



Treatment Update Webinar: Total Market Approach For Condom Programming

JUNE 21, 2016

Lauren Alexanderson, AIDSFree: Greetings, and welcome to today's webinar: A Total Market Approach for Condom Programming. My name is Lauren Alexanderson and I'm the melo-manage manager for the AIDSFree project. Before we begin today's presentation, I would like to quickly review the Adobe Connect environment and set a few norms for today's webinar.

Today's webinar has three presentations followed by a discussion period during which our speakers will address your questions. Within the Webinar environment, please make use of the Q&A box on the bottom-right side of your screen, to share your thoughts, note your questions, or ask for help with sound during the presentation. Questions you ask are visible only to you, our presenters, and technical support. If you are experiencing difficulties, our technical support will respond to your questions privately. We will collect your technical questions for our speakers and save them for the discussion period.

It is great that we are able to connect people from so many places today, but your experience may vary based on your internet connection and computer equipment. I will briefly go over a few troubleshooting steps if you have technology challenges today.

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Questions that do not get answered during the Q&A session will be compiled after the webinar, shared with presenters, and responses from presenters will be shared with participants. To get us started, I will now turn us to our moderator, Ibou Thior

Ibou Thior, AIDSFree: Thank you Lauren, I would like to thank everyone for joining us today. My name is Ibou Thior, senior HIV prevention technical advisor for AIDSFree. Today's webinar is organized by AIDSFree. We have gathered PATH leaders and implementers to discuss availability of access to and usage of condoms and family planning products and services in low and middle income countries. The speech of the day on A Total Market Approach for Condom Programming, which is very relevant for new 20 by 20 United Nations population fund in collaboration with the World Bank, the Reproductive Health Supply Coalition, the United States Agency for International Development, USAID, and the International Labor Organization. The purpose is to increase the availability and access of 20 billion condoms in low and middle income countries by the year 2020. I would like to now introduce our first speaker, Marguerite Farrell, of USAID

Marguerite Farrell, Office of Population and Reproductive Health: Good morning everyone! (waiting for my presentation to load). So today I'm going to talk about a total market approach for family



planning. Now my focus is going to be a little bit different because we have really expanded a total market approach to look at family planning services.

Most total market approach exercises focus on commodities or products, but this is an expansion on the concept, looking at family planning services. Social marketing and donations by donors to ministries of health have really done a good job of getting short term, or resupplying family planning methods, through drug shops sometimes, out to the last mile. What's really missing is a real choice and a real family planning mechanism long acting reversible contraceptive, and also permanent methods.

So we really expanded this concept of Total Market Approaches in the Office of Population and Reproductive Health to really look at services which we thought were the main barriers to true choice and method.

So what is Total Market Approach? The rational use of all segments, public and private, to provide health products and services equitably. Our office has decided that total market approaches are one of our Office of Population and Reproductive Health focal areas. I'll also touch on the importance of sustainability and scale up briefly in this presentation.

A Total Market Approach brings all of our services delivery areas together. Some of you are maybe new to this concept, but most of you are likely thinking with a Total Market lens in your program. I know of many programs that only focus on the public sector. I don't know of many that only focus on the public sector or the private sector. Most systems are mixed public/private systems. If a program does only focus on one sector, it's maybe because they're compensating work on other donors, and aiming not to duplicate. This is also an important component of a Total Market program and practice. And for us, the definition of private sector is public, nonprofit and for-profit, that includes the public sector, providing maybe donated products to the poor. Non-profit sectors include NGOs, faith-based organizations, and even informal sectors. For profit is the true commercial part of the private sector.

You may have heard the term, whole-market approach, we are really talking about the family planning market. These are the key pieces of the market: the methods, the clients, and the sources or the providers. We are talking about the current market and the future market. We can look at the past to understand the past markets and look at what aspects have changed and why. What has stayed the same? The market is always dynamic and changes. Health systems, above all, are very dynamic. All of these dimensions are subject to change. But what we really want is a healthy market, with enough services and products in the right places for diverse clients and their needs. That they are affordable, and that even at the last mile, underserved populations can access these services and products. The market is generally discussed in supply, but another real contribution that I think that we made in our total market approach is to see that demand greatly influences it.

We as a community can grow demand in countries in all family planning in general, for services in different sectors, and for new or underused methods. So, a lot of TMA really looks at supply, but I'm saying demand is also a really important component, especially family planning methods that often have little or no knowledge in countries.

