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REVIEW OF DFID APPROACH TO SOCIAL MARKETING

ANNEX 2: OVERVIEW OF SOCIAL MARKETING

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Title: Review of DFID Approach to Social Marketing
Annex 2: Overview of Social Marketing (SM)

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1. DEFINITIONS OF SOCIAL MARKETING

There have been many attempts to come up with a definition of social marketing in the public health context which is accurate and comprehensive. The following is an example:

"Social marketing programmes engage the resources, techniques and dynamics of the private commercial sector to [bring about behaviour change and] make products [and services] with a public health benefit widely available and affordable" ***adapted from MSI definition***

The difficulty is that no definition can adequately express the many forms and models that have been developed within SM programming. There are in practice almost as many forms and models of SM as there are country programmes.

The core competency of SM programmes is the distribution of commodities through commercial sector channels. However, many SM programmes have developed components of distribution through other channels---through NGOs, direct to the labour force of large firms, and to the uniformed services. PSI reports that 44% of its condom "sales" in Lesotho and 25% of condom sales in Mozambique are through non-retail outlets. Forty percent of ITN sales in Mozambique are through NGOs and health centres. This responds to a need to improve targeting to low income or at-risk populations.

SM programmes are engaged in a variety of service delivery mechanisms that do not employ existing retail selling. These include the franchising of FP services through establishing private networks, the establishment of VCT Centres either under direct management or by agreement with the public sector, and improvements to the provision of STI service delivery, often through public sector services.

A few SM programmes have developed extensive, in-house sales and distribution systems in countries where domestic distribution systems are weak, as in Mozambique (and even in countries where it is said to be strong, as in Pakistan and China).

The employment of commercial sector advertising and promotional resources, while significantly contributing to behavioural change components, and widely employed as important tools to gain reach and frequency in messaging, cannot alone generate the necessary social and behaviour change imperatives required to create significant health seeking environments. Most SM programmes are

moving towards both in-house and collaborative arrangements with NGOs and CBOs engaged in community-based activities so as to add depth and weight to message delivery and BCC components.

Many SM programmes are moving away from purely “commodity brand” selling to address wider behavioural change issues that often compete with efforts to sell products---such as the promotion of delayed sexual debut or the reduction of numbers of partners within HIV/AIDS programming.

The definition of SM as a commodities based activity also ignores the many uses of commercial sector marketing techniques in the promotion of health-seeking behaviour in other fields, such as in smoking cessation, breastfeeding, nutrition and hygiene.

In addition, while SM programmes are generally engaged in marketing, they may offer other forms of support to private sector entities, sometimes indirectly (improving the skills of distributors or advertising or research agencies) but in a few cases in a defined programming role. The China UK support to improved production quality of domestic condom manufacturers, and the SOMARC Central Asia programme to improve logistic management skills of distributors are examples.

Thus, while the shorthand definition may suit the ‘base’ model that defines the delivery of a product or service through the private / commercial sector described below, the evolution of social marketing practice described in the section on the historic background has rendered the shorthand definition obsolete. Nevertheless, it does seem helpful to distinguish clearly between the following:

Social marketing of products, being the promotion and delivery of health products such as condoms or insecticides. This is what donor agencies and almost all developing country governments generally think of as ‘social marketing’. In practice, most DFID funded projects encountered belong to this category, and all those in our set of case studies.

Social marketing of services, being the promotion and delivery of health services such as VCT or sterilisation. The reason it is worth distinguishing this from product marketing is because different business models have emerged.

Using Marketing / Advertising techniques with BCC and Health Education , which are used in social marketing but which can also be used in a wide range of programmes promoting behaviour change and health seeking behaviours, such as the design of messages promoting breast feeding or delaying marriage.

2. HISTORIC BACKGROUND TO SOCIAL MARKETING

The social marketing of commodities for family planning and STI prevention sprang out of initiatives by the government of India in the 1960s. They realised that target audience access to low-cost condoms through the public sector was inadequate. They developed working relationships with mass-consumer goods companies to distribute subsidised condoms through commercial sector channels into the general retail marketplace. In this way low-income consumers would have better access to these commodities.

In the 1970s Population Services International was created in the USA and began to expand the India experience, primarily through USAID funding, exclusively in family planning in South Asia. In the 1980s USAID launched the SOMARK project that was managed by the Futures Group that began to explore an important refinement, collaboration with manufacturers to support their own brands of family planning products primarily through subsidies in support of demand generation activities in return for reduced pricing.

The growth of SM activities expanded significantly in the 1990s owing to the AIDS epidemic and the urgent need to expand access to, and use of, low-priced condoms.

The success of these approaches has led to the development of world wide Social Marketing (SM) programmes, managed by a number of major international organizations and domestic entities. More FP products have been added. In 2001 over 1.3 billion condoms, 105 million OC pills and 8.7 million injectable contraceptives were distributed, worldwide, resulting in almost 27 million couple years of protection (CYP), up 50% from 18 million CYP in 1998.

