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New York, 22 - 24 November 1971

DEMAND FOR CONTRACEPTIVES IN DEVELOPING COUNTRIES 1/

by

Peter King *

1/ The views and opinions expressed in this paper are those of the author and do not necessarily reflect the views of the Secretariat of UNIDO.

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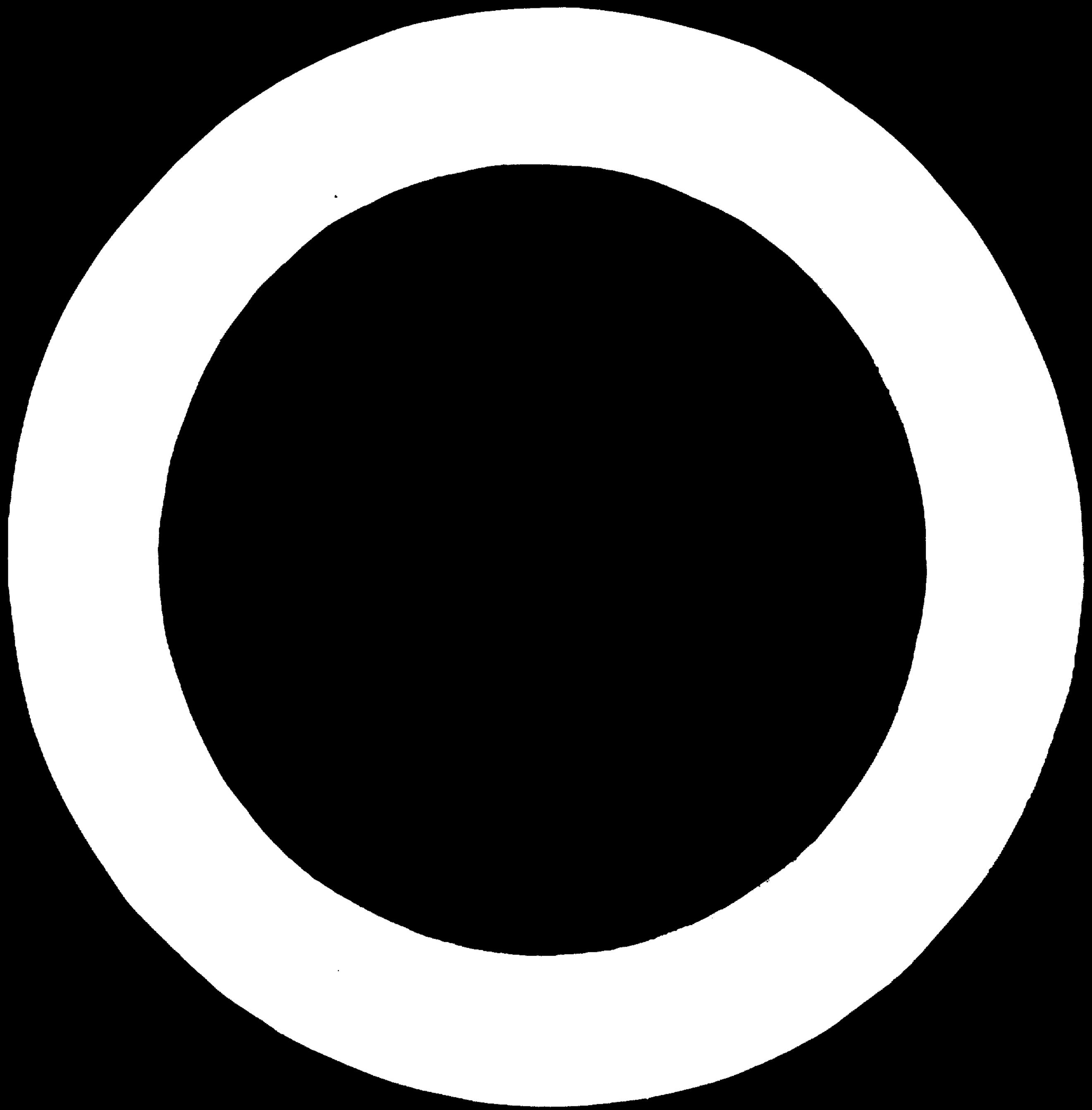
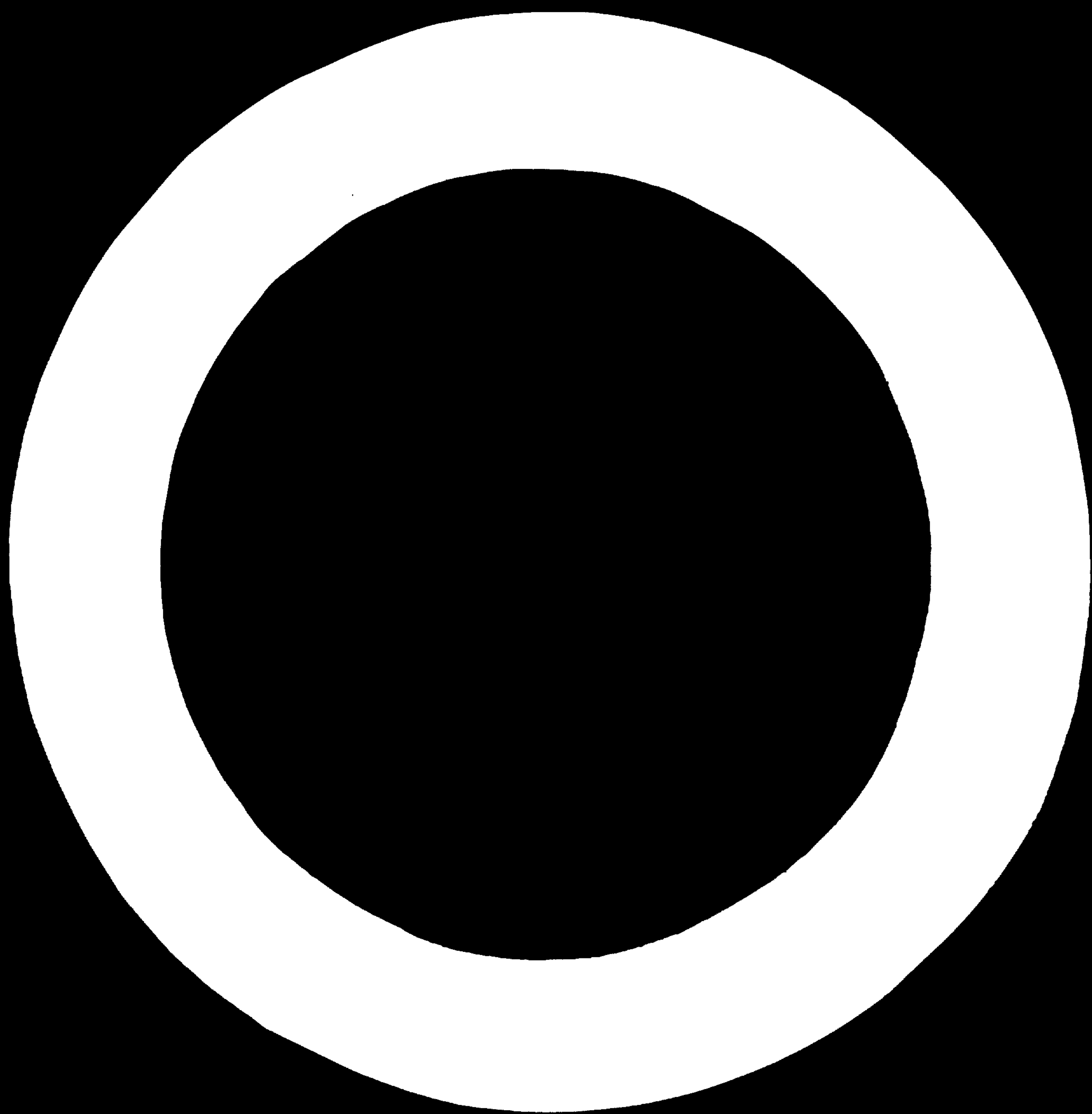




