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D03488

Distr.
LIMITED

ID/WG.116/9
21 December 1971

ORIGINAL: ENGLISH

United Nations Industrial Development Organization

Expert Group Meeting on the Production and Distribution of Contraceptives in the Developing Countries (Sponsored by UNIDO in conjunction with UNFPA)

New York, 22 - 24 November 1971

ASPECTS OF CONDOM MARKETING [1]

by

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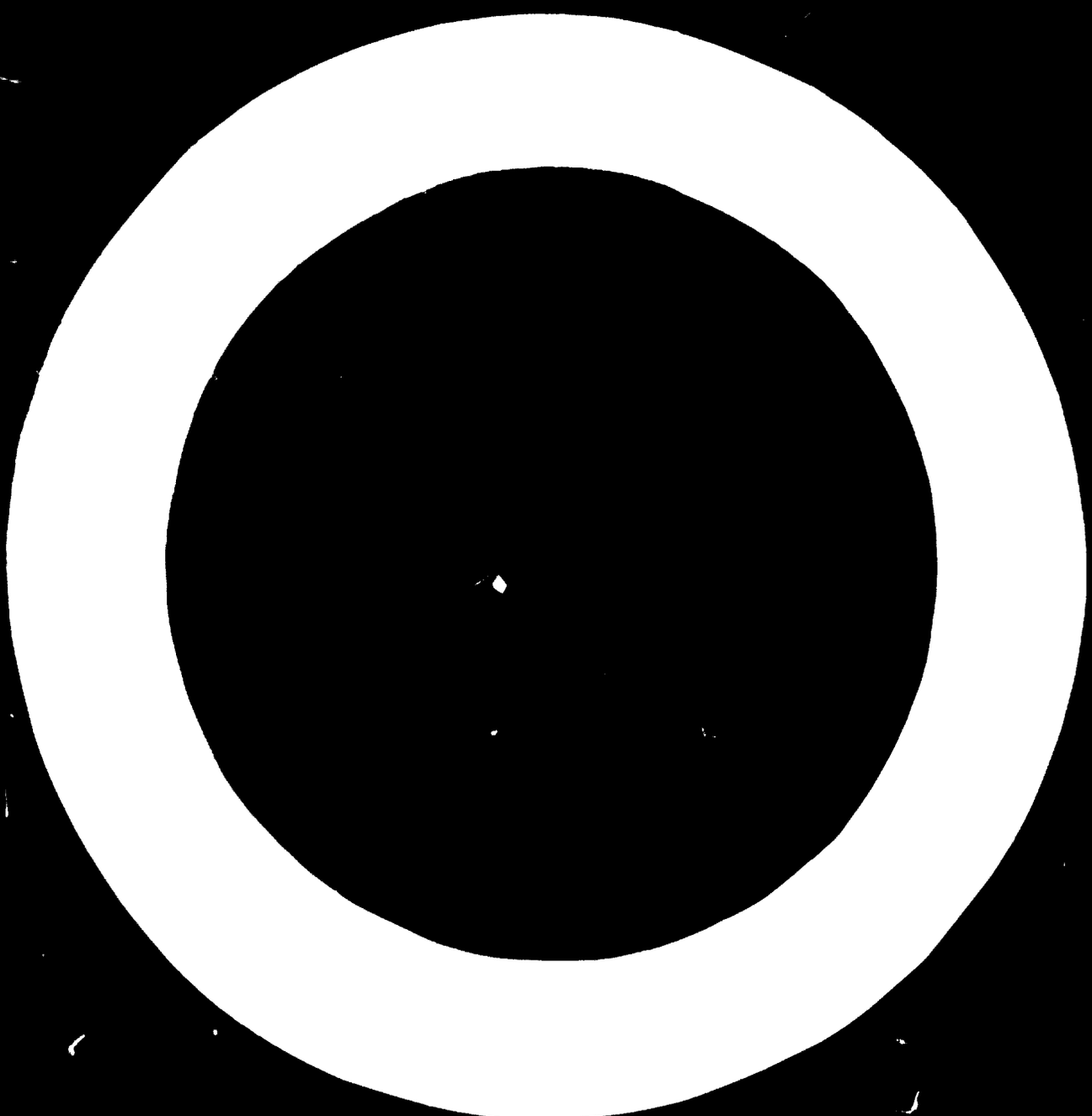