Independently, in the 1970s, USAID's Office of Nutrition began searching for ways to create demand for a wide range of maternal and child health (MCH) products and services through the use of commercial sector marketing experience. This approach sprang from the observation that, in many low-income countries, the commercial sector managed to successfully supply, to a majority of low-income consumers, a wide range of modern consumer goods, while USAID-supported MCH programmes (that were often providing free services through public sector provision) were much less effective in attracting users. This led to the development of Social Marketing practice in support of health education and IEC programmes, on a wide scale, with a concentration on improvements to service delivery and demand generation activities across a wide range of programmes. These were often managed through the public sector, although many NGOs took up the methodology as well. Very often no product is involved (breastfeeding and nutrition programmes) and the concentration, and development of SM practice, in this field, has been towards holistic social and behavioural change programming.

The technology that evolved out of this experience integrated modern marketing practices with social and anthropological forms of research and community

participation / social change programming. These activities were largely USAID supported across a wide range of programmes including the MotherCare, REACH, HEALTHCOM, BASICS, AND VITAMIN A programmes. Products or services may be promoted (growth monitoring, ORS, Vitamin A supplements) and may be supplied from the public or NGO / CBO sectors, or products distributed through the commercial retail sector as well. Experience within these USAID programmes has demonstrated that where a product or service is concerned social forms of research have inadequately been able to address issues such as preferences for pricing, branding and preferred source of supply. At the same time the use of market research techniques fails to catch the social and behavioural issues surrounding a product or service use. However where these research methodologies can be combined the range of inputs received is able to generate a cohesive set of inputs that leads to better programming.

More recently, provision of ITNs for Malaria prevention has been a significant addition to the SM portfolio of products in this field.

3. JUSTIFICATION FOR SM

The primary justification for SM programmes that distribute products through the commercial, retail sector is centred upon a number of imperatives:

- Public sector provision is often inefficient and ineffective. Growing demand and evidence of significant levels of unmet need have demonstrated the lack of capacity of public sector services to meet the expectations of consumers and meet agreed MDGs.

- Access to public sector commodities may be difficult or impossible for some segments of consumers (unmarried youth seeking family planning services or condoms, CSWs seeking condoms are examples). Public sector provision of preventive measures, rather than curative measures, is often poorly strategised from a service perspective.

- Ease of access, through a local shop, rather than the travel time, cost, stock-outs, crowds and waiting times at public health services will, likely, lead to better access and more consistent use.

- Conversely, the prices charged by purely commercial operators may render the products unaffordable by large segments of the population, so that subsidy, either of price or promotional costs, is justified.

- Purchase, even at a subsidised price, will more likely lead to a positive attitude of self-seeking, a greater sense of ‘value’ and more consistent and proper use.

4. MODELS AND TRENDS IN SM

Basic Mass Distribution Model: The original SM model was based on family planning imperatives that targeted all women (and men) of reproductive age. The advantage of

employing SM to gain widespread national distribution through retail shops was evident. Effectiveness and cost analysis was, primarily, based on total sales as against total programme costs – often expressed as a cost per CYP.

Improvements to Basic Model: Weaknesses to the distribution systems in many countries led SM programmes to add budgets to tangibly support commercial sector distributors and wholesalers. The level and extent to this support varies considerably across countries. At one end of the scale South Africa, for example, hires a team of 12 salesmen who help to open new retail outlets. At the other end of the scale the Mozambique SM programme has 80 sales and promotional staff who are directly engaged in selling to the wholesale and retail markets, and manages its own regional warehousing. SM programmes develop a wide range of strategies to supporting retail selling. Some provide only point-of-sale material. Others engage in establishing product-oriented 'kiosks' in markets, others send promotional teams to run promotions at retail shops and to target audiences in groups, some train pharmacy staff in counselling and quality of care issues.

Models of Targeting: SM programmes have used their own sales teams to help open up 'down-market' outlets in order to strengthen sales to low-income groups. Subsequently, with the addition of condoms for HIV/AIDS prevention, more attention had to be paid to targeting to those most at risk. There are wide variations in how individual SM programmes have responded to the need to better target distribution. Most agree that collaboration with NGOs and community-based organisations is an attractive means of targeting, as is distribution through large public and private sector entities and firms. Few SM programmes accomplish this to a significant degree. 25% of Mozambique SM condoms, 44% in Lesotho, 11% in Swaziland are distributed through non-retail outlets (NGOs or workplace). The Mozambique ITN project distributed about 40% of ITNs through NGO and public health centre sales. Most programmes, however, have limited approaches to targeted selling beyond retail. A further refinement has been to develop service delivery networks (sometimes referred to as 'franchised' networks) through private sector providers offering a range of FP services and products, as in Pakistan.

Constraints to Targeted Selling: A number of constraints exist towards better targeting of sales beyond retail outlets.

Cost is a primary factor. Although there is little reliable data on the relative cost of distribution through various mechanisms a recent OPR of the Mozambique ITN programme noted that total retail cost per ITN sold was $6.71 and through NGO sales $19.95 (including extensive 'counselling' services). A study by Barberis and Harvey (DKT-1997) notes that retail SM condom programmes in 14 countries averaged $2.14 per 100 condoms sold while community-based distribution cost $9.93. Neither study explored the relative value of distribution to accomplish targeting goals however.

Many programmes report that collaborating partners are unable, or reluctant to sell commodities. They prefer to either give them away or give revenues to sales agents rather than handle cash-inputs for repurchase. A number of SM programmes have responded through provision of free, 'sample' or unbranded commodities.

Limitations to budgets and clearly defined strategies aimed at non-retail sales within programme design. The role of SM programmes as a supply source for NGOs, CBOs,

and Ministries (such as uniformed services) appears unclear as a 'core' component of SM programmes.