Introduction

The main weight of our discussions at these meetings will be on what might be termed the supply function: the development of new and improved contraceptives, the problems of production and physical distribution. My objective is to broaden the discussions even wider to include the subject of contraceptive demand, as the problems of supply can never be far removed from the problems of demand. There are definite demand problems which should concern us all. My remarks will cover these three areas:

(1) Patterns of contraceptive demand

(2) Present trends in the growth of demand, and

(3) Opportunities for generating an even more rapid expansion of demand.

Patterns of Contraceptive Demand

Firstly, look at some quantitative information on current usage patterns. Reliable data on contraceptive consumption and production covering the developing countries is hard to come by. Fortunately, the Population Council published a year ago a study by A.D. Sollins and R.L. Belsky* which included what are generally regarded as the best and most detailed estimates available on world-wide contraceptive production and consumption; and the data I will present is drawn from that study.

Table 2 (Table 1 has been deleted) provides estimates of total "world"[1] usage in 1968 of the five most popular product types. Note that the U.S.A. accounted for 35-40% of the 42-49 million users of contraceptives in the "world", a point we will come back to later. Condoms and orals are shown as tied for first place, both being more than three times as popular as any of the other products.

Chart 1 rearranges the Population Council data to permit comparison of the percentage of users of contraceptives per 100 females, aged 15-44, in the more and the less developed regions of the world.[2] The total user rates are further broken down by major channels of supply; commercial, I.P.P.F., and government programmes. The height of each bar estimates the percentage of reproductive females using contraceptives. The areas of the segments of the bars measure the total number of users, by channel of supply.

*Commercial Production and Distribution of Contraceptives - Reports on Population/Family Planning, No. 4, The Population Council, June 1970.

[1]The Population Council study definition of "world" excludes mainland China and the central-managed economies.

[2]Population base definitions and data have been taken from the 1970 estimates provided in UN Population Division, Working Paper No. 30, December 1969.

Table 2. Population Council Report No.4, June 1970; reproduced with minor modifications

ESTIMATED USERS OF CONTRACEPTIVES, BY TYPE OF CONTRACEPTIVE,

FOR THE WORLD AND THE UNITED STATES: 1968[b]

(Numbers are expressed in millions)

Type of contraceptive	World[a]	United States
Aerosol foam	1-2	1-2
Condom	17-19	4-5
Diaphragm	2-3	2-3
Intrauterine device	5-6[c]	1-2
Oral contraceptive	17-19	7-8
All specified types	42-49	15-20

a Including the United States but excluding Mainland China and Eastern European countries with centrally planned economies.

b The estimates of users given in Table 2 are derived from Table 1 according to the following assumptions and should be regarded as a rough approximation.

Each cycle of oral contraceptives is sufficient for the average menstrual cycle of 28 days. The number of users is then 12/13 or 92 per cent of the number of cycles distributed per month, where "user" is construed as woman-year of protection.

For condoms, studies in the United States and other countries indicate an average of 100 to 130 coital experiences per couple per year; assuming that not all condoms purchased are utilized, we have elected to use 1.1 to convert "gross of condoms per year" to "users."

Foam users may be calculated from the same coital experience rate. At a dosage of 1 gm per application, a factor of 0.4 will serve to convert "cans sold per year" to "users."

For diaphragms, used mainly in the United States, users have been estimated by extrapolation from studies by Charles F. Westoff and Norman B. Ryder ("Reproduction in the United States, 1965.")

c This includes four million users in developing countries through national programs.

The striking thing about this chart is the tremendous, absolute and relative importance of the commercial sector in the more developed regions of the world; and its precipitous decline in importance, absolutely and relatively, in the less developed regions. The achievement to date of government health service programmes in the developing countries shows up pretty well when compared with the performance of their sister institutions in the developed regions.

If the usage data could be broken down into five levels of development instead of two, the contrasts would undoubtedly be even more pronounced. Oceania (which includes Micronesia and Polynesia as well as Australia and New Zealand was supplying orals alone to 25.7 per 100 females, aged 15-44.[1]

Per capita consumption of orals and condoms in the U.S.A. in 1968 was, respectively, about 200 times and 150 times the comparable consumption rates in India. The Indian commercial sector was supplying, in 1968, not more than 0.3 users per 100 females, aged 15-44; or about one quarter the rate for less developed regions shown on Chart 1. (And, probably, 75% of these women came from the affluent classes of four major metropolitan cities.

One final comment about the chart. Do not conclude that, if the less developed region could catch up and reach the contraceptive usage rate which the more developed region reached in 1968, the population problem of the less developed regions would be solved. Far from it, usage rates on the order of 40 or more per 100 females will probably be required to depress birth rates to acceptable levels.

Clearly, the National Programmes in the developing countries have a very long way to go. An it would appear that, unless the commercial sector begins making a more significant contribution to the solution of the total problem, the managers of the National Programmes who are charged with achieving the over-all national goals, are going to be hard-pressed, to say the least.