So in a series of questions, we have laid out how to think about Total Market Approaches in a programmatic context. Are we maximizing participation of all FP provision of all the actors? The public sector, the non-profit, the saved space commercial sector. Which populations are each of these serving and where? Can the clients afford to pay? Do the clients pay? Is there enough income to generate cost recovery? Who is serving the poor? Are there any clients who aren't being served? What types of service delivery approaches can each do best? And how can we - most importantly in many countries in Sub-Saharan Africa that we work in - how can we grow the whole family planning market?

We want to make sure that when USAID graduates from its countries because they've done such a good job in programming, that family planning will still be provided. So, here are the income quintiles; this is just to give you an idea of how to think about this. You know, Q1 represents the extreme poor. Q5, the final or richest quintile. It's important that as you think about the family planning market, to look at the demographic and health service data for FP by income quintile, by modern contraceptive prevalence rates, and by total fertility rates. And look at the differential between the quintiles as well as other indicators, such as the source of data and the DHS where people go for various different methods, public or private.

Also, look these differences for education, and rural/urban. In general, in a Total Market Approach, Q1, the very poor, should be served by free products and services. Q2 and 3 are perhaps social marketing segments or the social franchising segment which really is social marketing, which is really social marketing for services. So Q2 and Q3 need some subsidy to be able to access products.

Q4 perhaps can have manufactured modeled products. We have a product [lying here Micogynonfee], which we have used in eleven Sub-Saharan African countries. It's at a fairly affordable price for Q4. It's at 75 cents to a dollar per cycle, instead of usually the six dollars per cycle that real commercial [moral] contraceptives charge in Sub-Saharan African markets.

And then Q5, the wealthiest, they generally have the ability and are willing to pay, but when you look at the actual data about where these different quintiles are going for products and services, you can often see that Q5 is selling to the public sector for free. Q1's usually completely underserved and may not even have any health posts or health clinics in an area, in a geographic area.

I'm going to present a series of case studies to think about a Total Market Approach to family planning. Here we have Morocco. In the mid- 1990s, the National Family Planning Program established in Morocco had made significant improvements in contraceptive access and use to both the public and private sectors. In 1995, the Moroccan government had faced growing economic constraints and they desired that family planning services be centralized to the local level. They sought to preserve their role as a service provider, but they wanted to do it in an economically sustainable fashion.

USAID funded a market segmentation study to identify the relative size of consumer segments based on their choice of contraceptive method and their choice of public versus private and the level of unmet needs. The analysis found a mismatch between older women's' desire not to have additional children and the low use of long-term contraceptive methods, IUDs and female sterilization at the time.

Based off the medium to high economic status of both older city-dwellers and older working class, the study highlighted the opportunity for the private sector providers to play a larger role, in the provision of long-term methods in urban areas. While the government targeted some of these to rural areas to reduce barriers to poor woman who wanted to contracept, but weren't contracepting.

Here's another quick case-study about total market approaches in Malawi, for family planning. There's longstanding MOH support of NGO family planning provision. There's contracts with faith-based-organizations, the Christian health organization of Malawi. The Ministry of Health serves as a steward and has contracts with these faith-based providers for family planning.

The Ministry, both finance these contracts and oversees their implementation. There was a big push for cash-sharing, for clinical offices to provide permanent methods, and for community health workers to provide injectables.

They work through their fixed facilities and they made sure that there was free family planning services at the community level. They used Maurice Stokes international for mobile clinical outreach to rural areas and also social franchising which are networks and there are CBD's of injectables and other methods.

So you can see in Malawi the modern contraceptive prevalence rate creased from 7% in 1992 to 42% in 2010. And they also have the country with the largest use of voluntary female sterilization.

One more quick example of TMA for services in Bangladesh. Bangladesh is one of the first countries in the world to show that even a poor country, with low levels of education, could have increases in even poor people using family planning when there is a strong family planning program.

Matlab provided doorstep NGO short term methods, pills and condoms, by leading public health visitors. This doorstep delivery was discontinued in the 1990s, and it really morphed into social marketing. They have the world's largest social marketing organization -- social marketing company. Its sales of pills, condoms, injectables, IUDs and implants and its responsible for about 35% of the modern contraceptive prevalence rate in 2007.

There's a lot of family planning in multiple private channels: Drug shops, pharmacies, clinics, social franchises, and a shops project which is our biggest flagship project worked on adding private LARCs and PMs into private maternity hospitals. There was a proliferation of private maternity hospitals when more and more people decided to go to those hospitals for their delivery services, so shops added LARCs and PMs which they didn't really have until then.