Models of Behavioural Change Communications (BCC): There appears to be a wide range of approaches to BCC by SM managers. These range from undertaking focus group discussions so as to better understand aspects of health-seeking behaviours in order to improve mass media and mass promotional forms of SM activity. Some SM programmes manage, successfully, peer education activities but these are, generally, small in scope compared to the kind of coverage they can achieve through mass media. Large-scale community-based activities can only be achieved through collaboration with a range of partners – NGOs, CBOs and the public sector. Some SMOs endeavour to accomplish this through their own resources. Most find that they have neither the budgets nor management and monitoring resources to achieve significant impact, on a large scale unless, or until, national programming managed by others – such as a National AIDS Control Programme – can integrate SM as a component of a wider programme. In practice this rarely happens.

At the same time many SM programmes are moving away from communications strategies designed, solely, to promote use of a commodity or service into more holistic approaches to self-seeking health behaviours.

In part this approach has resulted from observations that SM programmes tend to 'lap up' unmet needs relatively quickly. Those consumers who are pre-disposed to use a product or service (early adopters) are quick to become SM consumers. However, over time, sales tend to stagnate and hit a ceiling. Efforts to better understand the constraints that impede take-up of SM products and services by 'late adopters' require much more attention to the social, economic and behavioural issues surrounding desired health-seeking behaviours and the addition of the primary 'influencers' around them into the target audiences to be included. Efforts to create better one-on-one approaches, as well as broader 'advocacy' components are required.

HIV/AIDS SM programmes are adding messages on reduction in partners or delayed sexual debut as well. Several programmes, Nigeria and Mozambique are examples, expend most of their budgets on these more holistic approaches to HIV/AIDS prevention. This trend, if carefully strategised and planned (which is not always the case), positions SM programmes to play a broader role than they traditionally have and leads to implications concerning the strategic 'positioning' of SM within these broader agendas, an issue that is not well strategised, or budgeted, at the project design phase across all programmes.

There are three models where SMOs form integrated BCC programming partnerships designed to better address the need for more holistic message strategies and more community-based activities approaches.

1. SMOs obtain budgets to make these collaborative arrangements and undertake separate contracts with a range of NGOs and CBOs (SADAC Regional Project, Mozambique).

2. A model where an integrated programme is developed by a donor and the management of that programme is placed with a Managing Agent. That Agent contracts with an SMO and either one large NGO (ITNs Mozambique) or a range of NGOs and CBOs (UK China Project). In both these models the SMO retains the more traditional SM role adding collaboration in supply of commodities and in message development.

3. A more complex model where the SMO is contracted to sub-contract a major NGO who in turn sub-contracts to a range of CBOs, while the SMO builds into its own management functions and capacity to manage the integrated programme (Nigeria).

The need for SM programmes to actively engage in the management of community-based BCC activities is becoming established within most SM programmes, either directly or through sub-contract. The capacity of SM programme managers to effectively implement such programmes appears, however, to be limited. The scale and scope of these activities, in most SM programmes, falls far short of gaining the same kinds of coverage as that achieved through the more traditional reliance on retail distribution and promotion. Some SM managers see this issue as conflicting with their core rationale and core 'competencies' preferring to concentrate scarce donor resources in the wider, national scope of their retail efforts. This model is, also, constrained by budgetary issues and the lack of clear strategies for community-based components built into programme design.

Models of Brand Ownership

Two broad models of brand ownership exist. The most common is the 'own brand' model where Social Marketing Organisations (SMOs) bulk purchase commodities and repackage them under their own brand names, either from domestic manufacturers or from the international market. The second model is termed the 'manufacturers' model where SMOs promote the brands of manufacturers or importers / distributors. In this model SMOs sometimes 'overbrand' a range of commercial-sector products and brands. In general decisions on whether to engage in 'own brand' or the 'manufacturers' model rests with an analysis of the willingness and capacity of manufacturers or importers to provide brands at prices that meet the price targets that programmes want to set for acceptability by target audiences. In the condom market for HIV/AIDS prevention it seems to be, generally, assumed that very low prices (often set below the ex-factory cost of production) are needed. Few programmes have been developed for the manufacturers model in the condom market for this reason. The market for hormonal contraceptives has been found to offer the best opportunities for the 'manufacturers' model, however, as has the ITN market (along with smaller markets for products such as iodised salt and ORS packs). In these markets manufacturers are able, in general, to bring very low-priced products into the market providing that they can see strong potential for growth, and eventual profits.

The professed advantages of the manufacturers model are that manufacturers, or importers, co-finance market development and have a stake in the programme's success. The potential for eventual hand-over to the principals leads to a greater opportunities for market self-sustainability and withdrawal of donor funding over time. However experience to date indicates that few markets have achieved this goal and only in more middle-income countries (primarily in South America and Turkey) where pricing pressures are less severe.

Total Market Development Models: In general there is inadequate data that allows for a thorough understanding of the impact of SM programmes on overall markets. SM programme managers tend to view their activities in isolation from overall market impacts.

For this reason USAID, working with the Futures Group under the CSM project, have begun to explore more holistic approaches to the development, and issues of segmentation, within total markets. A trial, in Northern India for OC pills, is designed to cohesively support public sector, SM sector and commercial sector players and to help each clearly identify those segments of the market that they can best serve in the most cost effective ways.