Present Trends in the Growth of Contraceptive Demand

It is almost impossible to make a quantitative estimate of the trend in the total demand for contraceptives in the developing countries that is much better than a guess. Informed opinion has it, however, that total demand

[1]Population Council, Op.cit, Table 7

Chart 1

1968

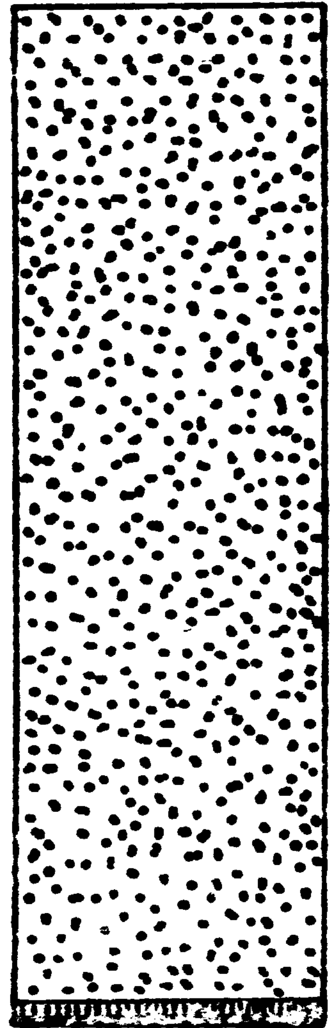
Contraceptive Users

per 100 Females aged 15-44 by Channels of Supply

Users per 100 Females 15-44

21 20 19 18 17 16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1 0

More Developed Regions
Total Reproductive Females: 110 Million

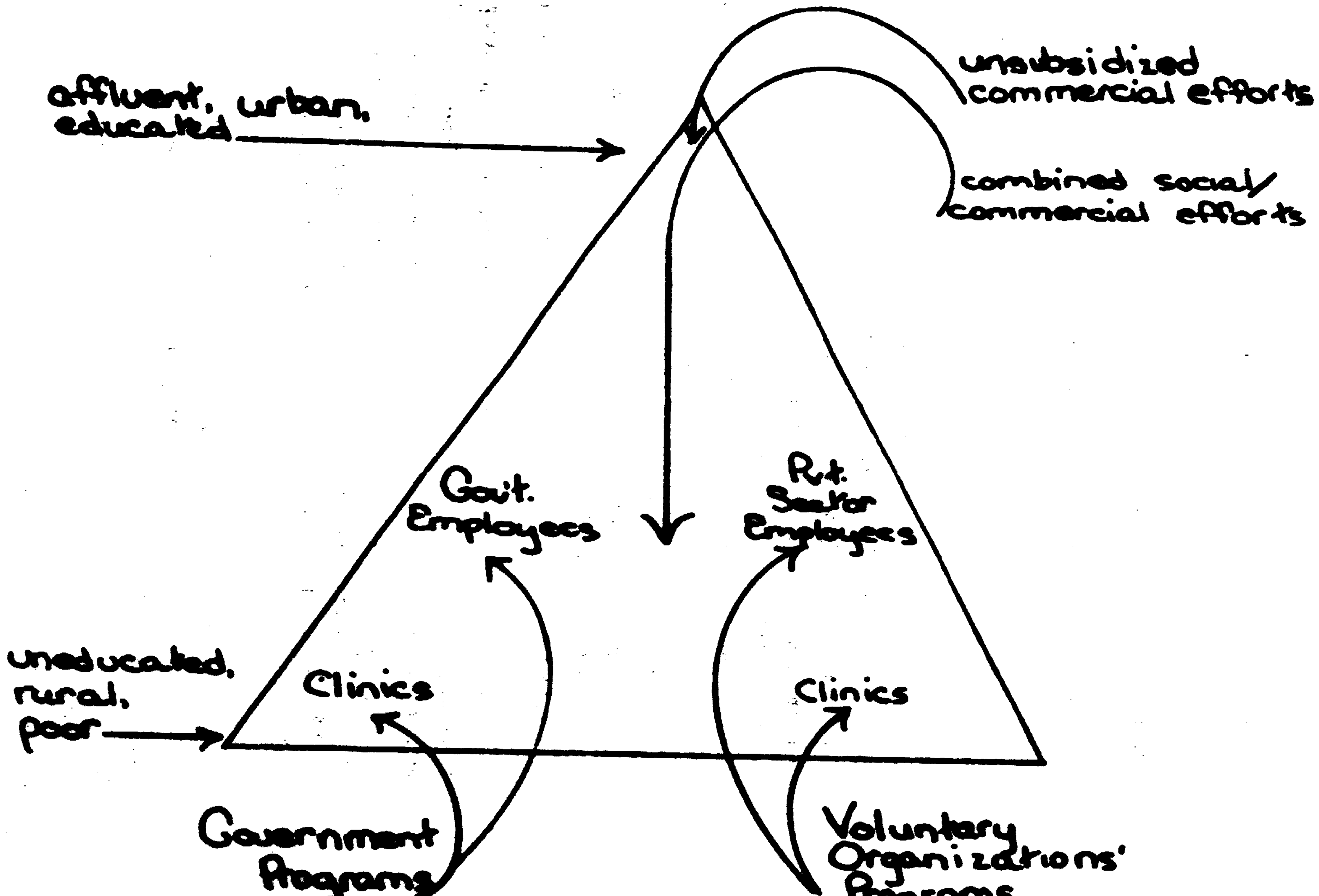


Less Developed Regions
Total Reproductive Females: 370 Million

Key
- Commercial Channels
- IPPF Affiliates
- Government Health Service Programs

Source of Data: Population Council, Reports on Population/Family Planning, No. 4, June 1970

Major Family Planning Program Thrusts in the Less Developed Regions ~ present and potential ~



is growing, probably on the order of 5 - 10% annually and certainly not as much as 20% per year. The difficulty in measuring trends is that time series data on consumer purchases are needed, covering each of the several types of contraceptives for every developing country; needless to say, such data just are not available.

Another way of estimating total demand trend is to add up the demand met by each major channel of supply. Here too the measurement problems are at present insurmountable, but an attempt to do so raised issues which deserve comment.

Clearly, most countries now have more than one "programme", though often in countries with "National Programmes", the official programme is considered the only "programme". This tendency to ignore the less prominent promotion/distribution systems serving contraceptive users has probably contributed to the general lack of awareness of and therefore concern about the low performance of the commercial sector in the developing coutries. In the future, it may become common to recognise multiple "programmes" in a single country, statistically and otherwise. And this would be a good thing because the trend in performance of these individual "programmes" may be different and the growth of total contraceptive demand depends on the sum of the achievements of the individual "programmes".

Chart 2 shows the major types of programme designs now operating, schematically indicating their primary target groups. Except for one, the names used to lable the programme types are conventional; and no one would have much trouble fitting most field programmes into one or another category. But there are clearly some new types of programme designs which do not seem to fit the conventional typology. I have grouped them under the heading "combined social/commercial efforts".