In a little over a decade when talk has been almost entirely of the new methods of contraception, such as the I.U.D., the oral contraceptive and prostaglandins, it is surprising to note that quietly and almost surreptitiously the world production of the condom has steadily increased. In West Germany it has probably increased by one quarter to one third maybe more. In the U.K. it has roughly doubled. Japanese production has gone up from approximately 1,500,000 gross to 5,500,000 although the United States has remained at much the same level. Indeed, it is believed that many of the major manufacturers have some spare capacity still available, although certain smaller manufacturers are known to be working to capacity.

Future growth is however difficult to forecast and depends largely on the policy of developing countries, the donor organisations which often assist them and the extent to which the consumption of a developed country can be mirrored elsewhere. Consumption per head in three such developed countries, the U.S., the U.K. and West Germany is very roughly the same; in Sweden it is probably higher at about 11 condoms per adult male per year.

In the U.K. about 32% of married couples use the condom and total sales are about 1,100,000 gross per annum. If all couples used the product all the time consumption would be some six times greater or about one third of the world total capacity today. Although it is probably a futile exercise to try to measure the ultimate potential, in the U.K. for instance, during the time when oral contraceptive users have gone from zero to 1.8 million, sales of condoms have increased by about one fifth. One can count on less than the fingers of a hand those countries whose sales have lost ground and of those, at least one - Sweden, has shown a marked recovery since 1969.

There is incontrovertible evidence that the appearance of the oral contraceptive and the I.U.D. have helped to expand the total market. Whether they have done this simply because they have succeeded in bringing

the question of sex from the kitchen to the drawing room, is another subject question.

A recent paper by Mr. Jeremy Byles, catalogued "Ten Major Methods of Contraception" described the condom thus: "Condom - this is simple to use, reliable and popular, but it requires a decision to be made before each intercourse." One other point should be referred to: "the interference of pleasure".

As researchers and demographers examine the world population problem they have one constant wish at the back of their minds: the ideal contraceptive. They often fail to remember that the sexual urge is the strongest we have and a formidable opponent. One can tamper with a body by clothing it, shoes encompass feet, a hat covers a head, parts that were never designed to be so protected. A condom covers a penis, the penis naturally objects.

Albeit the condom is still the major method of contraception today, even in a developed society such as the U.K. Millions of couples have educated themselves to adopt it and believe it is the ideal protection. They have done this, for instance, in countries such as the U.S.A., the U.K. and Mexico, countries with considerably different products. However, we believe that in the U.K. we have achieved, as do many of the Japanese manufacturers, the most acceptable product.

The argument of thicker condoms for greater safety and less acceptability against thinner condoms giving less safety but greater usage is not a new one. In the U.K. we believe we have also achieved a very safe product with a thinner film of latex and indeed LRI's thinnest product is approximately one third lighter in weight than the average American condom.

Peter King's discussion paper, written in 1966 (1), is now comparatively well known but unfortunately it seems to have had little effect on the Standards Bodies' opinions. Its deductions are still valid. Insistence on an exceptionally high standard, such as in the U.S.A., leads to a thicker product which means that sensitivity and acceptability

are adversely affected.

When LRI supplies donor organisations or developing countries governments or Family Planning Associations, it always ships condoms manufactured to the British Standards Institute Specification. In the recent past we have been made aware by some developing countries purchasing authorities that the quality of the shipments they have had from elsewhere has been suspect; very often a product is not only faulty but it is also much too thick to be acceptable - especially to those who have been introduced to the product for the first time.

Developing countries also have to contend with the historic association of the condom with prostitution and venereal disease. This hurdle has to a great extent today been overcome in developed countries. But there may be enough evidence to postulate thet there is e correlation between the thickness of the product in the market end the reputation it has es a prophylactic.