This model, referred to as the "Third Generation" model by the Futures Group is designed to appreciate that SM programmes are not being implemented in isolation from all other programmes – whether public sector, NGO activities or commercial marketing. SM programmes impact on all the other sectors and their activities impact on the SM sector. Consumers may, in effect, be users across all sectors. SM brands may take users from the public sector or from the commercial sector. Their demand-generation activities may expand demand from these other sectors, and vice versa. The "Third Generation" model attempts to provide an overall management of these total markets – designing market segmentation strategies for each to ensure better targeting; collaboration on issues of pricing and sustainability; the management of demand generation activities across all sectors. Negotiation with manufacturers to explore potentials for a combination of manufacturers' own brands and SM brands (where that is appropriate) and pricing and market segmentation approaches between them. Issues of SM brands and potentials for sustaining them, in the future, through handing them over to the commercial sector. Improvements to public sector commodities (packaging, logistics management, quality control) and service delivery and issues of public sector pricing (where appropriate) and better targeting of public sector supply to those who cannot access either SM or commercial sector brands.

In the India example FGI is hired, by USAID, to manage the overall programme. Experience to date is reported to be positive in that all sectors including the public and commercial sectors and the SM programmes operating are collaborating well with FGI.

At the same time a number of ITN programmes (Mozambique, Tanzania and a range of programmes supported by the USAID Netmark project) are moving towards more holistic approaches to market development through a mix of support to manufacturers own brands and SM brands, clear total market development and targeting strategies, and clearly defined exit strategies (even if over the long term) for subsidies and SM programming.

These trends need to be more explicitly explored across all SM programmes so that clear long term strategies are understood and that address issues of market segmentation, equity and efficiency across all sectors – whether the commercial sector (within manufacturers and / or own brand models), the NGO / CBO sector and public sector provision.

5. COST EFFECTIVENESS

Most SM programmes continue to record cost effectiveness based on the cost of provision of commodities per quantity, most usually for condoms and FP products on a cost per CYP basis.

Cost effectiveness studies tend to assume that all programmes are reliant upon similar models of implementation. The very significant variance in models employed militates against this assumption. Some programmes spend significant sums on expenditures to support distribution, others very little. Very different ratios exist between the relatively low cost of distribution through retail and the higher costs associated with community-based selling. A growing number of programmes are distributing free commodities to NGO partners. Some spend significantly more on promotional efforts than others. A number of programmes spend a majority if their promotional budgets on general health-seeking behaviours rather than on promoting products or services only.

PSI and DKT have begun to provide illustrative data on health outcomes, but this data is based on the volume of products sold and takes no account of the broader health benefits accruing from the growing inclusion of more general health-seeking behaviours being promoted. This data is, also, difficult to compare with alternative approaches to SM as methodologies may not be similar.

A significant revision to the way SM programmes assess their effectiveness in achieving over-arching health goals is needed and is discussed at more length in Section 5.

At this point the assumption that appears to be accepted across all donors is that SM programmes do meet acceptable levels of cost effectiveness, reach and health impacts to target audiences even though the empirical data to **support these assumptions can be much improved.**

PSI reports the net average cost per 100 condoms sold in 2001 across 42 countries at $10.80; the net cost per female condom sold across 11 countries at $2.23; OC pills per cycle across 21 countries at $0.57; injectable contraceptives per vial across 14 countries at $1.95; ORS per sachet across 10 countries at $0.31; ITNs across 12 countries at $6.35 and retreatment kits at $3.79.

DKT reports its cost per 100 condoms sold in 2002 at $3.60.

SM programmes have been shown to improve cost effectiveness as they mature. Stallworthy, Meekers (SM Quarterly 2000) reports, per condom sold, the following shifts in cost effectiveness per year of programme maturity across 23 SM programmes:

Programme age -- years	1	2	3	4	5	6	7+
Cost per condom sold. US$	**0.53**	**0.43**	**0.35**	**0.32**	**0.29**	**0.19**	**0.17**

It is noted that the average programme saw a steady decline in costs per condom sold through the first 5 years of the programme and significant declines only in year six and onwards.

PSI Mozambique records the following data:

Programme age	1	2	3	4	5	6
Cost per condom sold US$	**0.41**	**0.31**	**0.32**	**0.29**	**0.31**	**0.23**

PSI notes that the shift in cost effectiveness is somewhat slower than it could be because of the relatively high spend, in that country, in promotional costs not related directly to condom selling, as a percentage of all costs, and the relatively high costs, in that country, relating to distribution.

6. REACH TO TARGET AUDIENCES INCLUDING THE POOR

The evidence base for the capacity of SM programmes to reach target audiences, including the poor, is weak although improving. Too many programmes continue to assume that distribution efforts to target specific consumers do have the required impact and many programmes confirm this through focus group discussions only. Systematic monitoring tools that survey total populations of users and determine the precise profile of SM users, as against other users, is still the exception rather than the rule. In the 11 Case Studies reviewed only two (Mozambique condoms and Nigeria condoms and OC pills) have clear, quantitative analyses of the socio-economic profiles of their consumers. In both cases the general conclusions are that condom sales are reaching low-income groups at least in proportion to the socio-economic characteristics of the populations as a whole. The OC pill market in Nigeria demonstrates, however, significantly more higher-income groups have a preference for the SM product.

