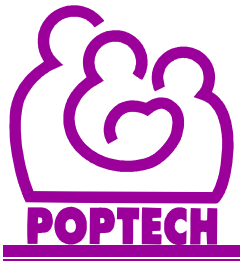

MIDTERM EVALUATION

OF

POPULATION SERVICES INTERNATIONAL'S

IMPROVING HEALTH THROUGH SOCIAL MARKETING

PROJECT

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ACRONYMS AND ABBREVIATIONS

BCC	Behavior change communication
BITNET	Pilot ITN distribution program initiated in Blantyre with PSI
BLM	Banja La Mtsogolo (Marie Stopes International Malawian affiliate)
CDC	U.S. Center for Disease Control and Prevention
CHAM	Christian Health Association of Malawi
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
EU	European Union
Global Fund	The Global Fund To Fight AIDS, Tuberculosis and Malaria
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HPN	Health, Population and Nutrition
IEC	Information, education, and communication
ITN	Insecticide-treated net
JHU	Johns Hopkins University
JICA	Japan International Cooperation Agency
JSI	John Snow, Inc.
KAP	Knowledge, attitudes, and practice
KfW	Kreditanstalt für Wiederaufbau (German development bank)
MK	Malawian kwacha
MOH	Ministry of Health and Population
MSH	Management Sciences for Health
NAC	National AIDS Commission
NGO	Nongovernmental organization
ORS	Oral rehydration salts
PSI	Population Services International
SO	Strategic Objective
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

Population Services International (PSI) began its social marketing program in Malawi with U.S. Agency for International Development (USAID) support in 1994. The Chishango condom was the first socially marketed product. The German development bank (KfW) began cofunding this project in 1995. Several years later, PSI expanded its product line by adding maternal and child health products, specifically insecticide-treated bed nets (ITNs) in 1998, retreatment kits in 1999, and oral rehydration salts (ORS) in 1999, under the brand name Thanzi. In November 2002, PSI also introduced a safe water treatment product, WaterGuard, although this product was not directly supported by USAID. PSI has strived to develop working relationships with a variety of international organizations and donors working in Malawi, which has served to further strengthen and complement the core component of USAID's original project. This midterm evaluation was designed to cover the period from the beginning of the current project (2002) to date. Overall, PSI has effectively met and in several cases exceeded the original goals and objectives of the project. The key findings and recommendations are summarized below by product.

CONDOM SOCIAL MARKETING

The Chishango condom, which experienced a sales plateau after several years in the market, has had significant success since it was relaunched in 2002, exceeding its original sales targets and allowing PSI to set new targets for condom sales during the life of the project. There is high visibility of the brand and high brand awareness among Malawian consumers. The relaunch of the condom, which generated a significant amount of controversy at the time, has helped to further desensitize the issue of condoms. PSI's strong technical skills in marketing and promotion and behavior change communication (BCC) as well as the innovative use of nontraditional media are clear strengths of the project. The key recommendations for further strengthening the condom component include

- considering strategies to strengthen distribution among retail outlets,
- reassessing the needs of high-risk audiences and how condom social marketing may address these needs,
- reassessing the degree to which existing generic advertising and BCC interventions are addressing the key behavior indicators included in PSI's log frame, and
- incorporating short-term mechanisms for evaluating the effectiveness of BCC interventions.

PSI has made an important contribution to the Ministry of Health and Population's (MOH) program to increase the distribution of subsidized ITNs. With MOH support, PSI succeeded in a very short period in expanding distribution to over 420 antenatal clinics. In general, the program has benefited from well-coordinated, multidonor support as well as an overall commitment to make ITNs widely accessible in Malawi. Given that the program has evolved significantly and that there are multiple donor agencies involved, it will be

important for USAID to work in conjunction with other key stakeholders to further strengthen both the overall program and PSI's role. The issues to be addressed immediately include

- developing a coordinated donor strategy to address the short and long-term supply needs for ITNs;
- determining whether PSI's capabilities may be helpful in supporting replication and expansion of village health committee sales;
- clarifying the use of ITN (subsidized green nets) revenue and financial support of distribution and logistics;
- determining how to use the underspent USAID funds in PSI's budget for the ITN program given that net revenue has been used to cross-subsidize net distribution (originally programmed for in USAID's budget); in the future, PSI should be more open in discussing with USAID issues related to project expenditures and multiple funding sources; and
- expanding PSI's communication initiatives to address other key malaria prevention behaviors, particularly retreatment of nets.

ORAL REHYDRATION SALTS SOCIAL MARKETING

PSI has also made important progress with the Thanzi product in the last several years. There is an overall high awareness of the product as well as good availability in retail outlets since it is the second most widely available PSI product (the Chishango condom is the most widely available). The key issues to be addressed for Thanzi include

- identifying the source of supply for the next ORS procurement,
- establishing targets for the indicators in the ORS log frame and focusing future marketing and promotional support on these key knowledge and behavior indicators, and
- determining sustainability objectives for Thanzi.

WATERGUARD SAFE WATER SYSTEM SOCIAL MARKETING

The WaterGuard product launched by PSI has had strong success in the few years that it has been available in the marketplace. There is anecdotal evidence that the product has been well accepted among Malawians, and there is high potential for future growth of the product. According to PSI's distribution survey, the product has high visibility in retail outlets and strong brand awareness. Given that PSI has privately funded WaterGuard for the first two years, the key issue is to clarify future donor support for the procurement and promotion of the WaterGuard product.

GENERAL FINDINGS

The large majority of organizations that were interviewed regarding their work and collaboration with PSI were very supportive and complimentary of the expertise and responsiveness of the organization. PSI was frequently recognized as the foremost social marketing organization in Malawi and commended for its strong skills in mass media and communications. To further improve the program, it is recommended that PSI

- strengthen overall communication and coordination with the MOH,
- develop stronger ties with the Ministry of Education, and
- ensure the utmost transparency for all donors and international organizations that are funding complementary activities.

As the program for social marketing of health products evolves, a few issues should be taken into consideration for the future, including

- initiating discussions about the future sustainability of the various components of the social marketing project,
- determining sourcing alternatives for products that will require future support,
- initiating discussions about how to ensure growth in the overall condom market, and
- monitoring lessons learned in other HIV/AIDS prevention activities and tracking investments in HIV/AIDS behavior change interventions.

I. INTRODUCTION

In July 2004, the U.S. Agency for International Development (USAID)/Malawi requested that POPTECH conduct an evaluation of the USAID–supported social marketing project operated by Population Services International (PSI) at the midpoint of its five-year contract. The evaluation was designed to determine

- the changes and improvements that should be made to PSI's program in order to make it more responsive, effective, efficient, and sustainable; and

- the issues that should be considered for the future after the current social marketing project ends in 2007.

(The scope of work for the midterm evaluation is included as appendix A.)

PSI/Malawi is a nongovernmental trust registered under the laws of Malawi and an affiliate of PSI based in Washington, D.C. With funding from USAID, PSI began the first phase of its condom social marketing program in 1994. The German development bank (KfW) began partial support of this project in 1995 by providing condom commodities donations and other support. PSI expanded its services in phase II by adding the social marketing of maternal and child health products, namely insecticide-treated nets in 1998, retreatment kits in 1999, and oral rehydration salts in 1999. With these additions to the product line, the social marketing program addresses HIV/AIDS, malaria, and diarrhea—the three biggest contributors to morbidity and mortality in Malawi.

In March 2002, USAID/Malawi decided to continue supporting and expanding the social marketing and behavior change program as part of the AIDSMark program. This program was designed to address specific priority activities under the USAID/Malawi Health, Population, and Nutrition (HPN) Strategic Objective 8 (SO 8)—increased use of health behaviors and services.

The goal of the program is to improve the overall health status of Malawians through social marketing. The objectives are to

- mitigate the impact of HIV/AIDS by increasing the use of improved, effective, and sustainable methods of reducing HIV, especially among Malawian youth: through social marketing of Chishango condoms and Youth Alert! and

- increase the adoption and appropriate use of quality child survival products, specifically insecticide-treated nets (ITNs) and oral rehydration salts (ORS). To accomplish this, PSI developed an integrated social marketing strategy for the following branded commodities: Chitetezo nets, Thanzi ORS, Chitetezo retreatment kits, and the WaterGuard safe water treatment system.

In order to accomplish the tasks set forth in the scope of work, the evaluation team met with multiple counterpart organizations, various departments within the Malawian Ministry of Health and Population (MOH) and the Ministry of Education, and the international donor community. (Appendix B contains the persons contacted.) In addition,

the evaluation team spent a week with PSI senior management in Blantyre and completed field visits to the Mulanje, Zomba, and Salima districts and reviewed numerous pertinent documents (the final appendix, appendix F, contains the references). The work plan for the evaluation is included in appendix C.

II. BACKGROUND

Malawi is a landlocked country in Southeastern Africa. The estimated population was approximately 11.5 million in 2003. With a per capita gross domestic product of US$ 180, Malawi ranks as one of the poorest and least developed countries in the world. Over 70 percent of the population lives below the internationally established poverty line according to United Nations Children's Fund (UNICEF) sources. Eighty-six percent of the population lives in rural and relatively inaccessible areas of the country, creating a population density of 105 persons per km^2, among the highest in Africa.

Malawi's pervasive poverty and weak infrastructure has a direct and negative impact on the population's health. Statistics from the 1998 Census and the 2000 Demographic and Health Survey (DHS) show

- a crude mortality rate of 20.9;
- an infant mortality rate of 104 per 1,000;
- an under–5 mortality rate of 189 per 1,000;
- a 15 percent HIV infection rate;
- tuberculosis cases have increased from 95 per 100,000 in 1987 to 275 per 100,000 in 2001;
- malaria prevalence in children under 5 is estimated at 42 percent; it is further estimated that malaria is responsible for 40 percent of deaths in children less than 2 years of age; and
- more than 800,000 Malawians are living with HIV and more than 80,000 die annually.

PSI began its social marketing program in Malawi with USAID support in 1994 with the Chishango condom as the first socially marketed product. The brand name, Chishango, means shield in Chichewa. KfW also began cofunding this project in 1995. Several years later, PSI expanded its product line by adding maternal and child health products, namely insecticide-treated nets in 1998, retreatment kits in 1999, and oral rehydration salts in 1999. In November 2002, PSI introduced WaterGuard, a safe water treatment system.

In February 2002, USAID/Malawi extended its support of the social marketing program through the AIDSMark program, which was designed to expand the distribution, sale, and promotion of the socially marketed products as well as to increase the effectiveness of the behavior change activities, primarily the Youth Alert! program. The new project was budgeted at over US$ 11 million for five years and began in April 2002. In addition, other international agencies, such as KfW, Japan International Cooperation Agency (JICA), UNICEF, the World Health Organization (WHO), and the Department for International Development (DFID), United Kingdom, are also funding complementary PSI social marketing activities.

III. FINDINGS

After several years of a static market, PSI relaunched the Chishango condom in May 2002; it was repositioned to target primarily young men as a strategy to increase sales. Anticipating resistance to the targeting shift and opposition to a proposed new packaging and advertising graphic showing a woman's bare thigh, PSI involved both the Censorship Board and the MOH in the design phase of the project. Representatives of both groups attended an initial planning workshop during which they discussed and agreed upon the new packaging and advertising designs. However, the Censorship Board was not shown the final design before the campaign was implemented by PSI. The materials were seen in advance by the National AIDS Commission (NAC), DFID, and USAID. While these organizations expressed support, they warned PSI to expect controversy.

The launch of the new campaign was met with both positive and negative reactions. The greatest controversy centered around the new package design and large billboards, both featuring the bare thigh photograph. The use of a photograph instead of a drawing was not culturally appropriate and intensified the debate. As a result, PSI faced considerable criticism from the press, religious organizations, politicians, and the general public. A compromise was reached with the Censorship Board in which PSI replaced the offending photograph on billboards with the old Chishango logo but did not alter the package design. Partly as a result of this experience, PSI introduced additional steps into the testing and approval process to deflect future problems. While PSI received some negative publicity as a result of the relaunch, condom sales increased dramatically, and almost overnight, condoms were at the forefront of public discussions. Ultimately, the debate helped to further desensitize the issue of condoms and increase Chishango brand awareness.

PSI's oral rehydration salts (ORS) product, Thanzi, was introduced in 1998. There is a high degree of recognition and acceptance among Malawians for this product. It is widely available in grocery stores, wholesalers, and many kiosks. Thanzi-painted wall billboards are highly visible throughout the most traveled sections of the country, although media advertising tends to be seasonal. An unbranded ORS product is also distributed at no cost at MOH facilities.

The highly subsidized insecticide-treated nets (ITN) (green-colored bed net) program for distribution at antenatal care health centers was launched in November 2002 as part of the MOH's strategy to dramatically increase the availability of ITNs. The green nets are sold at 50MK (approximately US$ 0.47)[1] and are targeted specifically to pregnant women and children under 5. The program has been highly successful, and the current demand for the green net continues to outpace supply. In 2003, the first full year of distribution, more than 1.2 million bed nets were sold, which dramatically revised projections for 2004 and 2005. The MOH predicts that the Abuja target of 60 percent coverage of children under 5 and pregnant women will be reached in early 2005.

The commercial ITN product (blue colored) of PSI, Chitetezo, was introduced to the Malawian public in 1998. The product has been steadily gaining acceptance. The retail price of the blue Chitetezo net is 395MK (approximately US$ 3.73). There is a sufficient margin, which encourages retail and wholesale outlets to stock and sell the net even though

[1] Based on an exchange rate of 106 Malawian kwacha to US$ 1 in September 2004.

there was little media promotion during 2003. M'bwezera Chitetezo is the ITN retreatment kit sold by PSI at 30MK. It was introduced in 1999, a year after the introduction of the PSI blue net. Sales have been strong and there has been a measurable increase in outlets stocking the tablets.