I just want to focus on the fact that it also took the social marketing corporation twenty years to become fully sustainable, I think there's a lot of donor fatigue with social marketing organizations sometimes, but it takes a long-term commitment to build to capacity an organization before they become sustainable. You can't start a social marketing organization and decided that you are going to shut it off in five years, that's just kind of a waste of the tax-payers resources.

So, moving on, because I've gotten my warning, and I don't want to take the other speakers' time, I want us to talk about sustainability. Briefly, you know, there are a lot of ways to look at sustainability. Some people think you have to sustain everything you are doing right now. That's not necessarily true because health systems completely evolve and change the way that they deliver services overtime.

I explained how there used to be doorstep delivery in Bangladesh, of resupply methods, but that morphed into social marketing later. Later, that can morph into true commercial provisions when there's very high use and maybe there's a UHC that's providing financing for people to be able to get their products and services. The most important form of sustainability is that people have a norm, that a norm is changed, that people contracept at the population level. That's a norm that hasn't changed. TFR doesn't usually go up. mCPR doesn't usually go down. It may stagnate or plateau, but mCPR, modern contraceptive rate, doesn't usually change once it gets really high.

So, these are questions to think about as you think about total market approaches in your country. How effective are each of the service delivery approaches in your context? Are they reaching new clients? Who are those clients? Does it help clients switch between methods according to their reproductive intentions and their lifecycle? Which ages are using which contraceptive methods? Segment it by age and see if there are differences. Are poor, underserved, vulnerable populations truly reached with a wide method choice? How widely available are the different methods? And through which service delivery approaches? Public, private, NGO, faith-based? And are integrated services improving both outcomes? Sometimes when there are integrated services, family planning gets lost, so it's important to make sure that in an integrated service delivery package, family planning is still a priority.

I want to quickly mention two eLearnings that we developed recently on our GMA working group. We have a total market approaches for services and a total market approaches for products. We also have a social marketing eLearning, we have a private sector eLearning, we have a financing for health eLearning, which is about credit, we have a social franchising eLearning. These are all on the USAID eLearning courses platform which are completely open to everyone so I encourage you to take those courses online. Thank you.

Ibou Thior, AIDSFree: Thank you Margaret. For our attendees, add your questions for Margaret in the Questions and Answer box for our discussion section. The next presentation is of Doctor Kim Green of PATH.

Kimberly Green, USAID/PATH Healthy Markets Project: Hey, thank you Ibou. So I'll be providing a case study on a total market approach in Vietnam. So, first off, why the total market approach in Vietnam and why now? The HIV response in Vietnam is really at a crossroads: the epidemic is concentrated in key populations, and through PETFAR support, Global Fund, and other major donors, the Ministry of Health treatment effort has contributed to a steady decline in new HIV infection, and with these results, the Ministry of Health has embraced the 90-90-90 target by 2020, and elimination of HIV by 2030.

However, there is a significant and major challenge which is faced by the Ministry of Health and key implementers, which is that nearly 80% of the national program is funded by external donors, What's happened is that with Vietnam achieving middle income status in 2009, a number of major donors have left or have dramatically reduced the size and geographic scope of the programs, and that also influences the number of free and socially marketed condoms that are available in Vietnam.

And so this comes with both good news and bad news. The good news is that with the reduction of subsidized condoms, there has been further growth in the commercial market. And there are local condom manufacturers in Vietnam and they have previously manufactured in Vietnam but only for export to other countries.

So with these shifts we have also seen local manufacturers seeing an opportunity to invest in their own local markets, which is exciting. Then of course with economic growth we see an increasing purchasing power, and willingness and preference to pay, particularly in urban areas.

And of course, with good news also comes bad news. The bad news is that there's a wild west condom market. The market's unregulated and there are no mandatory standards that apply, so what's happened is that there's now an abundance of low quality and fake products. There was a study done in 2014 through UNFPA and USAID and what they found is that 50% in the wholesale market were substandard, which is clearly a huge concern.

So I want to turn now to the PATH USAID Healthy Markets project and TMA effort. The Healthy Market project is a five-year initiative funded USAID, started in 2014 and it is part of the PATH for effort in transition supporting the Vietnam government and sustainable financing, now that it's a middle income country.

There are three key objectives; the first is really in leveraging private sector engagement and investments. The second is on demand generation on HIV Goods and Services whether they be free, partly subsidized, or commercial, and the third objective really focuses on increasing sustainable supply of HIV Goods and Services, and that's where I will place most of the emphasis for this presentation.