N. Price (Health Policy & Planning, 2001) reviews available data on SM programme reach to the poor and vulnerable and concludes that condom SM programmes are unlikely to be pro-poor in their early stages but, as they mature, inequities diminish. Low-income groups with some disposable income can be reached, if not the very poor.

The general lack of a convincing evidentiary base for reach, through retail, to target audiences established for programmes is, generally, put down to the high cost of undertaking such research and a lack of budget provision for it. In a number of case-study countries, notably Southern Africa SADAC Regional condoms and Mozambique ITNs research was sub-contracted to other entities engaged in the production of wider, national baselines and evaluation studies. In both cases the research protocols were not ideal and the research projects were so delayed that they failed to provide adequate inputs for programme design modifications in a timely manner.

While there is a growing evidentiary base for the assumption that SM programmes are able to reach low-income groups, at least in proportion to the percentage of them in a given population (mostly urban and peri-urban) there is inadequate data available across

all programmes to convincingly demonstrate this point. There is a tendency, for example, to assume that SM programmes only serve urban or peri-urban consumers. There is, however, evidence that many rural consumers regularly come in to markets to obtain supplies. It is estimated, for example, that in many Asian markets over 80% of rural consumers can regularly access SM commodities through routine commercial market outlets, even those designated as peri-urban. There is inadequate data, from Africa for example, concerning the extent to which rural populations are accessing SM products. More quantitative research is needed. Although relatively costly, such research needs to be built in to all programmes as a matter of course.

7. MARKET SHARE OF SM PROGRAMMES

The contribution that SM programmes make to national prevalence rates varies considerably across countries. Data on the impact of SM programmes is, generally, weak. Few countries have reliable data that clearly delineates use, by consumers, of products procured across all potential sources. Most DHS studies do not differentiate between SM brands and commercial sector brands nor explore the leakage issue between public sector and retail. Most programmes make some effort to estimate market share based on commodities distributed. Where, however, reliable research is available on usage this data is found to be unreliable. The recent national study in South Africa, for example, notes that SM and commercial sector condom sales account for less than 4% of all condoms distributed yet usage data shows 16% of consumers purchase condoms from retail.

SMOs record the percentage share of SM sales although, in many countries, reliable data on actual commercial sector sales are inadequate often owing to 'grey markets' for products and leakage into the commercial sector from the public sector. These studies can only be regarded as estimates. In the 5 condom projects used as case studies for the review (excluding China, where the market share of the infant SM programme was negligible) market share was significant and estimated as follows:

Country programme	Mozambique	South Africa	SADC	Nigeria	Pakistan
Total % share	**33%**	**2.5%**	**43-48%**	**86%**	**63%**
% share of retail market	**89%**	**66%**	**98%**	**81%**	**86.7**

The health impact of SM programmes, as a percentage of the total impact, cannot realistically be assessed. It needs to be better appreciated that consumers are not restricted to one source of supply or another. Many consumers may avail themselves of free commodities part of the time but procure either SM or commercial sector commodities at other times. Few programmes clearly understand the dynamics at work within these total market environments. It is unclear whether SM users, for example, are new users or have switched from public sector supply (presumably a benefit) or from commercial sector supply (presumably not a benefit). These issues need to be much better understood by programme managers.

8. IMPACTS ON THE COMMERCIAL SECTOR

There is little evidentiary base for assessing the impact of SM programmes on the full-priced commercial sector brands. The general assumption, in respect to condoms, appears to be that very low prices charged by most SM programmes will segment the market, naturally, through price / quality perceptions leaving the full-price market to upper income groups. At the same time SM programmes claim that their promotional spend (and the spend of others) will actively support the growth of the commercial sector. There are a number of examples where SM programmes spend more on 'generic' promotional spend than 'branded' selling. SM programme managers point out that the commercial sector appears to grow, successfully, even in condom markets dominated by SM brands. The exception is where SM programmes enter the market with higher-priced brands in order to generate a 'cross-subsidy' and improve overall cost effectiveness. In South Africa this strategy has been claimed, by Durex condoms, to have 'eaten into' their market. No clear evidence is presented for this assumption. Certainly the SA SM brands have taken market share from the commercial sector but commercial sector sales have also been rising. Alternatively The Futures Group reports that efforts to support domestic manufacturers' condom brands in Indonesia were severely impacted by the lower-cost SM brands in the market.

Impacts on the commercial sector are more evident in markets were SM products are closer, or at, full commercial prices. In broad terms these markets include hormonal contraceptive products and ITNs in many countries. In Nigeria, for example, the SM OC brand has 22% of the market of the highest socio-economic group and 14% of the market among the lowest income group. This indicates that SM sales are probably impacting negatively on the commercial-sector market where SM prices are very close to full commercial prices. In such markets the 'manufacturers' model appears to be the more effective mechanism.

However in many of these markets demand is so low that strategies are developed to include a retail price subsidy on full-commercial prices so that the market will be developed more quickly. The 'own brand' model is employed in a number of countries for this reason. It appears that this is felt to be the most effective mechanism for providing a retail subsidy. However few country programmes managing the 'own brand' models for hormonal contraceptives and ITNs appear to have clear 'exit' strategies. Without such strategies it may be assumed that the 'dominant' SM brand will 'squeeze out' potential developments of a commercial market in the future.

