

Commentary

Social Marketing: No Longer a Sideshow

Philip D. Harvey

For many years the social marketing of contraceptives was held to be an interesting but not a central part of the international family planning movement. The heavy lifting, everyone thought, would be performed by government programs, managed by developing country government agencies that would provide services and contraceptives free of charge.

This attitude is changing. Although government programs are still the largest family planning service providers in many countries, the contraceptive needs of poor populations are increasingly being met by a wide variety of independently managed contraceptive social marketing (CSM) programs and by a growing number of commercial contraceptive suppliers. In 2005, social marketing programs served the contraceptive needs of 36.7 million couples in 73 countries and provided hundreds of millions of condoms for HIV/AIDS prevention (DKT International 2006). This contribution means that social marketing programs accounted for about six percentage points of the contraceptive prevalence in the developing world (excluding China), and roughly 20 percent of the birth spacing methods used by couples in developing countries (United States Census 2004; PRB 2005).

All major contraceptive methods are included in the social marketing effort. In 2005, social marketing programs sold 131 million cycles of oral contraceptives, 20 million injectable doses, a half-million intrauterine devices (IUDs), two billion condoms, and emergency contraceptives, female condoms, implants, and spermicides. A few social marketing campaigns promoted sterilization. Manual vacuum aspiration (MVA) kits for first-trimester abortion (and related purposes) were also sold in very small numbers, and this category is growing. Social marketers are also becoming interested in misoprostol,

which, because of its multiple uses, can be introduced even where abortion is restricted.

A few examples of the impact of CSM programs in 2005 are as follows:

- In Bangladesh, social marketing provided 4.2 million couple-years of protection (CYPs), equivalent to 15 points of contraceptive prevalence.¹
- In India, six independent social marketing programs provided slightly fewer than 10 million CYPs, serving 4.5 percent of India's 216 million eligible couples.
- In Ethiopia, social marketing provided more than half of the country's contraceptive services in 2005, serving 1.5 million couples.
- In Latin America, 21 programs provided supplies to several million customers at prices that represent a transition from subsidized sales to full commercial market access.

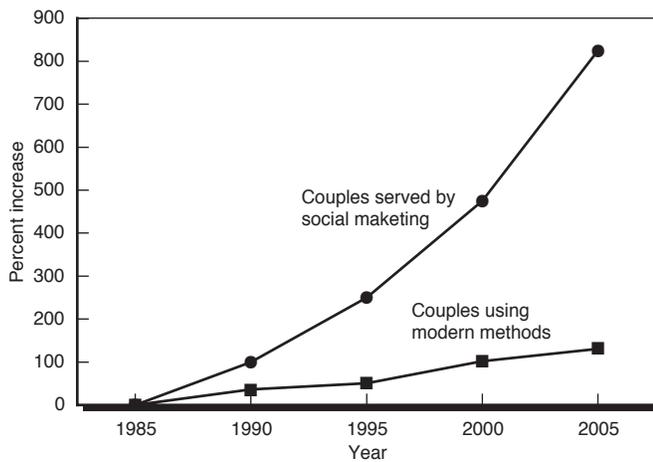
Of course, social marketing programs have been expanding at the same time that the use of modern methods has been growing rapidly worldwide through many different channels. Social marketing has grown faster than the overall trend, however. In the past two decades (1985–2005), the number of couples using modern methods has more than doubled (from 122 million to 282 million), whereas the segment served by CSM programs has increased ninefold (from 4 million to 37 million) (for percent increases, see Figure 1).

There are several possible reasons for the increasing popularity of the social marketing approach:

- As more poor people move to urban (or less rural) areas, they are easier to reach with CSM programs.
- As communications improve around the world and as incomes rise, CSM advertising and modern packaging become more appealing, especially to today's increasingly younger clients.
- CSM programs generate significant sales income, which helps them to expand and stabilize.