If a country has a good quality, thin product regulerly supplied it still hes to motivate people to use it. Dr. Malcolm Potts said laet yeer [2] that "meny people find it easier to initiate action to deal with the reality of pregnancy than to take precautions against possible conception. The normal practice of family plenning is, efter ell, e rether remote goal which is to make a statistically rather uncertain event which may teke place in nine months time somewhet more improbable." Moreover, "sociological studies suggest that abortion is en acceptable form of fertility control to meny individuals, although it is frequently condemned by the community." The realities of abortion stetistice are frightening in all conscience and even more so when they reach the level they do in countries where the concept of family planning is to a greater or lesser extent condemned by either church or tradition. One of the strongest human emotions is employed when a women discovers she is pregnant with a child she does not want. It ie fear. It is this fear which often leads her to a desperate solution, the illegal or non-medical abortion.

In many developing countries it may be possible to use this emotion to a more constructive end, if a programme is based on the condom as the leading method. A ruptured condom, when it occurs, causes the couple to fear the consequences, evidenced by the free presence of semen. Should couples be motivated to fear the presence of semen long before each act of intercourse takes place, the eagerness to use a condom for the act should be paramount. Such an attitude to semen as a substance per se can only be described as somewhat controversial, reminiscent perhaps of the strictures of English 19th century morality. Nonetheless, it would at a stroke solve the two problems of a motivation programme:

1. the curbing of the desire to have a large family,

   and

2. the mental approach essential to ensure that such a desire is achieved.

There is a world of difference between the two phrases Family Planning (which begs the question how big?) and Birth Control (which does not). If a family is "Family Planning" there is indeed a greater drive to efficiency once the desired family size is being approached. The Growth of American Families Study (1959) [3] shows that Jews choose the potentially most effective methods, Protestants the next most effective and Catholics the least. Before the arrival of the oral contraceptive, the findings may now be termed irrelevant, but the high incidence of condom usage by Jews is still borne out by condom consumption figures in Israel today. Any population programme has to some extent be structured to fit the religion and tradition of its country and if necessary these local doctrines and dogmas must also be re-interpreted by the programme to suit it. For instance, the Moslem religion does not overtly deprecate birth control. It sees the chief function of man as not merely to procreate but to give his children the best possible upbringing. The logical extension of this thought is "less children".

In 1960 Professor David Glass [4] found that the desired family size varied from two children in Austria, 2.2 in West Germany, 3.6 in the U.S.A. and 4.2 in Canada. A projection of four children per family is no solution to the world problem especially when it is repeated in a country such as India. Unfortunately, also, there is in the wealthier countries such as the United States little correlation between the national attitude to population growth and the personal attitude towards limitetion of family size. Family planning is useless as a concept if it is simply re-interpreted as "family spacing".

It may regrettably be valid to compare the probable decline in the birth rates of Hungary and Poland and East Germany today with the decline in the U.K. of the 1930's when, with a population of around 43 million, the Registrar General once predicted a population in 2000 of six million. It is now 56 million. The slump was a slump because the people affected had known a higher standard of living. It is regrettable, but true, that many countries will take too long to reach a standard of living which will bring home the lesson of family planning, so that they realise what they will lose if they have too many mouths to feed.

Japan is a case in point. The population's first reason for adopting birth control was prsdominantly economic as the uncertainties of the post-war situation unfolded. Japanese demographers have deduced that the moment when family planning and birth control become a reality to the individual is when hope of real benefit from it dawns and the desire for higher standards asserts itself.[5] This has also been found where intensive help programmes are directed to problem families. With the rise in prosperity the use of contraception is increasing. It is also indicative that the success of the Japanese programme justifies (or is it the example?) the succinct summary of many demographers of the best programme possible in any given set of circumstances: the condom plus abortion on demand.

The U.K. Family Planning Association long term planning group has only this year completed a study of the non-medical methods of contraception.(6) They have not found, as have certain major oral contraceptive manufacturers, that there appears to be a natural saturation limit for female medical methods, but have discovered that the condom is the method of choice for a large proportion of the population who wish to use a non-medical method. Indeed for many years most family planners believed that the main target for programmers should be the woman and not the man. It is only comparatively recently that it has been seen that, even in societies where the woman is thought traditionally to be the dominant partner, it is possible to motivate the man to take the initiative in contraception. Japan is a male dominated society; the condom's success in arguably directly related to this. The continuing steady level of sales in the United States, despite the popularity of the oral contraceptive, also occurs in a society which for long has been labelled "female dominated".