SM programmes working in environments where 'own brand' SM products are being used to develop a market where present demand is low need to be aware that the situation can evolve over time, and need to be shaped so that these brands do not hinder prospects for the development of a purely commercial market over time. Clearly defined strategies need to be put in place to ensure that, as the market develops, the commercial sector has ample opportunity to participate in that development; that clearly defined market segmentation strategies are put in place; that SM managers must be willing and able to implement strategies that may actually hinder the growth of their subsidised commodities in order to support the commercial sector. In the long term they should be willing to pass over their brands to the commercial sector should this strategy be found feasible in any specific country environment. These issues can only be

realistically achieved through clear strategic planning and vision from donors and by the willing collaboration by SMOs.

9. SUSTAINABILITY ISSUES

In the condom market it is assumed that the relatively high level of product subsidies required to meet demand from very low-income consumers requires a long-term subsidy to maintain programme inputs. As sales volumes increase and programmes mature their cost per commodity sold declines. Few programmes appear to have clear strategies for achieving cost effectiveness goals. In the condom market USAID notes that the SM programme in Bangladesh has been able to recover all costs except commodity costs and that mature programmes should aim to achieve this goal. For condoms this may be assumed to be $0.03 per condom sold. PSI's 2001 data across all 42 of its condom programmes averages $0.108 per net cost per condom sold. Three countries (Pakistan, Cote d'Ivoire and India) are in the range of $0.044 and $0.052. Four more (Nigeria, Zimbabwe, Haiti and Cambodia) range between $0.052 and $0.098 and the remaining 35 countries range from $0.113 to 6.365.

Most condom programmes purchase condoms in bulk on the international market and repackage / re-brand them for sale. The alternative approach that provides support to domestic condom manufacturers (or importers) to develop their own brands in a given market has had some modest successes, particularly in middle-income countries. However as commercial sector condom margins are relatively low, as is promotional spend, few countries have managed to sustain markets, should donor support be withdrawn, without raising prices. Programmes of support to condom manufacturers' or importers' brands have, also, found it difficult to compete with an entrenched 'own brand' SM programme.

Within the hormonal contraceptive market more success has been achieved in the promotion of manufacturer's, or importers, own brands whether sold under the original brand names or over-branded to distinguish subsidised products from unsubsidised. Manufacturers, particularly in the OC pill market have been able to sustain pricing levels affordable to low-income groups providing market demand can be created through donor inputs in order to reach a profitable level of sales volume. The constraining factors of this model have been that priority countries, as seen by manufacturers, may not be the same as those prioritised by donors. Global collaboration has been somewhat disappointing as a result although individual country arrangements have proven successful. As a result SM programmes for OC pills continue to develop along both lines – through re-branding by SMOs and through promoting manufacturers own brands, depending on the country environment and the level of support and co-operation of manufacturers.

A relatively new market has development, more recently, for treated mosquito nets against malaria (ITNs). Strategies for SM approaches to the ITN market are

still under trial and development and vary considerably across countries. In general it is appreciated that domestic manufacturing of ITNs is a relatively low-technology industry and can be developed in most countries. At the same time there is evidence that even low-income consumers will pay relatively large sums for malaria prevention as they are well aware of the high cost of treatment. As a result it is felt that developing 'own-brands' by SMOs are more likely to impact, negatively on the development of the purely commercial sector in many countries. At the same time few countries, particularly in Africa, have a developed market for ITNs. The cost of developing targeted approaches, only, is seen as unsustainable. Along with target approaches the whole market needs to be opened up and developed at the retail level. A few countries are trying to accomplish this through support to commercial sector manufacturers brands only. In other countries subsidisation is seen as crucial if the retail market is to be opened up quickly. Here the most common approach is for SMOs to purchase nets and over-brand them as SM brands. The long-term implications of this approach, on the future development of the purely commercial sector, are often not adequately strategised, however. Meanwhile in both models various mechanisms are put in place to subsidise targeted approaches to the poor, particularly in rural areas through SMO or NGO management or through agencies such as UNICEF and the public sector. Voucher schemes to accomplish this are also being tested in some markets.

Present trends indicate that most SM programmes, while they are moving towards more cost efficiency as they mature, can only be sustained through continued donor funding. Sustainability requires long-term donor commitments and, ideally, a mix of donors.

In the 10 countries studies for this Review 5 were funded by multiple donors although two more had some, small donor participation as well, and 3 were entirely funded by DFID (China condoms, Pakistan and Nigeria ITNs) as follows:

	M'bique Condom	S.Africa Condom	SADC Condom	Nigeria Condom FP	T'zania ITN	Kenya ITN	M'bique ITN
% non-DFID funding	87%	37%	small	30%	33%	small	11%

DFID has responded to the need for longer-term commitments through increasing funding cycles from a more traditional 3-year cycle. Nigeria in working with a 7 year funding cycle, Tanzania ITNs 6 years. Kenya ITNs 5 years. DFID is planning a five year ITN programme in Mozambique.

10. WHO PAYS WHAT?

The SM model of delivery of a health benefit assumes that the cost burden can be shared by consumers and, at the same time, there are adequate margins of profit to be earned by distributors, wholesalers and retail outlets to give them the necessary incentives to actively engage in their distribution and sale. A notional example, taken loosely from the Mozambique condom programme shows the following financial data per 100 condoms:

Cost of programme to donor	**= $23.00**
Consumer pays	**= $ 1.40**
Total payments	**= $24.40**

Costs paid for commodities	**=$ 3.00**
Costs paid for distribution	**=$ 0.90 (less income)**
Cost of operations	**=$20.50**
Total Costs	**=$24.40**

Note: cost of distribution is the income of wholesalers, distributors and retailers.