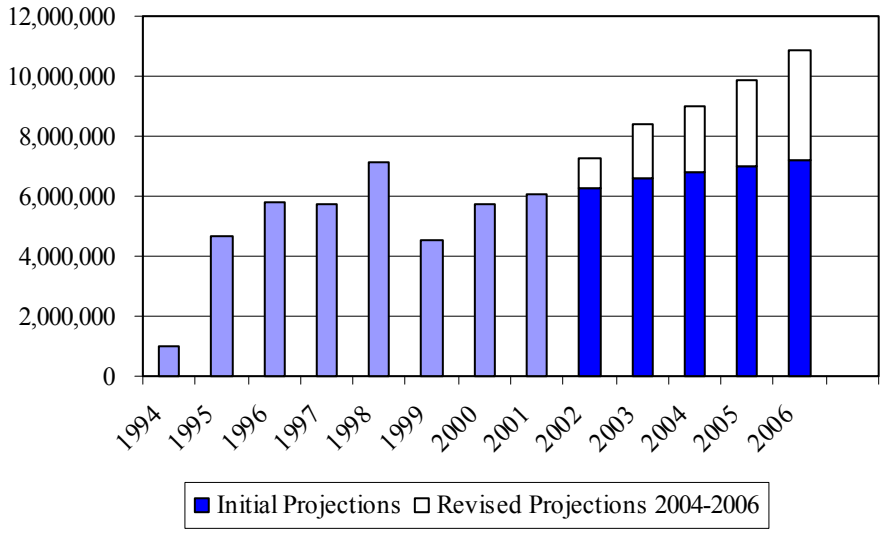
WaterGuard is a safe water treatment system launched by PSI in 2002. Although the product was initially launched with PSI's own discretionary funding, the product may receive additional funding from WHO to support future procurement and to increase distribution and use of the product.

CONDOM SOCIAL MARKETING (CHISHANGO)

Sales, Pricing, and Revenue

After the launch of the Chishango condom in 1994, condom sales increased steadily until 1998 and then stagnated for several years. By 2002—the first year of PSI's new cooperative agreement with USAID—condom sales were restored to their 1998 levels. During the life of the current project, sales of the Chishango condom have exceeded the sales projections included in PSI's original proposal. PSI's initial projections were for annual increases between 2.5 and 4 percent (see figure 1, initial projections). Given the success of the relaunch of the Chishango brand, PSI has modified its projections and is now projecting sales of 10.8 million condoms by 2006 (see figure 1, revised projections). These trends in condom sales clearly point to the success of the relaunch of the Chishango brand.

Figure 1
Chishango Condom Actual Sales and Projections, 1994–2007



The current price structure for Chishango condoms covers approximately 28 percent of the cost of goods sold, meaning that the revenue generated from condom sales covers 28 percent of the commodity, packaging, and importation costs. Other marketing, distribution, and operational costs are not covered. The sales revenue generated by the Chishango brand will average about US$ 102,000 annually and is estimated to reach US$ 511,000 at the end of the five-year project (see appendix D for PSI's financial overview of all product

sales, revenue, and operating expenses). USAID may consider directing condom sales revenue to a revolving fund to begin to develop resources to cover future condom procurement as one alternative for ensuring future supply. It should also be noted, however, that the condom product will not achieve sustainability at the current price levels. Some level of commodity support will always be needed if the product continues at the same price level.

Distribution

The PSI distribution infrastructure for commercial products, including condoms, includes an integrated sales force of five salesmen, five vehicles, five drivers, and two merchandisers. This force is responsible for the distribution of condoms, ITNs, ORS, and the safe water supply product. Condom distribution specifically is also supported by 23 bicycle salesmen that serve as a link between wholesalers and retail outlets in rural areas. PSI also supports an institutional sales representative (one salesman, one vehicle, and one driver) that sells condoms directly to nongovernmental organizations (NGOs) , employers, and others.

Although sales are increasing, distribution coverage of the Chishango condom has decreased since 2001. In terms of the total number of outlets served, distribution decreased from 50 percent in 2001 to 43 percent in 2003.[2] The decrease among high-risk outlets, such as bars/nightclubs, kiosks, motels/rest houses, and taverns, is the most significant, declining by 13 percent to 29 percent. Distribution to bottle stores, supermarkets, gasoline stations, and pharmacies decreased by 1 percent to 10 percent, and distribution coverage increased among groceries by 1 percent and wholesalers by 13 percent. PSI has stated that these decreases are related to an overall downturn in the economy that inhibits the small retailer's ability to purchase condom supplies and a new vehicle policy (in response to vehicle and inventory thefts) that was implemented by PSI shortly before the time of the distribution survey that required that all vehicles return to their home base by 5:30 p.m. PSI is examining several new vehicle security systems to remedy this situation and allow the distribution force to maximize its time on the road, while protecting these key assets.

While it is somewhat disconcerting that distribution coverage has decreased, the distribution survey shows that there has been a decline in the availability of ***most*** consumer goods. The survey concludes that Chishango condoms have approximately the same availability as bread. It is also worth mentioning that PSI has worked hard to establish relationships with reputable retail outlets to ensure that a high percentage of sales are collectable. As a result, they are also careful about expanding to unreliable retailers. However, since access to condoms for young men and women appears to still be an issue in some areas, it will be important to identify strategies to make condoms more accessible to this key target audience. It will also be important for PSI to take into consideration the results of the first behavioral surveillance survey that was conducted in Malawi earlier this year by Family Health International. This research will be critical for identifying other high-risk groups that should also be targeted with condom promotion and HIV/AIDS prevention messages.

[2] Brueton, Valerie, National Distribution Survey for PSI/Malawi's Social Marketing Products, 2003. (Fieldwork completed November–December 2003.)

Marketing and Promotion

The success of PSI's Chishango condom marketing is remarkable and well documented. While specific details of sales are discussed in other sections of this report, it is clear that PSI's marketing and promotional strategy for Chishango has worked. All marketing, promotion, and behavior change communication (BCC) is consolidated in the PSI Communications Department. The department follows an integrated marketing communication model that is research driven and begins and ends with the consumer. Chishango marketing is discussed in detail as it is the major socially marketed product, but many of the observations about Chishango apply to the marketing of PSI's other products as well.

Virtually all types of media available in Malawi have been used in Chishango campaigns: radio, television, print advertisements, billboards, posters, vehicle display panels, calendars, point-of-sale graphics, video shows, live dramas, consumer and trade giveaways, and signs on buildings. While extensive audience research from external sources is not yet available, the reach and penetration of PSI's advertising is obviously great, based on sales results, existing media surveys, and internal studies. For example, PSI products, including Chishango, are on the top 10 lists of most remembered product advertisements in all media categories reported by the Malawi All Media Survey 2004. PSI's 2003 Consumer Profile Survey reports brand awareness of Chishango at 92 percent.

Radio is the dominant mass medium in Malawi. There are radios in 90 percent of urban homes and 73 percent of rural homes. Radio listening is a well-established habit. Seventy-two percent of those surveyed listen to MBC Radio 2 every day. Therefore, radio is the best method for reaching people of all ages, literacy levels, and economic status throughout Malawi. PSI correctly relies heavily on radio for both branded and generic messages about condoms and its other products. PSI's Consumer Profile Survey found that 87 percent of those surveyed first learned of Chishango from radio. Television must be used very selectively because of low coverage and high cost.

Table 1 on the following page shows expenditures for advertising/promotion and BCC for PSI's socially marketed condom, ITNs, and ORS in various media. For most products, investment in BCC exceeds advertising expenditures, sometimes by a considerable margin, as is the case with Chishango. Spending for radio is high for all products because the medium provides the most cost-effective way to achieve high reach and penetration for PSI's commercial messages. The media mix and levels of expenditure seem appropriate and fully justified in light of sales results.

PSI's Communication Department has developed elaborate systems for ensuring that all media materials and campaigns are well researched, carefully planned around detailed qualitative data from target groups, pretested, well produced, and thoroughly posttested. Techniques for quickly preparing and altering materials for focus group testing using digital cameras have greatly accelerated design and pretesting. The skills and experience that the department has acquired in advertising and product promotion are available to support all PSI communication activities.

Table 1
Marketing, Promotional, and Behavior Change Communication Expenditures, April 2002 to June 2004
(in US$)

Category	Chishango Condoms	Chitetezo ITNs	Thanzi ORS	Total Expenditures
Television	24,000	0	0	24,000
Radio	81,000	26,000	35,000	142,000
Print	187,000	0	5,000	192,000
Point of Purchase/Promotional	36,000	0	30,000	66,000
Subtotal Marketing/Promotional	***328,000***	***26,000***	***70,000***	***424,000***
Subtotal BCC	***1,065,000***	***33,000***	***7,000***	***1,105,000***
Grand Total	**1,393,000**	**59,000**	**77,000**	**1,529,000**

Other Indicators

PSI has developed an HIV/AIDS prevention log frame that is being used to guide the program's condom interventions. In addition to sales targets, the log frame also mentions some key knowledge and behavior indicators, which are summarized in table 2 on the following page. The data sources (baseline and target) for these indicators are the Demographic and Health Survey, which is being conducted again in 2005, and the Secondary School Knowledge, Attitudes, and Practices Survey, which is scheduled to be repeated in the near future. PSI also has conducted several rounds of a Condom User Profile study (the most recent was conducted in December 2003). However, few of the indicators tracked in that survey correspond to this log frame, so it is difficult to monitor PSI's progress toward these targets.

Other Issues

In general, there are few other commercial condom brands available in Malawi, and the results of the distribution survey suggest that the sales of other condom brands have remained static since 2001. It appears that it will take some time for a well-segmented condom market to develop in Malawi. Interestingly, however, the Malawian affiliate of Marie Stopes International, Banja La Mtsogolo (BLM), has also recently launched a new condom brand, Manyuchi. The Manyuchi condom is priced at 20MK for a box of three and is also clearly positioned for a young male audience. Although PSI is concerned about the rationale for launching this new condom brand, the Manyuchi condom is priced well above the Chishango brand. If Manyuchi is successful, it will help to further segment the condom market, providing yet another alternative to consumers.

Table 2
Knowledge and Behavior Indicators for HIV/AIDS Prevention Among 15–24 Year Olds*
(figures in percentages unless noted)

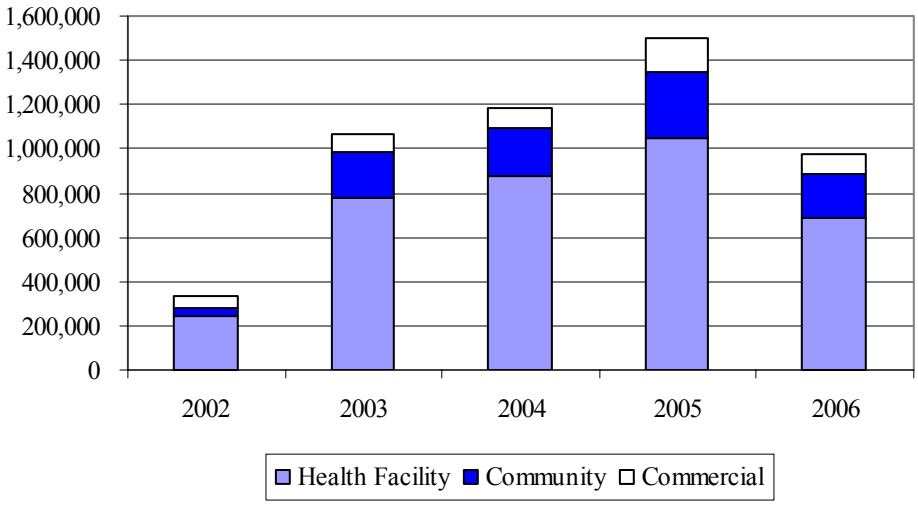
HIV Indicators	Baseline		Target	
Knowledge/Attitudes	**Male**	**Female**	**Male**	**Female**
Increase spontaneous recall of how to prevent HIV				
Abstain	71	65	81	75
Use condom	76	57	84	67
Limit number of partners	14	25	30	40
Increase knowledge that healthy looking individuals can transmit HIV/AIDS	88	83	93	88
Decrease in myth that you can tell who has HIV/AIDS by looking	63	56	55	49
Increase in exposure to HIV/AIDS messages before first sex act	79	77	90	90
Increase in knowledge that sexual intercourse is most common method of transmission	94	92	98	98
Increase in knowledge that you can get HIV/AIDS with only one sexual encounter	87	86	95	95
Increase in knowledge that condoms are effective in preventing HIV/AIDS	88	78	93	85
Increase in belief that they could get a condom if they wanted one	79	57	85	67
Increase in belief that they have easy access to condoms	76	66	82	75
Behavior				
Increase in median age at first sex act	15 years	16 years	16 years	17 years
Reduction in number of sexual encounters	71	44	63	39
Reduction in casual sexual partner in last 3 months	28	16	20	12
Increase in condom use in last sex act	37	32	50	45
Increase in recognized risk of HIV for users that did not use a condom	66	65	75	75

SOCIAL MARKETING OF INSECTICIDE–TREATED NETS (CHITETEZO)

Sales, Pricing, and Revenue

Insecticide-treated nets (ITNs) are sold through three different supply channels. Chitetizo blue nets are sold through commercial channels at 395MK (US$ 3.72) and green nets are sold in collaboration with the MOH's National Malaria Control Program (NMCP) through antenatal care facilities at 50MK (US$ 0.47) and at district health offices at 100MK (US$ 0.93). As seen in figure 2 on the following page, sales of ITNs have increased significantly since 2002. In the original proposal for this project, PSI estimated that 200,000 green nets and 100,000 blue nets would be sold annually during the life of this project. The sales for the highly subsidized green nets have radically surpassed these early estimates since the original proposal was developed prior to the MOH's approval of a national program with a three-tiered pricing system. For the distribution program, PSI receives support from USAID for the ITNs in marketing, management, and distribution. UNICEF provides the ITNs (using DFID funds) and some logistics and distribution costs. PSI's current agreement with UNICEF states that sales revenue from green nets will be used to subsidize the cost of distribution since the dramatic increase in net volume has increased PSI's overall warehousing and distribution costs.