In our strategy, there are four key elements that we utilize for sustainability. The first, of course, is the total market approach, and we are really using a lot of experience that PATH has generated in a number of countries through family planning with TMA, including in Vietnam, and how to generate data, and how to better segment population to balance access and equity. We are also applying basic marketing principles, selling them in the right locations and doing the right promotion.

A third element of our work has been in partnership with the private sector, both through CSR efforts, but also in shared value and co-creation space, which has been really interesting. The fourth element, which is very exciting, is social enterprise, which is an evolving area in Vietnam, and some of our key collaborators are social enterprises that distribute a retail condom.

So now I want to focus on our TMA goals and some of the steps that we have undertaken. There have been four key goals that have guided our work. The first has been supporting a transition from free and partially subsidized dominated condom approach to a true TMA with access to commercial products for populations affected by HIV. The second, that's linked to that, is really identifying commercially viable ways to reach key populations with affordable and preferred condom brands, and also importantly operating on a national level, working with the Ministry of Health, helping them with rational commodity planning and targeting subsidized condoms to those who need them the most, and of course, as Marguerite also mentioned, the very important elements of demand generation.

Our efforts in Vietnam have really been concentrated in three key categories, the first has been really understanding the context, really in terms of policy and barriers, primarily towards condom regulation and quality issues, which have been really key. The second has been in understanding the actual market. What is the volume of condoms that are sold? Their value and growth, and also understanding existing distribution networks. The third has been measuring consumers' condom use, their preferences and willingness to pay.

The second area has focused on supply and demand, so that's been focusing on partnering with the local condom manufacturers and distributors to brand and deliver quality affordable condoms to key populations. And then, also, of course, working on the demand side. And then the third element is working on policy and planning, so advocating for condom quality standards, but also working together with national and provincial HIV leaders to utilize the TMA to plan and prioritize how to use resources.

So I want to focus on a couple of key areas of our work. The first is our market analysis and segmentation. In looking at condom volume and growth, we looked at data from 2010-2014. We also looked at data before 2010, and what we can see is that although there has been uneven growth in the commercial sector, the proportion of volume of commercial brands has increased, sales have increased. 2014, about 80% of the sales were commercial, and we see something similar in 2015. And also in forecasting we see a relatively consistent and steady growth in the commercial condom market.

Now turning to consumer behavior and willingness to pay, we conducted a study in six high HIV prevalent provinces, and there we looked at those that were using condoms, what were doing most of the time in terms of procuring them. We found that the majority of key populations that were procuring condoms were buying commercial condoms, between a third and three-fourths.

And then, we looked at a willingness to pay, and here we see that the majority of individuals were willing to pay a commercial price, which is around 2000 dong or about 8 cents per condom. There was also a significant portion that was willing to pay more than that.

So I want to turn now to look at the development of local condom brands and distribution systems. We worked with two WHO local manufacturers, sorry, 2 WHO pre-qualified local condom manufacturers,

and they've been using the market research generated to either develop new brands or to utilize brands that they've used in other markets.

So two of the brands have launched, and about 10 million condoms have been sold to the commercial system. And I want to focus specifically on one of those condoms brands that have newly launched. The brand's name is Gallant. It's manufactured by Medevices, and what's really interesting is the approach that has been undertaken to reach both key populations and the wider market.

So they've sold condoms to a traditional condom market, GBO, and they're distributing to traditional outlets and non-traditional outlets. That's a very typical way for distribution to occur. But at the same time they are also selling directly to key population community based organizations, who are then selling condoms to key population clients. Also selling within hotspots, such as through pharmacies, and there's a burgeoning in-growth online business for condom sales.

A third piece that has been really interesting has been working with social enterprises so one is called condom homes and they are retailing condoms online to men that have sex with men, to young men. And also a company called Dragon Fruit which is developing an app called Grab Condom, which is a condom door-key locator.

Dr. Kimberly Green, USAID/PATH: So, some final thoughts; I think what's been interesting in Vietnam has been our efforts to seed innovation. We've utilized an innovation fund, which has invested some really interesting and creative ideas across the distribution retail value chain.

The second is that by working in a vibrant and dynamic economy, there's been a number of private sector partners with whom we've been able to level and engage with. One of them is MTV. They've been a great partner. They've offered free airtime and are doing some really fun and innovative work. But also we've been able to leverage from the condom manufacturers themselves, Medadvice3S. They distribute the condoms to the community-based organizations and also offer them an access price.

The third key element really has been this emphasis on quality, as I've mentioned in the beginning. Quality is a huge challenge. The terrain related to quality and regulations fortunately are changing their decree, which is meant to take place and should change things within a couple of years once the regulation has teethed. But we've been working in the meantime on the condom quality seal; partnering with anti-counterfeiting authorities and also implementing consumer education.

