

# **ITN National Social Marketing Project in Cameroon**

## **Midterm Evaluation Report**

**Name of PVO:** Population Services International

**Program Location:** East, South and Center Provinces of Cameroon

**Cooperative Agreement No:** HFP-A-00-02-00043-00

**Program Dates:** October 1<sup>st</sup>, 2002- September 30<sup>th</sup>, 2005

**Date of MTE Submission:** October 29<sup>th</sup>, 2004

**MTE writers and editors:**

Alan Handyside, Team leader and external consultant

Dr. Leonard Mbam-Mbam, Health Advisor, World Health Organization

Dr. Emmanuel Forlack, East Province Coordinator, PNL

Shannon Bledsoe, Associate Director for Family Health, PSI/ACMS

Theresa Gruber-Tapsoba, Country Representative, PSI/ACMS

Mary Warsh, WCA Senior Associate Program Manager, PSI

Melissa Merten, Child Survival Program Manager, PSI

## **TABLE OF CONTENTS**

<b>TABLE OF ACRONYMS</b>	<b>4</b>
<b><u>MIDTERM EVALUATION</u></b>	
<b>1. EXECUTIVE SUMMMARY</b>	<b>5</b>
<b>RECOMMENDATIONS</b>	<b>9</b>
<b>2. ASSESSMENT OF PROGRESS</b>	<b>11</b>
<b>2.1. Background</b>	<b>11</b>
<b>2.2. Program Objectives</b>	<b>12</b>
<b>2.3. Program Strategy</b>	<b>12</b>
<b>2.4. Research and DIP Modification</b>	<b>13</b>
<b>2.5. Implementation of Program</b>	<b>13</b>
<b>2.5.1 Media and Promotion Materials</b>	<b>14</b>
<b>2.5.2 Training and NGO Collaboration</b>	<b>15</b>
<b>2.5.3 Public Sector</b>	<b>16</b>
<b>2.5.4 National Malaria Control Program</b>	<b>17</b>
<b>2.6. Sales &amp; Distribution</b>	<b>18</b>
<b>2.6.1 ACMS Sales</b>	<b>18</b>
<b>2.6.2 ACMS Distribution</b>	<b>19</b>
<b>2.6.3 Public Sector Issue of Nets</b>	<b>19</b>
<b>2.6.4 Abuja Net Targets</b>	<b>20</b>
<b>2.7 Comparison with Other Countries</b>	<b>21</b>
<b>2.8 Pricing</b>	<b>21</b>
<b>3. MEASURABLE INDICATORS</b>	<b>23</b>
<b>4. BUDGET SPEND</b>	<b>27</b>
<b>5. CROSS CUTTING ISSUES</b>	<b>28</b>
<b>5.1. Community Mobilization</b>	<b>28</b>
<b>5.2. Communications for Behaviour Change</b>	<b>28</b>
<b>5.3. Capacity Building</b>	<b>28</b>
<b>5.3.1 PVO Strengthening</b>	<b>28</b>
<b>5.3.2 Local Partner Strengthening</b>	<b>29</b>
<b>5.3.3 Sustainability</b>	<b>29</b>
<b>6. PROGRAM MANAGEMENT</b>	<b>31</b>
<b>7. CONCLUSIONS</b>	<b>32</b>
<b>8. EVALUATION ANNEXES</b>	<b>33</b>
<b>9. REQUIRED ATTACHMENTS</b>	<b>45</b>

<b><u>PVO RESPONSE</u></b>	<b>57</b>
<b>1. PVO COMMENTS and ACTION PLAN</b>	<b>58</b>
<b>2. WORKPLAN</b>	<b>61</b>
<b>3. ANNUAL BUDGET and FORM 424a</b>	<b>64</b>

## **TABLE OF ACRONYMS**

ACMS	Association Camerounaise pour le Marketing Social
ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immunodeficiency Syndrome
BCC	Behavior Change Communications
CBD	Community Based Distribution
CBO	Community Based Organisation
CR	Country Representative
CS	Child Survival
CSGP	Child Survival Grants Program
DHS	Demographic Health Survey
DIP	Detailed Implementation Plan
EPC	Eglise Presbyterien du Cameroon
EOP	End of Project
FEMEC	Federation des Eglises et Missions Evangeliques du Cameroon
FGD	Focus Group Discussion
GOC	Government of Cameroon
HA	Health Animators
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IR	Intermediate Results
IPC	Interpersonal Communication
ITN	Insecticide Treated Net
KAP	Knowledge, Attitudes, Practices
LLN	Long lasting Nets
LQAS	Lot Quality Assurance Survey
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MIS	Management Information Systems
MOH	Ministry of Health
NGO	Non-Governmental Organization
PLAN	Plan International - Cameroon
PMSC	Programme de Marketing Social au Cameroon
PNLP	National Malaria Control Program
POS	Point of Sale
PRISSM	Promoting Improvements in Sustainable Social Marketing
PSI/W	Population Services International –Washington
PVO	Private Voluntary Organization
RBM	Roll Back Malaria
SCS	Service Catholique de la Sante
SOW	Scope of Work
UIC	Community net treatment centre
UNICEF	United Nations Childrens Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
WRA	Women of Reproductive Age

## **MIDTERM EVALUATION**

### **1. EXECUTIVE SUMMARY**

Malaria has been a major problem for many years in Cameroon and is endemic in most of the country. Malaria is the leading cause of mortality with a reported 2 million cases annually. The disease particularly affects those vulnerable groups such as the 850,000 women who are pregnant each year and the 2.6 million children under five years of age.

USAID/GH/HIDN/NUT/CSHGP has provided funding to the value of \$1,299,937 over a period of 3 years commencing October 1<sup>st</sup> 2002. This funding is to be matched by funds from PSI to the value of \$650,000.

As part of this program, a mid-term evaluation has been carried out in Cameroon by a three man team between 27<sup>th</sup> August and 12<sup>th</sup> September 2004<sup>1</sup>.

### **PROJECT GOALS AND IMPLEMENTATION**

The goal of the project is to reduce the incidence of malaria related mortality and morbidity in pregnant women and children under five years of age in three provinces of Cameroon, namely East, Centre and the South.

The objectives of the program are to increase informed demand for ITNs and net treatment and convince the families already owning bednets that the most important people to sleep under nets are pregnant women and small children; to increase equitable access to ITNs and net treatment; and to increase capacity to sustain ITN programming in Cameroon and that of PSI to achieve health impact through MCH interventions.

A KAP study conducted in 2001, showed that bednet ownership was small and mainly in urban areas. Only a small number of people knew that it is important that young children and pregnant women should use nets as protection from malaria. Knowledge of ITNs was small and very few people knew where to obtain one. There was limited knowledge about their value in protecting from mosquitoes. Accurate understanding of malaria transmission was low, particularly in rural areas.

The Performance Indicators in the DIP were mostly unchanged from the PSI proposal, and agreed by USAID/GH/HIDN/NUT/CSHGP in June 2003.

### **FINDINGS**

ACMS works well with the National Malaria Control Program (PNLP) at a central level, and also at a local level in each of the 3 project provinces (Centre, East and South). ACMS also works with selected NGOs who provide access to the rural communities through their personnel trained by ACSM as CBD agents. ACMS itself sells and

---

<sup>1</sup> Alan Handyside, an independent consultant and team leader, Dr. Emmanuel Forlack, East Provincial PNLN Coordinator, Dr Leonard Mbam-Mbam, Health Advisor of WHO.

distributes nets and re-treatment kits to the commercial sector in urban and peri-urban areas. This is now being extended to more rural outlets.

The communications strategy to date has been to use mass media, drama and IPC with a local troupe (caravan), and interpersonal communications (IPC) via NGO peer educators, including those of ACMS. Initial communications have been mostly generic, but branded advertising has now commenced.

To date, eight radio spots have been produced, these being three generic spots in French and equivalent translations into local dialect, and two branded musical spots. By August 2004, 1,440 generic spots and 360 branded spots for Super Moustiquaire, the bundled net, have been aired. ACMS plans to air 840 radio spots for Super Moustiquaire and Bloc re-treatment kits between October 2004 and February 2005, along with 72 TV spots on the two branded products.

Three different billboard posters have been generated, covering malaria transmission, vulnerable populations (pregnant women and under-fives), and re-treatment. These are very visible in all of the three target provinces, with 300 sites using double-faced posters.

A local theatre troupe (caravan) has been trained and has been giving performances to NGOs, women's groups, religious organizations and local societies, as well as marketplace IPC. Different types of presentation have been developed, focusing on the relatively low cost and high value of ITNs in comparison with conventional malaria treatment, demonstrations on how to treat and re-treat ITNs, and their value in preventing malaria.

To date some 52 NGOs have become involved with the ACMS program, most receiving training and materials and many purchasing product for onward sale in their communities. Representation among NGO partners has been achieved in all three target provinces.

## SALES AND DISTRIBUTION

ACMS commenced selling Super Moustiquaire into the commercial trade in March 2004. In the six months to end August, 35,333 ITNs have been sold across all of the three target provinces, and the objective is to reach 72,000 by end 2004. Although no volume target was part of the DIP, the PSI proposal suggested that 200,000 ITNs would be sold by EOP.

The launch of Bloc treatment kit as a stand-alone product did not commence until August 2004. Sales in this month amounted to 940 units. It is believed there will be an increased demand for re-treatment kits for the remainder of the project.

Distribution of Super Moustiquaire is good in all of the three target provinces with 205 regular points of sale have been negotiated directly by ACMS sales people. There are a greater number of stockists in total since ACMS promoters sell stock from appointed wholesalers to other retailers.

Most of the distribution points are new ones to ACMS. Typically they are clothing shops, some toiletry stores and those outlets dedicated to selling baby products and

household goods. As yet only a few pharmacies stock ACMS ITNs and kits, but the project plans to expand its sale to pharmacies by the end of 2004.

One of the limitations to the ACMS program to date has been shortage of readily available stock. The initial injection of funding from PSI/W of \$150,000 has proved insufficient to create a viable revolving fund for continuous availability of commodities. A request for additional funds from PSI/W is being prepared, and this will greatly improve ACMS' capacity to expand sales.

## NATIONAL MALARIA CONTROL PROGRAM

There is a National Strategic Plan which recognizes malaria as being a major cause of morbidity and mortality. This plan aims to have 60% of children under five years of age and pregnant women sleeping under an ITN by end 2005 ('the Abuja target').

In 1999, the public sector commenced a program to open up net treatment centres. There is now a centre in each of the 10 provincial capitals. These centres provide information on malaria, can sell nets, although these are small in number, and also treat nets which are brought in by the public.

Under HIPC funding, 157,000 nets were delivered to health centres in 2003 and given away free of charge to pregnant women along with tablets for treatment. This initiative was supported by the Minister of Health and widely covered by radio and TV. Unfortunately, there were insufficient nets available to provide distribution to every health centre in the country, and this left many unsatisfied potential consumers.

A further 678,000 nets was delivered to the public sector provincial depots in May 2004. Unfortunately, the decision was taken to treat these with liquid, rather than with tablets. The logistics of how to get these nets treated and issued is unclear at present. The process being delayed further by the Ministry of Finance, which has yet to release the funds to pay for the treatment.

Cameroon has been successful in obtaining funding from Global Fund for its malaria program. This includes the provision of 1.14 million nets and nearly 2 million tablets at a total cost of \$7.1 million. These nets are to be targeted at children under five years of age and issued free of charge on the basis of production of a card verifying a completed course of vaccination. 800,000 of these nets are forecast to arrive in February 2005, but this looks a little optimistic.