Figure 2
ITN Sales and Projections by Type of Facility, 2002–2006

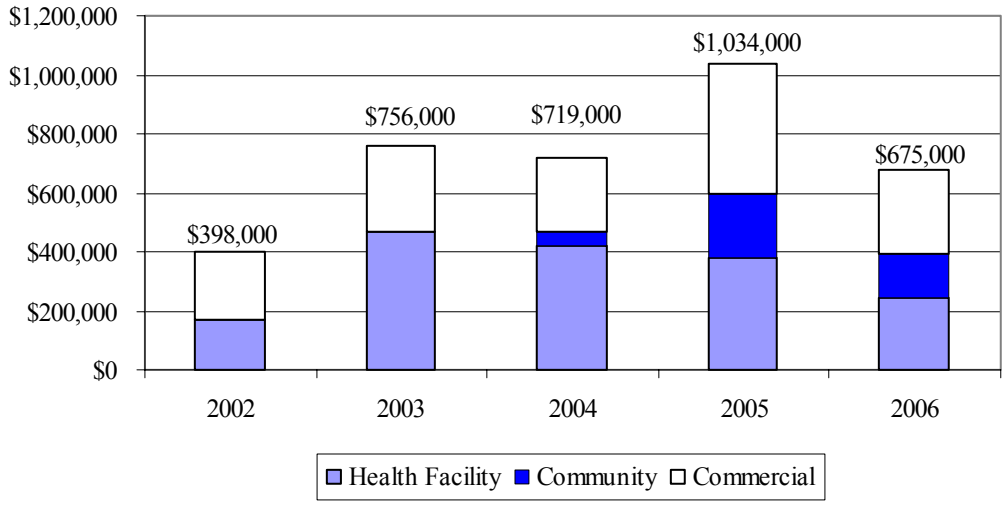


As seen in figure 2, sales of the green nets at the health-facility level are estimated to represent approximately 72 percent of all sales. Sales of the green nets at the community level represent about 19 percent of total sales. This element of the program has been more difficult to implement since it relies heavily on village health committees, which are not active in all communities. The commercial sector sales (blue nets) are consistent with PSI's original projections. PSI currently estimates that by 2006 there will be some saturation of the ITN market and demand for nets may decrease. Therefore, they estimate a reduction in ITN sales in 2006. However, these estimates are preliminary (since there is little precise information available about market saturation levels) and should be reevaluated as additional information becomes available.

The sales revenue generated from the sale of ITNs is shown in figure 3 on the following page. Over the life of the project, it is estimated that US$ 1.7 million will be generated from the sale of green nets in health facilities, US$ 407,000 from the sale of green nets at the community level, and US$ 2.1 million from commercial net sales. Figure 3 also shows a reduction in estimated revenue due to the reduction in overall sales (as projected in figure 2).

The current price structure for green nets covers approximately 26 percent of the costs of goods sold, meaning that the revenue generated from sales covers only 26 percent of the commodity, packaging, and importation costs related to the nets. This program will need to be highly subsidized in order to continue distribution at the same magnitude. Given that price also continues to be a major obstacle for households that do not currently have a net, the project might need to identify additional strategies for targeting ITNs to rural or high-risk areas. The current price structure for blue nets covers approximately 85 percent of the commodity and packaging costs. This price structure, however, is not sufficient to cover marketing, promotional support, distribution, and general operations. As described below in the section on other issues, the MOH is concerned about the use of ITN green net revenue. The MOH has expressed interest in developing a strategy to use net revenue for future procurements of nets.

Figure 3
ITN Revenue by Type of Facility, 2002–2007
(in US$)



Distribution

It is well recognized that PSI was extremely successful in responding to the MOH's initiative to expand distribution of the subsidized green nets to the national level. In a period of approximately 2 months, it achieved distribution to approximately 420 health facilities (almost 100 percent). The ITN green nets are also being distributed to district health facilities for distribution through village health committees. There are several factors that have affected the ability of community health committees to take a more active role in net distribution. In some instances, MOH staff is not clear about how to manage ITN funds. In addition, there are many village health committees that are inactive or not interested in ITN distribution. PSI is also working with a number of small NGOs (e.g., World Vision) to make green nets available for distribution through its facilities. Management Sciences for Health (MSH) is working at the village health community level in approximately eight districts and is helping to strengthen the community health committees. PSI has approached MSH about examining a pilot program to strengthen net distribution at the community level.

For the blue nets, PSI's 2003 distribution survey shows that availability in wholesalers increased from 27 to 37 percent of wholesalers, but decreased from 54 to 32 percent in supermarkets, and from 56 to 20 percent of pharmacies. Again, the survey reports that the major reason for retailers not carrying the net was insufficient capital to purchase them.

Marketing and Promotion

The number of insecticide-treated nets socially marketed in Malawi by PSI in cooperation with the MOH has greatly exceeded original expectations. The socially marketed net sold in shops is promoted through commercial advertising and generic messages. Consumer demand created through the social marketing activities extends to nets bought from health centers and community-based health committees. Some of the same media used by

Chishango also are used for Chitetezo, but there is greater emphasis on media involving interpersonal exchange, such as live drama and mobile video presentations.

Advertising and promotion of ITNs was greatly reduced in 2003 because the high demand exceeded supply very quickly. However, radio advertising combining the promotion of nets with advertising for the retreatment product, M'bwezera Chitetezo, was increased in 2004. With little advertising, ITN sales during the first half of 2004 totaled 680,287, which was 105 percent ahead of estimates and 176 percent more than the same period in 2003.

Other Indicators

PSI's log frame for knowledge and behaviors related to ITNs is shown in table 3 on the following page. The baseline for these indicators is an ITN knowledge, attitudes, and practice (KAP) survey that was conducted in 2000 for the BITNET project (the pilot ITN distribution program that was initiated in Blantyre with PSI and used as a model for the national green net distribution program). In addition, the National Malaria Control Programme and UNICEF have just issued an interim report from the July 2004 survey of malaria prevention and treatment at the community level and ITN coverage in Malawi. This survey incorporates several of the key indicators from PSI's log frame. It shows that net ownership has increased to 43 percent; there are approximately 1.9 nets per household in Malawi. The survey shows that there has been an increase in the percentage of pregnant women and children sleeping under ITNs (see table 3). Although the results are not included in the interim report, the survey also includes questions on many of the knowledge indicators included in table 3. If a complete report is not issued, it will be important for PSI to gain access to these data. In addition, PSI should determine whether this survey would be repeated again in the future since it may mean that it does not need to conduct its own KAP. Another important issue identified in the interim report is that the large majority (67 percent) of respondents who do not have a net state that cost is the major obstacle for them. This result suggests that there may be a need for further targeting of nets to those populations that cannot afford them. The data included in table 3 were provided by PSI as part of its log frame for malaria prevention.

Other Issues

Perhaps because of the huge volume of nets being distributed and the relatively high revenue being generated (approximately US$ 2 million over the life of the project), there is concern by the MOH about how the revenue will be used. USAID's policy for the social marketing program is that all revenue be reverted back to the program. One issue is that PSI's distribution, warehousing, and other operational expenditures increased substantially as a result of the expansion to the net program. Some of the increased costs were unanticipated; for example, UNICEF's agreement with PSI in October 2002 provided for packaging costs for 230,000 nets, warehousing costs (US$ 35,500) and distribution costs (US$ 37,000). In actuality, from November 2002 to December 2003, PSI distributed over 1.2 million nets; annual warehousing and distribution costs for green nets were approximately US$ 225,360. In summary, while some of these additional costs were anticipated, the program evolved and expanded so rapidly that it was difficult to estimate all of the costs involved with the program.

Table 3
Malaria Prevention Indicators
(in percentages)

Indicators	Baseline	Target
Knowledge		
Increase in adults that mention mosquito bites as a source of malaria	50	70
Increase in adults who mention that treated mosquito nets are best method of prevention	37	60
Increase in adults who mention children as a high-risk group	45	60
Increase in adults who mention pregnant women as a high-risk group	13	30
Increase in adults who can state at least one source for obtaining a net	59	75
Behavior		
Increase in percentage of children under 5 that slept under a bed net	18	40 (35.5% from UNICEF survey)
Increase in percentage of pregnant women who slept under a bed net	16	40 (31.2% from UNICEF survey)
Increase in percentage of nets treated more than once	33	60
80 percent of all mothers own a net and know how to treat it	–	80

As a result of concern by the MOH regarding the revenue being generated through green net sales, UNICEF signed an amendment and no-cost extension to PSI's agreement in November 2003. The amendment states:

> The revenues for the sales of green nets with public and NGO channels will be returned to PSI. PSI is authorized by the National ITN Guidelines to use up to 20 percent of the revenue to pay cash incentives to health workers involved in the promotion and sale of bed nets. The 80 percent balance must be used by PSI towards the ITN programme running costs including all costs associated with clearing and distributing the nets and retreatment kits in support of the Ministry of Health and Population's objective to achieving the Abuja coverage targets. PSI will submit audited financial reports once a year to UNICEF and the Ministry of Health and Population beginning from the date of the first PCA referred to here (June 2002).

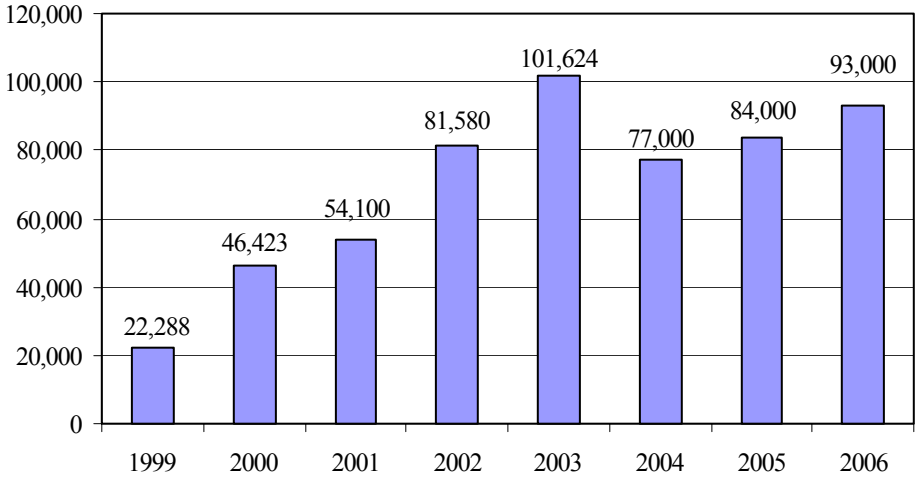
As a result of this decision, PSI has **not** had to use a significant portion of the ITN budget included in its agreement with USAID. PSI reported to the evaluation team that the underspending of ITN funds had been communicated to USAID; however, USAID officials were unaware of this. In the future, PSI should address budgeting issues—including both overspending and underspending—with USAID in a more direct and clear fashion so that the financial implications to the project are well understood. In this instance, the underspending will not affect USAID's overall objectives for the project and will mean that the project has the flexibility to reprogram these funds in new areas. The reprogramming of these funds should be addressed immediately with USAID.

RETREATMENT TABLETS SOCIAL MARKETING

Sales, Pricing, and Revenue

As seen in figure 4, the sales levels for M'bwezera Chitetezo retreatment tablets are projected to reach 437,000 units over the life of the project—9 percent higher than PSI's original projection. Since the number of nets being distributed in Malawi is significantly higher than originally anticipated, PSI may consider specific strategies for increasing retreatment rates. (This issue is discussed further in the marketing/promotion and BCC sections.) The current retail price for M'bwezera Chitetezo is 30MK, and the current price structure covers approximately 26 percent of the cost of goods sold.

Figure 4
Sales and Projections for Retreatment Tablets, 1999–2006



Distribution

The number of outlets selling M'bwezera Chitetezo has increased slightly from 2001 to 2003; it is the only product that has increased in all types of distribution outlets. According to the 2003 distribution survey, 60 percent of pharmacies (an increase from 55 percent), 50 percent of supermarkets (an increase from 48 percent), and 30 percent of wholesalers (an increase from 23 percent) stocked the retreatment tablets.

Marketing and Promotion

Advertising and promotion for retreatment tablets has continued, both to increase sales of the product and to educate consumers about the need to retreat at least annually to maximize net effectiveness. Marketing and behavior change messages are delivered through radio spots, mobile video shows, and drama shows. Campaigns are timed to correspond with the beginning of the mosquito season, but messages reminding consumers that malaria is a year-round concern are also presented. Interpersonal media, such as drama performances and video shows, provide the best opportunity for actually demonstrating proper net use and retreatment. PSI is developing plans to intensify its program of product

demonstrations at sales meetings and rural markets and as a daytime activity for mobile video teams. Radio spots remind consumers of when the threat of malaria is greatest and of the importance of nets, especially for children under 5 and pregnant women. Radio messages also reinforce behavior change once made. While advertising of Chitetezo nets has been reduced, the fact that retreatment is heavily advertised and promoted means that nets are also promoted. As long as supply continues to lag behind demand, the decision to promote M'bwezera Chitetezo and limit advertising of nets alone is a sound one, since behavior change for retreatment has proven to be more difficult than persuading consumers to buy nets. While retreatment is not difficult, it must be done properly for the best effect. PSI should intensify its own BCC to teach and motivate correct practices and also should actively assist with MOH programs, such as the annual Roll Back Malaria campaign.

Other Indicators

PSI's log frame for malaria prevention includes only one indicator related to retreatment. It shows the percentage of mosquito nets that are treated more than once increasing from 33 to 60 percent. In addition, there are a few other indicators about retreatment knowledge and/or appropriate behaviors (e.g., benefits of retreatment, need for annual retreatment). Now that the program has been so successful in increasing distribution of nets, the program should begin to focus on the importance of retreatment messages and include additional indicators in the log frame.

ORAL REHYDRATION SALTS SOCIAL MARKETING (THANZI)

Sales and Revenue

As seen in figure 5 on the following page, during the early years of the Thanzi launch, from 1999 to 2001, product sales fluctuated significantly. However, Thanzi sales increased by 28 percent in 2002 and then increased again by 48 percent in 2003. The significant sales increase in 2003 is partly due to a price reduction implemented by PSI. In 2004, sales are expected to achieve 1.2 million units—a 32 percent reduction from 2003. This reduction in sales is due to limited procurement of ORS in 2004 because of lack of funding. Currently, PSI is projecting a 9 percent sales increase over 2004 levels for both 2005 and 2006.

The sales revenue from Thanzi sales is expected to generate US$ 168,000 over the life of the project (as seen in figure 6 on the following page). The recommended retail price for Thanzi was reduced from 8MK (US$ 0.07) to 5MK (US$ 0.05) in November 2002. The distribution survey conducted in December 2003 shows that the median price was 8MK, and only 17 percent of retailers charged 5MK or less, suggesting that the majority of retailers have not implemented the price decrease. The current price structure for Thanzi covers approximately 40 percent of the cost of goods sold.

