MARKETING STRATEGY FOR FAMILY PLANNING PRODUCTS IN INDIA (WITH SPECIAL REFERENCE TO BIHAR)

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ABSTRACT

The marketing of contraceptives has a long history in India, beginning with the launch of *Nirodh* condoms by the government in 1968. Since then, the national family planning programme has added oral contraceptive pills and has adopted a multibrand strategy that also supports NGO brands of condoms and pills. Marketing of contraceptive pills began in 1987, with the launch of *Mala D*—a government brand available over the counter without a prescription. In 1996/97, all socially marketed brands of oral contraceptive pills were made available without prescription. The condom is the most popular birth-spacing method and the most widely socially marketed product. Contraceptive use rise in all sub-groups of the population—uneducated as well as educated, poor and rich, rural and urban. The rise in contraceptive use and the pace of fertility decline, however, has not been uniform throughout the country.

Keyword: Contraceptives, Nirodh, *C*ondoms, Marketing, Population and Fertility.

Introduction:

The contraceptive prevalence rate in India increased from about 13% in 1971 to 41% in 1992/93 and to 56% in 2005/06. The method-mix has been skewed since the beginning and started to become more skewed in the 1980s. While the method-specific targets were eliminated in 1996, the method mix remained quite skewed toward female sterilization: the majority of contraceptive users depend upon sterilization—primarily female sterilization and to a small degree on male sterilization. However, there is evidence indicating that the use of spacing and traditional methods increased in recent years. For example, the proportion of sterilization users among all method users declined from 76% in 1992/93 to 68% to 2005/06—suggesting some effect of the elimination of targets on expanded method choice. While contraceptive use has increased at the national level as well as in all sub- groups; this increase, however, has not been uniform.

PRODUCT SPECIFIC ISSUES :

Given the potency of hormones, any drug-manufacturing process involving them must be conducted in strict manufacturing conditions that have dedicated facilities that are separate from facilities producing other drugs. The manufacturing process occurs in clean rooms with sophisticated systems for controlling the flow of air, water, waste, raw materials, and so forth. Workers wear protective clothing and are tested for their hormone levels. Quality-control procedures ensure adherence to exacting standards for content uniformity and, thus, product safety and effectiveness. India has the technical capacity to meet these requirements. The domestic market also provides sufficient demand to meet minimum economic-production quantities for OCPs. From a manufacturing perspective, producing emergency contraceptive pills (ECPs) is an add-on, as it involves one of the same active pharmaceutical ingredients (API), levonorgestrel, that is used in OCPs. India does not produce APIs for OCPs, but imports them from China.

Of the hormonal products examined here, OCPs are the best known and have gained international acceptance. Their efficacy is proven and products have evolved through several generations to minimize side effects and address special needs, such as estrogen intolerance. There is a long-standing bias among users and providers against hormonal contraceptives. Concerns usually relate to the short- and long-term effects of hormones, such as weight gain, nausea, irregular bleeding, and return to fertility. While some of these concerns are not fact-based, they are nevertheless important in the public's perception and acceptance of OCPs. A recent focus group conducted by HLL found that pill consumption might be associated with illness in people's minds. Increasing the acceptability of this method in India remains a challenge for marketers.

EMERGENCY CONTRACEPTION:

EC is a new product in India. Because it is used in unforeseen, time-sensitive situations, this product requires a unique marketing approach. One challenge is to generate sufficient awareness to get potential users to recall EC's existence and what to do to in the rare cases when they need the product. Healthcare provider also must be aware of and educated about the product. And ECs must be readily available in pharmacies.

The production volume of EC is low, leading to higher production costs per unit. As for regular OCPs, however, marketing and distribution costs and what the market will bear drive pricing, rather than production costs. Hindustan Latex Ltd. (HLL) sells ECs to Population Services International (PSI) at Rs. 10 to 12 for two tablets, while *NorLevo*, commercially marketed

by Win-Medicare, retails for Rs. 45. While India permits EC, the method is not free of controversy. Since 2003 the government family- planning program has included EC, but does not promote its use. In many other countries, EC is controversial as well.