The recent Hull study of problem families, conducted by Dr. John Peel(7), is also relevant for programmes when social workers and not medical or para-medical staff are used.

The group was specially selected for low socio-economic status linked with hyperfertility, the criteria being at least four pregnancies in the previous six years and one live birth in the last twelve months. There were few refusals, and most couples stayed with the project for twelve months or more.

The results of the trial, published in The Practitioner, May 1969, provided a failure rate, Pearl formula, user and method combined, of 3.1 per 100 woman years. Most of the pregnancies resulted from user failures, the method failure being under one per 100 woman years. These results bring this non-medical method of contraception well within the range of efficacy of the I.U.D.'s and approaching that of the oral contraceptive.

The trial procedure had both advantages and disadvantages. By contacting the husband in the first instance, Dr. Peel departed from the traditional approach to contraception, which was based on the, at least questionable, assumption that wives must take the active role in birth control in favour of a contraceptive that conformed more to the general practice of the U.K. population. On the other hand, in concentrating on hyperfertile couples of low socio-economic position, the trial was conducted in adverse rather than average conditions.

The results relate closely to those previously reported. Sagi (1962)[8] observed a rate of 2.6 for systematic users who had achieved their desired family size and Tietze (1966)[9] has more recently quoted a similar figure for "adequate users".

Nevertheless, it would be rash to take the example of the condom's marketing success in Japan or the U.K. and apply it rigidly to any given developing country where local conditions would vary so greatly. And, after all, the situation in the U.K., in which probably some two million fertile couples do not regularly take some form of oral or non-systemic precaution, is still deplorable. This is despite intense propaganda by the press, the Family Planning Association and commercial companies.

However, the condom as a non-medical contraceptive is the only widely accepted product that can be distributed to saturation point both safely and with the minimum of cost, utilising commercial channels of distribution. Moreover, a family planning programme based on the condom can, in many developing countries, be partly self-financing, thus avoiding the enormous burden of a comprehensive scheme utilising special clinics and medical or para-medical personnel. This motivation of the commercial channels of distribution through profit incentives has already been explored by several countries and should be examined universally.

The first textbook marking lesson to be learned is always the importance of distribution. Moreover, with family planning products it is vital not to be too choosy. The prospective user must find the product as easy as possible to purchase. In the U.K. LRI sell direct to any customer who can gather together £15, but also to the wholesale trade and of course the retail groups. There is additionally a strong mail order trade in the United Kingdom: "the plain cover" opportunity is essential for many. The automat (sited by law only inside a public place) is of great comfort to another section of the community. There are factory agents who sell to their work mates in the comfort of the semi-anonymity of the shop floor. However, the long lasting taboos surrounding the condom still restrict both its display and the variety of stockists. Until May last year pharmacists were forbidden by their association to display, despite their 25% share of the market. A comparative few do so now. None of the major supermarket chains will stock and thus the easiest opportunities to purchase are swiftly removed from half the adult population. On the other hand, in a population of 55 million there are already over 50,000 outlets of one kind or another, despite this gap.

As in the U.K., where the main outlets for the trade, the pharmacists and the barbers, have scarcely changed, so it is in other markets that traditions are built up which are not easy to break. Each country usually has its own unwavering channels. Normally the pharmacist is one of them, but not invariably and sometimes if the pharmacist trade has an exceptionally professional view of itself or if its shops are just too few on the ground, the marketeer and the consumer has to look elsewhere. General stores, grocers, tobacconists, street pedlars, bazaars, cafe waiters, street kiosks all have their place in particular countries.

It is not too much of a generalisation to say that condoms today are "generally" available in virtually all countries where free importation is allowed, to those that want them. Many countries have a plethora of brands and qualities and several price levels. In many ways this

price variety should be encouraged, and each brand, of which there should be only a "reasonable" number, should be seen and appreciated by the public to have and be worth its value - whether this value stems solely from the packaging or not. There are few countries even today where there is not a wide disparity of incomes, even sometimes among a group of semi or unskilled and within each income group a certain product can be sold and promoted as being desirably valuable and attainable. LRI have appreciated this for some time, perhaps stemming from the days when lower quality imported brands once tried to establish a market in England selling at about 1¢ a piece. It was a disastrous policy in a developed country with a high level of income, where such a product was immediately mistrusted.