The PNLN also determines policy in conjunction with the MOH, WHO, WB and other interested parties. However, announcements are sometimes made by the Minister of Health which can create changes to agreed policy.

As well as indicating prices at which nets should be sold nationwide, the Minister decreed that no health centre, whether public sector, confessional or private, would receive any free nets if they were found to be selling nets. ACMS was instructed not to sell nets to health centres. This has substantially affected the ACMS program design from that agreed with USAID, in that the roll-out of subsidized nets to clinics has been blocked.

GOC has exempted from excise duties all nets coming into the country for malaria programs. However, this has not been extended to netting material, which is one of the reasons affecting the delayed start-up of a local net manufacturing company.

At the present time there is an estimated pool of 300,000 nets in Cameroon. In order to meet the Abuja target of 60% of pregnant women and children under 5 years of age sleeping under an ITN, a further 1.5 million nets need to be made available to households in the next 15 months. Given present logistical problems in the public sector, it would appear that the 60% Abuja target is going to be very difficult to reach. There is also the spectre of leakage of these free nets into the commercial trade, which may affect ACMS' sales.

## PERFORMANCE INDICATORS

An LQAS study was conducted in August 2004 among 228 respondents. This methodology is somewhat different from that of the baseline KAP and the results should be treated with some caution.

There appears to be a growing recognition that malaria is transmitted only by mosquitoes, especially in rural areas, and the use of ITNs as a means of prevention is increasing satisfactorily. The correct identification of the vulnerable groups who should use a mosquito net is also growing, especially for pregnant women, as is the number of the target groups claiming to sleep under an ITN.

The number of outlets selling ITNs is increasing and 40% of people believe they would find one in a marketplace.

PSI has mainly fulfilled its requirements in delivering health impact through MCH interventions.

The change in program design brought about by ACMS' inability to sell nets and treatment kits through health centres means that several of the indicators are no longer relevant. ACMS/PSI will need to re-negotiate some of the indicators with USAID and develop a revised logframe.

## BUDGET SPEND

Of the obligated cost of the program at \$1,299,937, with 64% of time elapsed, 48% of this USAID/GH/HIDN/NUT/CSHGP funding has been spent. Of PSI/W's match of \$650,000, \$297,464 or 46% has been spent, almost entirely on commodities.

The main areas of shortfall in USAID expenditure are in field staff and fringes, due to financing of these items from other ACMS funds in the early part of the program, media and communication/education material, due to the delayed start of the program, and research and monitoring, but the latter will be corrected on payment of the recent LQAS study.

Given the improving sales position, communications work planned on the branded promotion, and final KAP study due in 2005, it is likely that the USAID/GH/HIDN/NUT/CSHGP grant will be fully utilized by EOP, although some re-alignment of a few line items may be necessary. Similarly, a further injection of PSI funding will bring their contribution to the mandated amount.

## CAPACITY BUILDING

During the course of the project, ACMS has built a strong team focused on the malaria project. All relevant staff has been trained and core knowledge is good.

PSI/W has also been assisted by the grant in that they too have increased staff devoted to child survival and specifically malaria, and PSI now has 16 programs worldwide devoted to nets and re-treatment. Capacity in Cameroon has also been improved by the training of public sector staff and those of the NGOs associated with the program.

## SUMMARY

The project has started well with a comprehensive BCC program and training of partner, public and NGO sector personnel. Communication activities are expanding and, among those exposed to the campaigns, there appears to be a growing understanding of malaria transmission and prevention. Capacity of both ACMS and other partner staff has been increased. Overall, it appears that the uptake of ITNs is growing nationally. Delays have occurred in procuring ITNs and kits but there is a heightened demand for ITNs which ACMS could well fulfil in its target provinces, provided further commodity funding is rapidly made available.

Despite the progress being made, it is felt that a 3-year period is inadequate to achieve the behavior change levels indicated in the DIP. The process itself does not lend itself to rapid change since the programs do not get underway until the DIP has been agreed. This generally leaves only about two years to achieve the indicated results.

## RECOMMENDATIONS

1. WHO and other stakeholders should work with the PNLP to determine a timed action plan for the issue of the GOC nets to pregnant women and children under five.
2. ACMS should continue to work closely with the PNLP and MOH to develop modus operandi for the implementation of policy decisions, especially where these impact on implementing agency programs.
3. ACMS should work with the PNLP on changing policy and continue to press for authorization to sell nets through health clinics given delays in the issue of free nets.

4. ACMS should proceed as quickly as possible to develop a proposal to PSI/W to increase the allocation of additional funding to allow improved purchase of commodities.
5. ACMS should commence distribution to pharmacies, open up retail outlets in each district of major towns and continue to examine new business opportunities, particularly among large private sector enterprises.
6. ACMS should examine ways of developing stockheads of product in more remote areas and should also look at ways in which deliveries of stock to its provincial outlets can be further improved.
7. ACMS should give attention to creating more visible point-of-sale materials in its outlets so that consumers will better identify stockists of ITNs and kits.
8. ACMS should ensure that the caravan troupe is better informed of all the retailers selling ITNs and kits in the vicinity of their performances, and should provide the troupe with megaphones for marketplace activities.
9. ACMS, PSI/W and USAID/GH/HIDN/NUT/CSHGP should revise the logframe and adjust EOP targets.
10. ACMS should consider if a re-alignment of line items for the remaining period of the grant is necessary, and propose any changes to USAID.
11. USAID/GH/HIDN/NUT/CSHGP should consider an extension to the Cameroon program after September 2005 in order to continue the ACMS' communications work and provide for improved coverage and better ways of developing the rural market.

## **ASSESSMENT OF PROGRESS**

### **2.1 BACKGROUND**

Malaria has been a major problem for many years in Cameroon and continues to be so. The disease particularly affects those vulnerable groups such as pregnant women and children under five years of age. Basic health indicators report under-five mortality as 150/1000 children, infant mortality is 74/1000 live births and maternal mortality 550/100,000. 40% of child deaths are due to malaria, with malnutrition, respiratory and diarrheal diseases also being major problems. A large number of people are affected by malaria, with an estimated 1.5 bouts of malaria per capita per annum. Recent projections estimate the population of Cameroon could be as large as 17 million people in 2004, with 46.4% of these being under 15 years of age and 15.5% under 5 years of age.

There are some 1,191 public health centres staffed with nurses and auxiliaries, and also national, provincial and district hospitals in the larger conurbations. However, since 68% of the population lives in rural areas where population density is lower, these people inevitably have poorer access to these facilities. The PNLN commenced establishing net treatment centres throughout the country in 1999, and there are now 10 centres, one in each regional capital.

Unlike some other countries, Cameroon has been active in malaria control for several years. It adopted a National Policy Declaration in 1997 and has had a Plan of Action since 1998. The President has personally supported the Roll Back Malaria (RBM) campaign and a Strategic Plan was developed and adopted in 2002. Funding has been growing in recent years to reach in excess of US\$7 million in 2003 and support is due to come on stream in 2005 from the Global fund. The major present GOC activity in ITNs is aimed at delivering free nets to pregnant women and the Global fund will focus on providing ITNs to those families with children under 5 years of age. (A more detailed account of the history and support given to malaria is to be found in Annex 3).

USAID/GH/HIDN/NUT/CSHGP has provided funding to ACMS to the value of \$1,299,937 over a period of 3 years commencing October 1st 2002, with the main objectives of increasing the use of ITNs, especially among pregnant women and children under 5 years, and especially in rural areas. This funding is to be matched by funds from PSI to the value of \$650,000 mainly for the provision of commodities.

As part of this program, a mid-term evaluation has been carried out in Cameroon by Alan Handyside, an independent consultant and team leader, Dr. Emmanuel Forlack, East Provincial PNLN Coordinator, and Dr Leonard Mbam-Mbam Health Advisor of WHO. The evaluation was carried out in country between 27<sup>th</sup> August and 12<sup>th</sup> September 2004.

### **2.2 PROGRAM OBJECTIVES**

The ultimate goal of the project is reduce the incidence of malaria-related mortality and morbidity in pregnant women and children under five years of age. This implies increased use of ITNs among these target populations, with a special emphasis on rural areas. There are various ways in which this can occur. Of those people who already have bednets, the communications element of the program can inform and help convince

the families in those houses that the most important people to sleep under nets are pregnant women and small children. The second way of meeting the objective is to persuade consumers of the value of ITNs and increase the number of nets purchased. Thirdly, it is also important to convince families with ITNs of the increased protection that they get by retreating the nets at appropriate time intervals.

### 2.3 PROGRAM STRATEGY

ACMS works with the National Malaria Control Program (PNLP) at a central level, and in 3 provinces, the Centre, East and South, to support PNLN programming and ensure that ACMS messages and activities promote the national goals for malaria prevention. ACMS also collaborates with PLAN Cameroon, which has trained a large number of rural women's associations as CBDs in the East province, and with other local NGOs that ACMS has trained in malaria transmission, prevention, and re-treatment. These NGO partners help increase ACMS' access to rural communities. ACMS itself sells and distributes bundled nets to the commercial sector in urban, peri-urban and, latterly, in more rural outlets.

The communication element to create behavior change uses IPC through its NGO partners and provincial promoters which hold net treatment demonstrations and educative sessions on malaria transmission and prevention throughout their provinces; utilizes mass media, mainly billboards and radio to date, with TV spots to begin in November 2005; and drama conducted by a travelling theatre troupe. Initial communications were mostly generic to help overcome the main misunderstandings identified in the baseline KAP, but branded advertising has now commenced. Thus, this USAID funded program delivers communication messages at all levels in the 3 target provinces, supported with activities particularly focused on the rural communities served by the partner NGOs in zones where they are active.

Sales of the ACMS bundled nets and re-treatment are generated through normal commercial channels and also via the NGOs, thus giving ACMS more direct access to the communities at which the program is targeted. It was originally planned that ACMS work through public- and private-sector health centres, including those associated with religious groups. However, this was effectively blocked by the MOH which announced at the time of the issue their of free nets to pregnant women, that any health centres, whether private or public, would not receive any free nets for distribution if these same health centres were found to be selling ITNs. Understandably, health centres are reluctant to go against the MOH edict. The MOH also expressly barred ACMS from selling nets through clinics even if the clinics agreed not to give out free nets, because the minister did not want any confusion among the population between free nets and those for sale.

The National Malaria Control Program (PNLP) is the coordinating body which has the mandate for driving the malaria initiative in Cameroon. ACMS works closely with this organization and is greatly appreciated for its technical input and communication work, since the generic communications produced by ACMS affects all potential net owners, whatever their source of supply. The PNLN has some resources and capacity for communications programs, but ACMS is the real driving force in terms of mass media

communications to the general public. Hence ACMS is providing an extremely useful service to the national initiative.

## 2.4 RESEARCH AND DIP MODIFICATION

The PSI proposal in 2002 used data from a baseline KAP financed by UNICEF in 2001. This showed that most respondents (98%) knew of malaria and most could correctly identify the symptoms of malaria. 91% of respondents had had malaria at some time and 59% knew that mosquitoes were the mode of transmission. However, there was also considerable misinformation about mode of transmission, and only 40% identified malaria as coming from mosquitoes uniquely. In 2001 only 9% identified a mosquito net as a means of avoiding malaria, and less than 1% named an ITN. In terms of net ownership, only 20% of urban respondents reported owning a net and this figure was only 10% in rural areas. Hardly any of these nets would be a treated net. Unlike in some other countries with an emerging net market, it was not particularly the head of household who dominated the usage of the net in the household. Usage by the target groups was low, mainly due to low net ownership, with usage by children under 5 years of age being about 10%, and 5% by pregnant women. Although 18% of respondents had heard of an ITN, few knew where to obtain one. The most common place for net purchase at all was in the market. 80% had heard of re-treatment, probably through the PNLP program of net treatment centres.