Distribution

According to PSI's 2003 National Distribution Survey, Thanzi ORS is available in 37 percent of all outlet types. After Chishango condoms, Thanzi is the second most widely available product marketed by PSI. In 2003, 80 percent of pharmacies stocked Thanzi (same as 2001), 74 percent of wholesalers (an increase from 68 percent in 2001), 68

percent of supermarkets (a decrease from 85 percent in 2001), 56 percent of groceries (a decrease from 62 percent in 2001), and 32 percent of kiosks (a decrease from 47 percent in 2001).

Figure 5
ORS Sales and Projections, 1999–2006

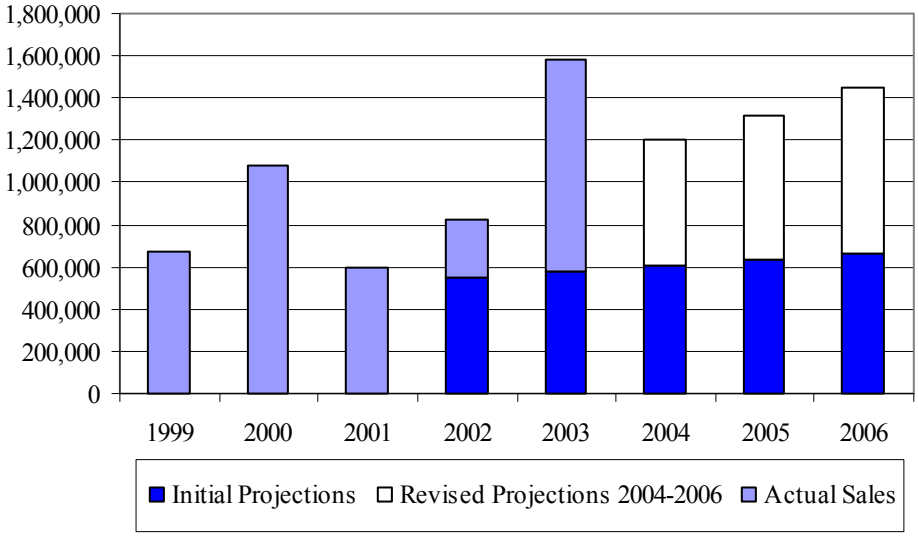
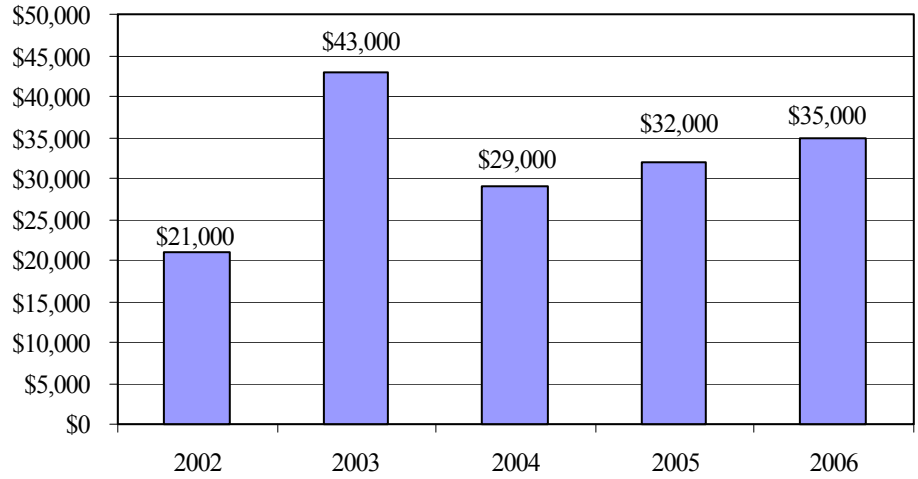


Figure 6
Revenue from ORS Sales, 2002–2006
(in US$)



Marketing and Promotion

Thanzi primarily is advertised and promoted through branded and generic radio spots, posters, mobile video shows, and drama shows. The fact that mothers who bring their children with diarrhea to health centers are taught to use ORS also reinforces product acceptance. Product shortage rather than weak promotion led to declines in sales in early 2003. A marketing strategy suggested to PSI by medical officers is to encourage mothers

to have Thanzi on hand in the home so that they can conduct home therapy before their children become severely ill.

Key Indicators

PSI has developed a log frame for its ORS product and developed indicators related to proper management of diarrhea disease as shown in table 4; however, specific baseline and targets have not been set. The KAP survey for ORS was conducted in 2001 and the 2000 DHS has ORS data. PSI will need to work with USAID to establish appropriate indicators for this component.

Table 4
Indicators for Proper Treatment of Diarrheal Disease

Indicators	Baseline*	Target*
Knowledge/Attitudes		
Increase in mothers who feel Thanzi is fairly priced		
Increase in mothers who know at least one outlet for ORS		
Increase in mothers who can correctly describe the technique for preparing and administering ORS		
Increase in mothers who mention ORS as a response to diarrhea management in children under 5		
Behavior		
Increase in children treated with ORS in last 2 weeks for diarrhea management		
Increase in mothers who report increased liquid intake and maintained food intake		

*Specific baselines and targets have not been set.

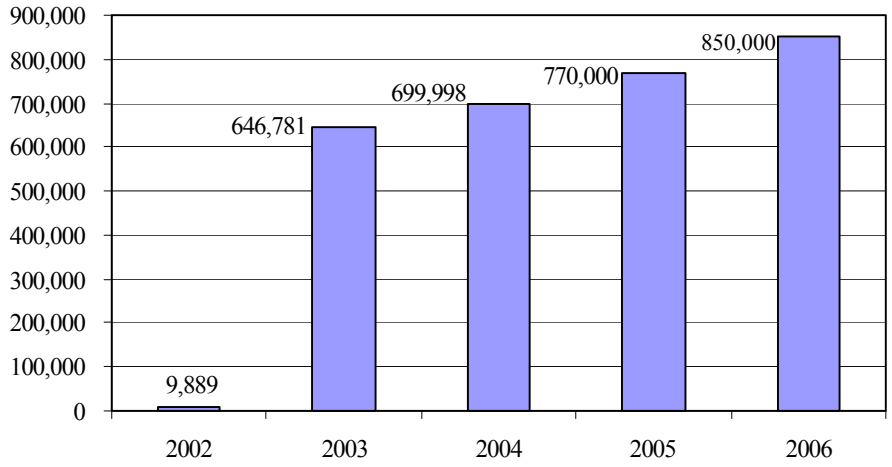
Other Issues

PSI has suggested that finding a source for the ORS product will be an issue in the near future because it has been unable to identify a donor that is interested in continuing to procure commodities. It will be important to address this issue to ensure the sustainability of the product in the Malawian market. While PSI received special approval to use AIDSMark funds to procure initial supplies, it is unclear whether this mechanism can be repeated in the future to procure additional supplies.

SOCIAL MARKETING OF THE SAFE WATER SYSTEM (WATERGUARD)

The WaterGuard safe water system, which was launched in Malawi in 2002, has been extremely well received. During 2003, sales reached over 600,000 units; PSI projects that sales will be over 800,000 units by 2006 (see figure 7 on the following page). The 2003 National Distribution Survey conducted by PSI showed that WaterGuard was available in 27 percent of all outlets, was most widely available in pharmacies (80 percent), wholesalers (70 percent), and supermarkets (64 percent), and was also available in 38 percent of groceries. Revenue generated from WaterGuard sales is estimated at US$ 30,000 per year. PSI has submitted a proposal to WHO to support these additional costs, but it is unclear whether the proposal will be funded. PSI has developed a general log frame for the WaterGuard product, but specific indicators/targets are not established since data collection for the baseline survey is delayed (due to funding delays).

Figure 7
Sales and Projections for WaterGuard, 2002–2006



Due to the increased risk of diarrheal diseases during the rainy season, compounded by the threat of cholera, WaterGuard campaigns are timed accordingly. Product shortages brought about by overwhelming demand following the launch limited sales. The product is now manufactured locally and the supply problem is largely resolved, but 2004 sales of WaterGuard are short of annual goals. Advertising and promotion will be intensified before this year's rains, given the promised support for the product from WHO. Branded and generic radio spots, mobile video shows, drama shows, branded mini-buses, branded taxies, billboards, community signs, posters, and leaflets are used to promote WaterGuard.

BEHAVIOR CHANGE COMMUNICATION

Increasing sales of PSI's socially marketed products are another indicator of behavior change. For example, increases in Chishango sales show that new customers and/or users are buying more condoms. Because condom buying generally results in condom use, sales can be translated into measurable behavior change. Increasing sales of Chishango, Chitetezo, M'bwezera Chitetezo, Thanzi, and WaterGuard indicate positive behavior change and important steps toward achieving clinical health indicators.

Long-term trends in behavioral change are best revealed by such studies as the DHS and PSI's condom user profiles, which access behavior at regular intervals over long periods of time. PSI is committed to conducting and encouraging research of many types to track the impact of its products and programs. An experienced research officer was recently hired by PSI and new research tools are now being developed with the help of PSI headquarters to improve monitoring and evaluation.

Youth Alert!

PSI/Malawi's Youth Alert! program for secondary schools is a multifaceted program that combines mass media with interpersonal interventions targeting in and out-of-school young people from 10 to 20 years of age. The purpose of Youth Alert! is to promote behavior change to prevent transmission of HIV and sexually transmitted infections (STIs)

and to protect against unwanted pregnancies among the young. Youth Alert! presents information and teaches life skills to enable young people to make informed choices about how to protect their health and how to make better life choices to achieve their goals. Youth Alert! delivers messages through a variety of media and approaches to promote abstinence, delayed sexual debut, safe sex among those who do not abstain, and decreased numbers of sexual partners. While the distribution of condoms in schools is prohibited, the ministry has expressed its support for the Youth Alert! radio program, school visits, and Youth Alert! literature.

The centerpiece is a weekly radio program, *Youth Alert! Mix*, launched in February 2003, that attracts a large and loyal audience. It is the top-rated radio program for youth by a large margin (48 percent to 19 percent for second place) according to the Malawi All Media Survey 2004. The program is broadcast on MBC Radio 1 and MBC Radio 2 (the Malawi stations with the largest audiences), both of which provide virtually 100 percent national coverage. Seventy-seven percent of respondents report listening to *Youth Alert! Mix* weekly.

Youth Alert! Mix radio listeners' clubs, organized and supported by the BRIDGE project, will soon be operating throughout the eight districts it serves. These clubs will provide supported venues where young people, both in and out of school, can personally engage with and discuss the issues presented in the *Youth Alert! Mix* radio program. BRIDGE is awaiting delivery of FreePlay self-powered radios to complete implementation of the pilot listeners' club activity.

Four teams of Youth Alert! educators visit secondary schools throughout Malawi to present a mixture of entertainment, health, and lifestyle education. Nonstudent members of the community, attracted by the excitement of the outdoor events, also attend these presentations. As of mid–2004, every secondary school in Malawi had been visited at least once. A total of 388 secondary school visits were made in 2003, reaching approximately 62,500 students. Almost 1,500 teachers attended a preshow briefing to prepare them to lead follow-up activities. School visits include music, drama, and interactive discussions of HIV/AIDS and lifestyle issues. The presenters are dynamic, enthusiastic, and energetic and are excellent presenters to students on their level.

An important and useful byproduct of the school visits is the collection at every school of questions most asked by students. These questions provide immediate reactions and opinions on how well the information presented is being received and understood and also guides planners in designing the content for future school visits, the *Youth Alert! Mix* radio program, and other information, education, and communication (IEC) and advertising materials.

A companion piece to the radio program and school visits, Youth Alert! Magazine, has been produced and distributed to every secondary student in Malawi. It is an activity workbook that complements secondary school visits and is designed to enable students and teachers to continue the work of Youth Alert! following a visit. A guide for facilitators has been printed and is ready for distribution. The guide will equip teachers and youth workers with the knowledge and skills to help young people gain more from the magazine and radio programs.

Research to evaluate Youth Alert! as a BCC intervention is ongoing. Two KAP surveys, one in secondary schools and one in primary schools, provide baseline data that will be followed up by a second round of surveys. Comparison of these studies with the next DHS will provide additional information on the behavioral change impact of Youth Alert! and other interventions, but it is essential that PSI continue and expand its own research to document behavior change since the DHS may not be available in advance of the completion of the project.

Soul City/PaKachere

The PaKachere Health and Development Communications program is a multimedia program managed by PSI/Malawi in partnership with Soul City/South Africa. This activity is regionally funded, primarily by the European Union (EU), with additional funds from DFID and Irish and Dutch aid programs. The South African–based NGO, Soul City Institute for Health and Development Communications, is the prime recipient with subagreements in eight other countries. The Malawi program is not currently financed by USAID, but it is described here because of its complementary relationship with key components of the USAID program. The purpose of PaKachere is to produce and disseminate carefully designed and extensively tested branded media materials to promote increased knowledge of critical health issues and to encourage positive behavioral change. The chosen media in Malawi are television, radio, and print. The name PaKachere, meaning under the fig tree—a name with rich cultural associations for Malawians—was selected through a national competition organized by PSI that attracted 1,500 entries. Key health issues chosen for emphasis in Malawi are HIV/AIDS and maternal and child health.

While access to television in Malawi is very limited except in the largest urban areas (only 12 percent of homes receive broadcast television), the PaKachere program will be seen by a significant number of people, including policymakers and those in influential positions who may be able to act on some of the issues raised through legislation, regulation, and policy decisions, in and out of government. A second television series and two radio drama series are under development. The distribution of 1.5 million copies of the book *Living Positively with HIV/AIDS* will begin in 2004. PaKachere is important as a means of moving the discussion of HIV/AIDS to the forefront of public discourse and keeping it there, a need that is clearly recognized by PSI.

Faith-Based Initiative

The recent creation of a faith-based department by PSI/Malawi is part of a strategy to deflect criticism of its condom program by the religious community. The program provides a link and mechanism to facilitate the establishment of partnerships with a large and important constituency that may be underserved or incorrectly informed about HIV/AIDS. The goal of the new department is to reduce HIV/AIDS and sexually transmitted disease (STD) infection among adults and youth affiliated with religious institutions by expanding PSI's involvement with Malawi's faith-based organizations.

The program is headed by a Malawian lay preacher who is well known and highly regarded in the religious community. PSI wisely asked leaders from the country's three major faiths to nominate candidates for the position, review and evaluate applications, and choose who should be offered the position.

