Sometimes the products were given an umbrella brand (or 'over-brand' on top of the manufacturers' brand) such as "Red Apple" Central Asia and "Key" in Pakistan whilst other projects (e.g. Indonesia) simply encouraged manufacturer participation with their own brands in exchange for higher volume sales made possible by short-term donor subsidy on advertising.

In general, the manufacturer's model is a relatively low cost approach in terms of donor funding, e.g. in terms of donor cost/CYP. For the most part, product cost is carried by the consumer. However this model is reliant on the market being already quite developed, in terms of both demand [ability + willingness to pay for modern methods] and supply [existence of credible commercial partners]. This model is often assumed to be less compatible with the pursuit of social goals [serving the poorest, least profitable customers]. The reasoning behind this was that, in the 80s and 90s, the only manufacturers available to participate in the manufacturer's model were multinationals, whose pricing policies, urban-based detail forces and strategic goals were not usually aligned with more poverty- and access-focused donor funded programmes. However, more recent variations on the model have shown that this does not necessarily have to be the case. For example, Key Social Marketing sources from a local supplier whose lower pricing policy and higher volume strategy is more closely aligned with donors' access goals. Key Social Marketing also supplements Zafa's detail force with their own 'Mohalla Sangat' programme initiative focused on rural women and explained in the Pakistan case study later.

In contrast, the NGO model, while still using a commercial approach and working with commercial suppliers, is reliant on building a commercially-, though not for profit-oriented player [typically the NGO or an affiliate], including procurement and creation of its own brand, marketing and sometimes distribution system. As a generalisation, it is able to function in much less developed environments compared to the Manufacturer's Model, but it will tend to be costlier and less sustainable without continued donor input. In exchange, prices for the consumer are usually lower. Here too, recent variations have shown that this model in some circumstances can also be more cost-effective (Pakistani GreenStar's cost/CYP on its oral contraceptive is \$8) and sustainable (for instance PSI in Romania).

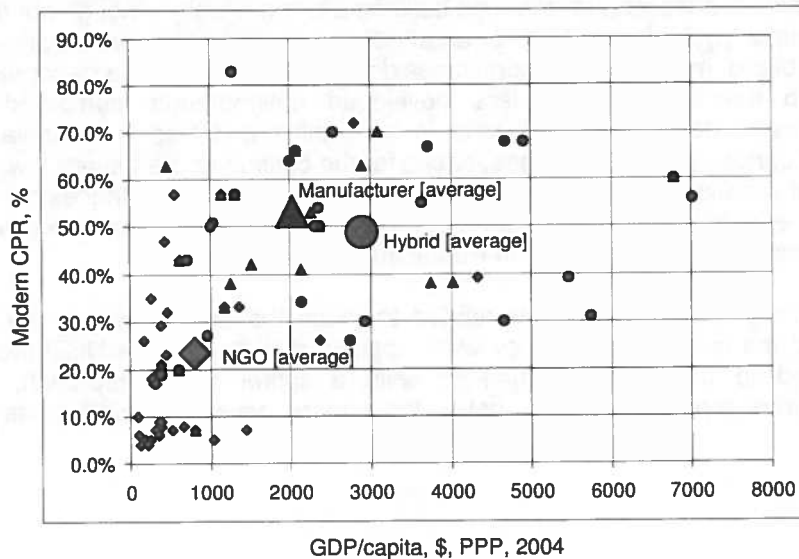
Evaluations of the earlier models tended to relate the two models to the level of maturity of the markets where they were applied, opining that the NGO model was best suited to an immature market, while a lighter touch approach, via the manufacturers model, may work better for a more developed market, as set out below:

Market development stages



An over-simplified reality check (with many arguable points), based on a list of countries where the different models have been applied⁴, indicates that the theoretical generalisations applied to the two models to a large extent match reality:

Where the models have been applied



Source: World Bank, UNDP, various, team analysis

⁴ Provided by Francoise Armand of PSP-One

The diagram plots each country by modern CPR % and GDP/ \$/ capita⁵, with NGO models in blue diamonds, manufacturers models as red triangles and hybrid models as green circles⁶. It is clear that there is very significant difference between the application of NGO model on the one hand (highly immature environments) and the manufacturer's model (more developed environments).

3.5. *Results of Manufacturer's and NGO Models*

One of the reasons that the focus on the two models has declined is the challenge in proving where the models are successful. While a summary of evaluations of the two models is beyond the scope of this paper,⁷ several factors are evident:

- o Success is dependent on many factors including the environment in which the models are attempted. For instance, the concurrent provision of free or heavily subsidised product can severely impact the success of the manufacturer's model as we have seen in Peru where the Government provided free contraceptives and the sales of commercial brands dropped significantly.
- o Clearly, the commercial environment plays a role as does the degree and availability of donor funding. In markets with stronger commercial markets where donors are "graduating" the countries from donor assistance, manufacturer's models are more likely to be used on the assumption that consumers can afford a more commercially priced product.
- o SOMARC⁸ reviewed what happened with 5 of 18 products that it had "graduated" from USAID support, meaning that the product management was transferred from the Futures Group to a local private sector or NGO partner that was expected to take over the marketing and selling of the product(s) after USAID support was withdrawn. During the life of the project, this partner was supported through technical assistance and training to facilitate this transition. Over time, USAID financial and technical support decreased. After the product became profitable, it is "graduated" and shifted entirely to the local partner. The study of five programs that graduated 1991-1993 indicates varied actions and results:
 - o Price increased in 2, decreased in 3 (inflation adjusted).
 - o Distribution declined in 1 country, stayed the same in 2 and increased in 3.
 - o Promotional spending declined in all countries.
 - o Sales of the product increased in 4 of the 5 countries.

⁵ While there is considerable auto-correlation between the two, it was felt that these two variables were the best to provide a single data-driven snapshot overview of the application of the different models. The overall story of NGO models being applied in the least developed environments would not change, regardless of which of the two variables chosen.

⁶ Some countries (e.g. Philippines) have had more than one model deployed. Both are shown. Note also the chart shows models deployed, but does not differentiate based on the actual performance/ success of each model as deployed.

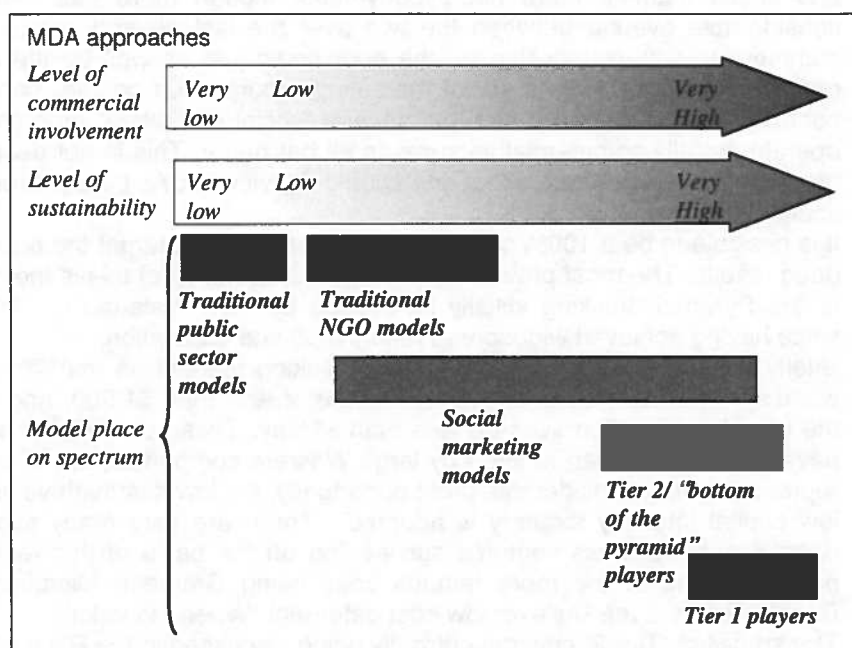
⁷ Readers are referred to the social marketing papers referenced at the beginning of this paper and to Kara Hanson et al. "Ends Versus Means: the Role of Markets in Expanding Access to Contraceptives" *Health Policy and Planning*. 16(2): 125-136. 2001.

⁸ Kincaid et al. "The Transition to the Commercial Sector: What Happens to Socially Marketed Products after Graduating from USAID Support?" Undated. Special Study 1. SOMARC III. A follow-on study has taken the analysis one step further: Sohail Agha, Mai Do and Françoise Armand, "When Donor Support Ends: The Fate of Social Marketing Products and the Markets They help create" PSP-One. December 2005.

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- Other competing condoms entered the market increasing consumer choice (known as “crowding in”)
 - The involvement of commercial entities as “partners” from the start of the project is also thought to play a role. However, their expectations also need to be realistic. In Ghana and Indonesia commercial partner expectations exceeded deliverable results resulting in tensions. Some implementers note that we have little knowledge of what actually motivates the commercial partners to participate, while others opine that their participation comes down to one or a combination of: added revenues/cost coverage or expanded market share/market coverage to the advantage of other products from the same source.
 - The control of the brand is also a factor, with risks increased in situations where the program is dependent on a single manufacturer's brand. The risk arises because the donor/implementer has made investments which are specific to the manufacturer (by helping to build his brand). The manufacturer therefore holds the leverage over the donor/implementer and may 'hold-up' the donor/implementer for higher and higher subsidies, threatening supply security problems otherwise. The challenge for the donor/implementer is to simultaneously find ways to incentivise the manufacturer to contribute private investment in building demand for the brand, whilst seeking to maintain leverage to switch suppliers. One possible way of doing this is through having built a strong umbrella brand. It is possible that the presence Key's (see Pakistan case study) umbrella brand was what permitted an easy transition from one supplier to another, although we have too few examples of such brand switches to know what would happen given a different set of variables/circumstances.
 - Where there is very low demand for contraceptives, subsidised contraceptives can potentially “crowd in” the private sector (Hanson)
 - The price of the product cannot be overlooked as an important element in determining the success of the project. For instance, in Jamaica, USAID brought in the SOMARC project in the mid-1990s to ease the transition to commercial prices in a very short period of time. To date, according to Hanson, the evidence on the extent to which price influences demand for contraceptives is mixed.
 - Most of the reviews of these models took place more than 10 years ago. External changes such as the emergence of generic low-cost suppliers, as well as internal management innovations in choice of building blocks can sometimes make it possible for the manufacturer's model or the NGO model to adapt from the 'pure' model according to the context, thereby pushing the boundaries within which they have normally operated. The Pakistan case study illustrates this very well.

3.6. From MDA “models” to MDA approaches

As the use of MDAs evolved, programs used the commercial/private sector to varying degrees. Now, additional market development approaches including but not limited to social marketing have evolved that can be used to increase availability and choice of contraceptives in sustainable ways. Conceptually, it can be illustrated as follows, ranking approaches by different levels of commercial involvement:



Even the most public sector based approach generally has some minimum level of commercial involvement (i.e. there are no current public sector approaches based on producing product within the public sector as well⁹). A public sector user fee would also be classified as an MDA on the left side of the diagram. The more you move to the right on the spectrum, the more you rely on commercial methodologies and approaches, the more commercial it becomes, until finally Tier 1 players at the high end of the market operate in a 100% commercial environment, whether in OECD or developing countries. The less donor funding a project has, the more financially viable it is, though there may be instances where a project does not generate the sales volume required to sustain the project.

It is very important to underline that the above diagram in no way implies that the more commercial models are necessarily "better" in terms of achieving RH outcomes. It aims to provide a framework for considering MDAs; examples of MDAs are detailed in subsequent sections.

The diagram is used to illustrate a couple of important points:

⁹ Other than in China, there is no known government manufacturing of RH commodities. However, there are examples of government involvement in manufacturing in other types of products, notably the Brazilian and Thai government involvement in ARV manufacturing facilities.

- MDAs can support several different approaches - from use of commercial methodologies in the public or NGO sector, through support for social marketing models through to fully commercial “Tier 2” approaches [see below for fuller discussion of this]. In theory, MDAs could even directly support Tier 1 market players, though indirect support through creating the right private sector enabling environment may be more a more appropriate role for the public sector and donors (Section 4.4 provides further details). The point is that MDAs are not only about supporting “social marketing” models. MDAs and social marketing are not synonymous, though there has been very considerable overlap between the two over the last several years. A fully commercial venture focusing on the poor could just as well be the desired outcome of an MDA as a social marketing program. Of course, part of the confusion arises from the fact that several “social marketing” programs now operate as fully commercial ventures in all but name. This is not necessarily “wrong” – but just evidence that one should not view MDAs purely through the social marketing lens.
- It is possible to be a 100% commercial venture, and still target the poor – with good results. The most prevalent conceptual articulation of this is the “Bottom of the Pyramid” thinking initially introduced by C.K. Prahalad in 1999, and since having achieved widespread recognition and adaptation.
- Briefly put, the “bottom of the pyramid” thinking recognizes that 70% of the world’s population has a per capita income of less than \$1,500, and 16% of the world’s population lives on less than \$1/day. These potential consumers have traditionally been ignored by large Western companies, but in fact may represent a very considerable profit opportunity, if a low-cost/high volume and low capital intensity strategy is adopted. There are very many successful examples of business ventures succeeding on the basis of this realisation, perhaps some of the more famous ones being Grameen Microfinance in Bangladesh and the Unilever low-cost detergent “Wheel” in India.
- The so-called “Tier 2” concept currently being discussed in the RH community is looks to create the possibility for entry of large-scale generic commercial product(s) targeted at the poorer or even poorest consumers, hitherto ignored by the branded commercial (“Tier 1”) sector. In some circumstances, a Tier 2 will happen through market forces as we have seen with Gedeon Richter’s older brands in Ukraine. Some implementers believe that there may be situations where facilitating the entry of a Tier 2 player (i.e. providing donor funding or soft loans) may be a cost-effective way of improving RH outcomes, while others may be wary of donor or agency ability to second-guess the market. For additional discussion of this, see 4.2 below.

3.7. *MDA building blocks*

In recent years, the NGO and manufacturers models have begun to make strategic and operational choices that blur the lines and render the usual generalisations and dichotomies less meaningful. The key point is that there is no one “model,” and especially not two discrete binary models, but rather a series of choices and “building blocks” with which to design and create an MDA to suite the country, markets and programme objectives.