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Figure 1 Percent increase in the number of couples who use modern methods of birth control and percent increase in the number of couples using contraceptives provided through social marketing, 1985–2005



The accelerating trend toward social marketing may also be reinforced by changes in government policies. In the Philippines, for example, the number of federal government clinics providing free pills and other contraceptives is decreasing. Social marketing is picking up the slack, both by providing inexpensive pills and condoms in thousands of pharmacies and by supplying contraceptives to local government clinics at prices those clinics can afford.

At the same time that the lowest-priced social marketing brands are meeting the needs of those coming from the government system, higher-priced social marketing brands are often a bridge for wealthier customers to move into the commercial market for contraceptives offered at full price. This process is facilitated by the aggressive promotion that accompanies social marketing—promotion that helps to keep commercial contraceptives reasonably priced. And commercial brands of contraceptives generally do well in social marketing countries. The massive advertising campaigns conducted by social marketers almost always increase the total demand for birth control, making room for increased sales of all contraceptive products, especially well-packaged, branded ones.²

Another reason for the increasing success of social marketing programs is that they are especially compatible with international economic trends. Social marketing has always relied on commercial resources and techniques to reach large populations quickly. No special training is required to convince shopkeepers, even in remote areas, to stock and display attractively packaged products on which they earn a fair margin; mass-media campaigns can be launched quickly to spread the message of family

planning to every home that has a radio or television; and commercial marketing techniques are widely understood and analyzed. Now, as many countries liberalize their economic policies, these resources are expanding and improving. Communications networks are proliferating and social marketers are making use of them. Transport systems are improving, making distribution of fast-moving consumer goods—including contraceptives—more efficient. Advertising agencies are competing for social marketers' business, and market research firms are increasingly sophisticated. CSM programs are riding these trends and benefiting from them.

The move toward the private sector appears to be well established. In Indonesia, for example, the National Family Planning Coordinating Board (BKKBN) achieved notable success in the 1970s and '80s by providing services and contraceptives through government facilities and encouraging incipient social marketing initiatives. These efforts brought modern-method prevalence in Indonesia to more than 50 percent. Today, while the BKKBN continues to play an important role, it has turned over much of the burden of contraceptive delivery to the private sector and to social marketing. The BKKBN now provides about 30 percent of Indonesia's contraceptives, while 55 percent are sold through private commercial channels. Social marketing, at about 15 percent, provides most of the advertising and promotion, thus maintaining and expanding the demand for family planning through all three channels.

In Latin America this process has accelerated. Commercial sales and social marketing of contraceptives have provided substantial levels of service in Brazil, Colombia, and Mexico for many years. The Colombia social marketing program has been operating profitably for some time, and DKT International's program in Brazil now provides profits to help subsidize programs in poorer countries. Several CSM projects in Central America also cover their own costs.

Advertising: The Fuel of Social Marketing

Advertising is an integral component of most CSM programs. Other family planning efforts—particularly government programs—do not advertise, or they do so unenthusiastically, typically with committee-approved content. Social marketers remind us that we promote birth control so that people can enjoy the pleasures of sex without the consequence of pregnancy; sexual pleasure is an integral part of the equation.³ Most social marketers are comfortable with this fact and take full advantage of it. Moreover, because the first level of success in CSM

programs is measured in sales statistics, advertising is self-reinforcing. It almost always works, so sales increase, and then advertising continues, improves, and expands. In 2006, for example, DKT's programs spent US\$12 million on advertising. This represented 40 percent of the organization's operating budget.

A Path to Self-sufficiency?

Potential profitability, or at least financial sustainability, is a new chapter in the evolution of international family planning programs. Such programs, traditionally financed by industrialized-country donors, have most often been designed to require only temporary support, with donors providing catalytic inputs for a decade or so and thereafter turning program responsibilities over to the recipient government or other local entities and phasing out foreign involvement. But as incomes in developing countries rise, social marketing programs, whether managed locally or run by international agencies, are increasingly able to phase out donor support while maintaining a presence in the country and continuing to provide low-cost contraceptives indefinitely.