Contacts have been made with more than 70 religious institutions, representing Protestant, Catholic, and Muslim faiths. Requests for assistance and a project proposal have come from many groups. A second program officer has been hired to facilitate youth programs and to deal with such issues as cross-generational sex, peer pressure, delay of sexual debut, and other HIV/AIDS concerns of youth. A strategy paper and a detailed log frame are nearing completion. A baseline study will be undertaken in the immediate future, to be followed by regular evaluations over the life of the program.

The potential contribution of the faith-based initiative for increasing the impact and accelerating progress toward the accomplishment of PSI's HIV/AIDS prevention and family health goals should not be underestimated. Additional resources should be invested in this program as they become available. The program should be separately branded and promoted to portray its willingness, capacity, and freedom to establish partnerships with all interested groups, regardless of their positions in respect to other products and activities that are a part of PSI/Malawi's program.

Mobile Video

PSI/Malawi has developed its capacity to produce high-quality video presentations that are shown to rural audiences using four mobile video vans. The programs mix short dramas, documentaries, music videos featuring Malawian artists, informational videos on HIV/AIDS and other health topics, and promotional and advertising messages for PSI products. Large crowds, often in the thousands, attend each screening.

Considerable value is added to the presentations through a live presenter who introduces the videos, provides commentary to relate the presentations to the local area, and often interviews local people. This interactivity contributes greatly to the enjoyment and appreciation of rural audiences. The unit now operates four vehicles that permit up to 660 shows a year at 126 sites nationwide that attract an audience estimated at 1.7 million. PSI's mobile video presentations carry messages to rural audiences that are more difficult to reach through print and electronic media and that are a vital element in PSI's behavior change strategy.

Based on limited observations of audience reaction during mobile video programs, it is suggested that a program including more short videos rather than fewer long videos would lead to greater audience attention throughout the program. Because of the great popularity of music videos featuring local artists, every effort should be made to recruit these artists to make music videos that promote PSI commodities and demonstrate their use.

Drama Shows

The PSI Communication Department contracts with three drama troupes to present plays throughout rural Malawi. The dramas provide information about PSI products, demonstrations, and seasonally relevant health information through a very popular format and extend message penetration into hard-to-reach areas.

COMMODITY SOURCING

Condoms

The condom commodities for the social marketing program are supplied primarily by USAID and KfW. Condom commodities for public sector distribution are provided primarily by DFID, although Project Hope also donated condoms in 2003. As shown in table 5, the estimated commodity shipments to be received for the social marketing program (USAID and KfW) total approximately 40 million condoms between 2002 and 2006. Although USAID/Malawi was not originally planning to provide commodity support to the condom social marketing initiative, USAID/Washington support for condom commodities became available in 2003. As a result, the project accepted condom donations from USAID/Washington and discussed with KfW the possibility of reprogramming its commodity support to the project to cover other costs associated with the Youth Alert! program. KfW has agreed to the reallocation of these funds, and PSI is expected to receive written approval for this by the end of September 2004. It is not clear which organization will continue to support commodities for the condom social marketing component at the end of the project.

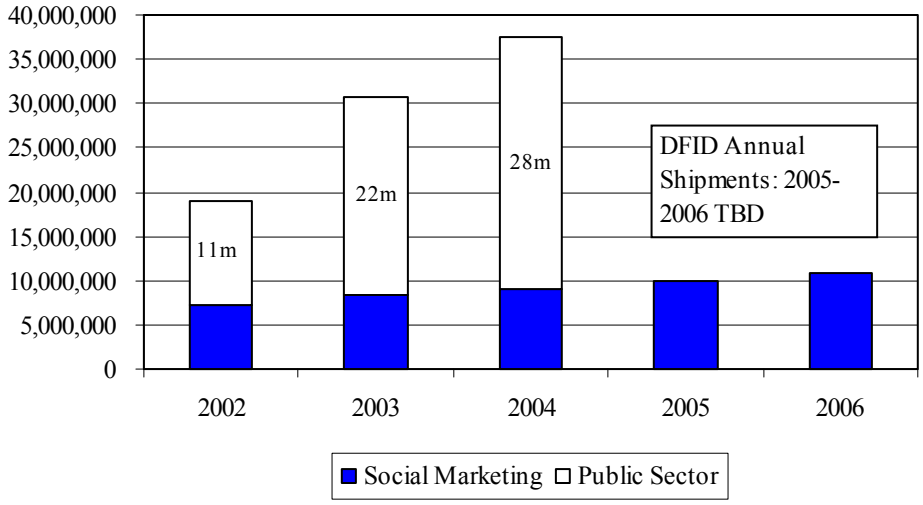
Table 5
Condom Commodities To Be Received by Donors

Donor	2002	2003	2004	2005	2006
USAID	-	11,577,000	10,920,000		9,000,000
KfW	1,901,347	6,912,000	-	-	-
DFID*	11,616,000	20,880,000	28,502,000	Unknown	Unknown
Project Hope*	-	1,350,000	-	-	-
Total	**13,517,347**	**40,719,000**	**39,422,000**	**Unknown**	**9,000,000**

*Public sector

In addition, it appears that there have been relatively large increases in the condom commodities received by the public sector from DFID and Project Hope. As also shown in table 5, the estimated commodity shipments to be received for public sector distribution between 2002 and 2004 represent over 62 million condoms. It will be important to assess whether there is real consumption of the condoms being distributed through public sector facilities. Otherwise, there is an increased possibility of products expiring as well as products leaking to the commercial sector and affecting sales of socially marketed condoms to audiences that can afford to pay for them. An oversupply of public sector condoms will also deter other condom manufacturers/distributors from entering the market.

Figure 8
Total Estimated Condom Universe: Public and Private, 2002–2006



Insecticide-Treated Nets and Retreatment Tablets

The blue ITNs being marketed commercially by PSI are currently provided by UNICEF, and PSI has also begun to procure them directly. If donations for this product will not be supplied after 2004, it is likely that PSI will need to reevaluate its price structure for this product so that it covers 100 percent of product and packaging costs.

Table 6
Blue Nets Received by Donors and Procured by PSI

Source of Nets	2002	2003	2004	2005	2006	2007
PSI Procurement		40,000	62,500	60,000	120,000	120,000
UNICEF	17,603	47,776	50,000			
Other		8,860				
Total	**17,603**	**96,636**	**112,500**	**60,000**	**120,000**	**120,000**

The green nets are primarily being procured by UNICEF (with DFID funding), although PSI indicates that beyond 2005 there is some question as to whether DFID funds will continue to be available for green nets, considering DFID will be contributing to the sectorwide approach. The MOH also estimates that there will be a shortage of 900,000 nets in 2005, based on the fact that it has planned distribution for 2 million nets (even with funding from The Global Fund To Fight AIDS, Tuberculosis and Malaria [Global Fund]).

Table 7
Green Nets Received by Donors

Source of Nets	2002	2003	2004	2005	2006	2007
PSI Procurement			60,000			
UNICEF	286,730	1,162,151	1,077,250			
Global Fund				1,100,000	1,500,000	330,000
JICA			600,000	Unknown	Unknown	Unknown
WHO*	80,000	70,000	65,000	Unknown	Unknown	Unknown
Total	**366,730**	**1,232,151**	**1,802,250**	**1,100,000**	**1,500,000**	**330,000**

*Nets are provided directly to the MOH for direct distribution (not through PSI)

Retreatment tablets are also being procured primarily by UNICEF although PSI plans to begin procuring as well in 2005. It should be clarified if funding beyond 2005 is available for this product as well given PSI's concern about procurement of nets by UNICEF (with DFID funds).

Table 8
Retreatment Tablets Received by Donors and Procured by PSI

Source of Tablets	2002	2003	2004	2005	2006	2007
PSI Procurement				120,000	120,000	30,000
UNICEF	728,086	1,629,320	2,745,000	1,100,000	1,560,000	370,000
JICA			660,000			
Total	**728,086**	**1,629,320**	**3,405.000**	**1,220,000**	**1,680,000**	**400,000**

Oral Rehydration Salts

According to table 8, PSI will require an additional shipment of ORS in 2005, which will require a special waiver by USAID to use AIDSMark funds for ORS commodity purchases. For the next shipment in 2006, PSI plans to make this procurement directly. However, the long-term sustainability of this product needs to be addressed given that international donors are decreasing their donations for this product.

Table 9
Oral Rehydration Salts Received and Planned From Donors

Donor	2002	2003	2004	2005	2006	2007
PSI Procurement		600,000	0		1,800,000	Unknown
USAID	1,200,000	1,800,000	0	1,800,000		Unknown
JICA			0			Unknown
Total	**1,200,000**	**2,400,000**	**0**	**1,800,000**	**1,800,000**	**Unknown**

WaterGuard

In order to launch the product, PSI made the initial procurements for the WaterGuard product. As described earlier, PSI is hopeful that WHO funding will be approved for the procurement of additional supplies and to assist with marketing and promotional support.

Table 10
WaterGuard Received and Planned From Donors

Donor	2002	2003	2004	2005	2006	2007
PSI Procurement	22,962	703,413	700,000		250,000	250,000
WHO				750,000	550,000	
Total	**22,962**	**703,413**	**700,000**	**750,000**	**800,000**	**250,000**

MONITORING AND EVALUATION

The social marketing and behavior change components of the health social marketing initiative have incorporated several important monitoring tools, including a distribution survey, consumer profile surveys, and knowledge, attitude, and practices surveys among secondary youth. The log frames have identified specific indicators for all products except

for ORS and WaterGuard, and it appears that PSI will be able to measure improvements toward these indicators by the end of the project.

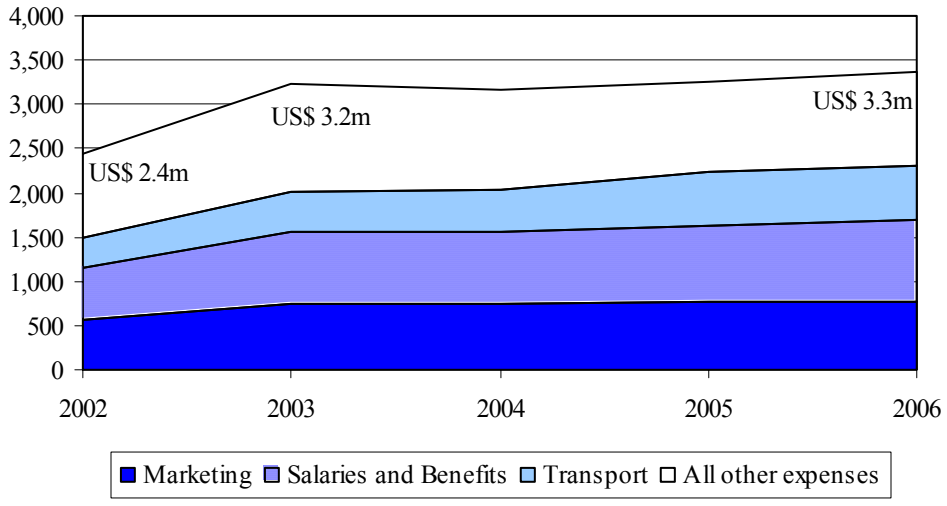
Given the strategic importance of the HIV/AIDS prevention behavioral indicators in USAID's overall framework and the fact that many of the specific activities that are targeted to secondary school youth are relatively new, it is recommended that PSI consider developing some short-term tracking mechanisms similar to operations research that are linked with its school-based activities and listener groups to determine how messages and exposure are contributing to behavior change.

Globally, PSI has also apparently identified the need to update the mechanisms being used to monitor and evaluate project interventions, and it is in the process of developing a number of new interesting research tools to facilitate this process.

FINANCIAL SUMMARY OF THE PROJECT

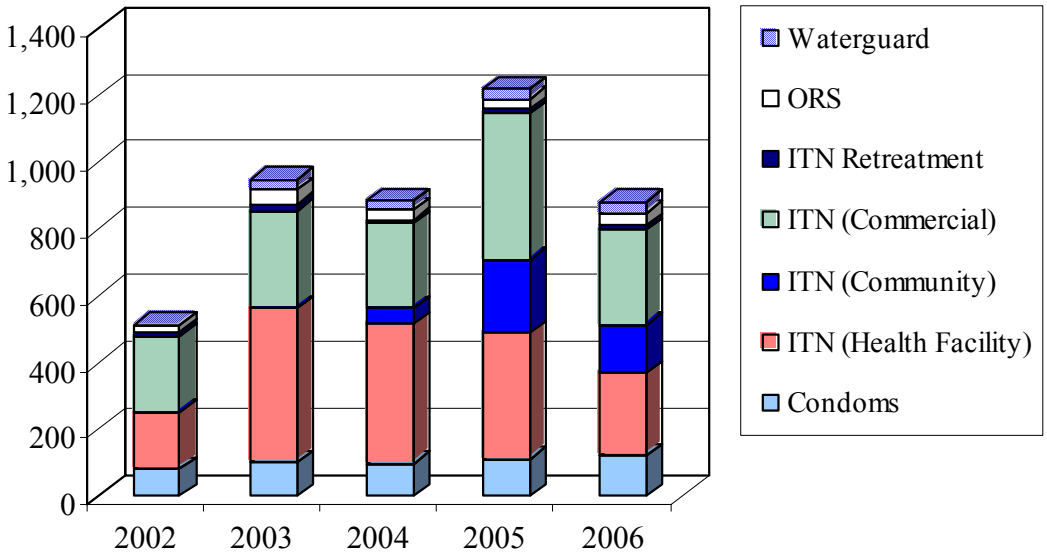
PSI provided an overall financial summary of its social marketing products for the purposes of this evaluation, including sales revenue, cost of goods sold, and overall operating expenses. The complete financial summary is included in appendix D. The summary of operating expenses is included in figure 9, which shows that marketing costs represent approximately 23 percent, salaries are 26 percent, transport (distribution) represents 16 percent, and all other expenses are 34 percent. These expenses appear to be reasonable given the overall requirements of the project and generally match cost breakdowns of similar PSI country programs.

Figure 9
PSI Operational and Marketing Expenses, 2002–2006
(Commodities Excluded)



The financial summary also includes all revenue generated through product sales, which is summarized by year in figure 10 on the following page. Over 34 percent of revenue is related to commercial (blue) net sales, 38 percent to health facility (green) net sales, 9 percent to community (green) net sales, and 11 percent to condom sales.