The table below has been adapted from earlier work done by PSP-One, and presents the various dimensions as blocks. Some are clearly linked, but others are independent.

Intervention design dimensions [not exhaustive]

| Dimensions | ←Less commercial | | More commercial→ | |
|---------------------------------------|---|---|--|--|
| Target segment | Very poor consumer, no co-payments affordable | Poor consumer can afford limited co-payments, but need major price subsidy | Low income consumer can afford co-payment, but still need some price subsidy | Middle income consumer can pay commercial prices [for low-priced product] |
| Price | Fully subsidized, no cost to consumer | Small cost to consumer, significant price subsidy | Full product cost charged to consumer, but little/no overhead | Full product price plus overhead, including profits, charged to consumer |
| Key performance indicators/incentives | RH effectiveness only [likely aimed at poorer segments] | Some measure of cost efficiency + RH effectiveness | Cost recovery of product cost + RH effectiveness | Profitability + RH effectiveness |
| Financial Sustainability | None – requires subsidy for foreseeable future | Low – some hope of donor phase-out in longer term | Medium – donor phase-out expected within 4-6 years | High – donor phase-out within 2-3 years |
| Cost, \$/CYP | High, e.g. \$20+ | Medium, e.g. \$5-\$20 | Low, e.g. \$1-\$5 | Very low, <\$1 |
| Principal/key decision maker | Government | NGO, with social aim | NGO with some for-profit incentive | Purely commercial player |
| Product | Basic, bought on price and quality, but not variety/novelty | Slightly newer, more advanced products | Newer, more advanced products, close to commercial standard | Commercial sector |
| Packaging | None | Some design effort | Considerable design effort | Commercial level design |
| Providers | Full time government employees | Community-based or NGO employees with gov. supervision | Community-based or NGO employees operating with gov. authorisation, but no supervision | Private, for profit employees, operating with authorization [where necessary] |
| Marketing/communications | Gov't managed, produced and funded. Generic RH demand creation, no brand marketing. | Some private sector marketing involvement, but main responsibility with gov. Some use of brand marketing. | Significant private sector marketing involvement. Significant use of brand marketing. | Main marketing responsibility with private sector, using commercial, brand-focused marketing techniques. |

The diagram carries the following key implications:

- Designing an RH MDA intervention is a complex process with many and mutually dependent dimensions and interactions
- There is no one “right” solution; instead the solution needs to fit the environment, to be aligned with the programme objectives, and needs to be internally consistent, including with the level of resources provided
- Broadly, examples of the far left column are found in the public sector; examples of the far right column are the purely commercial sector and the columns in the middle represent donor-supported MDAs.

4. EXAMPLES OF MDAS

A key challenge for us was how to think about and categorise this colossal set of examples and “building blocks.”

Bearing in mind that the Working Group focuses on improving “access and choice,” we have used our “key actors supply chain” diagram (above p. 12, Section 3.3) as a lens through which to look at examples of work with and through commercial markets, primarily on the supply side – distribution, procurement, product supply and allocation of funding.

The five primary means by which MDAs expand choice and access to products are:

- Shift costs from public purse to private pockets so poor and vulnerable can be better served
- Reduce the cost of the products
- Reduce the costs and/or increase the effectiveness of distribution
- Create a policy/enabling environment that encourages competition and choice
- Create demand through marketing

As we saw in the ends and means table (above), MDAs are ways to increase effectiveness and efficiency. A brief examination of these five ways MDAs enhance efficiency and effectiveness is provided in the following sections.

4.1. *Shift costs from public purse to private pockets so poor and vulnerable can be better served*

A key concern of publicly-funded reproductive health programmes is that poor and vulnerable people are not necessarily benefiting from programs any more than other segments of the population. Studies in a number of countries indicate a mismatch between wealth and source of product, often with as many poor people buying products as rich people obtaining free or subsidised products. Market development approaches have been developed to target finite resources to the most poor and vulnerable in three ways: 1) by better placement of subsidies 2) by transitioning consumers along the free to full price continuum and 3) with alternate financing mechanisms.

Limit or Direct the Subsidy - targeting subsidy at the most vulnerable: An important aspect of many MDAs is the emphasis on better targeting of the subsidy, particularly for the product itself. Different social marketing programs subsidise the product itself (more common in the NGO model), distribution, training, brand development and marketing to varying degrees. Subsidy of the product is thought by some to be too expensive and misplaced, given that some who could afford to buy at

full price are also receiving the subsidy. Others have argued that subsidy is necessary to reach poor people. However, some donors and implementers, particularly those working in poor countries, are comfortable with the overall programme cost/benefit analysis and are not overly concerned about the degree of subsidy lost to consumers who could afford full price.

To satisfy both camps, new market approaches are continually sought to ensure that the subsidy is received by those who need it. One approach has been to target subsidies directly to the consumer rather than via product. The rationale is that targeting the consumer allows resources to be spent on precisely those who most need subsidy, and does not adversely affect commercial entrants to the market due to artificial and unfair competition. Voucher programmes are one example of how such targeting can be achieved.

For malaria prevention, vouchers for insecticide treated nets put the subsidy directly in the hands of the consumer (as in PSI's programmes in Kenya and Tanzania) or go to the community via the distributor (as in the Malaria Consortium's programme in Mozambique). Voucher programs are relatively new and not extensively studied. Hanson et al have analysed a variety of targeting approaches and conclude that there is "potential for a voucher system to reinforce and strengthen a private sector delivery system, thereby potentially contributing to sustainability."¹⁰ They also note that voucher programs "require a mechanism for identifying eligible individuals and trying to maximise coverage and minimise leakage." The transferability of vouchers for sale or use may also be a concern. The Mozambique voucher program is only just starting in 2006, but it aims to provide support directly to commercial companies to allow them to set up sustainable systems for distribution and retail of nets.

User fees in the public system might also be considered a market approach, albeit focused on the efficiency (e.g. by requiring some level of payment, you theoretically prevent incentive to use services above required levels) and financial sustainability benefits that private finance can potentially bring, rather than on working through commercial actors. Concerns about the correct placement of the costs have been raised in relation to user fees, as have concerns about equity. Means testing (user fee exemptions) in public or private clinics, whereby individuals may be assessed for eligibility for free/subsidised government services, has not proven effective as the poor are often denied exemptions from user fees or other benefits. Providers may be conflicted by the need to grant exemptions while at the same time generate revenues for the clinic. Comprehensive coverage of this topic can be found on <http://www.eldis.org/healthsystems/userfees/>

Transitioning: With family planning products, many market development approaches have sought to use market segmentation approaches to ensure that the subsidy goes to those who need it. Transitioning involves encouraging consumers to purchase higher priced products. A country which has a high portion of its population receiving free contraceptives, i.e. 100% subsidised, (such as Romania, Peru and Indonesia using "Self-reliant Families Initiative") might seek to narrow eligibility requirements and encourage consumers to purchase a slightly subsidised or low cost commercial generic product. Such an approach balances carrot (making appealing products available at a price) and stick (limiting eligibility criteria).

Alternatively, through targeted branding and other marketing, consumer choice might be used to move consumers from a subsidised social marketing product to a fully commercial product (as in Pakistan where GreenStar's oral contraceptives are

¹⁰ Hanson et al. Unpublished work forthcoming as a chapter in a book.

subsidised whilst Key Social Marketing's OCs are not). With fewer wealthier customers receiving subsidised products, the intention is that more poor people can have access with the cost savings.

Alternative financing mechanisms: One concern that has been borne out in many countries (for example KfW/Uganda and condoms) is that after ± 30 years of social marketing donors will lose interest in paying for products. In response, other financing has been sought:

- One financing alternative identified has been health insurance (Uganda and elsewhere), where risk is pooled across a community that determines which services it wants included for a monthly flat fee; treatment costs are spread out over time and illness does not force a family to sell assets.
- Another variant on means testing being tried in Cambodia involves setting up an Equity Fund to pay for services of those eligible for free care; the community will determine eligibility, rather than the providers.
- Pharmaceutical companies themselves might also contribute, generally through price reductions (e.g. SOMARC in Indonesia in 1980s).
- Alternatively, in countries that USAID is "graduating" from contraceptive donations, Governments are expected to finance the contraceptive procurement themselves (Romania, Honduras). Such an approach reduces donor costs but not demands on the public purse overall (unless one assumes that governments can achieve better procurement prices versus donors, thereby increasing the efficiency of each dollar spent. For example, if USAID donates OCs made in the US, a Government may be able to buy at a lower price via UNFPA or other tender process).
- Lastly, cross-subsidies are another way that some programmes have ensured lower priced products for poor people. Cross subsidy may be within a product category (high- and low-priced condoms in Central America [PSI]), across product categories (subsidising contraceptives with revenues from pregnancy test kits in some countries by PSI in the 1990s), or across countries within an implementer's overall portfolio of programmes or a MDA partner's overall activities (PSI has used revenues from other programmes to maintain activities in under-funded countries such as Pakistan in the early 1990s; presumably the R&D pharmaceutical companies also use their revenues to cross subsidise less profitable activities). Aravind Eye Institute, where one-third of patients pay for the free eye care of the remaining two-thirds of the patients, is an example of cross-subsidy, albeit outside the reproductive health sector.
- By creating a "platform" from which several different health products can be marketed, some social marketing organisations have achieved a somewhat different means of cross-subsidy. By sharing staff, office, distribution and other cost-elements over several products, social marketers have lowered the cost of marketing each product.
- Output-Based Aid, whereby donor funds are provided on a "per service provided" basis, is being piloted with KfW support by Marie Stopes International in Uganda. The project aims to improve access to STI diagnosis and treatment by providing subsidised vouchers to lower-income individuals to receive STI services from accredited and trained private sector providers. From a donor perspective, Output-Based Aid seeks to increase efficient use of donor resources and ensure measurable results.

Reduce commodity costs for procurers and consumers: With pressure on resources increasing, the cost of the commodity component is coming under

increasing scrutiny. Consumers too are interested in lower contraceptive prices, and one way to reduce prices is to have a lower cost product. MDAs are therefore exploring ways to reduce commodity costs. Many of the MDAs for family planning are following similar approaches taken with HIV/AIDS treatment drugs (i.e. shifting to generics), though the costs for family planning products are considerably lower.

The prices of products from R&D based pharmaceutical suppliers have historically been a prime target for MDAs. Donors and implementers have **negotiated lower prices** for various markets, usually based on promises of increased sales volume. The so called "manufacturer's model" programmes, whereby a publicly funded entity negotiated with one or more manufacturer(s) to sell a product at a reduced price in exchange for marketing and/or distribution support, are examples of this. Past MDAs have provided support to market entrants (SOMARC Dominican Republic and elsewhere), but few new schemes are emerging that relate to a reduction in contraceptive prices from these suppliers. Ghana may be an exception, where the Ghana Social Marketing Foundation is in discussions with Organon.

There is some evidence to suggest that the gradual emergence of generic producers, some of which may be from developing countries (e.g. China), may be having an effect on prices offered by the R&D based industry. ICON has already seen some evidence of this in Schering's recent price reduction for ICON's global procurement. As second and third generation OCs are introduced, the prices for the older formulations have fallen. An early example of this may be seen in Ukraine where Gedeon Richter has reduced its prices for the older OCs to a generic-level price.

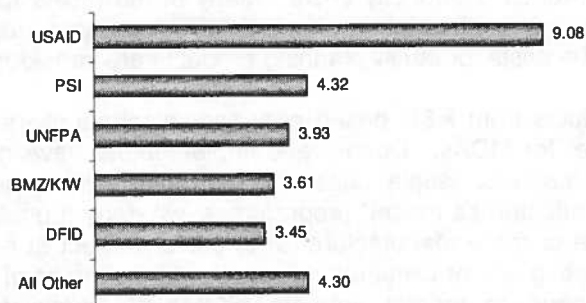
Differential pricing, whereby manufacturers agree to offer products at a lower cost in certain markets, is becoming more common particularly with expensive drugs. In the past five years, most pharmaceutical companies have offered some drugs at lower prices in developing country markets, primarily for anti-retrovirals and anti-malarials. Arguably, this trend began with contraceptives; the lower price that USAID and other large procurers have negotiated for contraceptives in developing countries for years is a form of differential pricing. The Morocco case study in the final section provides an example.

Another product cost reduction strategy that has emerged with injectables and some OCs is to **out-licence** a branded product, which may or may not still be on patent, to a generic manufacturer in developing countries. Organon has done this with oral contraceptives (OCs). For Cyclofem, the Concept Foundation is the master licensor to commercial companies and licenses the product to Pharmacia in the US and a generic Mexican licensee for manufacturing and sales in Latin America. Such out-licensing enables the pharmaceutical company to provide product at a lower price in developing country markets, while avoiding pressure to charge the same low price in developed country markets due to reference pricing.

Untying donor funding has potential to have considerable impact on the cost of products. USAID policy currently requires purchase of US made products, though an exception was recently granted to procure from Organon for reasons of price. The effects of this policy are illustrated in the figure below¹¹.

¹¹ Source: RH Commodity Security: Adequacy of the International Architecture for Finance and Supply, Report for DFID, DFID Health Resource Centre, Ditlev Schwanenflugel, July 2005.

MAJOR CONDOM PROCURORS 2002 – AVERAGE PROCUREMENT PRICES
\$ per gross (144); constant 2002 prices



Note: USAID prices are substantially higher than average. This is likely to be due to their use of tied aid (Buy American), though this has not been confirmed. PSI being higher may be due to part use of tied aid

Source: UNFPA, project analysis

Sourcing from quality-assured emerging market industry may increasingly become yet another tool for reducing costs on the product side. As technology and intellectual property rights (IPR) barriers decline for the older contraceptives, emerging market suppliers have increased their presence as suppliers to programmes. To date, **generics** have been supplied to domestically based programmes (Pakistan's Famila by Zafa). However, the existing market share of developing country manufacturers in their own markets as well as in poorer countries is unknown at present. Concept Foundation and others have suggested that non-indigenous manufacturers may never sell into some markets such as India and China, where the barriers to entry may be too high or the potential for profit too low. They also believe it may be unrealistic to expect generic manufacturers to enter developing country markets without assistance, given the minimal prospects for revenue relative to other markets.