I want to quickly acknowledge our remaining partners through the Ministry of Health, through USAID (our research partners), our partners in the value chain, media and of course our colleagues at path.

Ibou Thior, AIDSFree: Dr. Douglas Evans from George Washington University.

Douglas Evans, Milken Institute School of Public Health: Hi, I'll just apologize in advance since I'm a little unwell my voice may be a little bit scratchy.

I'm going to, firstly, talk about my overall work on the use of branding principles and brand research methods. Then I'll link that to the trouble market approach and focus on two case studies of research that I've done in recent years related to the trouble-market approach for condom programming. So this slide basically illustrates the idea behind a brand. I think we're all familiar with the idea of brands obviously from the commercial sector. Brands at their base consist of three things. One is a position; brands stand for something. They represent values that a consumer may associate with, and the basic idea of

association is at the core of branding. There's a quote here from Tim Calkins, an excellent volume from the Kellogg School of Management from a number of years ago on branding, "A Brand is a set of associations [mental representations] linked to a name, mark or symbol associated with a product or service. A name becomes a brand when people link it to other things." They also represent something to the audience. They have a kind of persona. You can think of it as having a personality just like a person would and in fact people are themselves brands. We're all brands in a way. We all have reputations that people associate with us. So brands themselves such as organization, products, services and behaviors in particular all can have personalities; most of the things we control.

Then finally how we implement our brands in the real world. This is something we have some control over; we create advertisements, we do marketing efforts. In the case of condoms, we're distributing our condoms, promoting them and placing them in various ways. But the audience experiences that and that experience is going to have an effect on their reactions and their behavior. The main thing that I want to point out is that behaviors like condom use and categories of condom use can also be branded. So I think that this is an important insight; I think we understand this is social marketing. But in the wider world of public health this isn't always well understood. So we can brand behaviors as much as we brand products and we can use products like condom brands to create a more positive association to the behaviors that underlie them.

This slide illustrates the idea of health branding, as I'm calling it, which includes the branding of health behaviors is based in behavioral theory. Brands create, what I call, positive brand equity. This is basically a measurement scale of some multi-dimensional construct. That construct is based in behavioral theories; specifically social cognitive theory and the integrated model also known as the final version of the theory of planned behavior, which might be a more familiar term to some people. I've written about this in a recent book of mine, which is cited at the bottom of this page. Basically health branding specifies the social role-modeling component of social cognitive theory. In health branding we show people engaging in a behavior, modeling a behavior, and this provides a specific role model that people can follow. It also specifies the attitude component of the integrated model; the idea that changes in attitudes targeted by health messages are themselves affected by brand equity. This brand equity construct is kind of a mediator. It's basically an explanation of why people engage in certain behaviors such as why people use specific condom brands or engage in condom use. This would apply equally to many other behaviors that we've been talking about including family planning and other health behaviors that would be of interest to the audience here today. Basically I think of brands as tools for intervention. They're a way of changing behavior. They're also tools for recruitment into programs, getting people to participate and engage in our programs as well as for translation and dissemination.

This is a model that serves to illustrate the idea that I'm talking about. The key thing to note here is that the notion of brand equity. We expose people to our social marketing efforts, to our condom brand in countries like Vietnam or other case studies that we've been talking about and this creates association. We see role models using the condom brands, forming positive associations and that predicts subsequent outcomes. For example, more positive social norms about condom use which should increase intentions for condom use and reduce risk behaviors. Another thing this model shows is that we can think of more complex lifestyles and brands. One of the powerful things about brands is it addresses multiple co-occurring behaviors such as co-occurring substance use and HIV risks can potentially be addressed through one brand as opposed to many of our programs which tend to be vertical and address one subject matter. Brands can address entire lifestyles.

What I'm going to do is briefly illustrate the use of this brand equity concept and brand research with two case studies. This one is a study that I did a few years ago in Zimbabwe. It's an evaluation of the Protector Plus condom brand in Zimbabwe. This slide illustrates the basic questions we had in the study; how can we use all four Ps (product, price, place and promotion) of marketing to create socially marketed condom brands that people want to 'buy'? By the way this study was published in the BMC Reproductive Health if anyone is interested. So we had an interesting naturally occurring experimental condition, if you will, in which they increased the socially market prices significantly in 2009 and they also converted to printing their currency to the dollar which effectively and greatly increased the cost of condoms and other products. We wanted to see the effect this price increase had, whether Zimbabweans would be willing to pay more for condoms and what potential effect on TMA would be in Zimbabwe. Obviously there are both free and socially marketed as well as some limited availability of socially marketed condom products in Zimbabwe.