Figure 10
Revenue Generated Through Product Sales, 2002–2006



MANAGEMENT AND OPERATIONS

In terms of overall management and operations, PSI currently has a large staff within the organization. There are 6 senior managers, 6 product/section managers, 21 staff in the communications department, 19 staff in sales and marketing, 13 in finance, 31 in the vehicle fleet, 27 domestic support staff, 27 working in the warehouse (and 10 temporary packers), 3 in the research department, and 1 fellow/volunteer. Although the team did not meet with all the people that work with PSI, it is clear that they have assembled a team of highly capable and committed individuals. The recruitment process appears to be strong. The senior management team is composed of a group of extremely experienced individuals. Many have prior commercial sector experience, and several senior managers also previously worked in consumer goods marketing and distribution with Unilever—a multinational company that is well known for rigorous training and employee standards.

The large size of the organization has clearly contributed to its ability to respond quickly and effectively to new needs and opportunities that arise within Malawi. PSI has tended to recruit directly for all positions, given the lack of support services previously available in Malawi. The new country director is analyzing the cost-effectiveness of this strategy given the current situation and assessing other opportunities that may exist for subcontracting some services.

OTHER DONOR SUPPORT OF PSI

PSI has put much effort into developing working relationships with a variety of international organizations and donors working in Malawi. Appendix E includes a detailed breakdown of all donor support by year and program area. Overall, the condom social marketing activities are being supported primarily by USAID, with some support from

KfW and JICA. The ITN distribution program is being funded by USAID and UNICEF. The ORS component is exclusively funded by USAID. The WaterGuard component is being jointly funded by PSI's own discretionary funding and WHO. The Youth Alert! program has the largest number of donors, with support from USAID, UNICEF, KfW, and grant funding from the Johns Hopkins University (JHU) through the BRIDGE project. The Soul City work is supported exclusively by Soul City through a regional European Union activity.

While joint funding from multiple donors is clearly complementary to the program's overall goals, there has been some concern expressed over the lack of clarity of how this support is targeted. While each individual donor has knowledge of where the specific funds are being attributed, there is less clarity over where other organizations are putting their monies. PSI's financial management systems are well equipped to track all program funds by donor program. However, it is recommended that PSI make an additional effort to let all partners know how their funding support relates to one another so that there is no confusion or concern over duplication of resources.

COLLABORATION WITH OTHER KEY PARTNERS

PSI has a strong and positive relationship with the National Malaria Control Programme, which is part of the MOH's Preventive Health Division. PSI's planning and logistics support of MOH public health campaigns has been well received. However, the MOH has repeatedly expressed concern about the use of ITN green net revenue and the lack of transparency in some of the project's distribution and logistics costs. PSI will need to address this issue immediately in order to maintain a positive working relationship with the MOH. In addition, discussions with the MOH's Health Education and Reproductive Health Unit indicated little communication and knowledge of PSI's program and objectives.

The National AIDS Commission (NAC) has also acknowledged PSI's work in support of HIV/AIDS and is considering channeling future funding to PSI. PSI's preliminary discussions with the Ministry of Education show promise for extensive future collaboration.

PSI has an agreement with JHU through the BRIDGE project and is currently supporting community mobilization, the development of listener clubs, and teacher facilitator guides in conjunction with Youth Alert! JHU also noted the impressive support of PSI in the recent, highly successful National Youth Congress. FHI's behavioral surveillance survey provides critical data for the validation of PSI's activities. This information has proven useful and additional future collaboration would be beneficial to both parties as well as to the donors. John Snow International's (JSI) DELIVER project shares and receives condom volume information with PSI. World Vision cooperates with PSI on net distribution and Youth Alert! activities to the projects in eight districts. It is also discussing some collaborative activities with the newly formed Faith-Based Organization Unit of PSI, in part because the director of this unit was previously with World Vision for 22 years.

IV. CONCLUSIONS AND RECOMMENDATIONS

The Social Marketing of Health Products Program has grown into a large and successful program that includes a variety of key products that are critical to helping USAID/Malawi meet its health goals. The program also includes key support from other international donors that has served to further strengthen and complement the core component of the original project. The key conclusions and recommendations for each component are summarized below.

CONDOMS

The Chishango condom has had significant success since its relaunch, clearly exceeding its original sales targets and causing PSI to set new targets for condom sales during the life of the project. There is high visibility of the brand and high brand awareness among Malawian consumers. The relaunch of the condom—which generated a significant amount of controversy at the time—has helped to further desensitize the issue of condoms. PSI's strong technical skills in marketing and promotion and BCC as well as the innovative use of nontraditional media are also clear strengths of the project.

Key Recommendations for Further Strengthening the Condom Component

Consider strategies to strengthen distribution among retail outlets. These strategies may include exploring partnerships with other commercial distributors to cover urban and periurban areas, allowing PSI to focus its own sales force on more rural and difficult-to-reach areas. Other strategies may include pilot testing more flexible credit terms for smaller retail outlets. Given that distribution to high-risk outlets has declined in the last two years, special consideration should be made to developing strategies to expand access in these outlets. Special strategies should also be developed to provide access to condoms for young audiences (in addition to Youth Alert! activities). These may include free sampling at PSI mobile video unit showings or developing a system for young men and women to purchase Chishango anonymously.

Reassess the needs of high-risk audiences and how condom social marketing may address their needs. While young men and youth in general are clearly the target for PSI's condom social marketing and HIV/AIDS prevention strategies, it will also be critical to incorporate the needs of high-risk audiences. Given that the results of the first behavioral surveillance survey will be available soon, this research will provide key information concerning additional target audiences that can be addressed through social marketing.

Reassess the degree to which existing generic advertising and BCC interventions are addressing the key behavior indicators included in PSI's log frame. While many of the *knowledge* indicators are currently being addressed with existing messages, it will be important to move ahead during the time remaining in the project to also address the key *behavior* indicators that are included as part of the project's overall objectives.

Incorporate short-term mechanisms for evaluating the effectiveness of BCC interventions. PSI's program includes several long-term evaluation mechanisms for measuring impact. Given the large investment being made in BCC, it will be important for

the project to also look at short-term mechanisms (e.g., operations research or pilot projects) to monitor the effectiveness of interventions and guide future development. PSI is clearly moving in this direction given the organization's development of new research tools. These tools should be applied as quickly as possible in Malawi.

INSECTICIDE–TREATED NETS AND RETREATMENT

PSI has made an important contribution to the MOH's program to increase the distribution of subsidized ITNs nationwide. With the MOH's support, PSI succeeded in a very short period in expanding distribution to the over 420 antenatal clinics. In general, the program has benefited from well-coordinated, multidonor support and an overall commitment to make ITNs widely accessible in Malawi. Given that the program has evolved and advanced rapidly toward the Abuja targets, it will be important for all key stakeholders to work together to identify weaknesses as well as to identify strategies to further strengthen the program.

Recommendations

Develop a coordinated donor strategy to address the short and long-term supply needs for ITNs. Given the transition toward sectorwide approach and the Global Fund, it will be important to avoid future gaps in funding for net procurement. There is uncertainty after 2005 concerning how nets will be supplied so it will be important for all donors to address this issue. In addition, the MOH is projecting a possible shortfall of 900,000 nets for 2005, even with the provision of 1.1 million nets by the Global Fund. It may also be necessary to develop a strategy for targeting nets to those who cannot afford to pay for them, given that there is a high percentage of households reporting that cost is still a barrier.

Determine if PSI's capabilities may be helpful in supporting replication and expansion of village health committee sales. While there have been several districts that have been very successful in replicating distribution and sales of ITNs through village health committees, other districts have had limited success given that some village health committees are weak or inactive. Given PSI's strong skills in distribution, sales, and financial management, it may be able to provide additional technical assistance and/or training in these areas. The MOH may wish to consider how these capabilities can best meet the program's needs and if there is an additional role for PSI to support the MOH.

Clarify objectives of ITN (green net) revenue and donor support of distribution and logistics support. USAID and PSI in collaboration with the various donor agencies supporting the ITN program and the MOH should determine how best to use the green net revenue. In addition, PSI should provide clear, detailed information on the distribution costs associated with each element of the ITN distribution program.

Expand communication initiatives to address other key malaria prevention behaviors, particularly retreatment of nets. While relatively little investment has been necessary to date to support the ITN program given the latent demand for nets, now that net distribution has increased significantly, increased attention should be placed on communication strategies to address other key behaviors (e.g., the need for annual retreatment and proper techniques for retreatment). PSI is also collaborating with the MOH on its annual retreatment campaign.

ORAL REHYDRATION SALTS

The Thanzi product has also had significant sales increases in the last several years. There is an overall high awareness of the product and good availability in retail outlets because it is the second most widely available PSI product after Chishango condoms.

Key Issues To Be Addressed

Identify the source of supply for the next ORS procurement. PSI will need to procure ORS in the near future given that there are no donors that are interested in supplying the product. For the last procurement, PSI received a special waiver from USAID to use AIDSMark funds to procure Thanzi. PSI proposes that a new waiver be sought to procure ORS for its next shipment, which will require reallocating some of the project's current budget.

Establish targets for ORS indicators and focus future marketing and promotional support on these key knowledge and behavior indicators. The key knowledge and behavior indicators will need to be established quickly in order to ensure that the project has sufficient time in the second half of the project to orient marketing and BCC interventions toward achieving them.

Determine sustainability objectives for Thanzi. Given that ORS is a product that is not currently being supplied by any specific donor, PSI and USAID will need to determine the sustainability strategy for Thanzi. If an alternative donor cannot be identified, PSI may need to increase Thanzi's price to a full cost-recovery level to cover future procurements.

WATERGUARD

The WaterGuard product launched by PSI has had strong success in the few years that it has been available in the marketplace. The product has high acceptability among Malawians, high visibility in retail outlets, and strong brand awareness.

Key Issue

Given that PSI has privately funded WaterGuard for the first two years, the key issue is to ***clarify future donor support for procurement and promotion of the WaterGuard product.*** PSI has submitted a proposal to WHO for funding of the WaterGuard product. Although there is strong support for the product within WHO, it is unclear with the recent changes in senior management if the proposal will be funded. If future funding is established, PSI should also develop specific knowledge and behavior indicators for WaterGuard as it has for its other social marketing products.

OTHER KEY PARTNERS AND DONOR SUPPORT

The large majority of organizations that were interviewed regarding their work and collaboration with PSI were very supportive and complementary of the expertise and responsiveness of the organization. PSI was frequently recognized as the foremost social

marketing organization in Malawi and commended for its strong skills in mass media and communications.

Recommendations for Further Strengthening the Program

Strengthen overall communication and coordination with the MOH. Although the Malaria Department within the MOH is especially aware of PSI's activities, other departments are less familiar with PSI activities. It would certainly benefit PSI to improve its coordination and communication with the MOH overall and particularly with the health education and reproductive health units. PSI should explore opportunities for providing assistance to the Health Education Unit to strengthen its IEC capabilities. PSI should also increase coordination with public sector coordinating committees for IEC and examine opportunities to provide technical support to the Health Education Unit.

Develop stronger ties with the Ministry of Education. Within the Ministry of Education, there is a new HIV/AIDS coordinator who is interested in identifying new opportunities and testing new strategies. This would be a great opportunity for PSI to strengthen and expand its ongoing activities with in-school youth as well as to develop strategies to target parents.

Ensure utmost transparency for all donors and international organizations that are funding complementary activities. While PSI's financial and management systems are quite capable of accurately tracking multiple donor programs and expenses, the nature of having programs that are funded by multiple donors can create a lack of clarity and concern over the duplication of resources. PSI should work to establish a system whereby all agencies are aware and comfortable with how their specific funding is being allocated and how it relates to other donor support.

V. FUTURE CONSIDERATIONS

As the program for social marketing of health products evolves, the following issues should be taken into consideration for the future as well as the follow-on project.

Initiate discussions about the future sustainability of the various components of the social marketing project. As mentioned in this report, the blue nets will need to be transitioned to full cost recovery so that PSI can continue to procure nets. The Thanzi product will also need to develop a sustainability strategy given that donor support for ORS is limited. Similar discussions should be initiated for all products in the program so that USAID, PSI, the MOH, and other partners, such as UNICEF and NGOs, are clear about future opportunities and expectations. One strategy is to develop revolving funds for future procurement. In this case, product revenue is deposited in specific revolving-fund accounts to ensure that revenue is protected and available for future procurements. These funds may be used for future procurements, or in conjunction with USAID and other stakeholders, for other purposes.

Determine sourcing alternatives for products that will require future commodity support. For products that will require future commodity support, USAID and PSI should begin discussing alternative sources for these products and approaching donors and international organizations to determine potential partnerships. For other products (e.g., ORS) USAID and PSI may jointly decide that the products should be moved toward 100 percent cost recovery so that future procurements can be funded through product revenue.

Initiate discussions about how to ensure growth in the overall condom market. It is clear that the condom market in Malawi is in the early stages. PSI's efforts are geared toward establishing and building demand for condoms to ultimately entice other condom marketers and develop a sustainable condom market. The launch of the Manyuchi condom (although it is another social marketing brand) will also contribute to further segmenting the condom market. For the long term, however, USAID should also begin considering strategies to ensure overall growth in the condom market and to create a favorable environment so that all brands (rather than a single brand) are benefiting from efforts to stimulate condom use and increase HIV/AIDS prevention behaviors. There is clear potential for additional growth in the commercial condom market. While it will be important for USAID to continue to encourage market expansion, it will be equally important to ensure that a balanced and sustainable market develops (rather than a market dominated by a single brand).

Monitor lessons learned in other HIV/AIDS prevention activities and track investments in HIV/AIDS behavior change interventions. There are huge resources being dedicated to HIV/AIDS prevention interventions worldwide and many groups that are working toward assessing and evaluating the impact of these efforts. PSI benefits from a large global network and extensive experience in HIV/AIDS prevention. It will also be important to examine other agencies and organizations developing progressive, advanced work in this area.

APPENDICES

APPENDIX A

SCOPE OF WORK
(from USAID)

Statement of Work
Population Services International (PSI): Improving Health through Social Marketing
Mid term Project Evaluation

1. Purpose

The purpose of the Statement of Work (SOW) is to identify a contractor that will evaluate the Social Marketing Program of Population Services International (PSI) that has been funded by USAID/Malawi through AIDSMark.