However, strong presence of emerging market manufacturers in the EPI (Expanded Programme on Immunization) vaccine business shows potential for interest in low-margin business,¹² as does strong presence of Indian manufacturers in the fragmented and low-margin business of older anti-malarials in Africa.¹³ We also know that 56% of India's exports of active pharmaceutical ingredients and finished products went to developing country markets in 2003,¹⁴ so clearly these markets are of some overall commercial interest to Indian firms, at least in some product sectors.

An example of sourcing from a domestic oral contraceptive manufacturer can be found in Key Social Marketing (KSM) in Pakistan (see case studies).

MDAs are seeking to make such progress by **assisting generic manufacturers** (especially "southern" low cost manufacturers) with registration, market sizing and scoping, business planning support, marketing and policy issues as well as providing assurances of increased volume in particular markets. Direct incentives might also be possible in the form of a loan or cash grant, contingent on a particular set of

¹² 60% of UNICEF's requirement for EPI vaccines is fulfilled by India, Indonesia, Cuba and Brazil. See page 14 of http://www.dfidhealthrc.org/shared/know_the/GHP%203%20paper.pdf

¹³ IPCA Laboratories Ltd is the largest supplier of anti-malarials to Africa, producing the low-margin, older products chloroquine, mefloquine, amodiaquine as well as a WHO pre-qualified artesunate-amodiaquine.

¹⁴ See page 14 of http://www.dfidhealthrc.org/shared/publications/Issues_papers/ATM/Grace2.pdf

milestones being met (e.g. launch, retail presence in x localities, y number of units having been sold), though no specific examples of this were identified.

Partnership with generic manufacturers has recently emerged under the new label of "Tier 2." The concept of tapping into emerging market suppliers, with their lower cost structures, has existed for many years (planned for Egypt and India in 1998). Several such partnerships exist (with or without the "Tier 2" label) with examples including KSM/Futures in Pakistan, PSI in Nigeria, ICON Romania, Jordan and other "Tier 2" study countries and Concept Foundation with many countries. A key aim is to bring more low-cost high-quality contraceptive suppliers into the market. Concept Foundation suggests that at least two and probably more like three or four suppliers for each contraceptive would be ideal.

As with all kind of activities that aim to "shape" or "develop" markets, there are inherent challenges in trying to second-guess markets, i.e. there will typically (but not always) be a good reason why market players are not in a particular market, and even if a donor or agency can correctly identify a market failure, they may not be in the best position to efficiently fix it.

WHO is developing a process for pre-qualifying generic contraceptive manufacturers, much as they have been already doing for ARVs, malaria and TB drugs. This would provide assurance to donors that the supplier meets international quality standards and would thereby make the supplier's products eligible to be considered for purchase by donors, international agencies and developing country governments. This would reduce some of the barriers to entry for emerging market suppliers and provide greater choice to procurers, with which to leverage price reductions during tenders. WHO pre-qualification is especially valuable in situations where IPR restrictions prevent a firm from registering the product in the US or EU (e.g. as with some ARVs, which are legally exempt from patenting in India but still on patent in the US and EU, thereby preventing the Indian supplier from registering the product with the US FDA or EMEA).

Another MDA advocated by some is for donors, Governments and/or implementers to make **buying commitments** for set quantities of products. The concept of long-term buying is already practiced by USAID using their contraceptive contracts with the R&D-based industry. At least one social marketing organisation (DKT) also signs 5-6 year buying agreements. Expansion of this approach to other procurement mechanisms would allow small and medium sized generic manufacturers to compete with R&D pharmaceutical companies for tenders. (See box) Such a buying commitment may lower procurement prices achieved, though some additional costs of supply management (MIS and warehousing) may be incurred. It has been suggested that funding of not less than three years will have to be committed and available.¹⁵

¹⁵ Longer-term contracting pursued by UNICEF for vaccines has not necessarily resulted in decreased prices but has resulted in increased supply security.

Generic vs. R&D Manufacture and Tendering

- Oligopoly created by classical tendering approach by UNFPA and others
- R&D manufacturers can deliver 10 million cycles because they have a manufacturing surplus. Wyeth and others can easily integrate an order into ongoing manufacturing; generic suppliers do not have surplus production.
- Generic manufacturers produce 10-80 million cycles per year vs. Wyeth or Schering producing about 50-100 million cycles per site and able to shift production across several factories globally.
- Stable commitments to buy a set amount of product would allow generics to compete. Would require commitment of 100-300 million cycles over 3 years.
- Commitment over time matters more than the quantity
- Donors/Governments/Implementers could get together to do pooled procurement
- RH Supply Coalition could coordinate and oversee the process (e.g. financing, negotiation)
- Requires consistent supply of donor or other buyer money, e.g. long term commitment to finance [3+ years]
- May incur additional MIS and warehousing costs

Pooled procurement is another MDA that could lower product costs by increasing the volume of purchases and thereby lowering the price. Programmes or even countries could join together to procure products. The logistical challenges of multi-programme and international procurement may add a prohibitive cost. Complexity and resulting costs were key factors in the DELIVER Project's assessment of the feasibility of a West Africa regional procurement, as they determined that the lack of standardisation of essential medicines lists, drug protocols, product registration and packaging increased the complexity of pooled procurement for the region to a prohibitive degree. Added complications (and potential costs) include the logistics of regional warehousing and transporting the products around several countries, communications and financing by each country. Nevertheless, pooled procurements may be viable in some markets, and in fact essential for supply security in some product sectors such as vaccines. The RH Supply Coalition could coordinate and oversee the process (e.g. financing, negotiation), though this too would likely add costs.

The benefits of pooled procurement are not necessarily that clear cut, and it may well be it should remain a relatively low priority, except in exceptional circumstances. Potential issues include:

- High cost and complexity of organizing multi-programme/ international procurement (as evidenced by the DELIVER West African programme)
- Many countries may reach economical order size without pooling with other countries (exception would be small countries, with low prevalence of the contraceptive in question)
- Pooling may go against the prevailing aid effectiveness trends, which tend towards supporting developing countries own procurement capacity, at least in situations where the market dynamics do not require pooling at an international level. This is in contrast to artemisinin-based combination therapies, TB drugs and vaccines, where supra-national pooling may be necessary to guarantee supply security and achieve some degree of price reduction.

4.2. *Reduce the costs of and increase the effectiveness of distribution*

MDAs can also increase the effectiveness of all steps along the value chain. Market development approaches can improve distribution effectiveness and reduce the costs of distribution. Distribution for family planning includes warehousing, transport to distributors and retail outlets and sometimes the services and training of the providers who offer the product to the consumer. Training is especially important in cases where a strong service element is necessary complement effective product usage.

Public to private distribution: For many years, social marketing programmes have sought to reduce the costs of distribution by shifting the costs from the public to the private sector. In this way, costs are borne not by the public sector but in part by the commercial outlets/distributors and by the consumer. This approach relies on the relative efficiency of the private sector. Social marketing programmes differ on the extent to which they use the private sector, depending in large part on the effectiveness of the distribution systems available in the country's commercial sector. While most social marketing programmes rely on these efficiencies to one degree or another, innovation in this area has been limited for family planning. ITN MDAs have focused a great deal in this arena of late in an effort to encourage more retailers and donors to stock the products (Futures Nigeria, Netmark Nigeria and elsewhere). While the principle was the same for both Nigeria programmes, the degree of funding used to entice manufacturers varied considerably from a (free) contact with a distributor to \$10,000 for agreeing to carry a project logo on the ITN packaging

Another example of a shift to private distribution is a purely commercial pharmaceutical network in India, and now other parts of Asia, called the Medicine Shoppes. This franchise, a subsidiary of the US-based Cardinal Health, the world's fourth largest community pharmacy franchise, is the largest chain of pharmaceutical retail outlets in India, with shops operational in Mumbai, Navi Mumbai, and at several other cities in Maharashtra, Gujarat, West Bengal, Goa, Karnataka and Andhra Pradesh. This is an example of the "bottom of the pyramid" approach (detailed in section 3.6 above) whereby a low-cost/high volume approach was adopted through the creation of more efficient distribution.

Private provider training: MDAs have traditionally paid for provider training with donor funds. The donor-funded CMS Project engaged the commercial sector (Upjohn-Pharmacia) in *Depo Provera* training of detailers and providers. However, in an evolution in commercial engagement, Hindustan Lever (Unilever's main operating business in India and the country's largest consumer goods company), which sells through Buying Circles (somewhat akin to Tupperware parties), has recently agreed to add family planning to the product line and train sellers in family planning with its own funds.

Partnership for commercial distribution: MDAs have traditionally relied on commercial distributors or donor-funded distribution systems. In some countries where commercial pharmaceutical and FMCG distributors may not cover the whole country, MDAs have identified another distribution system. For example, social marketing programmes in Southern Africa have tapped into Coke's distribution system to move condoms around the country.

Effective distribution: MDAs often make products available in outlets where consumers like to find them. Whereas public sector outlets might be too far from people's homes or otherwise undesirable places to visit, private distribution to drug

shops, private clinics and pharmacies can create greater access to the product, thereby increasing choice. The Medicine Shoppes mentioned above are also an example of how MDAs can enhance distribution. The Medicine Shoppe franchise prides itself in the value-added services that the franchisee provides beyond merely selling quality drugs, for example, SMS reminders for medicine refills, free and periodic medical camps, and free diagnostic services.

Social Franchising: Social franchising has the objective of improving access, quality and value for money of products and services meeting social objectives (e.g. public health). Social franchising uses commercial franchising techniques which leverage branding, economies of scale and a balance of economic incentives between franchisor and franchisee. The most common and widely documented product/service sector for social franchising is the reproductive health sector. Other sectors to which social franchising is being applied are in the supply of basic essential drugs, water services and, more recently, in the supply of TB and HIV/AIDS products and services.¹⁶

A social franchising MDA that has expanded access to a wide range of quality medicines and healthcare services is the CFW shops in Kenya (also known as the HealthStore Foundation). Helped by seed funding from the Bill and Melinda Gates Foundation channelled via Management Sciences for Health, CFW is a franchise network with 54 clinics and drug shops across Kenya. The drug shops have served over 700,000 patients, providing basic medicines in rural areas, whereas the more urban based clinics provide health services and products requiring a higher skilled healthcare worker.

A range of basic drugs and supplies, including family planning products, of guaranteed quality and standard price are provided by community health workers in the drug shops. The ready availability of these health workers has enabled the model to reach rural areas as has the economics of offering a wide range of products. Some of the CFW shop owners/franchisees also employ "bottom of the pyramid" thinking and employ itinerant sellers with some community health training. These health workers do not require (costly) premises from which to work, but they enable the franchisee to expand the potential catchment area to which he can sell product & therefore increase sales volumes. The model improves service quality and value for money as well. CFW provides franchisees with training in patient symptom management and counselling. Products are consistently available at standard prices in the CFW shops and clinics, and studies have also shown that competing pharmacies have had to lower their prices when CFW shops entered their region/area.

Many social marketing programmes have expanded from purely product marketing to marketing of integrated services including family planning, treatment of STIs, Voluntary Counselling and Testing (VCT) and primary health care. These have included programmes to provide targeted family planning service and VCT (GreenStar and to a lesser extent, Key Social Marketing; IPPF Member Association clinics; MSI clinics) as well as integrated services (Janani project with DKT/Bihar; Profamilia in Bolivia; PSI's Myanmar franchise "SQH."). In some cases existing infrastructure to deliver family planning services are being expanded to deliver other products and services (IPPF Member Association clinics and MSI clinics for VCT).

¹⁶ See <http://www.hlspinstitute.org/projects/?mode=type&id=15043> (from page 27) for a more detailed discussion of social franchising

Using an integrated platform can increase cost-effectiveness. Some are large networks with many facilities (Janani has 40,000 so far), while others are smaller. (See **India Case Study** and **Pakistan Case Study**).

MDAs that support services expand the choice of products and methods because a wider range of products can be delivered, including those such as IUDs requiring a trained provider. Some people believe that an MDA that focuses on services (vs. product only) provides a greater likelihood of having a demand-driven rather than a top-down approach as clinics will eventually stock a product that consumers demand. Subsidies may go to a specific brand or product (Janani, with product support from the Government), or to the whole range of methods offered by the clinic (GreenStar). Also, by placing the clinics in particular geographic areas, services can be targeted at particular populations.

4.3. *Create a policy/enabling environment that encourages competition and choice*

A focus of many MDAs is to foster an environment that brings more products to market. This was a key principle of the SOMARC project, and is now being carried forward in several ways. Many of them are low-cost interventions that do not require a great deal of outside support [See chart above on page 18, section 3.6 of schematic overviews of MDAs]; they have an even "lighter touch" than the manufacturers model. In some countries companies may opt to enter markets on their own, though few examples of this exist for family planning and surprisingly few for condoms (e.g. Ukraine, Russia and Romania OCs).

Registration facilitation: A programme or Government may provide support to a company that intends to register products. This may be in the form of assistance with registration itself (SOMARC, multiple countries) or through assistance programmes that are seeking to streamline legislation and governmental procedures for registration (University Research Corporation/USAID, Romania).

Similarly, **taxation and duty reduction** may foster an environment that encourages more suppliers to enter the market. This debate was led by a commitment in the Abuja Declaration to an elimination of import duties on ITNs, but has also been discussed in the context of family planning and HIV/AIDS (elimination of taxes on condoms is currently under discussion in the Dominican Republic).

Increased number of products - "Crowding in:" The presence of more products and competition should not only increase choice but also increase demand for family planning. Many MDAs aim to increase the number of products on the market through category marketing and working with manufacturers. Some are designed to foster direct competition at similar price points and targeting similar populations [Ghana Social Marketing Foundation], while others aim to have products available at different price points [GreenStar and Key Social Marketing Pakistan, Ghana Social Marketing Foundation OCs, SFH/Nigeria condoms, PSI/Myanmar OCs and injectables].