This is just a quick illustration of our study design. We were comparing current and former users of both the Protector Plus and Free/ Government Sector brands as well as Non-users as a control group.

This slide shows the results from the study. In the left hand column we have a list of Brand Equity Factors. These are some concepts that are pretty familiar to us such as the idea of brand loyalty, perceived quality, whether the brand is a leader in its category, what is the value of the project, the idea of brand personality and Market barriers. This is all with respect to the Protector Plus brand.

I'm going to move quickly through all of this because I know that we don't have a lot of time.

Basically what we see is that some of these factors are associated with higher willingness to pay. Particularly in the Protector Plus columns you'll see that there are positive higher odds ratio in several of the Brand Equity factors. Basically people have higher brand equity than what bought in. They have more positive associations with the brand and so they're willing to pay for protector plus. They would also be more willing to pay for condoms even if they're users of the Free/Government sector brands. So regardless of their current usage, they would be willing to pay more. But this has implication in that price is not necessarily a barrier to usage and Brand Equity predicts that.

So I'm going to give you, quickly, another case study/ program. This was a review of a number of country programs that are being implemented by PSI and basically the goal of this study, which was done in 2013, was to understand the effect of brand management on basically the total market specifically for condoms. Also how social marketing for brand management can be defined and how it can be a positive influence on the growth of healthy markets.

So basically what we did was a retrospective analysis of a number of brand management actions that can affect the health of markets in several countries; Kenya, Madagascar, Mozambique, Nigeria and Tanzania. They were chosen based on comparability in terms of the type of social marketing platform they had and also per capita at GDP levels being reasonably comparable. And we used existing national data sets like the DHS and other available data sets. Basically what we wanted to do was also account for variations in the markets over time like changes in funding levels, media, implementation and so forth. What we did was develop a composite measure of brand management and we attempted to account for the type, reach and frequency of brand management in each individual country. We were looking at the relationship between how active was the brand management and what affect that had on the total market.

So we basically used the Mixed Method Approach. We developed a coding scheme to quantify brand management actions. We weighted these equally and then we conducted both quantitative and qualitative analysis. I'm just going to mention the quantitative, where we did regressions and we looked at consistent economies; condom use with personal sex workers and condom use with last sex. Then we looked at this brand management factor and some co-variates to see what effect they had.

We ran into some challenges. There was a lack of DHS data during all the periods of interest. So there wasn't all the data available that we would've liked. We also lacked detail brand management data by year, reach, where it was delivered and also frequency and intensity (how much and how often). Basically what we were aiming to do was demonstrate a methodology that can be used to understand the relationship between brand management and the effect on total markets.

And basically we used Multivariable analysis methods. We were looking at an indicator of where the predictor was, a dichotomous indicator of awareness of brand and we also took a number of co-variates into account as I've mentioned.

Real quickly, this slide shows that there was a positive relationship between awareness of the brand as it predicted condom use that last intercourse and also a negative relationship in that the lower the funding was, the lower the condom use at last intercourse. Also there was an effective education. So higher levels of education predicted condom use.

I'm going through this very quickly because of time. Sorry.

We also found that when we combined the year of analysis, there were similar effects that as we might expect, awareness of the brand management activities predicted more condom use. And lower funding levels in the program zone, that would be the area of the country that was being analyzed, predicted lower condom use. We also saw a positive effect of education.

So basically we did see that brands are being actively managed in these countries and we see a relationship between active brand management and the behavior being targeted, mainly consistent condom use in this case.

But we definitely need better data on brand management in terms of implementation like reach, frequency of activities and also cost and location of activities. Without these kinds of detailed data, it's difficult to determine the exact effect of brand management. But this is clearly a promising area. If we have better understanding of our brand management and implementation activities, we're going to be able to get a better assessment of the effects on the total market in countries. So we do have a methodology now that can be applied over time. But we need better data collection and brand management systems in order to do this. This methodology can potentially be used frequently if we are able to develop better monitoring systems.

Thank you very much.

Ibou Thior, AIDSFree: Thank you Kim. We'll go to the second question. This is from Kadiro.

What role should a social marketing organization play in fostering the TMA agenda?

Marguerite, I think you can probably address this question.