Examples in this genus of programme are in operation in several countries including India, Pakistan, Ghana and Costa Rica; and in the planning stage in Colombia, Indonesia and elsewhere. So far the condom has received most attention, but programmes are working for foam tablets and orals also. Actually, it is still too early to classify all these various efforts into a single category. What they all have in common is some form of participation of the commercial sector. But the range of functions and the scale of participation varies widely. In some cases

a few retailers buy condoms from a family planning programme employee. India's Nirodh Programme, on the other hand, is a major mass marketing operation with hundreds of thousands of commercial organisations performing nation-wide the functions of retailing, distribution, advertising service, consumer research, information feed-back and data processing. In fact, all activities of the programme are performed in the commercial sector, except the top decision-making function which is performed by a single government officer and a few assistants.

Later we shall hear speakers discussing the future of various national programmes, the plans of I.P.P.F. and the prospects of the unsubsidised private sector. So I will not attempt to discuss the demand prospects of these sectors further. I will, however, in the third and last section of my remarks refer rather directly to the future potential of the hybrid social/commercial type of programme design, because this type of programme design trend is aimed at rectifying the problem of the low performance of the commercial sector discussed earlier.

Opportunities for Generating a More Rapid Expansion of Demand

Do major opportunities exist for generating a much more rapid increase for contraceptive demand than we have seen to date in most developing countries? I am absolutely convinced that they do. Ways exist which could materially improve the performance of all types of programmes referred to earlier, which could substantially increase the demand for every type of contraceptive. But personal convictions aside, it is certainly clear that we should leave no stone unturned in attempting to identify any such opportunities, as may exist. The present rate of growth of the usage of contraception is clearly too low in most developing countries to reduce birth rates to economically acceptable levels for a very long time, indeed.