It would thus appear that in 2001, bednet ownership was small and mainly confined to wealthier urban areas, and that only a small number of people knew that it is important that young children and pregnant women should use nets as protection from malaria. Knowledge of ITNs was small and very few people knew where to obtain one. There was limited knowledge about their value in protecting from mosquitoes. Accurate understanding of malaria transmission was low, particularly in rural areas.

The Program Outputs in the DIP were mostly left unchanged from the PSI proposal, and it is against these which the program will be measured. The CSHGP Project Planning Matrix is shown in Annex 4.

## 2.5 IMPLEMENTATION OF PROGRAM

The main thrust of the program is to create Behavior Change, particularly in the rural areas, and implicitly to sell an increased number of bednets. The focus of the behavior change is to encourage usage of bednets among the most vulnerable groups, namely children under 5 years and pregnant women.

It was originally planned in the DIP that ACMS would sell ITNs and re-treatment kits to the commercial sector in three provinces, namely Centre, South and East. They would also sell nets to health centres, both public and private, to make subsidized ITNs available to the vulnerable target groups. This has not happened due to the decree by the Minister of Health preventing sales to health centres, thus blocking this part of the program. ACMS has instead collaborated with NGOs and religious groups to facilitate entry into more rural communities and to better reach the prime target groups of pregnant women and under-fives.

### 2.5.1. Media and Promotion Materials

The communications strategy to date has been to use mass media, drama and IPC with a local troupe (caravan), and interpersonal communications (IPC) via NGO peer educators, including those of ACMS. Initial communications have been generic but branded advertising has now commenced. These communications are aimed at conveying messages and information about:

1. Mode of Transmission – Malaria is transmitted by night-biting mosquitoes
2. Perception of risk – children under 5 and pregnant women are the most vulnerable groups
3. Advantages and availability of products – Treated nets provide better protection than untreated nets, and re-treatment ensures continued protection is inexpensive, easy and safe.

The main mass media used has been radio, since television is limited in its coverage to mainly urban areas. The campaigns are also supported by billboards and point of sale (POS) materials (posters, stickers, etc). To date, eight radio spots have been produced, these being three generic spots in French and equivalent translations into local dialect, and two branded spots. By August 2004, 1,440 generic spots have been aired and 360 branded spots for Super Moustiquaire. ACMS plans to air 840 radio spots for Super Moustiquaire and Bloc re-treatment between October 2004 and February 2005, along with 72 TV spots for the two branded products. Three different billboard posters have been generated, covering malaria transmission, use by pregnant women and small children, and the third on re-treatment. These are very visible in all of the three target provinces, with 300 sites using double-faced posters. Smaller posters using the same images and self-adhesive stickers are also visible in most of the stockists but some work still needs to be done to better inform consumers of where bundled nest and re-treatment kits are available for sale. 1,221 of these posters have also been distributed to partner NGOs. Other materials have been or will be produced, including calendars, keychains, plastic bags, bumper stickers, caps and t-shirts for use in IPC and other group activities.

A local theatre troupe has been trained and travels through peri-urban and rural areas caravan-style with promoters and either the sales or communications coordinator. The theatre troupe has been giving performances to NGOs, women's groups, religious organizations and rural communities, as well as marketplace IPC, while the promoters open up new points of sale. A variety of presentations have been developed, focusing on the relatively low cost and high value of ITNs in comparison with conventional malaria treatment, demonstrations on how to treat and re-treat ITNs, and its value in preventing malaria. The troupe has been in operation since July, and was created in response to findings in a research study commissioned by ACMS earlier in 2004. Intending to reach rural populations through a regular weekly radio show, ACMS conducted a study to determine rural women's radio habits and found that the majority of the rural target population (especially in the East province) does not have access to the radio. ACMS decided instead to focus resources on IPC, creating the travelling theatre caravan. The caravan visits a different zone each month, following a planned route, agreed in conjunction with the sales promoters and head office marketing personnel. They give about 3 performances each day and have reached a large number of people in the target provinces. Their skits are very popular and attract large audiences and, after the drama is

finished it is usual for the group to reinforce the health messages given, demonstrate net treatment, and encourage net/treatment purchase when the sales promoter is present. There is a need for the provision of a megaphone so that the troupe can be better heard in noisy marketplaces and so that the gathered crowd can better hear their performance. It will also benefit their performances if some appropriate costumes can be provided.

#### 2.5.2. Training and NGO Collaboration

Part of the ITN program has been to explore new avenues for ACMS in working with Community Based Distributors (CBD) in the NGO sector. The purpose is to work with existing operations that already have greater access to the more rural communities than does ACMS traditionally, and train them as both IPC and CBD agents.

To date some 52 NGOs have collaborated with ACMS, most receiving training and materials (either from Plan or ACMS) and many purchasing product for onward sale in their communities. Many of these are small organizations but representation among NGO partners has been achieved in all three target provinces.

One of ACMS' major successes has been working with PLAN Cameroon in the Eastern province. Training was given to PLAN who then subsequently trained 128 local community based organisations (CBOs) under its own child survival grant. Most of these have 4-5 members and training covers vaccinations, respiratory diseases, HIV/AIDS, IMCI as well as malaria. The members promote good health practices in households in their local communities. Each group was issued with 50 PLAN-financed, with the instruction to sell them at less than CFA 5000 and create a revolving fund with the money. This was because the initial instruction from the Minister of Health was that all nets should be sold at this price. This decree was later amended to CFA3500 on the introduction of the ACMS net.

Once these initial nets were sold, the CBOs had no other source of good-quality nets. When ACMS began its program, it sourced these CBOs, providing them with nets, treatment and materials and offered the support of ACMS promoters in sales and demonstrations. The ACMS bundled nets have sold quickly in the main town, Bertoua, and a little more slowly in the extreme rural areas where, despite its subsidized low price, Super Moustiquaire was still thought by the CBOs to be beyond the means of some of the poorer populations. Shortage of stock at ACMS has inhibited the sales growth in some of PLAN's programs. The arguments used by PLAN CBOs to persuade people of the value of ITNs have been monetary, in comparing the price of an ITN with conventional treatment for malaria, and the pain caused by the disease. Often children have been used to testify to adults the value of nets in the management of malaria. A recent evaluation of the PLAN program has shown that in their target areas, one-third of children now sleep under a net at night. Messages on re-treatment are also given and PLAN has found there is a need to emphasise using one tablet per net and not treating several at once. It is believed that this practice stems from the earlier communal net treatment program organized by the PNL. PLAN's worthwhile program is closing at the end of September 2004 and a proposal for re-funding is being developed in partnership with PSI/ACMS and Helen Keller International for submission to USAID. The work carried out by PLAN has been highly effective and it is hoped that funding can be made available for their Cameroon activities.

AfroAid is a Swiss based umbrella organization that funds small NGO programs such as AHDSEFCA in Cameroon. This group operates mainly in and around Yaounde and works on cleaning up local areas and encouraging the use of clean water, as well as focusing on malaria prevention. AfroAid provides funding for the purchase of ACMS nets at the official NGO price of CFA2800, and then sells them to AHDSEFCA for CFA2500, who then sell on to consumers at CFA3500. This scheme gives a little more margin to the local NGO and, since joining up with ACMS in April 2004, they have sold 812 nets. They also plan to purchase Bloc re-treatment and commence a program showing local communities the value of re-treating nets.

ALHYSCA was created in 1999 and operates in the Central and Southern provinces. They commenced collaboration with ACMS on the promotion and selling of the female condom and have now moved into malaria and ITNs. Following training by ACMS, they have started malaria sensitization and ITN distribution through local groups, societies for employee protection and families within their communities. To date they have bought 2400 nets and these are selling well.

PHARE is another small NGO working in and around Yaounde. They have 5 peer educators and have been working on HIV/AIDS sensitization and condom use for several years. AMCS has trained their educators in malaria management and has provided them with marketing materials and 125 ITNs. To date they have sold 100 of these. They would like to increase the number of field workers and base them inside communities to save on travel costs.

For many smaller Cameroonian NGOs, funding is a problem and although they would like to expand their operations, they are inhibited from doing so. Although the ACMS ITN program is well appreciated, several local NGOs feel that the price of the nets are still too high for some of the poorer populations. Despite this, many also regard the issue of free nets with some concern, as they feel that the system may well be abused resulting in dissatisfied local communities.

### 2.5.3 Public Sector

For some years the GOC has been active with its malaria program. There is a National Strategic Plan which recognizes malaria as being a major cause of morbidity and mortality and aims to reduce these by 50% by 2010. Most specifically in relation to ITNs, this plan, announced by the President in Abuja, aims to have 60% of children under five years of age and pregnant women sleeping under an ITN by end 2005.

To this end the public sector commenced a program in 1999 to open up net treatment centres. There are now 10 centres nationwide, one in each of the provincial capitals. Community net treatment centres (UIC) are also being created within health areas of the provinces. To date 45 have been created nationally. The PNL action plan intends to eventually create at least one UIC in each health area. These centres provide information on malaria and also treat nets which the public bring in to them. WHO assisted in this program by giving the GOC 50,000 nets and 144,000 treatment tablets. Although some centres are very active, notably the one in the Eastern province, others are less functional. One of the main problems is that they are located in the main towns in each region and it

is somewhat difficult for members of the public, particularly those in rural communities, to transport their bulky nets to these treatment centres which are several miles away.

More recently, under HIPC funding, over 800,000 nets were ordered. The first 157,000 of these, were delivered in 2003 to health centres and given away free of charge to pregnant women along with tablets for treatment. This initiative was accompanied by promotional events in each of the provinces, attended by the Minister of Health and widely covered by the national TV and radio stations. This created huge interest and demand, but there were insufficient nets available to provide for every health centre in the country and many pregnant women who came to health centres to claim their free net left disappointed.

The second tranche of these nets, 678,000, was delivered to the provincial depots in May 2004. Unfortunately, the decision was taken to treat these with liquid, rather than with tablets as in the first issue. The liquid is currently in Yaounde and the nets are scattered nationwide. The process of getting these nets treated is being held up further by the Ministry of Finance which has yet to release the funds to pay for the treatment. A tender will need to be issued and the contractor, when appointed, will then have to either bring all the nets back to the capital for treatment or, alternatively, visit each of the provinces and treat the nets locally. Either way, this looks like being a long drawn-out process. A third alternative would be to procure tablets, possibly from ACMS, issue these to the provincial depots, and treat the nets there, in the health centres, or at home. This unfortunate situation means that, despite their being a large demand for nets, many pregnant women in the country are being denied accessibility.

Cameroon has been successful in obtaining funding from Global Fund for its malaria program. Amongst other things, this includes the provision of 1.14 million nets and nearly 2 million tablets at a total cost of \$7.1 million. These nets are to be targeted at children under five years of age on the basis of producing a card verifying a completed course of vaccination. The first 800,000 of these nets are forecast to arrive in February 2005, but this looks a little optimistic. In addition the Global Fund is providing for the production of 4 radio spots and 2 TV spots, with a projected airing of 183 radio and 52 TV spots. Funding for provision of posters, leaflets and brochures is also available, and the total cost of these marketing materials is \$113,000.