One version of this is the above mentioned "Tier 2" programme, where a fully commercial brand – likely to be a generic - is introduced at a price point above social marketing and public sector distribution but below commercial prices (under consideration or planned in Nigeria [SFH/PSP One OCs], Romania [ICON OCs] and Peru [ICON OCs and/or injectables]). Still another approach leads to a so-called "halo effect," whereby other products come into markets and increase their market share as a result of a social marketing brand even without direct assistance (ICON

Cool condoms is the Baltics). Numerous examples of this halo effect exist in other markets including ITNs [Tanzania] and water systems [Kenya].

The much talked about corollary of “crowding-in” is “crowding out”, whereby a free or subsidised product competes (with perhaps ‘unfair’ advantage of support or finance from donors or government) with commercial products, thereby making the market less attractive to new commercially-minded entrants or even to existing players. This is a rising concern in the Philippines. (See case study)

4.4. *Marketing and Demand Creation*

Category demand creation: MDAs can create demand for a type of contraceptive rather than for a specific brand. A range of manufacturers and distributors can take advantage of a generic marketing campaign, competing with one another to drive prices lower and grow the total market for a given commodity. There are examples of this in the malaria ITN field. NetMark (AED) implements this approach with a “closed club” in various African countries, and Futures Group has implemented a similar approach in Nigeria inviting any partner to participate, prioritising small scale distributors.

This increased focus normally goes hand in hand with a more commercial market development approach, and efficient and effective commercial systems and agencies are deployed. The intended result is both decreased public cost and increased effectiveness in reaching target groups.

Able to do more than the private sector: One of the key advantages that an MDA can have over a purely commercial approach is greater freedom with advertising. In many countries, social marketing programmes have successfully lobbied for permission to advertise their oral contraceptive. Because the Governments recognise the social goal of the MDA, they are willing to permit product advertising (Peru). Similar freedoms often apply for distribution as well as; in Pakistan Key Social Marketing detailers were permitted to sell the product on the spot rather than take orders, enabling the establishment of a strong push system.

Better Communications: MDAs can improve the effectiveness of BCC by taking a more commercial approach. Some programmes may rely on available marketing services, while others may create in-house marketing and promotion in the absence of their availability in the commercial sector. Costs may also be shared with the commercial sector (Indonesia and many SOMARC countries).

5. LESSONS LEARNED

Rather than draw conclusions about what we have learned, we believe this report provides an opportunity to ask questions about what an overview of MDAs tells us. In other words, we have learned that MDAs are complex and that asking questions is important.

In this section we raise what we hope are the most “sticky” difficult questions. We have provided our observations in order to further the debate and understanding of these tricky issues, not so much to provide the ultimate answers, which may differ according to the context. Some of issues discussed may be well known to members of the MDA Working Group, while others may merit further exploration by the group or individual members of the group.

5.1. *What are the characteristics that make a market attractive for a MDA intervention?*

Given the range of MDA interventions, it is next to impossible to generalise on this issue. Perhaps the most important point is that appropriate markets can be very different from one to the next. For instance, the GDPs in Morocco and El Salvador are very different, yet as both countries are being "graduated" by USAID they would certainly be considered likely candidates for a Tier 2 or other market-driven approach. The market development stages chart on page 15, Section 3.4 above may provide further insight.

Other characteristics that tend to be correlated with successful MDAs:

- Large and growing group of consumers and/or potential consumers who are willing and able to pay for the product.
- Clearly defined gap in the market such as a price range with no product. The implementer would need to have a product at a price point that matched the gap. The gap might also be the absence of a product such as an injectable that might be appealing to a set of customers.
- Programme backed by realistic, well-funded and well-executed marketing programme
- CPR with potential and likelihood to grow
- A well-segmented market, with Government and donors committed to a total market approach over the long term
- An environment of interest to credible commercial partners who could be engaged in a mutually beneficial long-term relationship
- Overall donor investment in reasonable proportion to programme outcome and risk

5.2. *What makes a good commercial partner?*

Assuming that the MDA includes some public funding, in general, the implementing agency will provide some form of payment/incentive to commercial partners, either for services rendered and/or for carrying out actions that would not otherwise have been commercially viable. The degree of that payment should be reviewed carefully to see if it is fair and justifiable. In some MDAs, the commercial entity may simply be a supplier, as we see in many social marketing programs where the brand is owned by the implementer leaving no larger role for the manufacturer.

In other MDAs, the supplier is more of a partner, in that risks and rewards may be more equally shared amongst donor/implementer and the commercial entity. For commercial partnerships to work, program aims have to match partners' commercial goals (i.e. maximize profits or further the firms longer term strategic interests). It is clearly possible to have goal congruence between social goals and profit maximizing goals, but it is not automatic, and typically a solid business case will be required in addition to any CSR or social goals the private firm may be supporting. Commercial partners should not be expected to commit to utopian projects; they should be expected to engage in reasonable risk and burden sharing. Donors may wish to consider managing risks and rewards by engaging in milestone thinking, where additional commitments are made on the basis of achieved results. The Ghana Social Marketing Foundation is currently dealing with precisely these issues, as they seek to develop a partnership with Organon and Famycare that goes beyond marketing support in exchange for increased sales volume. Some implementers have highlighted that we do not actually know for certain what incentives work for commercial partners, and often implementers do not have leverage over the

commercial partners. The challenge is to determine what would make the partnership have more give and take.

5.3. *What makes a good MDA implementer?*

While all the usual criteria apply for selection of any project implementers, to increase access and choice of products, implementers need to bring specific skills to the programme. As we have seen, there are already many players involved, so the implementer needs to add value. A good implementer brings:

- Most suitable network for influencing private providers – which is perhaps the most important, and most often overlooked point, and is even more important if the products require a strong service element to facilitate use;
- Best distribution;
- Lowest overhead relative to other projects of the same type;
- Demonstrated capacity to conduct procurement (if needed);
- Complete and correct understanding of “cost recovery,” including that revenues have to exceed the cost of the product in order to be “cost-recoverable”
- Staff skills should match the programme needs as they evolve in a dynamic market. MDAs are likely to require marketing skills and financial skills to manage a Profit and Loss.
- Clear policies on the use of programme sales revenues (which may be pure profit or may be required to be reinvested in the project). A sample policy might include:
 - When contraceptives are donated or procured with donor/Government funds, sales revenues are reinvested in the project during LOP

5.4. *What types of product are suitable for MDAs?*

For the most part, social marketing programmes – a major component of MDAs - have focused more on short-term family planning methods than longer term methods. Short-term methods such as condoms and pills are usually sold as FMCGs and OTC products (even though a prescription for emergency contraception and OCs may be required by law). Some projects have sought special permission to make products available outside of clinical settings.

Fewer MDAs have sold longer-term methods, with the exception of clinical services where a wider range of products and services, including IUD and implant insertion and sterilisation may be available. In certain markets, such as Latin America and parts of Africa, injectables may also be marketed. Programmes involving longer term methods usually include a service strong provider training and quality monitoring element and are often termed social franchising rather than social marketing.

Given sufficient services to support quality of care, MDAs which aim to increase availability and choice with longer-term methods may be an area for more programming, bearing in mind that the added provider training and monitoring can raise expenses. Organisations working with suppliers may also want to consider procuring better value (high quality, lower cost) IUDs and implants.

A related subject is the benefit and/or drawback of having a narrower vs. broader product portfolio. Some MDAs have successfully created a “platform” from which they can deliver a wide range of services more cost effectively than a limited range. The Medicine Shoppes, CFW, Janani, GreenStar and other franchise models demonstrate the benefits of clustering a range of products and services under one franchise umbrella. The Medicine Shoppes provide a cost effective system for a wide range of pharmaceutical products, and also provide accident insurance to their customers, which illustrates another form of product and service bundling to attract

customers. The sophisticated IT system provided by the Medicine Shoppe franchisor is what makes the management of a wide range of products and cross-selling of services possible.

In some cases, however, such as a situation where resources (financial or human) are limited, a program may be better off limiting the number of products it offers in order to be able to deliver a single product well. This may happen in some HIV/AIDS programs that could conceivably expand their product line from condoms to oral contraceptives, but opt not to because the shift in target audience and approaches would not necessarily be cost effective.

5.5. *What should be done about quality of care?*

Market development approaches often create a tension between quality of care and access. Making oral contraceptives and even injectable contraceptive available in informal drug shops creates greater access which may increase contraceptive uptake. But wide distribution through more informal channels also raises questions about quality of care when untrained staff work in such outlets; discontinuation may increase or other problems arise. Training such informal staff even with basic information can be challenging and expensive (though not impossible as SFH has demonstrated through training of Proprietary Patent Medicine Vendors. Implementers and donors need to assess the governmental restrictions on products and decide their degree of comfort with pushing for expanded access and/or focusing on quality of care.

Ensuring quality is a challenge, but ignoring quality is also not possible. Training providers is intensive and expensive and it may be difficult to identify and train staff in more informal clinics and pharmacies. Some managers have complained that quality issues are the "money sink" for private sector clinical programmes. On the other hand, DKT affiliate Janani in India has developed a very low cost system for ensuring quality across a network of 40,000 providers (see case studies).

5.6. *Is competition between MDAs good?*

Donor funds are used for MDAs when markets have failed. Many MDAs aim to use the donor funds to correct market failures. But such a market intervention is not without risk. Public funding of MDAs distorts the market; competition among commercial products and services is no longer purely market driven.¹⁷ Competition among MDAs may result. If the competition benefits the consumer, it is good. For instance, it can drive prices down (ICON, Baltic condoms) or increase uptake (PSI/MSI Uganda condoms) or drive innovations in programming. (In the joint Output to Purpose Review of Key Social Marketing and GreenStar in Pakistan, February 2002, several marketing and distribution innovations were attributed to competition between the two programmes). But it can also push out competitors (if the share each gets is too little to achieve cost recovery or cost per CYP goals), and can lead to non-productive name-calling with little benefit to the consumer. Clearly segregated distribution and pricing channels can help to mitigate unproductive or wasteful competition. Open communication would also help.

5.7. *How much is enough marketing?*

Regardless of the type of MDA, a strong marketing component needs to be carried out. While donors are usually happy to fund marketing, high donor investment does raise issue of sustainability as marketing is not generally a one-time expense.

¹⁷ Public funding for public services also distorts the market, as some people who could pay instead seek free or subsidised services.

Implementers need a long-term plan for how consumers, detailers, distributors and key influencers (e.g. doctors, nurses and pharmacists) will be reached.

At the same time, for many MDAs marketing is a key element of success. It is the "carrot" that will allow to move consumers away from subsidized products and increase their willingness to pay. While marketing expenses are not a one-time expense, there are likely to be higher upfront costs until certain volumes are reached after which marketing expenditures may be able to be reduced without affecting demand. Marketing resources are needed to reach the targeted volumes, but the challenge is in determining if the money is being well-spent, i.e. if the marketing is being done well or not.

5.8. *What's the best price?*

Most practitioners will be aware of the "Chapman" rule of thumb, whereby 1% of GNP per capita should buy 1 CYP. For example, if the per capita GNP of a country is \$300, then contraceptive supplies for a couple for one year of protection should cost \$3. However, the rule has only been shown to work with condoms, using 1991 data, and has not been shown to work for other products. An additional caveat is that the rule of thumb is "crude" in that it is only based on social marketing service delivery statistics, and does not control for the presence of other sources of supply.

Some observers find the Chapman rule too conservative, i.e. with the right marketing; couples would be willing to pay more, as the health and earnings benefits of avoiding unwanted pregnancy are generally much higher than one day of lost earnings. Indeed Chapman himself observes that the rule of thumb appears to no longer work for condoms; condoms priced above the 1% rule now sell at rates above 0.5 per capita which is considered a relatively high condom use rate.

Certain recent studies maintain that demand for contraceptives has been inelastic provided intensive demand creation activities are carried out. One study showed that sales did not reduce over time as the price of a particular product increased, while the intensive level of demand creation was sustained. (See Kara Hanson "Supplying Contraceptives." Options Consultancy Services).

5.9. *What are the issues with brands?*

Brands are an important element of many MDAs which set many of the interventions apart from other behaviour change interventions. Brands can play a key role in destigmatising a product so that the consumer can enter a pharmacy or clinic and ask for the product by name, rather than having to mention "oral contraceptive" or "condom." Brand image can also be a key determinant of consumption and willingness to pay and has a huge role to play in segmentation.

MDAs have used both product name brands and umbrella brands. An umbrella brand such as the Red Apple in the Central Asian Republics or the Green Key of Key Social Marketing can be useful for attracting products to a market and thereby increasing choice. The 'brand', to be distinguished from the umbrella brand, is the product brand name, such as 'Famila' (Zafa's product brand name in the Key Social Marketing example) or Nordette (the previous brand name that went with the Key umbrella brand when Wyeth was Key's supplier). Both brands and umbrella brands can ease the transition from one supplier to the next as we have seen in Pakistan with the Green Key logo during the transition from the Wyeth to Zafa products (which also included a brand change) and in Uganda with *Pilplan* to *New Pilplan* as USAID switched suppliers.

Brand strategies should match the target audiences. Social marketers have a tendency to position the products upmarket from where they need to be. In some condom social marketing programmes the target audience includes rural youth, and the advertising and promotion is “aspirational.” This means that the brand image and communications convey an urban or even western image of youth of higher socio-economic status than the actual target group. Such an approach assumes that the rural youth “aspire” to this lifestyle and therefore will want to use the social marketing brand associated with this urban style.

Brand ownership has been a contentious issue with MDAs. The brand can be owned by the donor, the implementing NGO, or the private sector manufacturer/distributor. When the NGO owns the brand, the fear is that the NGO can perpetuate its role in the programme, even when others may be able to do a better job at some point in the future. This could create organisational rigidities. A solution may be to give ownership to the donor. However in this case, the NGO’s incentives to build up the brand may be muted due to the risk of contract termination by the donor. Moreover, if the donor owning the brand results in frequent interference in the operations of the NGO, this may stifle innovation.