At the most simplistic level, all that is really needed to identify large numbers of specific opportunities for creating additional demand is to install in programme managers a consumer-oriented approach to all their activities, which is a lot easier said than done. The managers of programmes should be encouraged to:

(1) Systematically study their target populations as consumers (not patients) of the organisation's products and services;

(2) Ask themselves what are the controllable determinants of consumer demand for their organization's products and services (i.e., what specific things they could do which might produce greater consumer response; and

(3) Finally ask themselves what is the best feasible combination of changes in their demand determinants, the set of changes which they believe would generate the largest gain in demand.

The preceding remarks seem almost trite, yet those are the fundamental steps used by the most successful marketing strategists everywhere. And, those steps are seldom taken, sad to say, by people making key decisions in the major programmes in the developing countries. Not having been exposed to the consumer-oriented approach, it is natural that the attitudes and preferences of top officials, the medical leaders and foreign experts dominate almost completely decisions which affect variables which could have a pronounced impact on consumer demand; the preferences of the consumers themselves are usually never even considered. Even within the commercial sector in the developed countries, where the consumer-oriented approach is an accepted principle of management, changes in demand determinants may well be possible which can lead to significant demand gains in the developing countries. Have our contraceptives been designed with consumer appeal in mind? Which consumers? Are the right languages and most needed information used in packaging?

Those three simple mental steps led a group of marketing executives, working together for only two days, to recommend what became the basic strategy of India's Nirodh Marketing Programme, which has so far produced a 500% increase in consumer purchases of condoms, perhaps 1,000,000 new users, even though the strategy is not yet fully executed.

Before describing the Nirodh strategy, let us return to the earlier issue of the low performance of the commercial sector in developing countries. One prime reason is that there never have been any serious attempts to build mass markets for contraceptives in the poorer developing economies, because it would be totally uneconomic for a private firm to do so. The combination of very low consumer prices and very high costs for product and market development which would be required to achieve deep market penetration would inevitably mean heavy losses.

But the combined social/commercial approach can permit a total change in the picture. In the Nirodh case, the subsidy element consists primarily of provision of free condoms. (During the initial years, while sales revenue is low, additional funds will be provided to permit high promotion budgets to be maintained; later all operating costs which consist mainly of advertising expenses, plus a small amount for marketing research and the programme management, can be covered by sales revenue.) This subsidy made it possible to propose and implement a marketing strategy which was absolutely unheard of in India. Some twenty determinants of demand were drastically altered to generate demand. Among other things, the plan called for reducing consumer prices by 85%, spending annually 2000% more than had ever been spent on advertising a contraceptive and 300% more than ever spent introducing any new product in India. Small wonder that sales have increased so much.