One extremely useful contribution made by the GOC is to exempt from excise duties all nets coming into the country for malaria programs. However, this has not been extended to netting material, which is one of the reasons affecting the start-up of a local net manufacturing company.

#### 2.5.4 National Malaria Control Program (PNLP)

AMCS' collaboration with the PNLN is one of the most important partnerships in the program. The Director of the PNLN has been in the post since 1999 and is determinedly developing malaria initiatives in Cameroon. Amongst other activities, this involves fundraising from the GOC and other donors to provide commodities, funding for training local staff and others, and organizing such public events as Africa Malaria Day. The PNLN also determines policy in conjunction with the MOH, WHO, WB and other

interested parties. However, announcements are sometimes made by the Minister of Health that can create changes from agreed policy. Price is one of these.

At one stage it was announced that nets would be sold for no more than CFA5000, which was subsequently amended to CFA3500 on the introduction of ACMS ITNs. Thus the introduction of ACMS products influenced the MOH to revise their prices down from 5000 to 3500, and treatment from 1000 down to 500, making them more accessible to consumers. Also, the PNLN is permitted to sell nets through net treatment centres. These nets are purchased out of the MOH budget, but funding for this part of the program is not extensive so very few are actually sold under this mechanism. However, the overall reduction in prices affects both nets and treatment so, when they are sold, they too are cheaper to the consumers.

More importantly as far as the ACMS program is concerned, the Minister's instruction blocking the sale of nets in health centres has substantially affected the ACMS program design from that agreed with USAID, in that the roll out of subsidized nets to clinics has been prevented. A further decree from the MOH was that ACMS nets should be of 100 denier, although 75 denier is commonly accepted in most other countries as being more than adequate. This increased ACMS' product cost.

ACMS and the PNLN have cooperated well on the training front, and ACMS is valued by the PNLN for its input on technical matters. Thus, the present USAID/GH/HIDN/NUT/CSHGP program has helped the PNLN and the public sector develop the capacity of the workers in its program.

## 2.6. SALES AND DISTRIBUTION

### 2.6.1. ACMS Sales

ACMS commenced selling Super Moustiquaire into the commercial trade in March 2004. There were lengthy delays in obtaining the nets and insecticide for a variety of reasons, nearly all out of ACMS' control. In the six months to end August, 35,333 ITNs have been sold across all three target provinces, and the objective is to reach 72,000 by end 2004. Although no volume target was part of the DIP, the PSI proposal suggested that 200,000 ITNs would be sold by EOP. This looks achievable provided additional funding can be obtained from PSI.

It is an agreed part of the grant that PSI would provide \$650,000 over the life of the project. PSI has made \$150,000 available and it was calculated that with receipts from sales, this revolving fund would allow purchase of ITNs and kits to the value of the agreed sum. However, this projection is somewhat flawed. The length of time it takes to receive nets is about 3 months from time of order placement. In addition, it takes about 2 months before sales revenues flow back to ACMS. ITNs are issued to the 6 sales promoters but until these are sold and invoiced, there is no return-to-fund revenue. Finally, there is so much demand worldwide for nets that the manufacturer is requiring 90% of the value of the order to be paid up front at the time of the order. Thus, the funding provided by PSI is tied up for a considerable period of time and this has created stock shortages. A request for additional advance of funds from PSI is being prepared now. Provided this is granted, then larger quantities of product can be ordered at a time,

creating a stock buffer essential to the freeing up of stock and fulfilling the undoubted latent demand for the product.

Problems related to the supply of insecticide held up the launch of the bundled nets, since these require a tablet of insecticide in each pack. This has now been resolved but difficulties obtaining further supplies have meant that the launch of Bloc treatment kit as a stand-alone product did not commence until August 2004. Sales in this month amounted to 940 units. It is believed that with the heightened awareness for the re-treatment of nets, and with an increasing pool of nets from both ACMS and PNLP, there will be considerable demand for re-treatment kits for the remainder of the project.

### 2.6.2. ACMS Distribution

Distribution of Super Moustiquaire is good in all of the three target provinces. In total 205 regular points of sale have been negotiated, 107 in Yaounde and the Central province, 55 in the South and 43 in the East. Wholesale stockists have been appointed with 16 in Centre, 5 in the South and 5 in the East. The six sales promoters, two in each region, transfer sell to retailers using stock from these wholesalers and have also opened up retail outlets in their own right. Further work needs to be done in opening up more retailers so that every quarter of the major towns has at least one retailer present in the locality. There also needs to be improved linkage with the caravan troupe so that they know all the retailers in the vicinity of where they are giving their performances, particularly in market places. Limitations of stock have slowed down this distribution drive but once stock availability becomes freer this can be achieved.

Most of the distribution points are new ones to ACMS. Typically they are clothing shops, some toiletry stores and those outlets dedicated to selling baby products and household goods. ITNs are seen as a household product and the above outlets are where consumers believe they are most likely to find an ITN. As yet only a few pharmacies stock ACMS ITNs and kits, but a distribution drive into these stores is planned.

The logistics of distribution needs some attention, particularly as the program volumes increase. At present, other ACMS project vehicles can deliver ITNs in Yaounde with relative frequency and ease. There are two project pick-up vehicles (in addition to an all-purpose vehicle) which are used to deliver ITNs in bulk to the major depots in the Southern and Eastern provinces as well as more outlying areas in Central province. However, these vehicles also have to be used to deliver from these depots to outlying stockists within each province. Because of the distances involved, these vehicles are only able to run a provincial journey cycle about once per month. Bulkiness of ITNs means that they cannot be easily transported by ACMS vehicles carrying other products. Therefore, as volume grows and consumer demand increases, there will be a requirement for more frequent deliveries to stockists within the provinces. Presently, product is often couriered through ESI, a courier service, to provincial warehouses. There are plans to change this to delivering directly to provincial wholesalers, as the warehouses are not cost effective. Despite this, the requirement for additional transport arrangements needs to be addressed.

### 2.6.3. Public Sector Issue of Nets

Whilst the PNLN is a partner in providing ITNs and re-treatment to consumers, in a sense, it are also a competitor. From a public health perspective, the source of ITNs may not matter, as long as consumers are buying and using them, but the partnership programs have to work alongside each other and both should aim to be sustainable. Therefore the sales of PNLN products are relevant to the progress of the ACMS project.

As stated above, the PNLN has issued 157,000 nets free of charge to pregnant women through some of its health centres. When the second tranche of 678,000 nets will become available is unknown, but it is unlikely that all of these can be issued to pregnant women in a short period of time. There are about 850,000 births each year and thus at any point in time there are this number of pregnant women. However it is believed that only 20% of pregnant women go to health centres for ante-natal care. Thus, unless demand increases substantially with the issue of free nets, or more pregnant women go to health centres for reasons other than ante-natal care, then it could take a year or more before all of these nets are in use. The danger is that, in its drive to issue nets quickly to try and move towards the Abuja target, the health centres may be encouraged to issue ITNs to a wider population other than pregnant women. This abuse could lead to considerable leakage of nets into the commercial trade and be sold for prices less than the ACMS product, but give a higher margin to the trader. Potentially, this could cause some disturbance to the ACMS program during 2005.

#### 2.6.4. Abuja Net Targets

At the present time there is an estimated pool of 300,000 nets in Cameroon. This results from 50,000 nets from WHO, 36,000 from COTCO (Exxon-Mobile), 157,000 from PNLN, 35,000 from ACMS, and the balance from historical private-sector sales.

There are just over 3 million households in Cameroon and approximately 2.5 million households with a WRA living there. In the next 15 months over one million of these women will become pregnant and be eligible for a free ITN, and many will have a child under 5 years of age. For the 60% Abuja target to be met, more than 1.5 million ITNs will need to be in use by the end of 2005. Given the present pool of ITNs and the variables involved in actual use by the target groups, the actual objective should be to furnish a further 1.5 million households with ITNs in the next 15 months on top of the existing national pool.

There are problems with this. Although a considerable number of nets could become available during 2005 in the public sector, say 1.45 million, it will take some time to issue these ITNs correctly to the target groups of pregnant women and young children. Also, the research necessary to confirm achievement or otherwise of the Abuja target will need to be conducted in early 2006. If all the 678,000 nets were to become immediately available and given out over the next few months to pregnant women, by early 2006, most of these women will no longer be pregnant at the time of the research. If all the nets were held up until late 2005 before issue, then there is insufficient time to find enough pregnant women to give them to. The 800,000 expected Global Fund ITNs could also become available for issue to vaccinated children and, if they arrive early enough in 2005, then it is possible that many of these could be issued. But again, this depends on the effectiveness of the vaccination program, and the rate at which small children are brought to the clinics.

Therefore, it would appear that the 60% Abuja target is going to be very difficult to reach, given the delays in the GOC programs to date. ACMS has an excellent opportunity to contribute to assisting in reaching the target in their three target provinces, provided that sufficient stock is made available in the near future. Time is of the essence in this.

## 2.7. COMPARISON WITH OTHER COUNTRIES

It is of interest to note the progress of ITNs being made by other social marketing programs in other countries. Comparisons are influenced, amongst other variables, by the length of time the program has been operating, the amount and nature of the funding, the ITN history of the market, and the influence of both public and private-sector activities. Of the programs started in recent years by PSI, Malawi is performing best in terms of sales per capita at a rate of 0.098 ITNs/capita. This program distributes ITNs and re-treatment kits to the commercial sector and, in conjunction with the public-sector program, sells ITNs through government health centres. This program was the basis of the design of ACMS' program but, as noted above, ACMS has been prohibited by MOH from following this program design in Cameroon. Malawi's program is extremely successful and in 2003 alone it sold over one million ITNs. Zambia, Benin and Rwanda all have rates at about 0.02 nets/capita. In the last two years, PSI/Kenya obtained a large funding for an ITN program and now sells at a per capita figure of 0.021 ITNs. This is in a market where there is high demand and few public sector sales. Assuming that ACMS achieves its target by EOP it will be selling at a running rate of 0.008 nets/capita in 2005. Naturally, each country faces different constraints, and the importance of the public sector contribution in Cameroon is somewhat greater than in other countries, which may affect the SM results.

## 2.8. PRICING

Price is an important variable in persuading a large number of people to purchase an ITN. For many, especially in the rural areas in which the ACMS project has focused much of its activities, the absolute outlay is difficult to find, even at subsidized prices. The current consumer price for an ITN from ACMS is CFA3500 (\$6.50 at current exchange rates) and CFA600 for a treatment kit. ACMS has used various methods of IEC to show potential consumers that these prices are not excessive. This has included a comparison with the cost of treating malaria by other means such as medicines and cost of health consultancy. The communication efforts have focused on getting consumers to realize the value of the purchase of an ITN, as well as the health issues associated with malaria, but more work needs to be done in this area if large numbers of consumers are to appreciate this and purchase ITNs and kits. Behavior change takes time.

ACMS sells its product at cost-recovery, but the level of cost recovery is dependent on exchange rates remaining stable. The basic price structure for Super Moustiquaire is that wholesalers buy at CFA2300, organizations such as NGOs buy at the demi-wholesale/association price of CFA2800, retailers buy at CFA3000, and all sell to consumers at CFA3500. These margins for the trade are sufficient for most traders to feel that the absolute income per net sold is worthwhile.