This trend has been given a significant boost by increasingly competitive prices for contraceptives in international markets. The entry of Asian manufacturers and the steady improvement in their quality standards have meant that prices for contraceptives—pills, condoms, IUDs, and injectables in particular—have been decreasing over the past two decades. Condoms are available in large quantities, fully packaged, for less than 2.5 cents each; good-quality pills cost less than 20 cents per cycle. IUDs from India, made to exacting standards, are available for 70 cents each, and three-month injectables from Indonesia can be purchased for 45 cents per vial. These prices are remarkably low, enabling social marketing programs to maintain low consumer prices yet still generate respectable margins.

Cross-subsidies

Another way that social marketers cover costs is through cross-subsidization. Consumer prices are kept low for the principal brands while new brands are introduced at higher prices. The Philippine program, for example, maintains a low price on *Trust* condoms but has introduced the more expensive *Frenzy* and *Premiere* condoms to help generate income and to appeal to different market segments. The *Trust* condom sells to the consumer for 10 cents, comfortably within the affordability guideline of 12 cents per condom, while *Frenzy*, positioned to appeal to

the youth market, and *Premiere*, an upscale condom, sell to the consumer at 14 cents and 28 cents per condom, respectively. The premium brands bring in a disproportionate share of revenue. In Ethiopia, for example, high-priced brands constitute only 27 percent of condom unit sales but generate 68 percent of condom income.

Cross-subsidization has an additional advantage: the introduction of higher-priced brands means that donors need not subsidize the prices of contraceptives for those who can afford to pay more.

What about the Poor?

As income generation receives increasing attention from social marketing managers, an inevitable tension arises between the desire to raise prices and the goal of continuing to serve the poorest populations. The purpose of CSM programs is, after all, to make contraceptives conveniently available and affordable to very large numbers of poor people. Therefore, low, affordable prices must be maintained, at least for the core brands.

The guidelines for affordability include two closely related standards. The cost to a consumer for a year's supply of contraceptive products and services should not exceed 1 percent of per-capita gross national income (GNI) or 0.25 percent of per-capita GNI adjusted for purchasing power parity (PPP).⁴ These standards have been established on the basis of long experience; contraceptives priced within these guidelines have achieved large-scale coverage among sizable and culturally diverse populations over extended periods of time.⁵

As incomes rise around the world, these affordability standards are becoming easier to meet. Table 1 shows cost-recovery information for 11 countries where DKT operates social marketing programs. In all but one, social marketing managers can meet the affordability guidelines and still charge at least enough to recover the cost of contraceptive products, including trade margins, assuming that the contraceptives are purchased at competitive international prices. For example, if pills cost 20 cents per cycle, they can be sold to the trade for 21 cents per cycle, enabling the program to buy a continuous supply of pills with a bit to spare. A price of 21 cents to the trade implies a consumer price of about 29 cents per cycle, or \$3.80 for a year's supply of 13 cycles. This price falls within the affordability guidelines in any country with a per-capita GNI greater than \$380 or a PPP-adjusted GNI of \$1,500. A substantial majority of the world's developing countries are now above this threshold.

Beyond the costs of contraceptives, the table shows that some subsidies are required for operating costs in

Table 1 Theoretical recoverability of contraceptive social marketing program costs, 11 countries

Country	GNI per capita \$ ¹	GNI/PPP ²	Permissible annual consumer cost /CYP ^a	Commodity cost per CYP including normal trade margins	Commodity cost recoverable	Operating cost recoverable	Marketing cost recoverable	Start-up and/or special activities
Mexico	6,790	10,030	\$25	\$3–5	Yes	Yes	Yes	Donor
Malaysia	4,520	10,320	\$26	\$3–5	Yes	Yes	Yes	Donor
Brazil	3,000	8,230	\$21	\$3–5	Yes	Yes	Yes	Donor
China	1,500	6,600	\$15	\$3–5	Yes	Yes	Partial	Donor
Egypt	1,250	4,440	\$11	\$3–5	Yes	Yes	Partial	Donor
Philippines	1,170	5,300	\$12	\$3–5	Yes	Yes	Donor	Donor
Indonesia	1,140	3,720	\$9	\$3–5	Yes	Yes	Donor	Donor
India	620	3,460	\$6	\$3–5	Yes	Partial	Donor	Donor
Vietnam	540	3,010	\$5	\$3–5	Yes	Partial	Donor	Donor
Sudan	430	2,000	\$4	\$3–5	Yes	Donor	Donor	Donor
Ethiopia	110	1,000	\$1	\$3–5	Donor	Donor	Donor	Donor