Marguerite Farrell, Office of Population and Reproductive Health: Thank you. So I think social marketing programs are very invested in TMA. PSI has their own TMA methodology that they're using. I'm sure Kim and Yazmine, who are on this and are participants, can elaborate on. But I just want to say it's very context specific. You have to look at what is the modern contraceptive prevalence in this country. Is it low prevalence? Is it medium-low? Is it medium? Is it high? It's a different answer for each of those because social marketing really builds demand. It builds the overall market and builds the market. People pay something, even though it's a nominal amount, and you can use that money to reinvest in promotion and demand side activities.

You need to look at the poor and the near poor and what channels they're using. How are they accessing their methods? Is the MLH really delivering free methods with no stock-outs for the last mile? That's an important question. Also look at the existing commercial products and the price point. This may be different for condoms as I've seen in countries but for most of the other products the price points are quite high for injectable, oral contraceptives and projective-only pills combined with oral contraceptives and also for ...inaudible... And I haven't really seen the commercial sector robustly investing in the demand side. They're just not willing currently, I think. And that's a very low prevalence market. They're not really doing the formative research to look at the barriers, the misperceptions and really addressing them through mass media, min-media, intrapersonal communication, or community events. And social marketing is really priming the market for future commercial products. It's a real service being done for a lot of these companies and generic companies. So you have to have a long-term view when you think about this.

Also, some of these social marketing organizations have commercial products. And they're using those products to cross subsidize products for the poor. That's an important function. A lot of these social marketing organizations will become independent local organizations and local NGOs. So they're a part of the in-country capacity, if you will. I think you need to think about all of these things. If you have good answers to all of these questions and the prevalence is high to mid-high then maybe it's time to kind of phase out some of the subsidies to the commercial sector. But you better make sure that the poor really do have access.

Ibou Thior, AIDSFree: Thank you. Doug will probably try to answer the following questions.

Should we consider branding public sector condoms for free distribution? If so how will branding of free condoms help the TMA agenda?

Douglas Evans, Milken Institute School of Public Health: I definitely think that my research and the broader work that's been done on branding and the social marketing sector definitely shows that branding is predictor of behavior. Effective branding can increase adoption of behavior and clearly increase adoption of product use in socially marketed products. I think the work that we did in Zimbabwe definitely shows that brand perceptions and brand equity, as I call it, can have a significant effect on socially marketed paid condoms, subsidized condoms and also those that are freely available from the public sector. I think the key is the creation of perceptions in value for freely available condoms.

You know, we have to stop and think that people infer value based on cost to a certain extent. Higher the price, it's often equated with perceptions of value. I think one challenge we face is how do we make freely available condoms perceived as being valuable. What other forms of value can we associate with them [condoms]? So I think there are some unique branding challenges that chase us when we think about

freely available condoms within the overall context of socially marketed condoms. But I think we can definitely overcome those and we do have some preliminary evidence that suggest that branding freely available condoms can be effective in increasing those value perceptions. And given what we know about effects of brands over all, we would expect that to increase use.

So I think it is an important area and I think it's part of the trouble market approach because clearly there are going to be different levels of ability to pay. Willingness to pay is one thing but I think we have to take people's ability to pay into consideration as well.

So all of those things are important but I do think that branding can be an effective strategy for increasing usage of not only socially available condoms, but freely available as well.

Ibou Thior, AIDSFree: Thank you. There is a general question, which is very interesting. I think anyone who has an answer can try to address it.

Any information for how total market approaches for condom programming applied to things like female and Zika?

Dr. Kimberly Green, USAID/PATH: Yeah. This is Kim. I can take the female condom part of the question.

You know, as the female condom got us to a bit of a rough start and maybe part of that had to do with price point but also branding. But now there's a new generation of efforts around the female condom applying TMA that has us working with a condom manufacturer in China, manufacturing female condoms at a lower price. As well as working on the branding, market entry and if you're interested in that I'd be happy to link you to further information.

But the same approach is really applying to offering it free to the right population, offering subsidies to the right population, and also offering it through commercial channels as well.

Ibou Thior, AIDSFree: Would anyone else like to chip in? Ok, we'll move on to the next question.

I would like to know more about how demand generation can drive TMA?

Douglas Evans, Milken Institute School of Public Health: Yeah and I was just going to say, briefly, I mean that's a big question. But it's certainly what brands are all about, increasing demand but also essentially framing choices.

So the first thing that a brand has to try and do is make people aware of it, but then once people are aware of it, to try to frame choices into either, in our case, the healthier behavior or to avoid the unhealthy behavior. And then specifically, if we're marketing a socially marketed product, to choose our product. But yeah, brands are about demand creation. They're about getting people to associate positive value with engaging in a behavior or in the use of a specific product and so I think that it's a very powerful tool for creating demand. It's getting people to recognize that there's a benefit and that they're going to get something out of the behavior. And so I think that this is really one of the key things. We need to use our branding efforts very specifically in order to increase demand. But that is one of the essential functions of branding.