As seen above, large volumes of ITNs going through the public sector are planned for 2005. The introduction of a considerable volume of free nets through the health facilities could disturb the level of sales through the ACMS program and, by implication, of the pharmacies and other private-sector outlets. The proposal is to limit issue of free ITNs by the PNLP to pregnant women and those with young children. This is laudable but, unless strict controls on their issue can be instituted, carried out, and monitored, there is a serious risk of product leaking back into the trade or being re-exported. This could irrevocably damage the nascent private-sector business in ITNs and the sustainability of both ACMS and PNLP programs. Further dialogue needs to take place with all partners in the malaria program on the matter of free nets and pricing.

### 3. MEASURABLE INDICATORS

Many of the performance indicators relate to knowledge, awareness and behavior change. An LQAS survey was carried out in August 2004 as an indicator of progress towards these objectives set in the DIP. However, the methodology used by this small sample of 228 respondents is somewhat different from the original KAP, which had 2016 respondents. (LQAS methodology is noted in Annex 4). Notwithstanding the advantages of using LQAS as a measurement tool, the present LQAS study appears to have produced households with a higher incidence of net ownership than would be expected and this undoubtedly affects some of the results. However, the small sample size means the confidence limits on the results are somewhat broader than the KAP data.

From observation, many of the indicators will be attained but, for some, there will need to be a longer period of communications activity for all of them to be reached. The comments below relate to the consultant's personal opinion based on data obtained and field observations. The process of developing the DIP following award of the grant means that work could not commence on the program itself until June 2003. This leaves only 27 months to achieve the indicated targets.

**(In the notes below the mid-term results from the LQAS study are under the heading LQAS. The results are also presented in tabular form in Annex 5)**

**Goal:** Reduced incidence of malaria-related mortality and morbidity among children under five and pregnant women in East, Centre, and South provinces of Cameroon  
**This is to be measured by DHS surveys and national mortality data.**

**Purpose:** Increased use of ITNs among rural pregnant women and children under five

#### Intermediate Indicators

#### **IR1: Increased informed demand for ITNs**

**Output 1.1.** % of adults who know that malaria is only transmitted by mosquitoes increased

#### Indicators

- Baseline: 28% rural; 51% urban, Mid-term = 33% rural; 59% urban, EOP=50% rural; 66% urban
- **LQAS mid term:** 54% Rural, 55% Urban  
**The rural indicator shows increasing correct knowledge of transmission but the urban figure is unchanged. Increased communications work needs to be done if the EOP target is to be reached.**

**Output 1.2:** % of adults who identify ITNs as a method of malaria prevention increased.

#### Indicators

- Baseline: 1%, Mid-term =12%, EOP=25%
- **LQAS mid term:** 18.9%  
**It is possible that this indicator will be met by EOP.**

**Output 1.3:** % of adults who identify children under five and pregnant women as high-risk groups for malaria increased.

Indicators

- Baseline: 46%, Mid-term =56%, EOP=66%
  - Modified Baseline: Children under 5 years 37%, pregnant women 9%
  - **LQAS mid term:** Children under 5 years 42%, pregnant women 24%
- Knowledge about protecting children was already fairly high at the time of the initial KAP, and this has changed only slightly. Awareness of the need to protect pregnant women was less well known and this has grown, probably due to the public sector work as well as that of ACMS**

**Output 1.4:** % of 0-5s and pregnant women reported to have slept under a net the previous night increased.

Indicators

- Baseline: 4%, Mid-term=20%, EOP=33% (rural) and baseline: 10%, Mid-term=21%, EOP=33% (urban).
  - Amended baseline: Children under 5 years 10.5%, Pregnant women 5%
  - **LQAS mid term:** Children under 5 years 51.5%, pregnant women 45.5%
- The urban rural split is not available due to small sample size. There also appears to be an increase net ownership in the mid term research which gives inflated results.**

**Output 1.5:** Difference in reported use between 1<sup>st</sup> and 4<sup>th</sup> socioeconomic quartiles decreases by 25%.

Indicators

- Baseline: 25%, Midterm=22%, EOP=19%
  - Amended baseline: The figure is believed to have been 21%
  - **LQAS** results are under investigation but sample size is probably too small to give meaningful results.
- Preliminary urban data available looks to be unchanged from the revised baseline. Rural sample very small**

**IR2: Improved equitable access to ITNs**

**Output 2.1:** % of targeted outlets selling ITNs increased.

Indicators

- Baseline: 0%, Mid-term =25%, EOP=50%
- Indicator should be number of outlets and not percentage
- **Mid-term result:** Number of outlets selling ITNs now in excess of 205 in the target provinces

**Output 2.2:** % of adults who know at least one source of ITNs increased.

#### Indicators

- Baseline: 1%, Mid-term =12%, EOP=25%
- **LQAS mid term:** 60% but these include Health Centres. Commercial outlets figure is 40%  
**This indicator should be met as most people name the marketplace as a source of ITNs**

**Output 2.3:** # of outlets offering ITN subsidies to pregnant women and mothers of children under five increased.

#### Indicators

- Baseline: 0, Mid-term =25, EOP=50  
**No longer relevant as program design changed.**

**Output 2.4:** % of outlets offering ITNs at prices within the willingness to pay range of target populations increased.

#### Indicators

- Baseline: 1%, Mid-term =12%, EOP=25%  
**Most outlets are offering ACMS nets at CFA3500.**

**IR3: Increased capacity to sustain demand creation and delivery of ITNs in Cameroon**

**Output 3.1** % of PRISSM indicators in which ACMS is in growth or mature stage increased.

#### Indicators

- Baseline: 30%, EOP=75%  
**A second PRISSM has not been conducted as further analysis by PSI showed that the PRISSM becomes less valuable upon repeated application. A strategic planning session is planned which will indicate the stages of development of ACMS.**

**Output 3.2:** % of partner clinics integrating project messages and materials in normal health service delivery increased.

#### Indicators

- Baseline: 0%, EOP=85%  
**No longer relevant due to program design change**

**Output 3.3:** Project BCC materials used by at least two NGOs not funded by the project.

#### Indicators

- Baseline: 0, Mid-term =1, EOP=2  
**52 NGOs have used ACMS materials**

**Output 3.4:** At least one additional donor identified to fund targeted subsidy schemes.

#### Indicators

- Baseline: 0, EOP=1  
**ACMS is actively seeking an additional donor**

**Output 3.5:** At least one major international net manufacturer begins unsubsidized distribution in Cameroon.

#### Indicators

- Baseline: 0, EOP=1  
**This operation has not yet commenced due to taxes still being levied on netting material. ACMS actively petitions the government to remove taxes and tariffs on nets and treatment.**

#### **IR 4: Increased capacity of PSI in delivering health impact through MCH interventions**

**Output 4.1:** Number of project materials through Intranet, Profiles, and CD-ROM.

#### Indicators

- Baseline: 0, Mid-term =2, EOP=5  
**PSI/W has distributed Project Profiles: 17, Research Briefs: 4, Biennial Reports: 2, Issue Briefs: 1, AIDSMark publications: 11, Other: 2**

**Output 4.2:** Number of PSI MCH department capacity-building/planning workshops conducted.

#### Indicators

- Baseline: 0, Mid-term =1, EOP=3  
**These are held bi-annually. One has been held during the life of the project.**

**Output 4.3:** Number of MCH fundraising materials disseminated.

#### Indicators

- Baseline: 0, Mid-term =12,000, EOP=25,000  
**PSI has disseminated 11,500 fundraising materials, including ‘Disinfecting Water, Saving Lives: PSI’s Safe Water System Prevents Diarrhea’, ‘Meeting a Fundamental Need: Social Marketing of Micronutrients Prevents Anemia, Saves Lives’ and ‘Keeping Malaria at Bay: Mosquito Nets Treated with Insecticide are Inexpensive, Effective.’**

**With the substantial changes in the program design brought about by the MOH denying ACMS access to the health clinics, and the fact that results for pregnant women and children under five appear to be proceeding at different rates, it is recommended that ACMS/PSI re-negotiate some of the indicators with USAID and develop a revised logframe.**

#### **4. BUDGET SPEND**

Of the obligated cost of the program at \$1,299,937, with 64% of time elapsed, 48% of this USAID/GH/HIDN/NUT/CSHGP has been spent. Of PSI's match of \$650,000, \$297,464 or 46% has been spent, almost entirely on commodities. In total, therefore, 47% of the combined budgets have been spent already.

The main areas of shortfall in USAID expenditure are in field staff and fringes, due to financing of these items from other ACMS funds in the early part of the program; media and communication/education material, due to time spent developing a regional francophone insecticide brand and delays in the production of campaign materials, brought about by the main advertising agency falling into bankruptcy during the contract; and research and monitoring, but the latter will be corrected on payment of the recent LQAS study.

Given the improving sales position, communications work planned on the branded promotion, and final KAP study due in 2005, it is likely that the USAID/GH/HIDN/NUT/CSHGP grant will be fully utilized by EOP. However, there may be some need for a re-alignment (to be confirmed with USAID). For example, the travel line item may need to be increased to better reach more rural areas and training increased to improve staff capacity in reaching rural populations. There may also need to be some increase in consultancy and equipment line items, but these can be funded from local staff items and fringes. As far as the PSI match is concerned, a further injection of PSI funding will bring their contribution to the mandated amount.

## 5. CROSS CUTTING ISSUES

### 5.1 COMMUNITY MOBILISATION

The program has worked with NGOs in 3 provinces of the country. Training has been given in CBD and IPC and the large number of people effectively mobilized has improved their capacity tremendously. The introduction of ITNs and re-treatment programs to their already useful work in the communities has given them a renewed sense of purpose in being able to counsel the consumers in their target areas with something different. The communities themselves have been mobilized by increased awareness of the problems associated with malaria, and to take action by purchasing ITNs and using them for the more vulnerable target population. The simultaneous activities by the PNLN have also fostered a heightened awareness of malaria and its treatment and the general “noise” about the disease has made an enormous impact on demand for ITNs and re-treatment.

### 5.2. COMMUNICATIONS FOR BEHAVIOUR CHANGE.

This is one of the main thrusts of the USAID/GH/HIDN/NUT/CSHGP program. In the past, various messages have been developed by the GOC, but the quality of materials has not been sufficiently attractive to induce behavior change, other than very slowly and in limited numbers. ACMS has correctly used research-driven communications to develop BCC materials which appear to be having a useful effect at consumer level. This is reflected in the increased sales of PNLN ITNs as well as those of ACMS.

ACMS has been able to benefit from experience in other PSI markets with respect to malaria communications. This has been advantageous to the program itself in its strategic approach in Cameroon, and PSI/W also has gained additional insights into the use of BCC in addressing Child Survival programs. This information is shared through The Wave, PSI’s internet-based information and best practices site, and through CDs and other materials sent regularly to country programs around the world.

### 5.3. CAPACITY BUILDING

#### 5.3.1 PVO Strengthening

ACMS has increased the capacity of its staff through this program. New appointments have been made to manage the family health component of operations, which includes the malaria program. Both local and international training has been provided to research and communications departments, as well as to the ITN sales team. The addition of the ITNs and kits has broadened the base of ACMS portfolio and new distributive points have been opened which may well benefit other ACMS products, particularly condoms. This will increase ACMS’ health impact in rural areas and provide a model to scale up nationally when funds become available.

ACMS has also commenced using promoters (who were hired to facilitate net distribution in rural areas) to promote other family planning and MCH products in the rural areas (i.e. they will begin offering a 'package' to distributors and rural women's associations that include nets, insecticide kits, condoms, ORS, and the soon-to-be-launched safe water

product. This has helped ACMS re-think how they might be able to improve its distribution system, not only to reach rural populations, but also to offer an integrated package of products.