INJECTABLE CONTRACEPTIVES:

The manufacture of ICs is subject to requirements similar to those for OCPs and EC. *Depo-Provera,* the only injectable contraceptive marketed in India (by Pfizer), is manufactured in Belgium for packaging in vials and in the United States for packaging in pre-filled syringes. It is estimated that it would cost $2 to $3 million to establish a facility for manufacturing injectables in India. India probably possesses the technical capacity to manufacture ICs, although demand and marketing issues may dictate otherwise.

While all hormonal products face some perception and image challenges in India's market, injectables face a special set of difficulties, as they have had a long and troubled history in India. They still are associated with Western attempts to control India's population. Injectables often are viewed as an inferior method foisted on developing countries but scarcely used in developed ones. While it has long been known that depot medroxyprogesterone acetate (DMPA), known as Depo- Provera, causes bone loss, it recently was discovered that the osteoporotic effects of the injection grow worse the longer *Depo-Provera* is administered and they may last long after the injections are stopped. For this reason, on November 17, 2004, the United States Food and Drug Administration (FDA) and Pfizer agreed to put a black-box warning on *Depo-Provera*'s label. This warning is adding fuel to pervasive doubts about injectables' safety in India. ICs have become a banner issue for the feminist movement and a topic of impassioned political debate at the highest levels of government. The government of India has gone as far as issuing an assurance that ICs will not be included in state-mandated family-planning programs. ICs also have been included in a court case that challenges the safety and efficacy of a number of pharmaceutical products sold in India. ICs are associated with irregular bleeding and amenorrhea, which are not culturally accepted in India and are a serious barrier to its use. Hence, Pfizer's marketing strategy focuses on women who are educated enough to accept ICs' limitations and on those who already experience irregular bleeding, such as lactating women. The barriers ICs face in India, however, might not be issues in other markets. In India injectables may represent a case in which the export business is more promising than the domestic one.

INTRAUTERINE DEVICES:

The production of IUDs is more of an assembly process than a manufacturing one. India imports nearly all of the individual parts from Europe, the United States, Japan, and Malaysia; assembles the devices; and then undertakes final gamma sterilization in-country. India has established itself as the world leader in the production of IUDs. Every company interviewed for this assessment noted that it had additional capacity for IUD production. While some companies attempt to develop value-added features, IUDs have become a commodity, that is, the product and quality are uniform throughout the industry—a point manufacturers acknowledge.

At first glance, IUDs would seem to be an ideal method for a woman who desires medium- to long-term contraception. The device is inexpensive, cost-effective, has few side effects, and often involves a one- time procedure and expense. IUDs have an unfavorable reputation, however, owing to misperceptions and quality-of-care concerns. The misperceptions include a belief that IUDs cause infertility. A major qualify-of-care issue is that trained providers and IUD services are not adequately available at the primary and sub-center levels, sometimes causing complications not to be addressed in a timely manner. IUDs are not only provider-based, but also require a facility for the insertion procedure. The cost of the IUD itself is low relative to the extended period of protection. In India, public-sector clinics, hospitals, and other healthcare facilities provide and insert most IUDs. The public sector purchases the devices through tenders from generics suppliers, meaning that suppliers compete primarily on the basis of price. In addition, some private providers sell and insert IUDs. Organon, the only R&D supplier of IUDs in India, targets the private-provider market with its proprietary brand, *Multiload*. Contech Devices, an Indian manufacturer, is the only Indian company selling IUDs in the private sector. Contech estimates that the government supplies approximately 7.5 million units in the public sector and that the private- sector market is approximately 2 million units.

POLICIES FOR CONTRACEPTIVE PRODUCTS MARKETING :

Several policies, laws, and regulatory bodies govern India's pharmaceutical industry. Contraceptives are not subject to price controls, theoretically leaving manufacturers free to set prices. The schedule under which contraceptives are classified, however, has important implications on their pricing, marketing, and distribution.