In this analysis the consumer is receiving a subsidy of $23 per 100 condoms purchased.

11. THE USE OF INCOME FROM SALES

The majority of programmes offset general expenditures from sales income. The Review, however, noted that contractual arrangements with SMOs may not always be explicit concerning this. In countries selling multiple products, for example, it may not be clear whether the income from one product must be used to offset costs of that product or can be used for general overhead reduction. The SADC Regional contract makes no explicit reference to this. Revenue from condom sales may, therefore, be used for support of any new product launched in the country where the revenue is earned.

In the past some SMOs have suggested that revenues from sales may be set aside and lodged in some form of Trust Fund to allow SMOs to become more, financially self-sustaining. This concept springs from USAID establishment of Trust Funds to assist NGOs to sustain their finances – for example in the Philippines. This concept has not been seen favourably by donors to SM programmes.

It is suggested that contracts need to be more explicit concerning the precise use that income from sales may be employed.

12. INNOVATION

Many SM programs are exploring innovative ways to harness their skills within markets. These include, but are not restricted to, expanding private sector delivery of FP services through 'franchised', trained providers (Pakistan), the establishment of VCT services, improvements to STI services both through public and private sector providers (in a range of countries and often, but not always linked to provision of STI kits) and adding a wide range of products to the more traditional FP and STI/HIV/AIDS commodities. These include pregnancy kits,

clean delivery kits, ORS, multi-vitamins, iodised salt, safe water treatment and even snake boots and reflective belts.

It needs to be noted that many of these 'innovative' products, as defined by those SMOs that have been centred on FP and STI/HIV/AIDS programmes, have been widely promoted for many years by social marketing programmes managed by other SMOs engaged in the MCH field (note that the USAID NetMark project is managed by AED, a long-term practitioner of SM programmes within the MCH field). These programmes often employ marketing and advertising technologies to a wide range of programmes that may or may not include a specific product. These programmes add to the list such projects as breastfeeding, maternal and child nutrition, immunization, maternal health services, vitamin A tablets, introduction of new agricultural products, environmental health issues, and so on.

The process by which SM programmes mature and develop appears to have been inadequately strategised in many countries. SM managers claim that donor funding availability, donor preferences and funding cycles restrict their capacity to plan long term and in the strategic development of their operations. DFID has responded to this through developing longer term funding cycles for SM programmes (Nigeria – 7 years is one example). There appears to be some conflicts in understanding as to whether SM programmes should concentrate on developing their corporate strengths so that they can sustain and grow their operations permanently or whether their task is to develop markets and domestic capacities to manage them, and then withdraw from them.

A critique is that SMOs are too intent on developing their own products and brands and pay too little attention to the wider market and opportunities to utilize their expertise to develop the total market. SMOs claim that they would like to do that but donors do not provide funding for it (as the USAID CMS programme has in a few countries only). This issue needs to be actively considered by donors in strategising opportunities for employment of SMOs. In general, while subsidised, own brand products will likely remain as a requirement even over the long term in many countries, much more attention should be paid to long-term considerations towards creating more synergies between SM operations and employment of the private sector – not only manufacturers but the potential for distributors as partners and then as brand managers. If necessary SMOs can supply TA to these approaches, rather than manage them themselves.

Where SMOs have developed private sector networks or collaborated with public sector entities to establish networks (FP / RH franchises, VCT Centres) there is doubt expressed as to whether these operations rightfully fall within their long-term remit. SMOs are seen as specialists in the development of broad, national markets. The establishment and management of site-specific networks impact only marginally on this broader remit. It is suggested that SMOs might be employed to establish networks only where they have a clear exit strategy that involves the take-over of the network by some other private sector or non-profit

entity. VCT centres managed by SMOs that are collaborations with public sector facilities are seen as a doubtful strategic direction for SMOs. It is suggested that they might establish trial sites but that ultimately they will not be able to sustain their operations without continuous donor funding, unless the public sector entities are able and willing to take over management and funding. SMOs can supply training and technical assistance to these networks and promote them as a core service.

SMOs are criticised for developing market networks but not considering innovative extensions to their use. PSI in Zimbabwe has tested the distribution of commercial sector products through their distribution system. SFH in South Africa is negotiating a for-profit contract to act as a marketing and sales agent for several condom manufacturers. This issue does not seem to be clearly strategised across SM management as a future direction for sustaining SM operations where it may be practical to do so.

The whole issue of 'innovation' needs to be better strategised. This can only be done through close collaboration between donors and SMOs in the development of long-term strategies for the operations of SMOs in each country and include long-term sustainability issues, appropriate exit strategies, better use of the strengths of each SMO, clearer analysis of total markets and the role of SM within each (including clear market segmentation strategies) and more collaborative arrangements with all other sectors.

13. HOW DFID PERCEIVES AND USES SM

DFID's experience with SM programmes dates to 1989 and an SM programme in India managed by Marie Stopes. Development accelerated in the mid-1990s with some 11 projects managed through PSI, DKT, the Futures Group, IFH, IPPF, Marie Stopes. Total expenditure in 1995 reached about £2.8 million.