Some of the research that has been done for this project has also had an impact on other ACMS initiatives. A study carried out on rural women's listening habits (radio) showed that the target population in certain rural areas does not have the level of access to radio that was previously believed, and this has led to think of other ways of reaching rural populations (i.e. through the caravan, women's and church associations, and promoters -- all of which is now planned for other products such as condoms and the safe water product).

Through input from malaria staff in PSI from other countries, ACMS staff has also benefited from their experience and expertise. This cross-fertilization of experience in programs in practice gives a broader perspective to the ACMS program.

### 5.3.2 Local Partner Strengthening

The major partners in the ACMS program are the PNLN and several NGOs. All of these have received training from the ACMS team and the modules developed by the program are now included in the trainings of these organizations. The function of ITNs and re-treatment are now better understood and ACMS' generic communications have benefited all of these organizations' work.

Before this project, ACMS did not for the most part seek out partnerships with other NGOs. This was really the first project where ACMS began building relationships with other NGOs, and this has been expanded to other projects. ACMS now has strong collaborative relationships with many local and international NGOs, as well as with the National Malaria Control Program. All of the BCC materials were developed in collaboration with a large number of partners, which is not usually the way ACMS had developed communication campaigns in the past. As part of this, ACMS has helped facilitate the National Malaria program's efforts to bring partners together to discuss malaria-related issues by hosting partner meetings and by keeping partner collaboration on the PNLN' agenda.

### 5.3.3. Sustainability

The ACMS program has helped commence raising awareness of the means of transmission of malaria and the ways in which malaria can be avoided. The DIP rightly enumerated the large population at risk and the program has gone some way in fulfilling the latent demand for ITNs and correct usage for vulnerable people. However, creating a critical mass of behavior change will take time. It is likely that reaching the targeted national pool goal of ITNs and their correct re-treatment will take a longer period of time than that of the present program.

Financially, ACMS makes a reasonable cost recovery which, by the end of the currently funded USAID/GH/HIDN/NUT/CSHGP project, will go some way towards the purchase of product in the future. In addition they are seeking ways in which this can be improved. They are also seeking other donors to support the program. However, if the

ITN and re-treatment uptake is to continue to grow and marketing efforts are to be further supported, then additional funding will be required for the next three years at least until the products reach their full potential. Continued communication is undoubtedly necessary, as is the effort to create wider accessibility in the rural areas.

## **6. PROGRAM MANAGEMENT**

The ACMS ITN program has built a dedicated ITN team comprising the Assistant Program Director, Marketing Manager, Sales Manager, research assistant, six sales promoters and the caravan troupe. This team benefits from the existing ACMS structure, which provides integrated resources including packaging, finance, administration, human resources and MIS.

In the initial stages of the program, a dedicated team such as this is of vital importance. Often in SM programs, existing business is built around condoms, FP and other product programs. Malaria ITNs and re-treatment kits are frequently a new product category to many in the organization and need unique development of training, communications and materials. Because of the product's physical bulk compared to condoms and FP products, careful thought needs to be given to logistics and management on how to integrate these products into an existing tariff of products, and distribution is sometimes different from existing structures.

The ACMS team has worked well together, especially in using research to develop its BCC strategy, communications activities and materials. Other in-house resources have integrated the ITN project well. However, care must be taken not to try and absorb the ITN project into mainstream activities too early. New development projects need nurturing and focus of attention in a single-minded way by experienced personnel. The project has clearly benefited from this in its first two years.

The project benefits from management input from PSI/W where there are now positions of MCH Director and a Child Survival Coordinator, who oversee projects globally. This allows experiences to be shared across programs and, where new methods and skills are developed, to be integrated into new programs. Technical input is also received from PSI's Senior Technical ITN Advisor, which is beneficial to all projects, and keeps programs abreast of new methods and information on malaria related topics.

## 7. CONCLUSIONS

The project has started well with a comprehensive BCC program and training of partner public and NGO sector personnel. Communication activities are continuing and, among those touched by these, there appears to be a growing understanding of malaria, its cause and methods of prevention. Capacity of both PSI and other partner staff has been increased. Overall, it appears that demand for and uptake of ITNs is growing nationally.

Despite the progress being made, it is felt that a 3-year period is inadequate to achieve some of the behavior change levels indicated in the DIP. The process itself does not lend to rapid change, since the programs do not get underway the DIP has been agreed. This generally leaves just over two years to reach the indicated results. An extension to the project to continue and expand the good work in progress should be considered.

## ANNEX 1 CONTACTS

### ACMS/CAMEROON

Mme . Theresa Gruber-Tapsoba  
Mme. Shannon Bledsoe

Mr. Bouba Tchamaki  
Mr. Sali Adamou  
Mr. Patrice Bende  
Mr. Maurice Kwite  
Mr. Jules Onanina  
Mr. Anselme Ndzie  
Mr. Salomon Ndjock  
Mme. Bernadette Nga  
Mr. Marcellin Ondoua  
Mr. Paul Bina

Permanent Secretary  
Directeur Adjoint Sante Famille &  
Technical Advisor PSI  
Administration Manager  
Sales Manager  
Marketing Manager  
Research Manager  
Promoter Yaounde  
Promoter Obala  
Promoter Bertoua  
Promoter Ebolowa  
Promoter Sangmelima  
Promoter Batouri

### CARAVAN

Mr. Maurice Akolo  
Ms. Rolande Loe  
Mr. Jean Marie Awona

Animator  
Animator  
Animator

### MOH

Dr. Jean-Blaise Doaw

Delegue Eastern Province

### PNLP

Dr. Okalla Abodo

Permanent Secretary /MCP

### AFRO AID

Mr. Dani Horowitz  
Mme. Suzanne Apanda

Vice Chairman  
President Yaounde Branch

### PLAN INTERNATIONAL

Dr. Esther Tallah  
Dr. Mfomyam Cristopher  
Presidents, Chairmen, Secretaries of local CBO's

Health Coordinator  
Child Survival Project Coordinator

### PHARE

### ALHYSCA

Mr. Gabriel Eka'a Owona

Coordinator

## **ANNEX 2    BIBLIOGRAPHY**

ITN Proposal PMSC, PSI, Dec 2001  
Child Survival SM of ITNs in Cameroon Detailed Implementation Plan, PSI April 2001  
ITN Marketing Plan, PSI, 2004  
National Strategic Plan for Malaria, MOH, May 2002  
National plan for Communication on Malaria, MOH, January 2004  
Child Survival Grants Program, ITN/CAM Annual Report, ACMS October 2003  
DHS 1998, Macro International, 1998  
Baseline KAP, IRESCO, March 2001  
KQLA Survey, ACMS, August 2003  
Availability of ITN Study, Action Synthese, 2003  
Market Structure for ITNs, ACMS, March 2003  
Agency Briefs for Research, ACMS, 2004  
Pre test of Logos, URAD, November 2003  
Pre test of IEC Material for ITNs, EOCAP, March 2004  
Female Listeneing Habits, URAD, February 2004  
Monthly Activity Reports, ACMS, March-August 2004  
PSI Annual Sales &Health Impact Report, PSI/W, 2003  
Sales Data, ACMS, March – August 2004  
Organograms, ACMS, 2004

### **ANNEX 3 History of Malaria Program in Cameroon**

Malaria control began in Cameroon in 1992, and a National Policy Declaration was adopted in July 1997. Malaria control had traditionally focused on treatment of cases, vector control, and IEC activities, which are supported by training, operations research, and epidemiological surveillance. In May 1998, the first Plan of Action was developed.

In December 1998, a Working Group for Malaria Control was created which included the National Coordinator; the Director of Pharmacy in the Ministry of Public Health; two members from the health education unit in the Ministry of Public Health; two entomologists from the Community Health Division of the Ministry of Public Health; a representative from the WHO, UNICEF, and research institutes (OCEAC, ORSTOM) and two paediatricians from the Central Hospital of Yaoundé.

Following the launching in 1998 of the RBM initiative by the WHO Director General, the President of Cameroon officially supported malaria control in a letter to the Director General of WHO, and the Minister of Public Health signed the Abuja Declaration to Roll Back Malaria in April 1999 on behalf of the government. The official debut of the Initiative was the national launching conference on July 25, 2000 with participants from the Ministry of Public Health, other ministries, partner organizations, NGOs, universities and research institutes, the press, religious institutions, the community, and delegates from the different levels of the health system.

A situation analysis of malaria in Cameroon was conducted between November 2000 and August 2001 to serve as the basis for planning the program. This analysis informed the elaboration and national adoption on April 2002 of a Strategic Plan for Malaria Control for the period from 2002 to 2006.

Major partners of the RBM Initiative include WHO, UNICEF, UNDP, the World Bank, and the European Union. Other partners include several other ministries, NGOs, private sector clubs, such as the Lion's Club International; universities; research institutes, and communities. WHO and UNICEF are viewed as the leaders of the RBM initiative in Cameroon, along with the Ministry of Public Health. They assisted the government in instituting a tax exemption for importation of bednets and insecticide and in sponsoring early consultancies.

Between 1999 and 2002, WHO provided some 50,000 nets and 144,000 insecticide tablets to MOH net treatment centres, and COTCO (Exxon-Mobile) issued 36,000 pretreated nets to populations along the Chad-Cameroon pipeline in 2002. The National Malaria Control Program issued 157,000 ITNs through health centres in 2003 directed towards pregnant women, and ACMS commenced its ITN and re-treatment program in March 2004, mainly targeting communications at women of reproductive age and parents of young children but selling to the commercial sector.

Before 2003, government expenditures for malaria were difficult to ascertain, since the budget was not organized by program. The 2000-2001 bulk investment budget allocated by the MOH for malaria and HIV/AIDS control was about \$2,857,143. Allocation of a specific budget from government sources started in 2003. Unfortunately it seems that the amount allocated in the year 2004 was less than the previous year, probably due to

misunderstanding of the funding allocated by GFATM, which is meant to be an additional funding to rapidly scale up malaria interventions, and not an alternative funding source to the state budget.

Additional budgets from the HIPC initiative of respectively \$1.7million and \$7million were allocated in 2002 and 2003 for the purchase and distribution of treated bednets to pregnant women (157,000 in 2002 and 678,000 in 2003). Another funding from the same source previewed the purchase and distribution of treated bednets to another 800,000 pregnant women, but this was later reduced.

WHO allocated \$204,000 for years 2000 to 2001 and \$170,000 in 2003 and 2004 to the RBM Initiative from extra-budgetary sources, giving a total of \$374,000.

## **Annex 4 LQAS Methodology**

Lot Quality Assurance Sampling (LQAS) was initially designed in the 1920s to assess the quality of industrial commodities (Robertson et al., 1997). Over recent decades, the method has been adapted by health-system evaluators and is quickly being recognized as a viable means of assessing health-worker performance and intervention coverage. Multinational agencies and various institutions have been involved in health applications of LQAS. For example, WHO adapted the method to monitor immunization services, and it created a manual to assist health managers in using LQAS to assess both coverage and quality of immunization services (WHO, 1996).

The hallmark of LQAS is the division of the target population into smaller, administratively meaningful units (lots) and the selection of small, random samples from each of those units. Data gleaned from these stratified random samples provide supervisors and program managers with a sufficient amount of information on which they can base management decisions. In addition to enabling managers to monitor sub-divisions within their project area, LQAS also offers the flexibility of aggregating data across sub-divisions to obtain a coverage estimate for the entire project area.

LQAS has a number of advantages over cluster sampling. Five such advantages are presented below.