A third alternative is to have a private company manufacture and distribute the product, subsidised by a donor. In this structure, the private company owns the brand, and the NGO acts as an intermediary between the donor and the private company, as well as performing supplementary functions. The advantage of this structure is its perceived sustainability: The donor seeks to reduce its involvement gradually until eventually, commercial provision becomes self-sufficient. The problem is that the private company’s incentives may diverge from those of the donor (for example, failing to distribute condoms near brothels to prevent the spread of AIDS, in a SM programme focused on HIV prevention). Moreover, the donor’s intention to reduce its involvement may be thwarted if the private company holds it up for greater and greater subsidies.

There are risks to each choice and the optimal brand ownership structure will differ in each situation, according to the actors/institutions involved, the market, the programme objectives, for example. Although choosing the ‘best’ brand ownership structure may be easier when setting up entirely new programmes, many donor funds build on existing institutions and in these circumstances, improving on existing models may be more practical and less risky than a wholesale changeover to an “optimal” model, especially if much human capital is tied up in existing models. The key challenge is to choose the brand ownership structure in a way that aligns incentives for each actor to invest their optimal effort in achieving the programme goals, bearing in mind that brand ownership structure is but one parameter affecting incentive alignment.

5.10. When should a programme be cancelled or changed?

Cancelling MDA programmes on short notice can cause more disruption to the market than not having begun them. Government and donor strategies need to be clear and agreed upon for a set period of time with milestones for review and redefinition. Donors’ exit horizon should also be clear; in some countries donors will commit to stay for the longer term and in other cases, the timeline is short. Likewise, in order for programmes not to be cancelled for quality reasons, success criteria need to be made clear (see below). If a strategy change is planned, all partners need to be given ample warning so that adjustments can be made. Each of these parameters will help ensure that donors balance their need to stay committed to a

strategy while also maintaining a responsiveness and flexibility to changing circumstances.

In the case of a crisis or unplanned interruption, MDAs may be able to withstand crises given their link with the private and commercial sector which continues even in challenging circumstances. A free distribution system would be 100% dependent on donor and Government support, whereas a commercial or slightly subsidised product might be able to continue to sell through an upheaval. An example of this might be condom sales in Congo (Kinshasa) during years of unstable Government and fluctuations in donor presence.

5.11. What are the correct levels of cost effectiveness, commercial viability and sustainability?

One of the compelling arguments for MDAs is their ability to achieve results in a cost effective way. MDAs may have a degree of cost recovery, which can vary from a small proportion of costs (cost minus) to a profit (cost plus). But MDAs have often blurred the line between financially sustainable and commercially viable. This report does not seek to judge what degree of cost recovery is sufficient or better, but only to bring the issue out of the depths of rhetoric to the light of day.

Investment in marketing has come to be considered sustainable, while investment in product subsidy is not. The debate about the merits and impact of each approach may continue, but it is important to understand that most MDAs require donor funding with no financial return. One programme categorised itself as having a "lighter touch" than even a manufacturers model (which is assumed to have a high degree of cost recovery), yet the programme has a \$35 million grant for marketing, research and other support. In the same country, an NGO model is operating, and also carries out marketing and provides a product subsidy. While one or both may well be good investments, neither is a commercially viable programme.

A viable project has the following characteristics:

- Has good chance of reaching break-even within a 3-5 year time frame;
- Distribution system that reaches the intended audience;
- Absence of catastrophic free or heavily subsidised product competition;
- Implementing agency and commercial partners are carrying appropriate proportion of risk, i.e. have clear and logical incentives and consequences if promises are/are not delivered; and
- Accountable and milestone-based: results are measurable, and donor can pull out if the project is not working.

But given that MDAs are operating with some use of public funds, a project also needs to have a well thought out explanation of how the project will benefit the poor. Are the two compatible?

Programmes, donors and Government need to clearly define their expectations with regard to sustainability. A goal of "becoming sustainable" leaves open the interpretation of sustainability. Instead, as noted in the table below, sustainability can be defined in explicit financial terms (% of product cost recovered, years until break even etc) and/or in terms of institutional sustainability.

The overall challenge remains to measure whether a programme's benefits stand in reasonable relation to its costs and risks. MDAs have used indicators such as cost/CYP to measure effectiveness, but even these measurements can be problematic. In Pakistan cost/CYP was found to be limiting for not accounting for

future CYPs due to the longer-term sustainability of the programme (when consumers will buy a full-price brand), while in the Philippines cost/CYP is thought by some to have created an incentive for dumping subsidised product. New benchmarks are needed to measure the cost effectiveness of MDAs. For instance, a programme might present total investment required to reach breakeven or project investments needed to create an uplift in CPR.

Another important consideration in this equation is the impact of public funding on commercial markets. The commercial sector has been used to varying degrees to increase availability and choice of contraceptives in financially sustainable ways. But sustainability can also have trade-offs; high level of commercial involvement may have high financial sustainability from the donor and government viewpoint, but may also be expensive to the consumer. An important consideration is the long-term impact of public/donor support to markets. While there is some concern that donor/government funding (i.e. subsidy) distorts markets, the evidence of the results of MDAs and particularly their impact on markets is inconclusive.¹⁸

6. KEY PRIORITIES AND GAPS

While this report cannot provide an exhaustive review of MDA issues, we highlight here a few critical issues that arose from the interviews and readings.

6.1. *Define success*

One of the most crucial elements of MDA design, implementation and evaluation is clear agreement -- among Governments, commercial partners, donors and implementers -- on the programme aims and objectives as well as the determinants of success. Alignment of incentives of each implementer along with the agreed-upon objectives is also important to ensure a coherent vision for the country.

These are important parameters to set as they can guide the decisions about program continuation and change. Given that public funds are being used to support private and commercial ventures, donors and implementers often try to be both viable commercially and socially. This combination is not always possible, and project partners and donors should be clear about what is possible, particularly during project design, proposal writing and evaluation.

Defining the measurements for success of the MDAs is about making choices. Such choices include tradeoffs: between sales volumes and price, cost per CYP vs. longer term sustainability, cost recovery and serving the poor. No project should set out to "have it all" and donors should be sceptical of a proposal that provides both fully viable commercial goals and direct service to the poorest of the poor. Most projects will be hybrids, comprised of different building blocks and tools, whilst others may open the possibility for service to the poor by shifting consumers as discussed above.

For example, ICON's *Cool* condom social marketing programme in the Baltics is successful in many regards, yet received a somewhat critical evaluation as it could not achieve all the planned objectives to serve the poor, drive down condom prices, recover the full cost of the condom *and* create a good income stream to enhance the sustainability of the Member Associations. In contrast, IPPF's efforts to enhance the sustainability of the Latin American clinics were considered highly successful, even though the clinics lost their poorest clients because the prices were unaffordable. Programme participants had determined that sustainability of the clinics was the most important criteria.

¹⁸ See Hanson et al as "Supplying subsidised contraceptives" at www.options.co.uk.

Nonetheless, as with many public health interventions, it is difficult to link interventions with results. For example, in the mid- to late-1990s Pakistan's CYP increased dramatically, concurrent with GreenStar, Key Social Marketing as well as public sector outreach. While all interventions likely contributed, it is difficult to attribute differentially the CPR increase to each intervention. Evaluations should be designed to establish as much of a causal link as possible.

A similar attribution problem exists in measuring the "uplift" that a brand or campaign may have on other brands in the category or on reproductive health as a whole. An example of this from malaria interventions is the ITN voucher programme in Tanzania which resulted in women seeking ante-natal care earlier. In that program, the vouchers had their own potential benefits to lowering malaria infection rates among pregnant women using the nets, but also other reproductive health benefits. Programs need to determine what factors will be used to measure success and impact.

One of the challenges with determining indicators for success is the balance between short- and long-term benefit. For instance, a highly subsidised MDA is likely to increase sales in a relatively short time period whereas generating demand for a higher priced brand may take longer.

These examples highlight the need for careful consideration of incentives at all levels. Incentives can be used to enhance segmentation in a multiple MDA setting. For instance, the public sector could be incentivised for mitigating against leakage into the private sector. NGO social marketers could be incentivised to attract commercial products to the market. Such an approach has not been tried to a great extent. It is important to remember that each intervention has effects on the total market and on markets within it.

While not a complete list, the following table provides an indicative notion of the various options for defining MDA success. At the very least, a review of the table should spark debate and comment about the programme at the design stage.

| Objective | Indicators |
|--------------------------|--|
| Health Impact | <ul style="list-style-type: none"> • CPR • Unmet Need • Discontinuation • Reduction in unintended pregnancies |
| Sustainability | <ul style="list-style-type: none"> • Govt able to pay on its own? • Consumer/commercial sector pay 100% • Product self-financing • Institutions capable of managing programmes • Business confidence is built in manufacturers, distributors and retailers, so affordable access is sustained |
| Cost donor/government to | <ul style="list-style-type: none"> • % paid for product by consumer vs. donor/govt • Decline in cost of products • Decline in market share of subsidised/free products vs. increase in market share of commercial/partially subsidised products • Decline in cost of distribution paid by donor/public sector • Public/donor expenditure of IEC/BCC/promotion/advertising • Increase in Government expenditure on FP • % revenues exceeding product costs |
| Targeting of subsidy | <ul style="list-style-type: none"> • % of population reached via commercial sector |

| | |
|---------------------------------|---|
| | <ul style="list-style-type: none"> • % of poor people buying commercial products • % of rich people seeking services in public sector • Decline in A&Bs receiving free/subsidised commodities |
| Availability/Choice to consumer | <ul style="list-style-type: none"> • # of commercial/subsidised brands available • Decline in consumer price of products • % GDP/per couple/CYP • cost per CYP • Increase in # of pharmacies/outlets selling product, esp. in rural, poor or otherwise hard to reach communities |
| Create Enabling Environment | <ul style="list-style-type: none"> • Decline in duties/taxes on contraceptive imports • Speed of product registration • Cost of product registration |

6.2. Take a Total Market Approach

The Total Market Approach commonly refers to an objective of growing an entire market for a given health commodity by supporting a range of partners to reach the segments of markets that they have the comparative advantage to reach. For instance, in the Philippines several different MDAs are being applied – lower cost procurement by the government for free distribution, NGO model social marketing for the poor and a commercially viable model for those who can afford to pay full price. While there may be some unproductive overlap across the MDAs (see case study), the goal is that MDAs should be complementary and ideally, even synergistic. A Total Market Approach aims to grow all three segments and considers how the three interact.

Taking a total market approach to understanding the market in a particular country helps to ensure that the selected MDA responds to the needs of the country. In the past, countries were segmented on the basis of being an NGO model or manufacturers model country. Now, we recognise the value of looking at the country's market as a whole and considering which types of MDAs can be applied within different market segments.

The case of the Philippines also underscores that MDAs are not confined to the commercial and NGO sphere. Governments can also be involved and take advantage of the cost savings. In India, the Government out-sources some health care service delivery to the private sector. Overcoming the tendency for the public sector to shy away from the private sector is particularly important now with SWAP funding and other centralised mechanisms. Governments need to be aware of the value that a Total Market Approach can provide and the potential for MDAs to increase access and choice as described above. With the shift from donated to locally procured contraceptives underway in many countries comes an increased role for the Ministries of Finance along with the Ministries of Health to be involved in total market approaches.

Donors should also be involved, and arguably, need to play a stronger role in ensuring that the total market is well understood *before* designing programmes to increase access to and choice of contraceptives.

A total market approach also demands donor coordination to ensure that donor funding is not working at cross-purposes. In Peru and the Dominican Republic, Government- and donor-supported free distribution undermined the success of the commercial market. (See also the Philippines case study.) A total market approach might mitigate against conflicting objectives and approaches.

With many donors having differing viewpoints of the roles of the private and public sector, it seems especially important for good analysis and clear communication about the total market and the MDA responses to it. Programmes need to be structured to be responsive to the market needs of the country, rather than the philosophies of the various donors and implementers. Given that markets are dynamic, an approach that was successful three years ago may require a different approach once users have been shifted along the free to full price continuum. Donors and implementers should be flexible and responsive to but not rash about these changes, while at the same time keeping focus on strategy and principles as noted above.

A Total Market Approach needs to be carefully managed in a given country to be successful. This role should ideally be adopted by government or failing that, the funding agency. This also requires a sound understanding of the concept by the donor or funding agency. (See Pakistan case study for an example.)

6.3. *Understand markets*

Governments, donors and implementers need to understand markets better. For instance, understanding not only *ability* to pay but also *willingness* to pay, based on underlying attitudes is a key success factor in any marketing program. Implementers especially need to have marketing skills to be able to design and implement good marketing strategies. Greater understanding of market segmentation is needed not just among implementers, but also among Governments and donors. One interviewee noted that one role for market segmentation data is at a strategic level in order that programmes can be designed to meet the needs of the various segments.

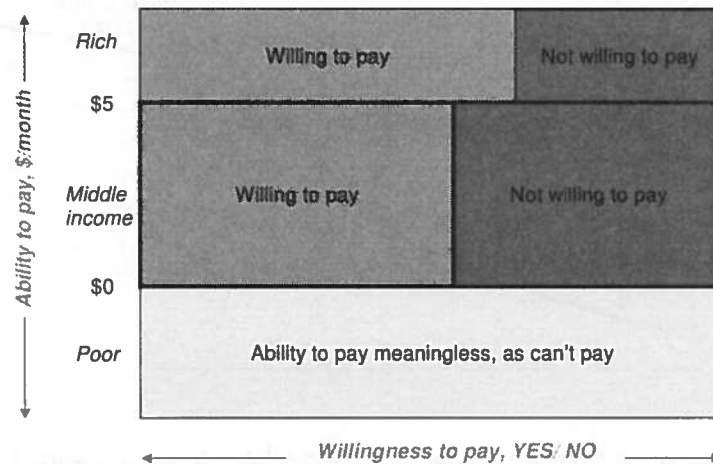
It is worthwhile exploring some key concepts in customer segmentation by price. As a very broad general rule, MDAs will tend to target the "working poor", i.e. the part of the population who is able to pay some contribution,¹⁹ though not at Western commercial level prices.