But in many markets LRI finds it is able to reach varying income levels through in part "subsidising" its low priced sales by its sales of higher priced brands to those income groups who can afford them. Unless this were done it would only be possible to reach the better-off. This fact of life will remain: unless a commercial company is able to develop its own more expensive branded products it will not be able to assist the low income groups, either commercially or through a family planning programme, to the fullest extent.

The policy of maintaining differing price levels both for different markets and segments of those markets is complicated by the fact that LRI is one of the few condom manufacturers prepared to do this. Japanese products for instance are almost always exported at the same price levels and to all comers. Where price becomes the sole criterion and no distribution policy exists, it becomes increasingly difficult to build a market and a brand franchise. The main LRI brand, Durex, is now the best known outside Japan and the U.S.A., where it is not sold. This has been achieved by a combination of willingness to adapt to the existing market traditions and conditions and a normal consumer company's faith in its brand name.

The consistency of an excellent pack design, both in form and presentation, has greatly aided consumer acceptance of the product. Simple to use, smart yet discreet, easily pocketable, the establishment of such a pack will always prove of great advantage in any market. Moreover, this pack must be seen to protect, as the consistent quality of the product is of vital interest to the purchaser.

Promotion is the hardest problem. Taken to task by Sollins and Belsky in a Population Council report "Commercial Production and Distribution of Contraceptives"[10], it is hard to refute the charge that condom manufacturers have been idle in this sphere. However, there is a considerable difference in the image between the oral contraceptive and the condom and the natural reluctance in many markets to allow any form of advertising, let alone display, for the product is only now changing slowly. Nevertheless, where cinema, TV and radio advertising is allowed we use and will use them. Where press advertisements are not restricted to the personal columns we use them. A growing advertising budget is carefully allocated to those countries at whatever state of development, where we think additional sales are attainable. A considerable variety of point of sale material, available in the local language where necessary, is provided where it can be used.

It is important to emphasise how different a condom is from a razor blade or soap. In few countries will the disposable income ever rise to the level where massive promotional campaigns will be viable even at the increased prices which ensue. Moreover, the product has universally a somewhat distasteful image. It is a lone hard battle that the condom manufacturers fight to change it and a battle in which none except a few enlightened Family Planning Associations assist.

Perhaps it is only right to point out the battle is becoming more confused as the number of people in the world afflicted by some kind of venereal infection approaches the 500 million mark, or about one seventh of the world's population. Conorrhoea is the commonest of these. It is estimated that there are about 150 million cases each year

and this is increasing steadily. The condom is the only contraceptive which gives a measure of protection. It also helps prevent re-infection when one partner has contracted one of the less serious diseases such as Trichomoniasis or Candidiasis and a sexual relationship continues. Those developing countries who have a population problem and a disease problem should remember the condom.

LRI welcome the current interest expressed by demographers and donor organisations in a greater co-operation between non-profit Family Planning Associations etc. and the commercial sector. We are particularly interested in discussing joint marketing and promotional campaigns for our major brands in those countries where funds will never be forthcoming from our own margins where the product itself suffers and where balance of payment problems make it difficult for the host country to allow free importation. However, we invite many developing countries to make a start now by examining their tariff and other non-tariff barriers. We in turn will be prepared to discuss with them adjustments we might be able to make in our price levels. It is oft times said that the population explosion is a greater danger to the world than nuclear war. If this is so, the restrictions which at present surround the free dissemination of all contraceptive products to all who want them is a major disservice to mankind.

As we explained to those delegates who visited us in London, the module size of manufacturing plant used by the world's major manufacturers is that which is necessary to embody all the technical developments to make an acceptable, thin, high quality product. Scaled down appreciably to reduce the capital cost, the efficiency of the process is reduced and quality suffers. Raw materials are more expensive to purchase.

Testing and packaging, however, can easily be done on a local level. I has a side benefit also of being more labour intensive and therefore creating its own minor industry. The personnel needed to run and maintain an

automatic prime manufacturing plant are few in comparison. LRI are prepared to assist any developing country which is interested in creating such an operation, both in technical advice and support and later in marketing expertise.