On March 23, 2005, India adopted international patent-protection standards. Until that time India did not recognize international patents and agreements. Nonetheless, the patent law's affect on contraceptives will be minimal, at least in the short to medium term, as only formulations patented after 1995 will be protected. All currently marketed contraceptives are already off patent. As a result, generic-contraceptive manufacturers can continue their operations with no change in practice, including exporting their products. With the exception of *Depo-Provera,* all hormonal contraceptives and IUDs manufactured in India are for domestic consumption.

MARKETING STRATEGY OF FAMILY PLANNING PRODUCTS IN BIHAR :

Bihar has a very high total fertility rate in comparison to other states and country fertility rate (2.7 children per woman). Except for Infant Mortality Rate (IMR), which is only marginally higher in Bihar than in India, the demographic situation of Bihar is extremely difficult. On the socio-economic front too, Bihar lags far behind the other states due to its high fertility, educational backwardness, and unemployment. The Infant Mortality Rate is 56 per 1000 live births and Maternal Mortality Ratio is 312 per 100,000 live births which are higher than the National average.

The state is predominantly rural with 89.5 percent people living in rural areas. It comprises 37 districts with 9 Divisions, 101 Sub Divisions, 533 Blocks, 130 towns and 45098 villages. All the districts have a rural population of over 80 percent and 7 districts having rural population of over 95 percent. Rural areas are socio-economically much less developed. In rural areas of Bihar, fertility (4.1 children per woman) is higher in comparison to urban areas (2.9 children per woman) and is the highest in the country.

In Bihar, marriages are mostly early and arranged where female mean age at marriage is lower than legal age. Percentage of girls married below the legal age of 18 is 64% with mean age of marriage for boys and girls are 21.6 and 17.6 years respectively. Out of total births, Bihar has 8 % of births to women aged 15-19 years. The society places a high emphasis on fertility with enormous social pressures to bear children immediately after marriage particularly from youth, which is a serious concern in the state that needs to be immediately addressed. In such a society and social pressure, many young people do not consider the possibility of delaying first child. Other young people want to delay child bearing, but do not know how to do so. It is difficult for newlywed couples to translate intent into practice, because of various barriers. These are conventional thinking that women have no right to decide; no confidence to fight against societal norms; lack of spousal communication; inadequate knowledge of contraceptives and RH services; and fear that contraceptive use can cause infertility.

Thirty-nine percent of women and men want more sons than daughters in Bihar. On the other hand, only 1-2 percent want more daughters than sons. The vast majority of women want at least one son (88%) and at least one daughter (85%). The desire for more children is strongly affected by women‘s number of sons. Among women with two children, 68% of women with one son and 77% of women with two sons want no more children, compared with only 20% of women with two daughters and no sons. In India, among women with two living children, 62% of women with two daughters and no sons do not want any more children.

SOCIAL MARKETING :

The social marketing of contraceptives has a long history in India, beginning with the launch of *Nirodh* condoms by the government in 1968. Since then, the national family planning programme has added oral contraceptive pills and has adopted a multibrand strategy that also supports NGO brands of condoms and pills. Social marketing of contraceptive pills began in 1987, with the launch of *Mala D*—a government brand available over the counter without a prescription. In 1996/97, all socially marketed brands of oral contraceptive pills were made available without prescription. The condom is the most popular birth-spacing method and the most widely socially marketed product.

Six social marketing organisations provide the condoms, with the largest market shares held by Hindistan Latex Family Planning Promotion Trust (HLFPPT) and PSI. Two brands—*Nirodh Deluxe* and *Masti*—account for about 39 percent of all condoms sold in urban Uttar Pradesh.

Oral contraceptive pills are much less popular than condoms. However, socially marketed brands are still available. Five social marketing organisations provide seven brands of oral contraceptive pills. *Mala D* (distributed by HLL/HLLFPT and PHSI) and *Pearl* (distributed by PSI) are the most popular brands.