The evaluation will provide basis for the Mission to make decisions on:

- What changes and improvements should be made to PSI's program in order to make it more responsive, effective, efficient and sustainable?
- What plans to put in place after the present social marketing project

2. Background

PSI/Malawi is a non governmental trust registered under the laws of Malawi and an affiliate of PSI based in Washington, USA. With funding from USAID, PSI began the first phase of its condom social marketing program in 1994. The German government financial cooperation (KfW) began co funding of this project in 1995. PSI expanded its services in phase II by adding the social marketing of maternal and child health products, namely insecticide treated nets in 1998, re-treatment kits in 1999 and Oral re-hydration salts in 1999. Through these additions, PSI/Malawi targeted HIV/AIDS, Malaria and Diarrhea which are the three biggest contributors to morbidity and mortality in Malawi.

In March 2002, PSI through AIDSMark requested USAID Malawi to continue supporting and expanding its social marketing and behavior change program in Malawi over the next 5 years. This program has been designed to address specific priority activities under the USAID/Malawi Health Population and Nutrition (HPN) Strategic Objective 8 (SO 8) - increased use of Health behaviors and Services.

The goal of the PSI program is to improve the overall health status of Malawians through social marketing. The objectives are:

- To mitigate the impact of HIV/AIDS by increasing the use of improved, effective and sustainable methods of reducing HIV, especially amongst Malawian youth: through social marketing of Chishango condoms and Youth Alert!

- To increase the adoption and appropriate use of quality child survival products, specifically Insecticide Treated Nets (ITNs) and Oral Rehydration Salts (ORS). To accomplish this, PSI undertakes an integrated strategy of social marketing of the following branded commodities:

- Chitetezo nets,
- Mbwezera Chitetezo Retreatment
- Thanzi ORS.

According to the 2000 Malawi Demographic and Health Survey (MDHS):

- Almost all Malawians have heard of Chishango condoms (PSI's branded condom). However, only 14% of men and 5% of women used a condom during their last sexual encounter. When engaging in sex with a non-cohabiting partner, 29% of women and 39% of men used a condom.
- 13% of households in Malawi own at least one mosquito net.
- 7.6% of children under five used a bed net the night proceeding the interview
- 17.6% of children under five had diarrhea in the 2 weeks proceeding the survey

3. Objectives

The objectives of this evaluation are to:

3.1 Assess the performance of PSI's Social Marketing Program
3.2 Determine the factors that have contributed to this level of performance
3.3 Recommend feasible strategies that could improve PSI/USAID's program.

The evaluation will focus on the following specific objectives:

(i) Assess and analyze the organization's progress towards targets, factors for such performance, benefits/impact of the social marketing strategies, and recommended alternative strategies, if any.

(ii) Assess the organization's financial system and determine how responsive and compliant to USAID financial regulations.

(iii) Assess and analyze the effectiveness and efficiency of the organization's system of distribution and information management of various health products and recommended alternative strategies, if any.

(iv) Determine the effectiveness of the social marketing strategies in inducing behavior change and recommended alternative strategies, if any.

4. Performance **Methodology**

Evaluation design

The evaluation team shall propose and organize the evaluation tools and process. The evaluation design/operational work plan will be presented to the Mission for comments during the Pre-evaluation meeting.

The Evaluation team shall work under the supervision and guidance of the Activity Manager for PSI. The Activity manager for PSI will organize all internal meetings as well as link the evaluation team to other relevant persons within the Mission such as the Activity Managers for HIV/AIDS and Child Survival.

Arrangement of Meetings

The Activity Manager for PSI shall organize the following internal meetings

1) The Pre-evaluation meeting

2) The mid evaluation meeting

3) The debrief meeting at the end of the evaluation.

The evaluation team will be responsible for identifying and organizing any other appointments and meetings that may be required. Where necessary, especially meetings with government officials/facilities, the Activity Manager for PSI and PSI staff may assist in arranging some of these meetings. The Activity Manager may participate in meetings with the government.

Annex 1 provides a detailed list of reports, studies and other documents that the team should review and take into consideration.

Field visits

The program is being implemented across the country. The team shall arrange to visit selected sites in consultation with the Activity Manager for PSI and PSI Country Director. Wherever possible, the evaluation team will be accompanied by a member of staff from either PSI or USAID.

5. Team Composition

The evaluation team will be composed of four experts in the following areas: Health Social Marketing, Financial systems, Behavior Change and Logistics management

5.1 Team Leader/Health Social Marketing Expert

The team leader should have a post graduate qualification in Health or a social science field. He/she should have at least 5 years experience in Health social marketing. Experience in

Health Social Marketing in a developing country is strongly preferred. The Team leader should also have at least 3 years experience in leading evaluation teams.

The Team Leader will provide leadership for the team, finalize the evaluation design, coordinate activities, arrange periodic meetings, consolidate individual input from team members, and coordinate the process of assembling the final findings and recommendations. He/she will also lead the preparation and presentation of the key evaluation findings and recommendations to the USAID/Malawi team and other major partners.

He/she will also take specific responsibility for assessing and analyzing the organization's progress towards targets, factors for such performance, benefits/impact of the social marketing strategies, and compare with other possible options. He/she will also suggest ways of improving the present performance

5.2 Financial analyst

The Financial Analyst should have a post graduate degree in Financial Management and have at least 4 years experience in conducting evaluations of health programs. Experience of having worked within a Health social marketing organization in a developing country is strongly preferred.

The Financial Analyst will focus on assessing the organization's financial system and determine how responsive and compliant the systems are to their various funding organizations. In addition, this person will also analyze the organization's financial audits recommendations, financial records including overhead costs. He/she will also suggest ways of improving the present performance.

5.3 Logistics management expert

The expert should have a post graduate degree in any logistics related field. He/she should have at least 4 years experience in logistics management of health products and 2 years experience as a member of an evaluation team. Experience of having worked within or evaluated a health social marketing organization is strongly preferred.

The Logistics Management expert will focus on assessing and analyzing the effectiveness and efficiency of the organization's system of distribution and information management of various health products and compare with other possible options of achieving the same goal. He/she will also suggest ways of improving the present performance.

5.4 Behavior change expert

The expert should have a post graduate degree in behavioral sciences. He/she should have at least 4 years experience working in a behavior change environment and 2 years as a member of an evaluation team. Experience of having worked within or evaluated a health social marketing organization is strongly preferred.

The behavior change expert in collaboration with the evaluation team leader will determine the effectiveness of the social marketing strategies in inducing behavior change. He/she will also determine some of the benefits, outcomes and impact of PSI's program approach and suggest ways of improving the present performance

6. Logistics

A six day workweek is authorized. Local holidays are not authorized. The evaluation team will be responsible for all off shore and in country logistical support. This includes arranging and scheduling meetings, international and in country travel (including vehicle rentals), hotel bookings, working/office space, computers, printing, photocopying. A local administrative assistant/secretary may be hired to arrange field visits, local travel, hotel and appointments with stakeholders.

7. Deliverables

The contractor deliverables shall include:

7.1 A written methodology plan (Evaluation design/ operational work plan) during the Pre-evaluation meeting (first/second day of arrival)

7.2 A draft report outline with possible issues for discussion during the mid-evaluation meeting (within 2 weeks of the evaluation)

7.3 A draft report for presentation during the debrief meeting that will be held a day before departure (using the report format provided below)

7.4 A final report a month after the debrief meeting (5 hard copies and a CD rom)

The Final Report shall include:

1. Executive summary, concisely summarizing critical elements of the main report
2. Table of contents
3. Introduction, describing the purpose and objectives of the evaluation
4. Background of the project
5. Findings

6. conclusions and lessons learnt
7. Recommendations for improving PSI's project
8. Recommendations for the future
9. Other information relevant to the evaluation but not necessarily central to it may be included in annex

The report shall not be more than 30 pages, excluding the annexes.

After the debrief meeting, the evaluation team shall incorporate comments received from USAID and stakeholders. Within 2 weeks, the evaluation team leader will send the report to the Mission for final comments.

Within 2 weeks of receiving the final comments from the Mission, the Evaluation Team, through the team leader, shall send the final report: 5 hard copies and a CD rom in Microsoft Word

8. Period of Performance

The in-country evaluation shall be conducted within four weeks; August 16, 2004 to September 16, 2004. The Final Report shall be submitted by Oct. 2004.

9. Illustrative Budget and Estimated Level of Effort (LOE).

The Evaluation Team shall submit a proposed budget indicating salaries, international travel, in country expenses, report printing and binding and miscellaneous direct costs as illustrated in Annex 2.

The budget shall be based on the following estimated level of effort (LOE):

9.1 Team Leader/SM Expert: 3 days of LOE in prep work offshore, 4 days of international travel, 28 days of LOE in the field and 6 days of LOE in finalizing report (Total of 41 LOE)

9.2 Behavior change expert: 2 days of LOE in prep work offshore, 4 days of international travel, 28 days of LOE in the field, and 2 days for report writing (Total of 36 LOE)

9.3 Logistics management expert: 2 days of LOE in prep work offshore, 4 days international travel, 28 days of LOE in the field, and 2 days for report writing (Total of 36 LOE)

9.4 Financial Analyst: 2 day of LOE in prep work off shore, 4 days international travel, 28 days of LOE in the field, and 2 days for report writing (Total of 36 LOE)

Annex 1: Selected list of documents for review

1. PSI's Social marketing proposal
2. CSP 2000-2005
3. Strategic Objective agreement
4. HIV/AIDS strategy
5. MOHP SWAP and JIP
6. National HIV/AIDS strategic framework
7. PSI's quarterly reports
8. PSI Annual reports
9. USAID PMP
10. Condom sale point profile
11. KAP studies on Youth
12. PSI KFW Evaluation reports
13. 2000 DHS
14. PSI Audit report

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

U.S. Agency for International Development/Malawi
Mexon Nyirongo, Health, Population, and Nutrition Team Leader
Cheri Kamin, Health, Population, and Nutrition Deputy Team Leader
Elise Jensen, Senior HIV/AIDS Advisor
Patricia Mengech, Africa Regional Specialist, USAID/Washington

U.S. Centers For Disease Control and Prevention (CDC)
Carl Campbell, Director
Nyson Chizani, Technical Officer

Malawi Ministry of Health and Population (MOH)
Habib Somanje, Director of Preventive Health Services, Ministry Headquarters
Storn Kabuluzi, Officer-In-Charge, Community Health Sciences Unit
Neema Kandoole, Head of Epidemiology Unit, Community Health Sciences Unit
Beth Deutsch, Behavior Change Initiative Technical Officer, Health Education Unit
John Zoya, Insecticide-Treated Nets (ITN) Project Manager
Len van der Hoeven, Sexually Transmitted Disease (STD) Technical Officer, Sexual and Reproductive Health Program
Julius Malewezi, Sexually Transmitted Infection (STI) Management Officer

Population Services International (PSI)
John Justino, Resident Director
Jones A. Katangwe, Deputy Director
Samuel McKeen Connor, Director of Communications
Sarah Gibson, Youth Alert! Coordinator
Charles Yuma, ITN Product Manager
Wanangwa Thindwa, Commercial Sales Manager
Erasmus Chirambo, National Sales Manager
Enock Phiri, Faith-Based Organizations Coordinator
Janet Jere, Faith-Based Organizations Staffer
Alfred D.N. Zulu, Personnel and Administration Manager

Ministry of Education
Robert Ngaiyaye, HIV/AIDS Education Technical Advisor

National AIDS Commission (NAC)
Bridget Chibwana, Head, Behavior Change Interventions
Robert Chisemba, Project Officer
Maria Mukwada, Community Response Coordinator

Department for International Development (DFID), United Kingdom
Anna De Cleene, Senior HIV/AIDS Advisor
Jean Msosa-Maganga, Program Assistant, Health

DONOR PARTNERS

Japan International Cooperation Agency (JICA)
Tatsuya Murase, Deputy Resident Representative
Evans Kachele, Aid Coordinator

United Nations Children's Fund (UNICEF)
Ketema Bizumeh, Project Officer, Malaria Control
Joyce Mphaya, Assistant Project Officer for Youth, Reproduction and Health
Belinda Abraham, Project Officer, School Sanitation and Hygiene Promotion

United Nations Population Fund (UNFPA)
Sjaak Baelaar, Acting UNFPA Representative
Ellen Thom, Voluntary Counseling and Testing Project Coordinator

World Health Organization (WHO)
Bill Aldis, Director
Winson Bomba, Health Information and Promotion Manager
Wilfred Dodoli, Malariaologist

The Global Fund To Fight AIDS, Tuberculosis and Malaria (Global Fund)
Kevin Carpenter, Coordinator

IMPLEMENTING PARTNERS

Management Sciences for Health (MSH)
Allan F. Macheso, Malaria Specialist
Enock Kajawo, HIV/AIDS Specialist
Rudi Thetard, Quality Assurance Specialist

Family Health International
Margaret Kaseje, Country Director
McPherson Gondwe, Senior Home-Based Care Officer
Ellita Chatipwa, SeniorOrphans and Vulnerable Children Officer

Malawi BRIDGE Project
Kirsten P. Bose, Chief of Party
Glory H. Mkandawire, Behavior Change Intervention Coordinator

Africare
Grace Kamba, Youth Empowerment and Support (YES) Program Manager

DELIVER Project, John Snow, Inc.
Veronica Chipeta, Logistics Associate

World Vision
Ethel Kapyepye, National HIV/AIDS Co-coordinator
Regina K. Mandere, Health and Nutrition Manager

Banja La Mtsogolo
Andrew Chikopa, Marketing Manager

FIELD VISITS

Blantyre
Atupele Kapito-Tembo, District Health Officer
Nyokasse Kamila, District Malaria Coordinator

Mulanje
Neffily Matupa, Nurse, Chonde Health Center
Mr. Semba, Deputy District Health Officer, Mulanje District Hospital
Mr. Sande, Malaria Coordinator, Mulanje District Hospital
Mr. Mwalilino, McCollell Wholesale, Mulanje District
Mrs. Khumbanyiwa, Kusadziwa ndi kufa komwe Grocery, Mloza
Mr. Mombezi, Uncle Charlie Chibuku Bar
Mr. Chilingulo, Shop Manager, Peoples Trading Center Superette

Salima
Salima District Hospital
Charles Mangani, District Health Officer
Mr. Mitochi, District Environmental Health Officer
P. Mwamlima, HIV/AIDS Coordinator
C. Kasawala, Matron

Zomba
Prince Bandawe, Skinner Grocery Shop and Bottle Store
Symon Thamangiwa, Lake Road Filling Station
Wezzie Gondwe, Chirani Pharmacy
Kumbukirani Wholesaler
Rizwani Wholesaler
Rose Wane, Nurse Midwife, Namikango Maternity Clinic, Christian Health Association of Malawi Facility
Fully Chigwenembe, Nurse Midwife, Mbulumbuzi Health Center, Chiradzulu

APPENDIX C

WORK PLAN FOR THE EVALUATION OF THE PSI SOCIAL MARKETING PROJECT

WORK PLAN FOR THE EVALUATION OF THE PSI SOCIAL MARKETING PROJECT

	August															September											Deliverables to USAID
	16	17	18	19	20	21		23	24	25	26	27	28		30	31	1	2	3	4		6	7	8	9	10	11	
Phase 1: Background and Introduction																												
Activities																												Evaluation Work Plan and Time Line
Team Briefing Meeting																												
Logistics Planning for Evaluation																												
Submit Draft Work Plan for Evaluation	**D**																											
Conduct Introductory Meetings, USAID, MOH, PSI																												
Phase 2: Conduct Field Work and Key Informant Visits																												
Activities																												Draft Outline of Report
Interviews with Lilongwe Key Informants																												
Attend Youth Alert! KAP Presentation																												
Visit Youth Alert! Secondary School Presentation																												
Team Work Session (reviewing new documents; discuss preliminary findings)																												
Continue Interviews with Key Stakeholders																												
Team Travel to Blantyre																												
Develop Draft Outline																												
Submit Draft Outline															**D**													
Follow-up Interviews and Final Data Collection																												
Phase 3: Synthesize Results, Identify Recommendations, Produce Report																												
Activities																												Draft Report by September 24
Team Working Meetings																												
Write Draft Report																												
Prepare Debriefing Presentation																												
Debriefing																											**D**	
Finalize Report and Incorporate Comments by USAID																												

Note: Bold "D" indicates a deliverable due date.