So I think that we have opportunities to do that. Some of it involves actually reaching people where there are and realizing that our audiences are in different places, physically but also mentally in terms of barrier to entry, to engaging in our behaviors and that requires us to use multiple promotional strategies.

So I think we have to be creative. I also think we have to look at what the commercial sector does and recognize that we may have a brand position or a Protector Plus brand in Zimbabwe, for example, represent something that we can market and promote that in different ways to different audiences.

So there are a number of strategies like this that I think we can use for branding to increase demand.

Narrator: Thank you Doug. I think we want to keep this webinar for one hour. I think we have four minutes left and we'll address two questions. The remaining question can be addressed offline after the webinar.

So the next one is for Marguerite regarding quintile five. Is there an impact from these high earners, who will also be high taxpayers, and expect to get free products as they've paid their taxes?

Marguerite: This is an excellent question and it's something I argue all the time.

We, and the health economists, are trying to make sure the subsidies goes to the poorest people from the public sector. But the truth is the resources and the financing to fund that comes from the taxpayers who are mostly formal sector workers and upper income quintiles anyways. So I think it's very germane to this whole push towards universal health coverage and how schemes are set up. Many of them add formal sector workers first traditionally and historically and then later added lower income and informal sector workers.

But I think some of the rollouts in sub-Saharan Africa are trying to add the poor sooner. So if you're going to do a UHC system or some kind of social insurance pooled risk pooling, that can be different. That can make sure everyone gets what they need or maybe the poor get it for free and there's some kind of cold pay by the upper quintile.

But this was really talking about what's happening today, here and now, before five different evolutions of a UHC system and a country could generally keep evolving. And saying, what can we do now to make sure the poor, who have suffered the most excess mortality and morbidity from unintended pregnancy. What can we do today to make sure that we can improve health outcomes?

Ibou Thior, AIDSFree: Thank you. So I will say the last question. I think, also, who for Kim to share the methodology the rest of the group. I we'll address that offline by using the mail system and sharing the link.

So the last question is; what is being done to attract commercial sectors to invest directly to developing markets?

Marguerite Farrell, Office of Population and Reproductive Health: So this is Maggie. I can talk a little bit about our BEAR project in two sentences and then others can fill in. Is that ok Ibou?

Ibou Thior, AIDSFree: Yeah.

Marguerite Farell, Office of Population and Reproductive Health: So we have a project with FIRE, FARMA and eleven sub-Saharan African countries that's using the manufacturer's model or investing for five years in demand side subsidy and Buyers for Perpetuity has promised us a low price micro-MNSP COC (combined oral contraceptive) for 75 cents to one dollar. So we've introduced these now in eleven countries. We've subsidized the demand side and our project is closing in September and they're going to keep that product at that low price in these markets and we're going to be monitoring and seeing how well these commercial sectors handle these products because the subsidies are over. So we'll see how well they do.

Usually the other BEAR pills are five to six dollars in most of these African markets and this is 75 cents to a dollar so it's significantly less. But I won't say that it's a quintile one or two product.

Ibou Thior, AIDSFree: Thank you. I know, also, for the 20-20 initiatives, which is really to provide twenty billion condoms by the year 2020. The commercial sector is on board. They were invited to several meetings right now to see how they can be involved in developing markets.

And I think that there is a series of studies that AIDSFree will be doing and those studies will also help in addition to additional studies that even the private sectors themselves would like to carry out to better understand the market and see what is their place in markets especially relative to condoms.

Dr. Kimberly Green, USAID/PATH: I was just going to add that I think that the data is really important because I think a number of commercial and manufacturer's condoms were the previous trend and this was needed at the time. There were large quantities of free and highly subsidized condoms. And a lot of the commercial manufacturers might not have seen the market. So that's why they weren't investing. But by generating that market data, by applying the manufacture model and by addressing some of the quality issues and regulations. I think that can provide a really environment to incentivize investment.

Ibou Thior, AIDSFree: Thank you. So before we wrap up, we would like to again thank all the participants for giving their time and expertise today. In the next few days, you will be receiving an email with a link to today's recording. Before we close the webinar I wanted to encourage you to take a moment to fill out the poll questions below, as the feedback will help us to improve future webinars. I would also like to encourage you to subscribe to the AIDSFree prevention update. The link to subscribe is now on your screen. Thank you all once again.