We repeat that there is no one blue print for the successful marketing of condoms in any given developing country. Each has its own particular problems which have to be solved and indeed we do not pretend the condom is essential broad-base for every programme. But it will always have an important part to play as the simplest and often the cheapest method available. While there is no real prospect of the ideal contraceptive becoming available in the foreseeable future, the oldest method will remain a major force. As we say on our showcards, it is safe, simple and effective.

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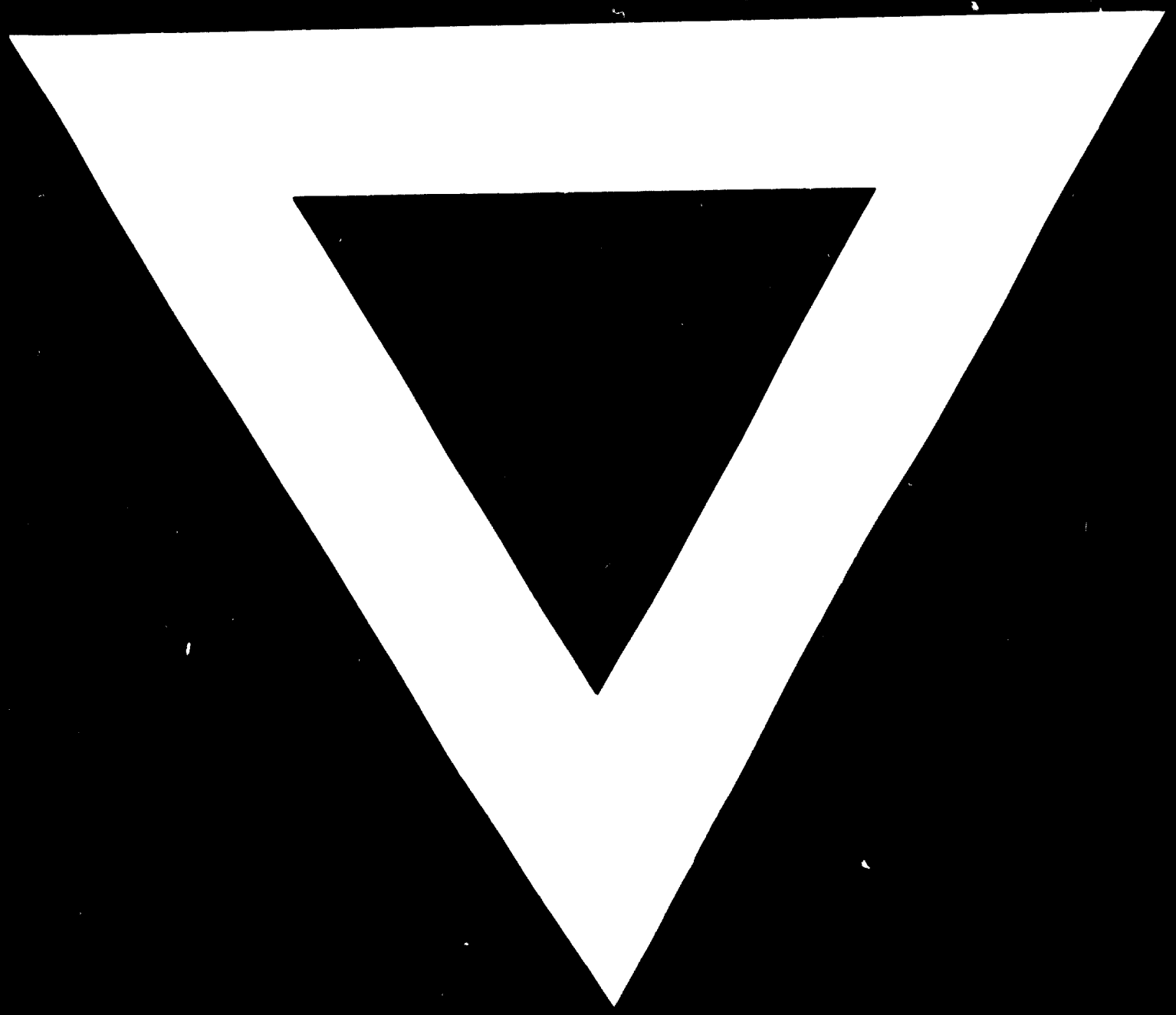

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