By implication, MDAs do not directly target those so poor they can pay nothing, nor those wealthy enough to afford Western product. Schematically, this can be illustrated as follows, with income levels set out on the left hand/ Y axis. The figures \$5/month as a cut-off point is illustrative only – this will vary by country, product type etc.

¹⁹ See information on the "Chapman" rule of thumb, above.

Market Development Approaches – target audiences

Rectangle symbolizes segments of sexually active population



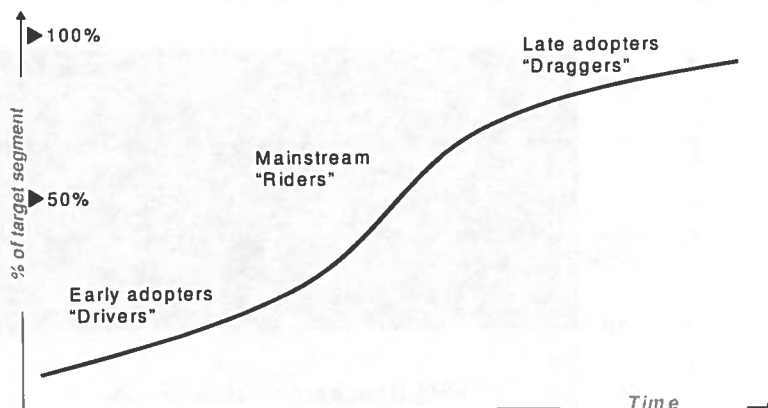
The diagram emphasizes the middle bloc/ middle income segment as the key target for MDAs.

Importantly, the diagram also outlines the second key dimension, which is willingness to pay. Not all of those who can pay are in fact willing to pay. Some may be willing to use but not willing to pay, while others may need to be shifted to wanting to use and also to pay. This is important, in a number of ways:

- The role of marketing is to move consumers from the “not willing to pay” blocs [which constitutes demand]. This can include moving nonusers to becoming users, as well as moving user from one source to another. Marketing can also influence the level of price that people are willing to pay; a willingness to pay a higher price can generate greater cost-recovery.
- Savings can be generated from middle income or rich users not willing to pay and currently drawing on subsidized supply, by transitioning them to commercial, less subsidized sources of supply
 - This can be done with carrots (making commercial supply more attractive) or sticks (e.g. means testing to restrict access to subsidized supply)
 - Improving RH outcomes for the poor assumes that savings from not supplying the wealthier are ploughed back into improved/increased RH supply for the poor
- The ease or difficulty of converting latent demand into actual demand is a key determinant of programme success. While contraceptive use is likely to be the key determinant of success, creating willingness to pay among those who are currently provided with free contraceptives may also be a determinant of success, depending on the program goals.

This latter point is illustrated by the following diagram, showing how products (or practices, e.g. safe sex) are adopted over time.

Segment lifestages



- Early adopters (a minority) are quick and relatively easy to attract
- The mainstream require more convincing and the example from early adapters, but may then switch more or less en masse
- Late adopters or holdouts require a lot of convincing, and may take many years to convert
 - In evaluating programs it is important to understand that it is much easier and cheaper to convert the early adopters than the laggards. It may well be socially desirable but not commercially attractive to try to convert highly conservative, religious rural peasants well set in their ways – which is an example of the limits and tradeoffs involved in designing MDAs.
 - Marketing can also move people along the value chain, though implementers note that they rarely have enough money to do it - especially in family planning programs. It is expensive indeed to recruit in the transition stage as it might take longer, require in-depth research and longer-term interventions.

6.4. *Ensure that MDAs are not only about financial sustainability but about effectiveness too*

MDAs are not just about prices, cost effectiveness and improved financial sustainability. The principal is that taking a market development approach is a means of enhancing the effectiveness of family planning delivery. An important aspect is to find effective ways to use existing systems to deliver family planning products, information and services. Examples include market women in Nigeria (and elsewhere) and the Janani health network in India (see case study).

Taking this broad approach to MDAs recognises that price is not the only barrier to access. Other barriers such as product and brand appeal, belief that the product is not effective, low social acceptance, etc. are also important and need to be addressed by MDAs. As one interviewee commented, "The social objective – not the price - is what distinguishes social marketing from commercial."

7. RECOMMENDATIONS

7.1. *Develop more tools*

Not enough easy to use, low cost tools are available to donors, Governments and implementers to understand and measure markets. In this section, we describe the process (tools) that can be used by MDAs to analyse a market opportunity, as well as to design, manage and evaluate MDAs focused on public health impact.

By design, MDAs use commercial sector techniques to create public health impact. MDAs therefore have borrowed and adapted a number of tools from the commercial sector. Such tools can be used to:

- Identify and understand markets
- Assess how markets can be used to improve reproductive health
- Determine needs and possible areas for market expansion (including competitor analysis)
- Define the potential target audience(s) for market development approaches
- Develop marketing strategies to reach the target audience(s)

One of the challenges is that some market assessment tools can be expensive to use, and donors have in the past at times been reluctant to fund their use.

This section takes the reader through a step by step process to conduct the necessary market research using some of the more widely recognised processes and tools for MDA design, implementation and evaluation, including

- Market Assessment
- Targeting
- Market Segmentation
- Willingness to Pay
- 4 Ps: Product, Price, Place and Promotion
- Tools to Measure Impact

7.1.1. *Market assessment*

As a first step to understanding a market, MDA designers and implementer's would want to gather data about the reproductive health market: who are the customers and what are the products. It is useful to start with a macro overview of the entire market. Data about contraceptive usage, barriers to use, access to supplies (where obtained and at what price), etc. are needed. An understanding of financing and procurement of supplies is also part of this equation.

Such data might be obtained from in-country resources like the Ministry of Health, donor reports and the Demographic and Health Survey. Other data about in-country pharmaceutical markets, such as that collected by market research firms like IMS, might also be incorporated to determine total market size for each contraceptive. However, reliable market data is not collected by research firms in all countries. Ideally, more in-depth information about the consumer and providers is obtained as the programme determines its objectives and approaches. Research may need to be commissioned, though it will often be possible to extrapolate useful data from a relatively meager base.

Market entrants will also want to fully understand current suppliers/ competitors and supply patterns, including distribution systems. Such competitor analysis provides an understanding of how the current market is operating and helps to identify weaknesses that a new entrant can exploit.

It should be possible to identify current market sizes (in units and value) and key drivers of future use, e.g. number of women, GDP per capita, urbanization or other. The end product of this phase is (at a minimum) a solid understanding of the current market size, historical growth figures, projected growth figures and what the key drivers of growth are expected to be. Everything else alike, a growing market is much more attractive than a stagnant or falling market, as it will be much easier for a new product to gain share of market. There are however important exceptions to this, e.g. if the reason for the market being stagnant is that current offerings are staid, and the new product has the chance to reenergize consumer enthusiasm around the category.

7.1.2. *Targeting*

With an overview of the market, designers and implementers can consider which parts of the population to target. A useful starting point is conceptualising the need for and role of targeting in health programmes aiming to reach the poor. Kara Hanson et al have a chapter that explains why targeting is important for reaching the poor, provides examples of what methods can be used to target different populations and reviews the evidence of six different approaches to targeting.²⁰

7.1.3. *Market Segmentation*

Once the programme is designed, implementers (and sometimes donors and Governments too) need to understand how target audiences can be segmented in order to develop appropriate marketing strategies to increase contraceptive use. A principle aim of market segmentation is to match users and potential users with the appropriate source of contraceptives.

Segmenting the market means splitting it into sub-categories with similar needs/desires in terms of the product/ service being analyzed. At its simplest, similar needs may be in terms of price/ quality desires (e.g. "cheap and cheerful" vs. "upmarket"), but good segmentations will typically be more complex than this, and include psychological variables as well. Importantly, these needs and desires do not relate to purely physical or product features, but to intangible factors as well - e.g. speed and/or discretion of service, impulse purchases vs. planned purchases vs indulgence purchases, etc. For example, the "young, female, middle class urban party crowd" is likely to be a different segment than the "Poor, rural male teenagers" segment.

The key point about a commercial segmentation is that it must be "actionable". This means that rather than just being descriptive or interesting in general, it must be able to drive commercial decisions, for example about if/ where to enter, how to promote etc. (see 4Ps section below).

Market segmentations are usually done through a combination of qualitative and quantitative research. It is unlikely that sufficiently targeted research is available off the shelf, so research will generally be commissioned, both quantitative (i.e. asking

²⁰ Kara Hanson et al, in *Targeting Services Towards the Poor* (forthcoming).

set questions to a large sample in a one-way interaction format) and qualitative (unstructured or semi-structured dialogue/two way discussions with smaller groups).

Currently, market segmentation is addressed by only a few groups. The Policy Project has developed a market segmentation analysis that uses the DHS data, asset indices and market data to divide women into distinct categories primarily based on socio-economic indicators. The POLICY Project analyses have been used primarily as policy tools. For example, POLICY's market segmentation analysis in Romania was used to demonstrate the large size of the segment that needed free government contraceptives. The POLICY segmentation methodology is established, but is not widely available and may be costly to conduct. While their segmentation studies provide an overview of the total market, they may lack detail about the social and lifestyle characteristics of the segments that is needed to develop marketing messages to reach particular target audiences.

The PSI/LSHTM working paper "Segmentation and a Total Market Approach" outlines ideas on how a market segmentation tool could work with population data along with data on effectiveness, equity and efficiency. The analysis would include factors on risk behaviour among users and non-users. Also, interestingly, it would include data about the preferred reproductive health supplier and brand including both public and private sector products. The paper suggests summarising data in two tables: one about what to do to grow the market (increase consumption) and the other about how to improve market dynamics by identifying levers to motivate potential users. While the data would be highly practical for programme managers and others interested in the market, the challenge is that to date very few countries have all of the necessary data available from population based surveys.

Chemonics is developing a customer segmentation tool that quantifies the commercial potential in each segment. The study, along with DHS analysis and a willingness to pay survey, is to be conducted in the Philippines for an estimated \$200,000. If Chemonics will be able to share this tool, it may be of some use to other programs in more developed markets, especially if the price to conduct the study can be reduced once the tool is developed.

As part of its work on making markets work for the poor (M4P), DFID has commissioned the Access Frontier tool. The tool segments the market into five groups, and focuses on how to increase the proportion of the eligible population who can access the product. The approach takes particular notice of the impact of public sector on markets. Little is known about the applicability of this approach to family planning.

7.1.4. *Willingness to Pay (WTP)*

Once the target audience is selected, implementers need to understand everything about these potential consumers. Implementers need to understand not only consumers' *ability* to pay but also their *willingness* to pay. WTP studies help implementers understand the implications of a product's price. In 2005 PSP-One conducted a seminar on WTP, to discuss tools that can be used to make decisions about increasing or setting prices for health products in developing countries. The Foreit tool is one of the most commonly accepted among MDA practitioners to understand what prices can be set.²¹

²¹ <http://www.psp-one.com/>

Revealed data, obtained by putting a number of products on the market at a range of price points, would provide an even more reliable indicator of willingness to pay. However, programmatic constraints and branding biases can cloud results. Market data from Romania and Ukraine where more than 15 oral contraceptives are available do give a sense of price sensitivities but the challenge is to match those sensitivities with individual users.

However, WTP does have limited applicability as additional information may also need to be collected. The key to using the WTP tool is understanding what data are sought and ensuring that the study obtains that data. For instance, PSI uses WTP studies as a basis of segmentation, by analysing the access and psycho-social determinants of consumption. However, decisions are not based on this data alone, as it needs to be situated within other, identifiable WTP determinants. WTP can also highlight a "price gap" between very low priced products and commercial products. For instance, PSI used WTP to make the decision to increase condom prices in South Africa to improve cost-recovery.

Most implementers agree that WTP alone is not necessarily a reliable indicator of what people would do if the prices went up. An examination of other barriers, other market activities, other players, alternatives, etc would also be required to get the full picture. Revealed data, (obtained from analysis of consumer behaviour faced with a number of products on the market at a range of price points) is the approach usually taken by the commercial sector; it provides an even more reliable indicator of willingness to pay because it reflects the behaviour of the consumer when faced with a choice, and ultimately, this is what marketers need to know. However, programmatic constraints and branding biases can cloud results. Collecting revealed data can also be very expensive.

The key to using the WTP tool is understanding what data is sought and ensuring that the study will address that data. The Foreit tool appears to be the best available, but it does have limited applicability.

7.1.5. "4Ps" of Marketing: Product, Price, Placement, Promotion

Based on the consumer and market research, the implementer can decide on an appropriate strategy, i.e. an internally consistent and market-fitting mixture of product, price, placement and promotion. Marketers often use these "4Ps" to ensure that their product (or service) is appropriately targeting the chosen segment of the market. For each target group to be reached, implementers consider each element:

Product: How the product (or service) should look and function to meet the needs of the target audience(s). This includes considerations of packaging, branding and product formulation.

Price: What the product (or service) costs to the consumer. This price should fit the target audience's ability to pay, and may also need to factor in incentives such as margins for wholesale and retail traders or providers who ensure that the product is delivered to the customer.

Placement: Where the product (or service) is available. Placement should factor in the type of outlet (e.g. clinic, store, bar, pharmacy) but also the operating hours of such outlets.

Promotion: What advertising and communications are used to encourage consumer uptake of the product or service. The channels selected must be those that reach the target audience(s).

The key point is that the strategy should be internally consistent within the 4Ps and tie in closely with the market research carried out.

For example, if the identified market segment is condoms to the "young, female middle class urban party crowd", considerations may include the following (though would need to be researched at the country level):

Product: packaging needs to look hip and fashionable, "fit into a handbag"

Price: to fit payment ability of targeted population segment, but in general, the young female urban party crowd segment may not be hugely price sensitive, compared to others such as a rural consumer.

Placement: Needs to be available either for advance purchase (hip and prominent displays in pharmacies, general retail, if possible) or a "spur of the moment" buy (washrooms in bars and clubs).

Promotion: Probably similar to mobile phone promotion: hip, happening, indulgence, sociable, "part-of-the-crowd" themes - likely to avoid "patronizing", "it's good for you", "this is what your mother and the government would recommend" themes.