In 2002 DFID supported at least 26 projects with a total value of over $150M and an annual expenditure in excess of £50M. (see Annex 3)

DFID has supported SM through the Health and Population Department. Although not stated as such, the basing of SM in HPD reflects the utility of SM in the arena of supply and demand of beneficial health commodities and services rather than in the arena of 'business' or economic development. This is the case even though SM programmes are, in reality, engaged in the development of many businesses either indirectly through purchasing commodities or services or, more directly, through working with manufacturers and distributors to improve operational and product quality and marketing skills, opening up markets for the development of domestic manufacturing and enhancing the pool of skilled domestic marketing personnel.

DFID's approaches have been, to some extent, limited by the small pool of SMOs available and by the somewhat limited approaches offered, in the initial years of involvement, through proposals made from these SMOs.

DFID's contribution to the development of SM strategies has been significant. The emphasis on moving SM programmes beyond retail selling and into more collaborative efforts to better target the poor and vulnerable and to appreciate that SM programmes need to pay more attention to the social and behavioural-change environments within which they work has been a key issue. DFID has influenced these directions through programme design processes and, in a number of cases (notably Nigeria), in using tendering processes to make sure that these imperatives are adequately expressed.

DFID's approaches have been somewhat limited by the lack of cohesive strategies for the employment of SM through HPD and the, natural, limitations to experience within country programme advisors. The limited cohort of experienced SM consultants has, also, been a factor. The quality of programme design work has, as a result, been mixed and could be improved. Several SMO country managers reported to this Review that they had tended to respond to proposals from DFID based on Project Memorandums that were somewhat weak on understanding 'marketing' issues but as they were in a tendering process they were somewhat reluctant to redesign the project's strategies. As a result the project had experienced significant difficulties and had to be, ultimately, redesigned.

DFID had developed through its Resource Centres a number of useful tools for programme managers (The Guide for DFID on Appraisal, Monitoring and Evaluation – Price / Pollard 1998 through OPTIONS for example) but more tools, such as this appear to be needed to help country managers better design, monitor and evaluate programmes.

14. HOW WELL DOES SM FIT WITH DFID'S WIDER GOALS?

DFID's wider development goals are usually quite well expressed within design documents and in logframes (at the Goal level). However it is noted that programmes still have difficulties in clearly understanding the empirical contribution that SM programmes play in meeting these goals. It is understandable that Goal level Indicators in logframes cannot be expected to evaluate, clearly, the precise level of impact that the programme may be having in meeting these broader aims. All the same it is somewhat surprising that so few SM programmes are not able to clearly enunciate the extent to which they are reaching target audiences – notably the poor or low-income and most vulnerable consumers -- and those that can do so, do not necessarily present clear data that demonstrates the extent to which their target audience consumers would, or would not, be users if SM commodities were unavailable.

Available data does present a reasonable assumption that SM programmes are able to reach target audiences effectively. The issue is more that, in general, the data is not explicit enough on how effectively. This would require much more explicit data on the socio-economic profile of consumers to be produced and clearer targets set for the reach of programmes to that specific cohort of users that are the primary target audience. Programme effectiveness needs to be judged on the extent to which these targets are reached, rather than on total sales only, and the extent to which the SM programme has created new, consistent users or whether their users are switching from the public sector or commercial sector.

PSI and DKT are producing illustrative data on the health impacts of their programmes. At the same time many SM programmes are clearly moving from the original model of SM that depended on simple calculations of costs per commodities sold (CYP) and into broader behavioural change issues. DFID needs to work with SMOs to better understand, and report, the effectiveness of these behavioural change objectives and the calculation of the result built in to analysis of health impacts.

The methodology being employed by SMOs to calculate health effects needs to be explored, by DFID, agreed. This will allow for better analysis on the health outcome costs of SM programming to be better assessed against alternative approaches.

15. COLLABORATIVE FUNDING:

SMOs state that one aspect of sustainability rests with multiple donors in support of individual programmes.

DFID funds a range of SM programmes in collaboration with other partners. In the eleven case study programmes only three programmes rely entirely on DFID funding. The percentage of other donor funding for the remaining programmes is estimated, as follows:

M'bique condom	S.Africa condom	SADC condom	Nigeria condom FP	P'stan	T'zania ITN	Kenya ITN	M'bique ITN
87%	37%	small	30%	76%	33%	Small	11%

16. BARRIERS TO ENTRY ISSUES

SM brands, in specific markets, are often able to develop a strong market presence. Donors may wish to tender a new funding cycle however. In this case their choices are limited. Unless brands, and some operations, can be transferred from one SMO to another they can only, realistically, continue to support the entrenched SMO or engage in the expensive proposition of developing new brands, in a competitive market. The transfer of brands has occurred between SMOs particularly when USAID has terminated a global programme and its global management has changed – for example the closure of the SOMARK project. USAID has appreciated that brand ownership is one thing but that the use of brands can be transferred from one SMO to another. DFID has now taken the same approach but it appears, only in respect to new brands. This issue needs to be more clearly resolved. Donors who fund programmes should, ideally, make it clear that they reserve the right to tender programmes in the future and that SMOs are required to hand over the use of brands and some defined support field operations to any other SMO who may be appointed in any country environment.