APPENDIX D

PSI FINANCIAL SUMMARY STATEMENT, 2002–2007

PSI FINANCIAL SUMMARY STATEMENT, 2002–2007

(Figures shown in 000; currency is in US$)

Category	Actual		Current Year 2004			Projected			Combined Total
	2002	2003	Actual 2004	Projected 2004	Combined 2004	2005	2006	2007	
Quantity Sales (Units)	April to Dec.	Jan. to Dec.	Jan. to June	July to Dec.	Jan. to Dec.	Jan. to Dec.	Jan. to Dec.	Jan. to March	
Condom (unpackaged single condom)	0	0	0	0	0	0	0	0	0
Condom (packaged condom)	6,275	8,414	4,377	4,623	9,000	9,900	10,890	3,000	47,479
ITN (health facility)	240	776	464	414	878	1,050	686	224	3,854
ITN (community level)	39	207	157	62	219	300	196	64	1,024
ITN (commercial sector)	58	87	60	30	90	150	98	32	515
ITN Retreatment Tablet	62	102	41	36	77	84	93	25	442
Oral Rehydration Salts (ORS)	508	1,583	720	480	1,200	1,320	1,452	400	6,463
WaterGuard	10	647	221	479	700	770	850	250	3,227
Total	**7,191**	**11,815**	**6,039**	**6,124**	**12,163**	**13,574**	**14,265**	**3,995**	**63,003**
Revenue									
Condom (unpackaged single condom)	0	0	0	0	0	0	0	0	0
Condom (packaged condom)	$82	$99	$45	$52	$97	$111	$122	$34	$544
Total Condom Revenue	**$82**	**$99**	**$45**	**$52**	**$97**	**$111**	**$122**	**$34**	**$544**
ITN (health facility+community)	$170	$466	$271	$0	$271	0	0	0	$907
ITN (health facility)	0	0	0	$149	$149	$378	$247	$81	$855
ITN (community level)	0	0	0	$45	$45	$219	$143	$47	$454
ITN (commercial sector)	$228	$290	$166	$87	$254	$437	$285	$93	$1,586
ITN Retreatment Tablet	$12	$21	$7	$6	$12	$13	$15	$4	$77
Total ITN Revenue	**$410**	**$776**	**$444**	**$287**	**$731**	**$1,047**	**$690**	**$224**	**$3,878**
ORS	$21	$43	$17	$12	$29	$32	$35	$10	$168
Total ORS Revenue	**$21**	**$43**	**$17**	**$12**	**$29**	**$32**	**$35**	**$10**	**$168**
WaterGuard	$1	$31	$8	$18	$26	$30	$33	$10	$130
Total WaterGuard Revenue	**$1**	**$31**	**$8**	**$18**	**$26**	**$30**	**$33**	**$10**	**$130**
Interest	**$6**	**$7**	**$3**	**$3**	**$7**	**$7**	**$7**	**$2**	**$35**
Total Revenue	**$519**	**$955**	**$517**	**$372**	**$890**	**$1,226**	**$887**	**$279**	**$4,755**

(Table continued on next page)

Category	Actual		Current Year 2004			Projected			Combined Total
	2002	2003	Actual 2004	Projected 2004	Combined 2004	2005	2006	2007	
Cost of Goods Sold*									
Condom (unpackaged single condom)	0	0	0	0	0	0	0	0	0
Condom (packaged condom)	$314	$337	$175	$185	$360	$396	$436	$120	$1,962
ITN (health facility)	$422	$1,365	$817	$729	$1,546	$1,848	$1,207	$394	$6,783
ITN (community level)	$68	$364	$276	$109	$385	$528	$345	$113	$1,803
ITN (commercial sector)	$211	$309	$211	$106	$316	$530	$346	$113	$1,825
ITN Retreatment Tablet	$48	$67	$27	$24	$50	$55	$61	$17	$299
ORS	$71	$95	$43	$29	$72	$79	$87	$24	$428
WaterGuard	$0	$26	$9	$19	$28	$31	$34	$10	$129
Total Commodity Costs for PSI**	**$227**	**$512**	**$312**	**$240**	**$552**	**$693**	**$503**	**$158**	**$2,646**
GROSS MARGIN	**$292**	**$443**	**$206**	**$132**	**$338**	**$533**	**$383**	**$121**	**$2,110**
Expenses									
Marketing	$572	$748	$266	$470	$736	$760	$773	$193	$3,781
Salaries and Benefits	$581	$806	$393	$438	$831	$878	$921	$230	$4,247
Transport	$341	$453	$298	$162	$460	$602	$615	$154	$2,625
All Other Expenses	$950	$1,218	$594	$542	$1,136	$1,008	$1,058	$265	$5,634
Total Expenses***	**$2,444**	**$3,224**	**$1,550**	**$1,612**	**$3,162**	**$3,249**	**$3,367**	**$842**	**$16,287**
Net Profit/Loss Before Taxes	**($2,152)**	**($2,781)**	**($1,345)**	**($1,480)**	**($2,824)**	**($2,716)**	**($2,984)**	**($721)**	**($14,179)**
Taxes	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Profit/Loss After Taxes	**($2,152)**	**($2,781)**	**($1,345)**	**($1,480)**	**($2,824)**	**($2,716)**	**($2,984)**	**($721)**	**($14,307)**
TOTAL USAID Subsidy per Year	**$1,826**	**$1,753**	**$1,079**	**$1,100**	**$2,179**	**$2,552**	**$2,552**	**$639**	**$11,500**
TOTAL KfW Subsidy per Year	**$464**	**$831**	**$166**	**$246**	**$412**	**$491**	**$368**	**0**	**$2,566**
Total WHO Subsidy per Year	**0**	**0**	**0**	**0**	**0**	**$238**	**$22**	**0**	**$260**
Total UNICEF Subsidy per Year	**$272**	**$237**	**$51**	**$71**	**$122**	**$71**	**0**	**0**	**$702**
Johns Hopkins Grant (Youth Alert!)	**0**	**0**	**0**	**0**	**$104**	**$95**	**0**	**0**	**$199**
Total Donor Subsidy	**$2,561**	**$2,821**	**$1,296**	**$1,417**	**$2,817**	**$3,447**	**$2,942**	**$639**	**$15,227**
Percentage Cost Recovery	**19%**	**26%**	**28%**	**20%**	**24%**	**31%**	**23%**	**28%**	**24%**

Note: Totals may vary slightly due to rounding. Shaded cells are partial year figures and are not used in totals.

*Commodity costs represented in this section are total commodity costs for the project, including donor contributions.

**For the purpose of this analysis, PSI's commodity costs (figures shown) reflect only 20 percent of actual, total commodity costs. This is the amount estimated to be covered by PSI through product revenues.

***Soul City expenses not included. Schedule of donor funding of PSI activities provided in donor financing summary, appendix E.

APPENDIX E

DONOR FINANCING OF PSI ACTIVITIES RELATED TO HIV/AIDS, MALARIA, AND DIARRHEA MANAGEMENT

DONOR FINANCING OF PSI ACTIVITIES RELATED TO HIV/AIDS, MALARIA, AND DIARRHEA MANAGEMENT

(Figures shown in US$ 000)

PSI Activities	Actual		Current Year 2004			Projected			COMBINED TOTAL
			Actual	Projected	Combined				
Condom Social Marketing	**April to Dec. 2002**	**Jan. to Dec. 2003**	**Jan. to June 2004**	**July to Dec. 2004**	**Jan. to Dec. 2004**	**Jan. to Dec. 2005**	**Jan. to Dec. 2006**	**Jan. to March 2007**	
USAID	$1,323	$1,332	$864	$557	$1,421	$1,340	$1,395	$350	$7,161
UNICEF	$0	$0	$0	$0	$0	$0	$0	$0	$0
KfW	$464	$831	$166	$246	$412	$491	$368	$0	$2,567
JICA	$40	$108	$0	$0	$0	$0	$0	$0	$148
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0
PSI Private Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	**$1,827**	**$2,272**	**$1,030**	**$802**	**$1,832**	**$1,831**	**$1,764**	**$350**	**$9,876**

ITNs and Retreatment	April to Dec. 2002	Jan. to Dec. 2003	Jan. to June 2004	July to Dec. 2004	Combined 2004	Jan. to Dec. 2005	Jan. to Dec. 2006	Jan. to March 2007	TOTAL
USAID*	$365	**($125)**	$12	$353	$365	$752	$752	$188	$2,297
UNICEF/ITN Revenue	$0	$243	$0	$0	$0	$0	$0	$0	$243
KfW	$0	$0	$0	$0	$0	$0	$0	$0	$0
JICA	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0
PSI Private Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	**$365**	**$118**	**$12**	**$353**	**$365**	**$752**	**$752**	**$188**	**$2,540**

Oral Rehydration Salts	April to Dec. 2002	Jan. to Dec. 2003	Jan. to June 2004	July to Dec. 2004	Combined 2004	Jan. to Dec. 2005	Jan. to Dec. 2006	Jan. to March 2007	TOTAL
USAID	$71	$294	$90	$77	$167	$234	$179	$45	$989
UNICEF	$0	$0	$0	$0	$0	$0	$0	$0	$0
KfW	$0	$0	$0	$0	$0	$0	$0	$0	$0
JICA	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0
PSI Private Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	**$71**	**$294**	**$90**	**$77**	**$167**	**$234**	**$179**	**$45**	**$989**

WaterGuard	April to Dec. 2002	Jan. to Dec. 2003	Jan. to June 2004	July to Dec. 2004	Combined 2004	Jan. to Dec. 2005	Jan. to Dec. 2006	Jan. to March 2007	TOTAL
USAID	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNICEF	$0	$0	$0	$0	$0	$0	$0	$0	$0
KfW	$0	$0	$0	$0	$0	$0	$0	$0	$0
JICA	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other (WHO)	$0	$40	$0	$0	$0	$238	$22	$0	$300
PSI Private Funding	$134	$177	$7	$180	$187	$94	$10	$10	$612
TOTAL	**$134**	**$217**	**$7**	**$180**	**$187**	**$332**	**$32**	**$10**	**$912**

Youth Alert!	April to Dec. 2002	Jan. to Dec. 2003	Jan. to June 2004	July to Dec. 2004	Combined 2004	Jan. to Dec. 2005	Jan. to Dec. 2006	Jan. to March 2007	TOTAL
USAID	$66	$253	$112	$113	$226	$226	$226	$57	$1,054
UNICEF	$29	$237	$51	$71	$122	$71	$0	$0	$459
KfW	$0	$0	$0	$89	$89	$179	$134	$0	$402
JICA	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other (JHU)	$0	$0	$9	$95	$104	$95	$0	$0	$199
PSI Private Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	**$94**	**$490**	**$173**	**$369**	**$542**	**$571**	**$360**	**$57**	**$2,114**

Soul City	April to Dec. 2002	Jan. to Dec. 2003	Jan. to June 2004	July to Dec. 2004	Combined 2004	Jan. to Dec. 2005	Jan. to Dec. 2006	Jan. to March 2007	TOTAL
USAID	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNICEF	$0	$0	$0	$0	$0	$0	$0	$0	$0
KfW	$0	$0	$0	$0	$0	$0	$0	$0	$0
JICA	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other (Soul City)	$44	$167	$265	$254	$519	$750	$750	$190	$2,420
PSI Private Funding	$0	$0	$0	$0	$0	$0	$0	$0	$0
TOTAL	**$44**	**$167**	**$265**	**$254**	**$519**	**$750**	**$750**	**$190**	**$2,420**

GRAND TOTALS	**$2,536**	**$3,557**	**$1,576**	**$2,035**	**$3,612**	**$4,470**	**$3,836**	**$839**	**$18,851**
Breakdown of Totals:									
USAID	**$1,826**	**$1,753**	**$1,079**	**$1,100**	**$2,179**	**$2,552**	**$2,552**	**$639**	**$11,500**
Other Funding Sources	**$711**	**$1,804**	**$498**	**$935**	**$1,433**	**$1,918**	**$1,284**	**$200**	**$7,350**

Note: Totals may vary slightly due to rounding. Shaded cells are partial year figures and are not used in totals.

* Negative $125,000 expense in 2003 is due to reallocation of ITN expenses to net program income (revenue). From July 2005 to March 2007, there will be a need to discuss use of USAID ITN funds.

APPENDIX F

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