7.1.6. *Tools to Measure Impact*

One of the most often cited complaints about social marketing programmes is that they do not know who they are serving. PSI has developed some tools to address this concern such as MAP (Measuring Access and Performance) and TRaC (Tracking Results Continuously), which examine issues of equity of access, product coverage, awareness and exposure and self reported risk reducing behaviour. While MAP and TRaC appear to be highly effective for measuring results and guiding marketing, more tools to understand who consumers are (and are not) need to be developed. Such tools need to present data in a format that can be easily used by implementers to make marketing and programmatic decisions. Once such tool is PSI's Dashboard. All implementers should be encouraged to conduct consumer research, and donors and Governments should be supportive of such essential market research.

The Futures Group/Europe has proposed a "**Market DHS**" to measure market characteristics on a regular basis. Just as the DHS is used to measure changes in health, a market DHS could examine changes in the market, including prices, availability and other factors and could be used to measure the performance of MDAs. Such a tool would be standardised with a studied conducted at periodic intervals. Like the DHS, data would be comparable year on year. The tool itself could build on existing data collection tools such as PSI's MAP, TRaC and market segmentation methodology. Other data about in-country pharmaceutical markets, such as that collected by market research firms like IMS, might also be incorporated to determine total market size for each contraceptive. Such a tool has strong potential to help focus donors, Governments and implementers on the objectives of MDAs. However, some worry that a new potentially costly study is not necessary as

many of the data already exist that would simply need to be compiled. An example of such a compilation is PSP One's Private Sector Wall Chart.²²

These tools will only be useful if donors and Governments are willing to pay for them. Research can be expensive, and some implementers have complained that donors want the information but are unwilling to pay for it.

7.2. *Conduct evaluations & share the results*

Like all donor-funded interventions, MDAs need to be evaluated. The challenge is that no single measure applies for all MDAs as the program context is important. But using the success indicators detailed above (section 6.1), programs can be grouped into categories and comparable evaluations developed. For instance, if financial sustainability is a goal, then an evaluation would look less at cost per CYP (on the assumption that donor funds spent during the program would support future CYPs) and more at cost recovery, the relationship with manufacturer, the commitment of the Government and the overall market potential. For programs focusing on targeting of subsidy, evaluations might look more closely at the cost per CYP to the donor and consumer, the income levels of product users and the impact of the program on public sector services.

A key challenge is linking the program interventions with other contextual factors and changes. However, analysis of the total market rather than the single MDA can help to highlight the context and delineate the impact of the MDA from other family planning programming. Findings from regular evaluations should be used to make adjustments and to realign the programme with country and market needs and conditions.

Another important aspect of MDA evaluations is the question of their long-term impact. When a programme has committed to creating a sustainable market, it would seem important to go back 3-5 years after the programme completion and measure the lasting impact. Such evaluation, combined with the total market analyses mentioned above, would be useful for donors to ensure continuity of programming. The donors' and Governments' lack of continuity with strategy and programming was cited frequently by practitioners as a constraint to effective programmes using MDAs.

Lastly, the exchange of evaluations and their findings would be beneficial for countries and for MDAs. Donors, implementers and Governments could enhance the development of MDAs by exchanging reports and evaluations.

7.3. *Other recommendations*

- Be realistic about what MDAs can -- and cannot -- achieve. Like other donor investments, MDAs take time and money.
- Push for maximum commercial involvement by default -- "why are we not doing this more commercially" and then consider how programme subsidies can broaden health impact.
- Have a strategy and follow it -- the market research and implementation should be driven by clear goals and objectives and backed with a coherent strategy to achieve public health impact.
- Assure realistic and consistent funding. Implementers have suggested a minimum investment of \$500,000.

²² <http://www.psp-one.com/>

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- Be responsive to the commercial environment. This includes being able to respond quickly to opportunities as they emerge.
 - Be willing to experiment with new ideas and move away from “design a perfect cathedral, to stand for 1000 years” mindset towards “Let’s launch 100 ships, and back those that work.”
 - Build programmes in response to the total market analysis, recognising that markets are dynamic and change.
 - Be consistent with programming over time, but balance this with a willingness to reallocate funding away from programs that don’t work (and agree in advance what “don’t work” means). At the very least, be aware of the negative effects of funding cuts.

Do not confuse commercial and market approaches with for-profit and no social aims. Markets and market-oriented approaches can work for the poor. As one interviewee said, “The challenge is not how to motivate people to use family planning but for us to figure out ways of addressing need.”

8. CASE STUDIES

Below we present three case studies to illustrate various elements of MDAs. It is important to remember, however, that each country is different and that MDAs should be developed in response to the country's market.

8.1. *Pakistan*

The Pakistan case study highlights several different MDA "building blocks," including

- The use of a local generics manufacturer to lower the price of oral contraceptives,
- A well-developed social franchising operation, successfully leveraging a large platform of clinics to make a wide range of quality-assured, low priced contraceptives available with improved provider quality of service, and
- The 'bottom of the pyramid' concept of using rurally based female entrepreneurs as distribution channels, as an effective means of scaling up with low capital intensity.

The case study highlights some of the trade-offs between financial sustainability and access, and discusses cost efficiency issues. Finally, the joint financing of two social marketing programmes, which at times are thought to be competing with each other, is explored.

Pakistan's social marketing programmes include several different market development approaches. GreenStar is a local NGO, affiliated internationally with PSI, that operates "Sab Sitara" (GreenStar) a clinical franchise network as well as a social marketing project for a full range of contraceptive product lines (<http://www.GreenStar.org.pk/>). A total of 17 products and services are marketed through its network of more than 17,000 trained private health care providers. Key Social Marketing, managed by the Futures Group, includes a network of trained family planning practitioners and injectable, emergency and oral contraceptive products (Famila-28, Nordette-28, Emkit and Depo-Provera) (<http://www.key.org.pk/>). Each does outreach to the community and trains and monitors providers. Both programmes are strongly identified by their logos which are found at the clinics and on the contraceptive packages. Social marketing products account for about 66% of all OC (oral contraceptives) use in and the country, 21% of injectables and 9% of IUDs (intra-uterine devices). Nationally, 25% and 3% of contraceptive providers in Pakistan are GreenStar and Key Social Marketing providers, respectively.

There are several differences between the programmes. To name a few that were observed during the joint-donor Output to Purpose Review (i.e. donor evaluation) in 2002:

- The two organisations have made different choices about the 'building blocks' of - for example - brand ownership, price, distribution channels, operational models and product range, and both are achieving good levels of effectiveness and efficiency, albeit in different ways.
- Key Social Marketing (KSM) products are priced at cost-recovery prices (e.g. OCs 12 rupees or approximately US\$0.20), whilst GreenStar products are more highly subsidised (OCs 7 rupees or approximately US\$0.116).
- GreenStar offers 17 products, including more service intensive IUDs and Voluntary Surgical Contraception and it has a 'heavier' in-house management

and sales staff, although still remarkably cost-effective, at \$5 cost/CYP (cost per couple per year of protection) for the overall programme in Pakistan.

- o GreenStar's hormonal brands tend to be more urban based than KSM brands, due to their focus on selling through franchised providers. Like GreenStar, KSM makes its sales through pharmacies and its provider network; both organizations use "Lady Health Workers" as an additional channel for reaching lower socio-economic classification women.
- o GreenStar's franchise model is more highly developed versus KSM's. Although both organisations have well defined, branded products, GreenStar's provider training is longer and monitoring more frequent and intense. This is not a flaw in KSM's model; rather, it is entirely appropriate, given the different product mix of the two programmes. Running a franchise model is managerially taxing; the justification for it lies in a product/service mix which dictates the need for more rigorous training, follow-up and monitoring due to the difficult nature of controlling quality. The clinically more complex IUD and VSC components of GreenStar's programme justify such an approach.
- o KSM uses its resources differently, in line with its particular business model and product range. KSM's Mohalla Sangat (MS) programme is one example. A KSM innovation, these make use of existing, community based MS meetings to deliver family planning messages, overcoming the twin barriers of immobility and illiteracy. Groups of 10-12 women are organised by a KSM provider, the KSM-developed cassette tape (another innovation that is a very cost effective way to get standardised, accurate family planning information delivered to men and women) is played, and the KSM provider gives a follow-on talk, where women are encouraged to ask questions. These meetings offer women a relaxed opportunity in which to ask private questions about reproductive health; they also help build the business of the provider. GreenStar now uses these meetings as well to reach low-income women and create demand for contraceptives. More than 93,000, mainly low-income, women had attended KSM MS meetings as of 2002, which are rigorously analysed for number and composition (income, first time user, etc) of attendees. GreenStar, which began using MS meetings slightly after KSM, is not as far down the learning curve in terms of its organization of the meetings, its analysis of them, or the numbers that have attended them. GreenStar organises larger groups of 25-40 women, and had reached approximately 25,000 women as of 2002.
- o GreenStar owns the brands it markets, whilst KSM owns only the KSM logo/'overbrand'. KSM's supplier, Zafa, owns the Famila brand and supplements KSM's marketing effort with its own in-house distribution and marketing.

By 2004, GreenStar had provided 1.8 million CYPs (including sales of 3.37 million OC cycles) and KSM provided approximately 245,000 CYPs (including sales of 2.31 million OC cycles). Interestingly, both programmes are now jointly funded by DFID and USAID, with the contract let by USAID. The arrangement puts to the test whether the products are indeed reaching different markets and having different impact in the market or competing for the same consumers to increase contraceptive usage. The programme also tests the value add of having two competing yet collaborative partners and specifically whether efficiencies and effectiveness can be increased through this collaborative effort.

At the start of the latest contract there were some teething difficulties between differences in understanding between Key Social Marketing and the GreenStar programme, and they both ended up selling a similar product to the same market

segment at slightly different price points, one subsidised and one not. GreenStar's strategy was to cross-subsidise their more highly subsidised range. This caused problems for KSM's sales, which had a more limited product and price range.

In recent years, GreenStar has increased its capacity to reach more underserved areas, with a major organizational restructuring to decentralize operations outside the main metropolitan areas. It has also adopted the Total Market Approach, redirecting resources to generic communications and a new strategy to segment each product line with multiple brands that segment the market.

An important aspect to further highlight in the Pakistan MDA example is the shift to a generic supplier for oral contraceptives. The Futures Group/Key Social Marketing was marketing Wyeth's Nordette which was manufactured in Pakistan. The project started out as a more traditional manufacturer's model, albeit with subsidy supporting the reduced price as well as the marketing on Wyeth's OC brand. In 2000, Wyeth requested a substantial increase in product subsidy, without which product security could not be guaranteed. Instead of rising to Wyeth's demands, KSM switched to a local supplier, Zafa, with a cost structure and strategic vision more in line with DFID's poverty focus. Within 2 months, this locally produced OC, *Famila*, became the largest selling brand in the market and a product subsidy was no longer needed, since Zafa's price to the KSM project was less than half of Wyeth's price.

Although Zafa's pill was already registered in Pakistan, external advisory input was brought from the UK Medicines Control Agency and KSM worked extensively with Zafa to ensure that the product met high quality standards. Additionally, Futures developed the brand name *Famila* and also was able to contribute the well-known green key umbrella logo. It was this logo that helped consumers transition from the Wyeth to the Zafa product. Zafa invested in its own production. Zafa is now a supplier of a GreenStar product as well, and is considering selling product in Bangladesh where Futures Group is working to increase the market for cost-recovering products.

Even though some donor investment had been allocated to assure that the factory met international quality standards, the overall costs to the programme were substantially reduced with this strategic choice, and it was no longer necessary to subsidise the price to the consumer either.

Finally, it is worth reviewing the details of GreenStar's franchise model, which is widely considered to represent best practice in social franchising. GreenStar franchisees include over 17,000 trained private health providers: male and female doctors in general practice, chemists and family health visitors. GreenStar offers a variety of services to attract these franchisees into the network, including access to wide range of quality-assured, subsidised contraceptives and clinical supplies; access to new medical techniques, 40 hours training in managing intrauterine devices, 8 hours training for administering hormones, management support; radio, TV and print advertising, personal contacts, and interaction with other medical professionals.

The concept of quality is embedded within every element of the GreenStar network. Providers are required to go through a training programme, which is customised to the level of care the provider is able to deliver. A business format manual specifically spells out to the providers and GreenStar team members what is expected of all parties in order to maintain quality in the network. GreenStar has attempted to develop a referral network that includes its own clinics, NGO partners, and other facilities for referral of clients seeking services that are not offered by a particular

GreenStar clinic. Refresher training is offered to franchisees; the medical record card was redesigned to better assist the providers in recording information about their clients, and a reward plan, based on quality as well as quantity indicators, is also offered. GreenStar trainers perform semi-annual supervisory visits to the GreenStar outlets, monitoring specified quality indicators via the comprehensive 'Supervisory Activity Sheet' (SAS); more frequent 'Quick Investigation of Quality' visits are made as well. Performance on the SAS is scored and analysed, and strategies are developed to improve under-performing sites. Surveys are also regularly conducted to assess the effectiveness of community meetings, to learn provider views and to monitor client impact.

According to an independent evaluation of four social franchising programmes in three countries, GreenStar clients and others in the community perceive the technical skills and quality of care provided by GreenStar franchisees to be nearly twice as high as other private providers.²³

8.2. Philippines

The Philippines case study explores the long-standing debate about sustainability and subsidy. Two donor-funded programmes are described and their different approaches to expanding contraceptive choice and access are highlighted. The case demonstrates the delicate balance between "crowding in" and "crowding out" and the need for market segmentation. Donor strategies are also discussed. In the Philippines, at least three MDAs are underway.

- o The Government has contracted DKT to supply low cost contraceptives to the public networks.
- o DKT, with support from USAID and KfW, is marketing a subsidised oral contraceptive.
- o Chemonics, with support from USAID, is providing market research and marketing and introducing commercial suppliers to the market.

DKT-Philippines (<http://www.dktinternational.org/Philippines.htm>) markets Trust condoms (its own brand) which are available in three fragrances (chocolate, mint, strawberry) and an unscented version. All sell at a retail price of 5 pesos (about 10 U.S. cents) for a package of three condoms. The program has sold more than 103 million condoms nationwide since 1991.