1) Cluster sampling, unlike LQAS, only yields overall coverage estimates. Because of this it hides differences in coverage between sub-divisions of a project's catchment area. While LQAS does not yield specific coverage estimates for sub-divisions, it does identify which sub-divisions have acceptable levels of coverage as well as those that are performing below expectation. In this regard, it is possible to target areas that require additional resources in order to achieve project objectives.

2) LQAS coverage estimates tend to be more precise than estimates obtained using cluster-sampling techniques. This greater precision is due to the fact that LQAS is rooted in principles of stratified sampling, which generally yields estimates with narrower confidence intervals than estimates derived from cluster samples of the same size. With LQAS, every stratum (e.g., village, ward) is sampled. With cluster sampling, many strata may be omitted in the selection of clusters.

3) As mentioned above, LQAS is a more efficient sampling design than cluster sampling. In many countries, families or individuals with similar behavioral patterns tend to live in close proximity to one another. The selection of neighboring households within a given cluster, as is done with cluster sampling, introduces a bias that does not exist when individuals are selected randomly. This bias is reflected in a statistical measure known as the design effect (DE). DE equals 1.0 (no design effect) if the sample design is as efficient as a simple random sample. There is no design effect

associated with LQAS. In contrast, cluster sampling is associated with increased sampling error and is therefore less efficient than simple random sampling. For cluster samples, DE is assumed to be equal to 2.0. There must be twice as many respondents in a cluster sample compared to a simple random sample in order to compensate for the increased sampling error associated with cluster sampling.

4) Surveys can be implemented at any time during a project. Traditionally, cluster surveys are implemented at the beginning of a project to gather information as part of a baseline assessment, then four years later at the end of a project to assess whether the project has achieved its initial objectives. While information gathered at the end of a project can be used for evaluation, it is too late to use for project monitoring. In theory, cluster surveys can be implemented as frequently as the project manager desires. From a monitoring perspective, however, the methodology can be impractical. It does not provide information on individual program units that can be used to manage projects more effectively and efficiently. In contrast, LQAS' relevance to local program units makes the methodology more practical for project monitoring. When used with a small questionnaire, LQAS is relatively easy to implement. It lends itself to multiple applications throughout the project cycle, providing useful information for both monitoring and evaluation purposes.

5) There is also evidence to suggest that studies using LQAS are less expensive than studies using cluster sampling (Robertson et al., 1997). For example, a cost analysis of PLAN/Nepal's LQAS assessment at midterm indicates that the total cost of the study was less than half that of the project's baseline cluster (KPC) survey. Many of the LQAS costs were already paid by the project (e.g., project employees were used as interviewers). Taking this into consideration, the baseline cluster survey actually costs more than four times as much as the LQAS assessment.

## ANNEX 5 CSHGP Project Planning Matrix

<p><b>Goal:</b> Reduced incidence of malaria-related mortality and morbidity among children under five and pregnant women in East, Centre, and South provinces of Cameroon (the “Intervention Area”)</p>				
Intermediate Results	Indicators	Achieved Mid Term	Measurement and Data Management Methods	Activities
<p>1. Increased informed demand for ITNs</p>	<p>1.1 % of adults who know that malaria is only transmitted by mosquitoes increased  <u>Baseline: 28% rural; 51% urban, Mid-term = 33% rural; 59% urban, EOP=50% rural; 66% urban</u></p> <p>1.2 % of adults who identify ITNs as a method of malaria prevention increased.  <u>Baseline: 1%, Mid-term =12%, EOP=25%</u></p> <p>1.3 % of adults who</p>	<p><b>Rural 54%</b>  <b>Urban 55%</b></p> <p><b>18.9%</b></p> <p>Baseline:</p>	<p>1. KAP</p>	<ul style="list-style-type: none"> <li>• Validate baseline KAP data</li> <li>• Conduct FGDs to probe consumer preferences and obstacles to use</li> <li>• Develop BCC strategy and marketing plan</li> <li>• Develop creative briefs for BCC</li> <li>• Produce and air radio spots and other productions</li> <li>• Develop print materials</li> <li>• Design and produce IEC materials for IPC</li> <li>• Monitor IPC activities (mystery client surveys)</li> <li>• Pre/Post-test</li> </ul>

	<p>identify children under five and pregnant women as high-risk groups for malaria increased. <u>Baseline: 46%, Mid-term =56%, EOP=66%</u></p> <p>1.4 % of 0-5s and pregnant women reported to have slept under a net the previous night increased. <u>Baseline: 4%, Mid-term=20%, EOP=33% (rural) and baseline: 10%, Mid-term=21%, EOP=33% (urban).</u></p> <p>1.5 Difference in reported use between 1<sup>st</sup> and 4<sup>th</sup> socioeconomic quartiles decreases by 25%. <u>Baseline: 25%, Midterm=22%, EOP=19%</u></p>	<p>Children&lt;5 years 37% Pregnant women 9% <b>Mid term:</b> <b>Children 42%</b> <b>Pregnant women 24%</b></p> <p><b>Baseline:</b> <b>Children&lt; 5 years 10.5%</b> <b>Pregnant women 5%</b> <b>Mid term:</b> <b>Children&lt; 5 years 51.5%</b> <b>Pregnant women 45.5%</b></p> <p><b>Baseline should be 21%</b></p> <p><b>Mid term:</b> <b>TBC</b></p>		<p>communications materials</p> <ul style="list-style-type: none"> <li>• Conduct EOP KAP</li> </ul>
--	---	---	--	---

<p>2. Improved equitable access to ITNs</p>	<p>2.1 % of targeted outlets selling ITNs increased. <u>Baseline: 0%, Mid-term =25%, EOP=50%</u></p> <p>2.2 % of adults who know at least one source of ITNs increased. <u>Baseline: 1%, Mid-term =12%, EOP=25%</u></p> <p>2.3 # of outlets offering ITN subsidies to pregnant women and mothers of children under five increased. <u>Baseline: 0, Mid-term =25, EOP=50</u></p> <p>2.4 % of outlets offering ITNs at prices within the willingness to pay range of target populations increased. <u>Baseline: 1%, Mid-term =12%, EOP=25%</u></p>	<p><b>Baseline should be Number not %</b> <b>Midterm number 205+</b></p> <p><b>Midterm: 60% but includes HC.</b> <b>Commercially about 40%</b></p> <p><b>Not applicable – change of program</b></p> <p><b>Most outlets selling ACMS net at CFA 3500</b></p>	<p>2. KAP, retail audits, health centre audits, distribution surveys</p>	<ul style="list-style-type: none"> <li>• Conduct retail audits</li> <li>• Procure nets and net treatment</li> <li>• Establish pricing structure and subsidy scheme</li> <li>• Launch branded cost-recovery net and net treatment in commercial outlets</li> <li>• Blitz wholesalers and retail outlets</li> <li>• Introduce targeted subsidies for maternal ITNs in selected sites</li> <li>• Recruit implementation partners for delivery of targeted subsidies</li> <li>• Launch branded high-end net through selected partners</li> </ul>
---	--	---	--	--



Intermediate Results	Indicators	Achieved Mid Term	Measurement and Data Management Methods	Activities
<p>4. Increased capacity of PSI in delivering health impact through MCH interventions</p>	<p>4.1 Number of project materials through Intranet, Profiles, and CD-ROM. <u>Baseline: 0, Mid-term =2, EOP=5</u></p> <p>4.2 Number of PSI MCH department capacity-building/planning workshops conducted. <u>Baseline: 0, Mid-term =1, EOP=3</u></p> <p>4.3 Number of MCH fundraising materials disseminated. <u>Baseline: 0, Mid-term =12,000, EOP=25,000</u></p>	<p><b>Project Profiles: 17</b>  <b>Res. Briefs: 4</b>  <b>Biennial Rpts 2</b>  <b>Issue Briefs: 1</b>  <b>AIDSMark Publ.11</b>  <b>Other: 2</b></p> <p><b>One Held Biannually</b></p> <p><b>11,500 fundraising materials disseminated</b></p>	<p>4. Project reports, PSI sales reports and contracts database</p>	<ul style="list-style-type: none"> <li>• Document best practices</li> <li>• Produce PSI Profile on targeting ITN subsidies</li> <li>• Produce “Product” CD for ITNs</li> <li>• Conduct yearly SWOT of MCH department</li> <li>• Conduct annual capacity-building/planning workshops for MCH</li> <li>• Produce yearly marketing plan for MCH</li> <li>• Design CS Intranet page</li> <li>• Fill Intranet (and web site where appropriate) with lessons learned documents</li> </ul>



## **REQUIRED ATTACHMENTS**

**ATTACHMENT A:  
BASELINE INFORMATION FROM THE DIP**

Several small and one major change have been made to the project's programming since approval of the DIP in June of 2003. ACMS had originally planned to segment the net market by selling a cost-recovery net through health centers and a higher-priced net through the private sector. These nets were to be different colors and have slightly different names to distinguish them in the marketplace. This model is based on the highly successful ITN program in Malawi. Unfortunately, the Ministry of Health (MOH) decided not to allow sale of nets through health centers in December 2003. This decision was based on the fact that the MOH planned to distribute cost-free nets (financed by HIPC funds) to pregnant women through health centers, and did not want any confusion between free and for-sale nets. The GOC has since also won Global Funds, which will provide cost-free nets for under-fives as well. This development means that ACMS now sells one net at the price originally intended only for the private sector. The net costs 3,500 FCFA and is the lowest price possible, given the need to build in margins for private-sector distributors. In order to better target women and children, ACMS has developed partnerships with a number of international and local NGOs and associations that are well positioned to reach vulnerable populations. Although ACMS' bundled nets are for sale to the general population, communications campaigns still point to the most vulnerable groups and target decision makers. Accordingly, there has been less emphasis on health center partnerships than was indicated in the DIP and more emphasis on NGO and association collaboration.

There have also been changes in timing, due to procurement and communications delays in the first year. Net and insecticide procurement were delayed in part by the desire to work with an in-country net supplier to help facilitate sustainable net delivery in Cameroon. It was eventually determined that this net supplier was unlikely to begin producing nets within the first two years of the project, and its partner in Tanzania was only able to offer nets at a price that would significantly increase prices for Cameroonians. Communications campaigns were delayed slightly by the development of a regional, francophone insecticide brand (which is also currently used in Mali), and because the ad agency that won the tender offer for the communications campaigns was later found to be going bankrupt (thus disrupting its capacity to deliver materials on time). The project has since recovered from both delays and is making up time. Campaigns that were planned for year 2 are beginning now, which means that communication/promotion funds that were to have been used in year 2 will be used in year 3.

Another change from the DIP is the decision not to create a weekly radio show and drama, which were intended to increase exposure in rural areas. ACMS commissioned a study in February 2004 to determine rural women's listening habits in order to produce an appropriate radio show. Instead, ACMS found that rural women (particularly in the East province) did not have high levels of access to radio. ACMS therefore decided to put resources into IPC, creating a theatre caravan to conduct demonstrations, give malaria prevention messages through skits, promote nets and treatment kits, and open up new points of sale. This has so far been a successful strategy and ACMS is hoping to expand it to include other products.