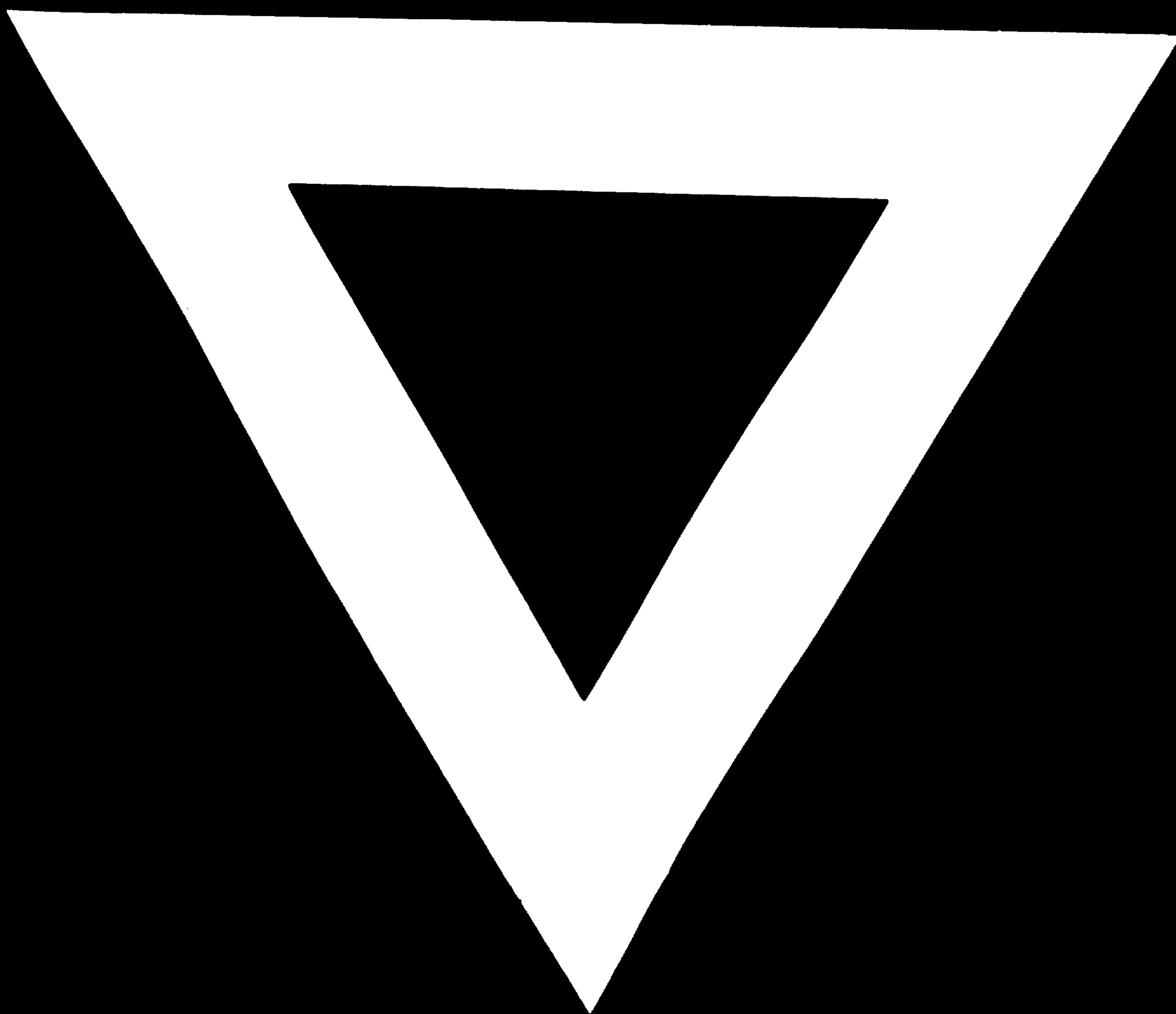
Summary and Conclusion:

Summing up, a striking feature of the pattern of demand for contraceptives today is the extremely low contribution of the commercial sector to birth rate suppression in the developing countries, compared with its pre-eminent performance in the more developed regions of the world. The present trend of total contraceptive demand in the developing areas clearly calls for increased emphasis on efforts of many kinds to generate a more rapid growth in demand through all programme thrusts. A pervasive concern for the attitudes preferences and responses of potential consumers at all levels in every family planning organization would quickly make a difference. But the commercial sector is now substantially blocked from using its arsenal of demand-creating resources and skills because of the hard economics of the market place.

Ways and means must be found to activate the potential force of the vast promotional, distributional and managerial resources available, to the commercial sector. Otherwise, government and voluntary organization programmes which are primarily designed to serve the poor must be expanded enormously at heavy cost to society, while existing resources remain unutilized.

With a little social engineering (and probably modest amounts of social money) ways and means can be found to rectify this situation in large part; ways and means which can pass the tests of social and political acceptability, operational workability and the financial feasibility in almost every part of the developing world; ways and means which would constitute excellent social investments for the world community.

The immediate need is for ideas, and better yet, concrete plans; plans whose objective is to produce maximum social gains without private losses; plans which can increase, not merely commercial sales, but also the demand for the contraceptive products and services of government and voluntary programmes; plans which can produce small sure gains and plans which might produce the quantitative jump in contraceptive usage which could mean so much to the economic development of two-thirds of humanity. We, at this meeting, representing the organizations that we do, have a special opportunity, perhaps an obligation, to make important contributions to the resolution of the issues I have tried to raise. I hope as we proceed to other topics, many of which will focus on problems of production of contraceptives, we remember that the production problem which all of us would most like to face is the need to expand capacity very much, very quickly.



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