In January 1997, DKT introduced Trust pills, a low-dose oral contraceptive. A month's cycle of Trust (DKT's own brand) sells for 20 pesos (40 US cents). In 2004, DKT sold 9.8 million cycles. The program provides approximately 60% of the total contraceptive market (including government supply). The product is fully cost recoverable, and the donor subsidy (now reduced to approximately \$1.4 million per year from previous \$4 million level) goes toward marketing. DKT also supplies the Government clinic distribution. DKT procures via 5-6 year contracts with generic suppliers. The program targets middle income consumers for whom commercial branded OCs are too expensive but who are able to pay something. DKT works with

²³ Montagu, D.,2002. Franchising of health services in developing economies. *Health Policy and Planning*, 17(2):121-130

commercial distributors to make the products available, and manages the marketing, distribution and procurement directly.

Chemonics (<http://www.chemonics.com/>) is implementing USAID's \$32 million 5-year effort to improve reproductive health in the Philippines. One element of the project is to encourage commercial contraceptive manufacturers to enter the Philippines market, for which approximately \$8-\$9 million has been allocated for market research, advertising and facilitation of company/product entry. Already Organon has dropped prices on Marvelon 28 from \$3 to \$1.15/ cycle. Generics will also be encouraged to enter. Chemonics is conducting market research to understand the consumer segments particularly focusing on the hormonal contraceptive market. Chemonics will not be involved in brand ownership or distribution of the products. They are also committed to leaving the country at the end of the project.

In theory, the combination of the programmes should increase choice and access for a wide range of consumers. Looking at the market from a price perspective, the three groups are targeting distinct markets. Within 5 years, USAID intends to "graduate" the programme.

The programmes are highlighting the delicate balance between "crowding in" and "crowding out." On one hand, a demonstrated increase in demand for contraceptives and reduction of barriers to access would likely encourage new products to enter the market – crowding in. On the other hand, the availability of a subsidised product in the same channels as the non-subsidised product would limit interest in the entering the market – crowding out.

This balance underscores the need for good market segmentation that ensures that free generics and lower price generic or over-branded products reach the consumers for whom they are intended, leaving the market open for commercial branded products to reach those who can afford full price. But markets are not that distinct, and the lower priced product may be competing directly with the non-subsidised product.

At issue is also perception of "subsidy." Here, donor funding is being used to subsidise the commercial entities introducing product with Chemonics and DKT's own brand (an over-branded generic). Both DKT and Chemonics use the donor funds for support to advertising and market research. But DKT is perceived to be marketing a subsidised product, while Chemonics is thought to be providing support to commercial brands. In reality, the programs receive approximately the same level of donor subsidy annually.

One way to limit the competition for shelf space would be to distribute Trust in clinics that serve the poor. Those who are concerned about contraceptive access for poor people might say that poor people should be able to access lower priced products in pharmacies and other retail outlets, not just the clinics.

Another potential complicating factor is the incentive structure. DKT's performance is measured on the basis of cost per CYP (couple year of protection). This creates an incentive for DKT to sell more products to improve the ratio. If cost recovery is determined to be a lower priority, one way to achieve a low cost per CYP would be to distribute large quantities of product on credit and not worry too much about the payments, a practice that might be referred to as "dumping." The high volume of Trust available in the pharmacies competes with Chemonics' objectives of bringing in

new generic products. Given the price differential, Trust does not compete with the higher priced branded products (Organon, Schering, etc.).

Better alignment of donor strategies could alleviate this situation, as long with a rethinking of indicators and incentives. For instance, DKT's performance might include measurements of the number of new products introduced, while Chemonics' might include an indicator on the number of lower income people purchasing the new products.

A publicly available evaluation of the DKT program has not been identified and the Chemonics program has recently begun and has not yet been evaluated.

8.3. *India*

The India case study focuses on an innovative social franchising model comprised of over 40,000 clinics. Using a social franchising model with high volume, low cost in order to reach poor clients, the network has provided family planning products to over 1.68 million people. The operating principle – that everything has a price (even if it is a small one) – is discussed alongside sustainability issues.

Janani (<http://www.janani.org/>) is a social franchise network in Bihar, India that demonstrates how “the energy of the private sector can be redirected” to deliver products and services to even the world's poorest people.

Janani includes 40,000 small rural Titli (Butterfly) health centres and about 500 Surya (Under the Sun) medical clinics. For a little over \$3 per CYP (couple year of protection), Janani has delivered 1.68 million couples with family planning protection in 2005. Part of the success of the franchise is that family planning services are integrated with other primary health care at the health centres and with more complex medical procedures at the clinics.

The overall principle is that if Janani increased patient volume, doctors would lower the prices for their services. Doctors further have an interest in buying into the franchise network in order to receive ongoing training, access to bulk procurement and advertising. An additional important factor is efficiency of service; Janani hires an administrator for each centre to ensure better management and free up the doctor's time to provide medical services.

Janani relies entirely on private sector tenets of money (profits), competition and entrepreneurship. All elements of quality are associated with a value; for instance, if a quality monitor discovers a health centre with a broken window, the clinic administrator is charged a fee. Competition is also built into the design of the program and monitoring is “ruthless;” work is peer reviewed and if something is found to be out of order, the fee for that service is awarded to the individual who discovered the problem.

The program receives approximately \$1 million in donor funds annually which is used to support training and marketing. The marketing costs are expected to decline because 85% of clients now hear about the clinics and centres via word of mouth. Other costs include operations, which are small, and the cost of clinic and health centre management which is paid out of the franchise fees. The family planning commodities are subsidised.

Futures plans include expansion of the program to 57,000 villages and 360 clinics. Janani is also in discussion on the possibility of the public sector outsourcing health care to Janani, which would be less expensive for the Government than managing their own clinics. Building on a commitment to use technology (“internally defined as processes by which the organisation transforms labour, capital, materials and information into products and services of higher value”) to “create viability in its operations,” Janani is also planning to expand the use of telephony to improve services. Another element of sustainability is that the clients will increasingly insist on high quality services and in this way become the stakeholders in the delivery of quality family planning via the franchise.

In the words of Janani’s now former president and founder, Gopi Gopalakrishnan “The core lesson from the Janani experience so far is frighteningly simple: that the challenge of the population programme is not that clients, even those poorest and unlettered clients, are uninterested in planning their families. It is that the providers are disinterested in such low cost, low volume products and services. Creating the requisite framework to correct this, and setting up a management system to sustain it, have been the true hallmarks of the Janani programme. And contrary to popular wisdom, Janani has also demonstrated that delivering services in the remotest parts and to the poorest communities need not be expensive.”

Evaluations, case studies and other data on Janani are found on their comprehensive website. <http://www.janani.org/marketresearch.htm>

8.4. *Uganda*

The Uganda case study discusses the pros and cons of publicly funded competition amongst two rival social marketing brands. The study provides a view of market segmentation via revealed results rather than market segmentation studies.

In Uganda two social marketing programmes sought to increase condom use, particularly among youth. The programmes provide a study for market segmentation and the impact of competing donor-funded programmes.

USAID initiated support of the Futures Group (SOMARC) to introduce *Protector* condoms in Uganda in 1991. In 1998, the Commercial Market Strategies project assumed the role of implementer. In 1997 KfW agreed to fund MSI to launch a second social marketing brand, *LifeGuard*.

Although the products themselves were slightly different (*Protector* was a regular male condom and *LifeGuard* a studded male condom) and had somewhat different brand images, the social marketing programmes were very similar:

- MSI and CMS (represented by PSI) each owned their brands;
- Both managed distribution with commercial partners, with both programs also supplemented by their own fleet of vehicles;
- Both subsidised the product and carried a recommended retail price of 100 Ugsh (approximately US\$0.06 in 2000) for a box of three;
- Both carried out market research and marketing campaigns;
- Neither was expected to become financially sustainable, though cost recovery (revenue generation) was expected;
- Neither project involved commercial suppliers directly in the program – *LifeGuard* was procured in India by MSI and *Protector* was donated by USAID;

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- o LifeGuard and Protector were sold in the same channels (drug shops, pharmacies, private and NGO clinics, general merchandise shops and other informal retailers); and
 - o Both programmes positioned the product as an HIV/AIDS prevention product with youth as the primary target audience.

A small distinction was that CMS marketed three other products alongside the condom (OCs, injectables and an STD treatment kit), while MSI marketed female condoms and at times also distributed other condom brands at commercial prices.

Perhaps most unusually, the public sector condom distributed for free was branded (*Engabu*). While this product did not compete directly with the two social marketing brands, it did represent an unusual step²⁴ toward increasing the popularity of free public sector condoms by branding them.

Many people disagreed with this MDA. Why invest in two such similar projects, especially in such a relatively small market with a population of just 22 million, half of whom were under 15? In other markets two publicly-supported brands might exist, but they would certainly be at different price points with differing degrees of cost recovery and possibly the involvement of a commercial condom manufacturer.

Others pointed out that market segmentation by price was certainly a challenge in a country with a per capita GDP of \$300. How many people were "wealthy" enough to buy a higher priced brand? Similarly, channel or geographic segmentation seemed difficult to achieve. Given that youth represented such a large portion of sexually active people, it seemed unlikely that either implementer would exclude youth from its target audience.

To most, spending hundreds of thousands of dollars of US and German funds on two independent projects seeking the same objectives seemed extravagant. USAID and Futures argued that *LifeGuard* should not be introduced to steal market share from *Protector*. To avoid this potential issue, the two products would be sold at the same recommended price of Ugsh100 (approximately US\$0.06 in 2000).

By 2000 sales of both products had increased dramatically. *Protector*, which had not sold more than 6 million condoms annually since *LifeGuard* was introduced, sold 10 million in 2000. *LifeGuard* also sold about 10 million condoms, resulting in a total market of over 20 million condoms in a country which had never sold more than 9.5 million in a single year. To be sure, some of this growth was not attributable to the programmes, but influenced by the rapid population growth and the multitude of campaigns about HIV/AIDS. But even discounting for those outside influences on condom sales increases, it seems highly likely that the direct competition of *Protector* and *Lifeguard* grew the condom market in Uganda.

Also interesting, though perhaps less surprising, is that *Lifeguard* was often sold at a price higher than the recommended consumer price of Ugsh100. This was in part due to disruptions in supply. But consumers and retailers perceived the *Lifeguard* product as a premium brand. Thus, the market in fact found a way to segment itself, regardless of donors' and implementers' intentions.

²⁴ At the time free branded distribution was unusual. Now many countries such as Trinidad and Tobago and others islands in the Caribbean, are purchasing commercially-branded condoms for free distribution, though the Uganda brand was developed specifically for Uganda by GTZ.

While there was no formal evaluation comparing these two programs, further background on the CMS project can be found on <http://www.psp-one.com/> and <http://www.mariestopes.org.uk/ww/uganda.htm>.

8.5. *Morocco*

The Morocco case study is an example of how donor support to contraceptive social marketing has created a sustained commercial market for oral contraceptives. The study notes the incentives used to create commitment of oral contraceptive manufacturers to the programme. The use of an "umbrella brand" and the importance of donor investment are discussed and the programme's long-term sustainability is highlighted.

Morocco's "Khanat al Hilaal" ("Pill of the Moon") programme is an example of how donor support to contraceptive social marketing has created a sustained commercial market for oral contraceptives (OCs).

The program was originally organised and funded in 1989 by USAID as a social marketing project under the SOMARC program and subsequently with the Commercial Market Strategies project. The program was designed to create incentives to bring commercial contraceptive manufacturers to the Moroccan market. Following USAID "graduation" of the activity in 2003, the programme still runs, but now entirely without donor support.

It is organized around Khanat al Hilaal "umbrella" brand ("Pill of the Moon"), held by the AMPF (an affiliate of the IPPF). The AMPF enters into a contract with commercial manufacturers to supply products, currently Schering (with Microgynon) and Wyeth (with Minidril). Only these two products are supplied.

Both products are sold under a common brand – Khanat al Hilaal ("Pill of the Moon"). Each product is individually branded as well as stamped with the Khanat al Hilaal brand.

The agreement specifies that the products should be sold at a price 30% lower than the price of the nearest comparable commercial product. The current social marketing price tier is at \$0.96 per cycle, whereas the traditional commercial sector sells at \$1.30/ cycle and above.

The products are distributed through the 5,000+ commercial pharmacies, alongside other commercial products. Approximately 2.7 million cycles were sold in 2004 via this channel, along with 4.3 million cycles sold of purely commercial brands.

Since its inception, the Khanat al Hilaal brand has been backed with very considerable marketing spend, both above and below the line, including both print, leaflets, posters, radio, Point-of-Sale and other. Initially paid for by USAID, the ongoing marketing is now paid by Schering and Wyeth through a 5% levy on wholesale prices. Anecdotally this comes to around \$100,000, of which about 80% is spent on marketing and about 20% charged by AMPF for handling the marketing. Thus, the social marketing programme is currently entirely self-financing and sustainable.

It is noted that the reason why the program is now commercially sustainable is the high upfront investment made by the donor (USAID) in brand creation. It is unlikely that creating the brand would have been a commercially viable investment, even if maintaining it may well be.

According to the CEO of Schering in Morocco, Schering are highly committed to continuing this programme over the long term. Benefits to Schering include:

- Corporate Social Responsibility (CSR) gains, (including not least in Morocco),
- Being a (small) profit centre and
- Being a platform for longer term growth as the Moroccan middle class continues to expand.

A further unstated – but possible – benefit include acting as a deterrent to generic entry, though it is unclear how much of a role this really plays in practice.

The program has been extensively documented and evaluated, most recently by the PSP-One project that sought to assess the long-term impact of social marketing on contraceptive sales. <http://www.psp-one.com/content/announcements/detail/2880/>

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| | Terry Scott | DKT/Philippines | |
| | Mimi Whitehouse | JSI | |
| Experts | Martine Collumbien | LSHTM | |
| | Peter Hall | | |
| | Kevin Kingfield | former Futures | |
| | Kara Hanson | LSHTM | |
| | Joachim Oehler | Concept Foundation | |
| | Don Levy | Chemonics International | |
| | Richard Pollard | Chemonics International | |
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