Effect of Social Marketing on Contraceptive Use :

Between *The Second National Family Health Survey (NFHS-2)* (1998–99) and *NFHS-3* (2005–06), the use of condoms and pills increased. Although use increased by more than 8 percentage points for the nonpoor (those in the three highest wealth quintiles), use did not change for the poor (those in the two lowest wealth quintiles). As a consequence, the gap in the use of condoms and pills between the poor and the nonpoor has grown from 5 to 14 percentage points. Since social marketing programmes focus on condoms and pills, the fact that this gap has more than doubled is of concern.

Social marketing’s share of the overall market for condoms and pills grew between *NFHS-2* and *NFHS-3* for both the poor and the nonpoor. At the same time, the commercial sector’s market share decreased. The increased overall use of condoms and pills by the non-poor could be attributed in part to non-poor consumers taking advantage of lower prices of socially marketed brands. However, given that the overall use of condoms and pills has not significantly changed among the poor, it seems that the poor may have shifted their purchases from commercial to socially marketed products, but that social marketing didn’t affect uptake.

Barriers to Effective Social Marketing :

Various social marketing programmes in India have helped identify barriers to the use of products provided by social marketing programmes.

Two ongoing programmes—Innovations in Family Planning Services Project II (IFPS II) and Sadhan Social Marketing Network—have been particularly informative. Both programmes focus on increasing the use of birth-spacing methods, especially condoms and pills, and have increased access to contraceptives. Although many social marketing efforts highlight condoms for HIV prevention, these two emphasise condoms for family planning. The *Yahi Hai Sahi* campaign and the *Goli ke Hamjoli* (“Friends of the Pill”) programme are two previous initiatives that have provided additional information on barriers to marketing condoms and pills. *Yahi Hai Sahi* sought to increase condom use in 10 northern Indian states. *Goli ke Hamjoli* aimed to increase and create a more supportive environment for oral contraceptive use.

Barriers that typically limit use of condoms or pills promoted through social marketing programmes include:

- The poor often lack convenient access to affordable birth-spacing methods. Even though an estimated 90 percent of women with an unmet need for spacing and 85 percent of slum residents have access to a pharmacy or chemist within one kilometre, many of these retail outlets do not carry socially marketed products.
- Owners of retail outlets may have little incentive to stock and promote socially marketed brands since they yield lower profits than do commercial brands. This is especially true for socially marketed condoms.
- Many pharmacies and chemists lack up-to- date information about low-dose pills, making it difficult for them to provide women with reliable information about the pill's safety and efficacy.
- Many men have unfavourable impressions of the condom. Some believe condoms decrease sexual pleasure or that condom use indicates infidelity or a lack of trust on the part of one's spouse. For these reasons, both men and women may be embarrassed to purchase condoms in a public venue.

The social marketing programmes described above have also helped inform various strategies for overcoming barriers to effective social marketing and increased contraceptive uptake. Social marketing programmes could reduce barriers through the following approaches:

- Include high-margin consumer products (e.g., iodised salt and sanitary napkins) in a bundle of products that includes condoms or oral contraceptive pills. This could increase profit margins for retailers and encourage more retailers, especially non-traditional outlets, to stock socially marketed condoms and pills.
- Introduce other financial incentives for retailers (e.g., trade promotions, quantity discounts, and gifts) to overcome the initial barriers to stocking socially marketed products. These incentives could also sensitise retailers to the value of product displays, point-of-purchase materials, and other materials that help increase sales.
- Increase the comfort of sales personnel in selling contraceptives, especially by providing them with information about the products. As a result, they will be able to help women use oral contraceptive pills and provide women with better information, such as technical updates to dispel myths and rumours.
- Develop and implement strategies for increasing contraceptive demand. Demand for condoms needs to be increased among the poor to address the large gap in use between the poor and the nonpoor. Demand for oral contraceptives needs to be increased among all women to help address the low rates of use in India. Regardless of how inexpensive contraceptive products are, they will not be used if people do not want them.
- Offer more contraceptive variety to potential clients. For example, none of the current socially marketed brands of condoms offer textured or other varieties of condoms, but a larger selection might appeal to young clients. Also, specific brands of condoms and oral contraceptive pills could be better targeted, and marketing strategies could be created to encourage poor men and women to use socially marketed products and wealthier men and women to use commercially available ones.
- Develop messages to help men and women overcome negative impressions of condoms. These messages could include: Condom use is an appropriate way for most couples to space their pregnancies. Condoms are not just for extramarital sexual activity. Men needn't be embarrassed when purchasing condoms.