^a 1 percent of GNI or 0.25 percent of GNI/PPP, whichever is less. GNI = Gross national income. PPP = Purchasing power parity. CYP = Couple-years of protection.

Sources: ¹ World Bank (2006). ² Population Reference Bureau (2005).

four of the listed countries and for marketing costs in eight countries. If living standards continue to rise, however, at least half of these programs have a chance to achieve self-sufficiency in five to ten years.

Thus, the social marketing system, first conceived and described by Peter King and his colleagues at Calcutta's Indian Institute of Management in 1964 (IIM 1964), has proved for more than 40 years to be a viable and important model for delivering family planning. Social marketing programs are likely to assume an increasing share of the job of delivering contraceptives everywhere in the developing world. Such programs already provide a significant portion of the world's contraceptives; as prosperity and commerce expand, these programs will become more self-sufficient and increasingly will serve as a bridge for large numbers of consumers to move up to fully commercial contraceptive products. Meanwhile, social marketing is expanding birth-control options for an increasingly diverse family planning public and helping to stem the spread of HIV / AIDS by advertising and delivering more than a fourth of the world's condoms.

Notes

- For prevalence estimates, see statistics for married women of reproductive age in the United States Census Bureau (2004). CYPs are derived from DKT International (2006). CYP conversion equivalents are as follows: 1 CYP equals 100 condoms, 14 pill cycles, four injections (if one per three months) or 12 (if one per month), 20 female condoms, 150 foaming tables, 0.29 implants, 0.29 IUDs, or nine emergency contraception doses.
- The increase in commercial contraceptive sales as a result of (or in conjunction with) CSM activities is sometimes called the "halo effect"

(see, for example, Enterprise Editorial Group 1989; Niebuhr et al. 2004; and Chapman et al. 2005:33).

- See, for example, Stycos (1977).
- For a review of the pricing issue, see Harvey (1999, chapter 8).
- Less precise factors are also taken into account, such as the price of a cup of tea or a single cigarette. The affordability of a pack of two or three condoms should be on par with these items.

References

- Chapman, Steven, Hibist Astatke, and Kimberly Ashburn. 2005. "The performance of social marketing interventions in the developing world: A systematic review." Paper presented at the 2005 winter conference of the Society for Consumer Psychology, St. Pete Beach, FL, 24–28 February.
- DKT International. 2006. *2005 Contraceptive Social Marketing Statistics*. Washington, DC: DKT International.
- Enterprise Editorial Group. 1989. "CSM halo effect cited in Bangladesh." *Social Marketing Forum* 17. McLean, VA: Enterprise Editorial Group.
- Harvey, Philip D. 1999. *Let Every Child Be Wanted: How Social Marketing Is Revolutionizing Contraceptive Use Around the World*. Westport, CT: Auburn House.
- Indian Institute of Management (IIM). 1964. "Proposals for family planning promotion: A marketing plan." Unpublished.
- Niebuhr, Birgit, Theresa Gruber-Tapsoba, Dipoko Degrande, and Kai Gesing. 2004. "Role of social marketing in HIV/AIDS prevention in Cameroon." Frankfurt: KfW Bankengruppe. Annex 3.
- Population Reference Bureau (PRB). 2005. *2005 World Population Data Sheet*. Wall chart. Washington, DC: PRB.
- Stycos, J. Mayone. 1977. "Desexing birth control." *Family Planning Perspectives* 9(6): 286–292.
- United States Census Bureau. 2004. *Global Population Profile: 2002*. Washington, DC: US Census Bureau.