REVIEW OF LITERATURE :

A review of the literature reveals several themes from the previous research. Some past studies has been produced here :

Durga Rao P. & Babu Suchakar M (2005) in their study "Knowledge and use of Contraception among Racha Koyas of Andhra Pradesh", reported that knowledge about contraceptive methods were satisfactory and the acceptance towards the female sterilization was more than the spacing methods.

Takkar N. et al (2005) in a cross sectional study on "Contraceptive practices and awareness of Emergency Contraception" among 284 educated working women, stated that, all the subjects were literate and majority (97.2%) had an urban background. Out of 190 married women, 154(81.1%) practised contraception; among them 73.3% were regular users. Eighty respondents underwent abortions of which 46 had spontaneous and 34 had induced abortions. Print and electronic media were the common source of public awareness in 149 subjects (47.7%).

Mehera Reeti et al (2007) conducted a study on "Knowledge of EC among 100 women with reproductive age coming for induced abortion" shows the result that only 27% of women were using regular contraception, Condoms were the most popular choice in 75% of all users. Only one woman out of 100 was aware of EC even though it was a predominantly urban and educated population. They suggested that in India, EC is much under publicized and underused. Efforts should be made to promote information, education & communication regarding EC, targeting all women of reproductive age group.

Chopra Seema & Dhaliwal Lakhbir (2009) conducted a study on "Knowledge, attitude and practice of contraception in urban population of North India", reported that 55.2% subjects were aware of contraceptive methods and majority of women had favourable attitude towards family planning but awareness of long-acting new methods is still not upto the expected level.

Donati Serena et al (2010) had conducted a survey on "Knowledge, attitude and practice on family planning in Kakching", Manipur, reported that attitude of the female towards family planning methods was positive whereas very few husbands showed positive attitude towards family planning. 90% of females requested more information regarding family planning methods. In addition, 83% were in favour of sex education in school.

Objectives of the Paper :

- To examine the marketing strategy for family planning products in India.
- To evaluate the contraceptive use in India.

Methodology:

The method used in this paper is descriptive-evaluative method. The study is mainly review based. It is purely supported by secondary and tertiary source of data, i.e. books, journals, papers and articles and internet.

To Sum Up:

Contraceptive use rise in all sub-groups of the population—uneducated as well as educated, poor and rich, rural and urban. The rise in contraceptive use and the pace of fertility decline, however, has not been uniform throughout the country. This progress at the national level masks important differentials among sub-groups of the population. For example, the gap in contraceptive use and fertility. The national fertility average in the future will depend upon what happens in four states—Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh, which, according to the 2011 Census, consisted of 366 million or about 36% of the population. Fertility has declined in all these states; TFR, however, remains high at around 3.7 in Madhya Pradesh and Rajasthan, and 4.3 in Bihar and Uttar Pradesh. These states experienced progress in recent years in their social settings indicated by increased female education and decreased infant mortality rates. Fertility and social setting in these states, however, appear to be where states like Kerala and Tamil Nadu were 30 years ago. What happens in these four states will determine what happens to the national averages. For example, fertility decline trends in these four states will impact the pace of fertility decline at the national level, and improvements in female education and reductions in infant and child mortality will influence when the nation will achieve MDGs two and four.

There is, therefore, an urgent need to design strategies, including public-private partnerships, to address especially for reversible contraceptive methods. Programmes should be designed and implemented to reach reproductive health services to the large population of married adolescents and young people so that they can delay their first births and effectively space future births. And finally, since men are key decision—makers in sexual and reproductive health matters, their active involvement and participation, as responsible sexual partners, husbands, and fathers, is necessary if reproductive choice for women, men, and adolescents is to be realised in India.

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