**ATTACHMENT B:  
EVALUATION TEAM MEMBERS**

Alan Handyside, Team leader and external consultant

Dr. Leonard Mbam-Mbam, Health Advisor, World Health Organization

Dr. Emmanuel Forlack, East Province Coordinator, PNL

## **ATTACHMENT C: EVALUATION ASSESSMENT METHODOLOGY**

The evaluation team, composed of the Team Leader (external consultant), a health expert from the World Health Organization and a community mobilization expert from the National Malaria Control Program (PNLP), assessed the project's progress through a variety of methods during a two-week period. The team spent time with all ACMS departments both in Yaounde and in each of the three target provinces, interviewing staff and reviewing project materials. They held meetings with the PNLN and NGO partners in Yaounde and in the peri-urban and rural areas of the three target provinces. They conducted trade visits to assess the level of product coverage and visibility, and spoke with both distributors and consumers to evaluate satisfaction with ACMS' distribution system. The team observed an NGO training and accompanied the theatre caravan throughout the South and East provinces to assess ACMS' IEC strategy. Finally, the team measured progress toward project indicators through analysis of an LQAS study that ACMS commissioned in July/August, 2004. The LQAS methodology is explained in Annex 4 of the Mid-term Evaluation Report.

**ATTACHMENT D:  
LIST OF PERSONS INTERVIEWED**

**ACMS/CAMEROON**

Mme . Theresa Gruber-Tapsoba	Permanent Secretary
Mme. Shannon Bledsoe	Assistant Director of Family Planning & Technical Advisor PSI
Mr. Bouba Tchamaki	Administration Manager
Mr. Sali Adamou	Sales Manager
Mr. Patrice Bende	Marketing Manager
Mr. Maurice Kwite	Research Manager
Mr. Jules Onanina	Promoter Yaounde
Mr. Anselme Ndzie	Promoter Obala
Mr. Salomon Ndjock	Promoter Bertoua
Mme. Bernadette Nga	Promoter Ebolowa
Mr. Marcellin Ondoua	Promoter Sangmelima
Mr. Paul Bina	Promoter Batouri

**CARAVAN**

Mr. Maurice Akolo	Animator
Ms. Rolande Loe	Animator
Mr. Jean Marie Awona	Animator

**MOH**

Dr.Jean-Blaise Doaw	Delegue Eastern Province
---------------------	--------------------------

**PNLP**

Dr. Okalla Abodo	Permanent Secretary /MCP
------------------	--------------------------

**AFRO AID**

Mr. Dani Horowitz	Vice Chairman
Mme. Suzanne Apanda	President Yaounde Branch

**PLAN INTERNATIONAL**

Dr. Esther Tallah	Health Coordinator
Dr. Mfornyam Cristopher	Child Survival Project Coordinator
Presidents, Chairmen, Secretaries of local CBO's	

**PHARE**

Coordinator

**ALHYSCA**

Mr. Gabriel Eka'a Owona	Coordinator
-------------------------	-------------

**ATTACHMENT E:  
ELECTRONIC COPY OF REPORT**

**ATTACHMENT F:  
SPECIAL REPORTS**

There are no special reports at this time.

**ATTACHMENT G:  
UPDATED PROJECT DATA SHEET FORM**

ACMS requested that the Rapid CATCH indicators be included in the 2004 DHS, which has just been completed. Final results will be available before the end of the year, and ACMS will forward them to USAID as soon as they are made public. An updated data sheet without these indicators is attached.

**Child Survival Grants Program Project Summary  
Mid Term Submission: Oct-29-2004  
PSI Cameroon**

**Field Contact Information:**

**First Name:** Shannon  
**Last Name:** Bledsoe  
**Address:** PSI--Cameroon  
 1120 Nineteenth St. NW, Ste. 600  
**City:** Washington DC  
**State/Province:** DC  
**Zip/Postal Code:** 20036  
**Country:** Cameroon  
**Telephone:** 237-988-83-34  
**Fax:** 237-220-92-24  
**E-mail:**  
**Project Web Site:** [www.psi.org](http://www.psi.org)

**Project Information:**

<b>Project Description:</b>	<p>PSI is implementing an insecticide-treated mosquito net (ITN) social marketing project to help prevent malaria in three provinces in Cameroon, particularly among disadvantaged populations. Malaria is a major health problem in Cameroon, second only to HIV in terms of the burden it places on Cameroon's health and development. Public sector resources are insufficient to satisfy the need for demand creation and supply of ITNs, and the unsubsidized commercial sector is beyond the reach of most Cameroonians. The project will meet that need while developing strategies to enhance ITN social marketing programs in other countries. As the Ministry of Health has requested that the project distribute nets only through the private sector and not through health centers as originally planned, PSI will target NGOs and CBOs to help reach vulnerable populations. PSI will also focus on lobbying to improve the net environment in Cameroon, and will encourage appropriate participation from a wide range of players in the commercial, NGO and public sectors. The goal of the proposed project is to reduce the incidence of malaria-related morbidity and mortality among children under five and pregnant women in the East, Central, and South provinces of Cameroon. The project's purpose is to increase the use of ITNs among children under</p>
-----------------------------	--

	five and pregnant women in the intervention area. This purpose will be achieved through three outputs that address the principal barriers to increased use of ITNs in the intervention area: 1. increased informed demand for ITNs; 2. increased equitable access to ITNs; and 3. increased capacity to sustain demand creation and delivery of ITNs in Cameroon.
<b>Partners:</b>	ACMS (Association Camerounaise de Marketing Social) Ministry of Health/PNLP PLAN International UNICEF World Health Organization EPC (Eglise Presbyterian du Cameroun) Service Catholique de la Sante AfroAid Multiple local NGOs and associations
<b>Project Location:</b>	East, South and Center provinces of Cameroon

**Grant Funding Information:**

<b>USAID Funding:(US \$)</b>	\$1,299,937	<b>PVO match:(US \$)</b>	\$650,000
------------------------------	-------------	--------------------------	-----------

**Target Beneficiaries:**

Type	Number
<b>0-59 month old children:</b>	641,800
<b>Women 15-49:</b>	855,733
<b>Estimated Number of Births:</b>	328,600

**Beneficiary Residence:**

Urban/Peri-Urban %	Rural %
60%	40%

**General Strategies Planned:**

Social Marketing

**M&E Assessment Strategies:**

KPC Survey

Organizational Capacity Assessment for your own PVO

Lot Quality Assurance Sampling

**Behavior Change & Communication (BCC) Strategies:**

Social Marketing

Mass Media

Interpersonal Communication

Peer Communication

**Capacity Building Targets Planned:**

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
US HQ (CS unit) Field Office HQ	PVOs (Int'l./US) Local NGO	Pharmacists Business	National MOH Dist. Health System	Health CBOs Other CBOs



receiving breastmilk and complementary foods				
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	0	0	0.0	0.0
Percentage of children age 12-23 months who received a measles vaccine	0	0	0.0	0.0
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	0	0	0.0	0.0
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	0	0	0.0	0.0
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	0	0	0.0	0.0
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	0	0	0.0	0.0

**Comments**

PSI requested that these questions be added to the DHS, which has just been completed. The final data will be available before the end of 2004 and PSI will submit this to USAID as soon as it is made public.

## **PVO RESPONSE**

## PVO COMMENTS AND ACTION PLAN

### PVO RESPONSES TO RECOMMENDATIONS

1. WHO and other stakeholders should work with the PNLP to determine a timed action plan for the issue of the GOC nets to pregnant women and children under five.

*This is ideal and ACMS will work toward this goal, though the action plan is hindered by the involvement of several parties with different priorities (ie MOH vs. Ministry of Finance, private contractors, etc). One of the reasons that Dr. Mbam Mbam (Health Advisor for the WHO) and Dr. Forlack (East province PNLP coordinator) were asked to participate in ACMS' mid-term evaluation, besides the contribution of their expertise, was to share first-hand the effect of MOH policies on the ACMS project. ACMS will continue to work with WHO and the PNLP on the expected issue of the GOC nets and will explore ways in which ACMS can help facilitate their intended use (ie, through targeted communications, sale of treatment kits to expedite the issue of the nets to target populations, etc).*

2. ACMS should continue to work closely with the PNLP and MOH to develop modus operandi for the implementation of policy decisions, especially where these impact on implementing agency programs.

*This is an ongoing process and ACMS will continue to lobby for policies that enhance the net environment in Cameroon. ACMS recently participated in an MOH- and WHO-sponsored policy elaboration workshop, wherein policy documents regarding ITNs and other aspects of malaria prevention and treatment were created. These workshops will continue in 2005. ACMS also hosts partner meetings in collaboration with the PNLP, where policy, communication and implementation strategies are discussed among partners. This facilitates partner involvement and allows for open discussion about policies that might hinder the expansion of malaria prevention and treatment programs in Cameroon.*

3. ACMS should work with the PNLP on changing policy and continue to press for authorization to sell nets through health clinics given delays in the issue of free nets.

*ACMS has discussed with the PNLP the possibility of selling at least treatment kits through health centers, and will continue to push for increased access to health facilities. ACMS also plans to hold a partner meeting to share the results of the mid-term evaluation and will use this as an opportunity to discuss next steps.*

4. ACMS should proceed as quickly as possible to develop a proposal to PSI/W to increase the allocation of additional funding to allow improved purchase of commodities.

*ACMS has submitted a proposal to PSI/W for the allocation of additional commodities funding. ACMS is also working to identify other potential commodities donors, or and/or to negotiate better credit terms with suppliers that would allow for larger stock purchases.*

5. ACMS should commence distribution to pharmacies, open up retail outlets in each district of major towns and continue to examine new business opportunities, particularly among large private sector enterprises.

*ACMS began increasing distribution to pharmacies after the observation was made by the evaluation team in-country, and will continue to do so. Pharmacies make excellent points of sale not only because of the health link (particularly with the treatment kit) but also because they often have large windows, which provide opportunities for high-visibility product display. ACMS has begun negotiating with large, private-sector logging companies in the East and South provinces, and will begin approaching these companies across the board more aggressively. In the last quarter of 2004, ACMS is also planning a sales blitz in the Center and East provinces to systematically open every point of sale possible within targeted zones. If this initiative is successful, ACMS will begin regular sales blitzes for all products.*

6. ACMS should examine ways of developing stockheads of product in more remote areas and should also look at ways in which deliveries of stock to its provincial outlets can be further improved.

*We agree. ACMS is currently researching ways of increasing stock in hard-to-reach areas, and doing so more efficiently so as to sustain (or increase) product delivery with less donor funding. One way of doing this is by developing better linkages with rural retailers and urban wholesalers, perhaps by offering incentives to pick the product up themselves rather than by relying on ACMS delivery. ACMS will continue to streamline and improve its rural distribution and overall delivery system for all products.*

7. ACMS should give attention to creating more visible point-of-sale materials in its outlets so that consumers will better identify stockists of ITNs and kits.

*ACMS is producing large, colorful banners to increase the visibility of ITN wholesalers in major towns, and is ordering calendars and stickers to help demarcate smaller retailers. ACMS is also considering painting wall murals for wholesalers in rural areas (this was a successful strategy for one wholesaler that sells Prudence Plus condoms). The point is well taken and ACMS will continue to find ways of increasing the visibility of the products.*

8. ACMS should ensure that the caravan troupe is better informed of all the retailers selling ITNs and kits in the vicinity of their performances, and should provide the troupe with megaphones for marketplace activities.

*ACMS plans to hold an in-service training for the theater troupe in the last quarter of 2004 to increase skills and to create new theater pieces. At this time, the actors will be provided with megaphones and costumes, and will practice using these new aids to attract and hold the attention of audiences in sometimes-noisy places. Based on the recommendation of the evaluators, ACMS is also purchasing audio systems and speakers for the ITN vehicles so that the caravan can play radio spots and jingles as it moves through both urban and rural marketplaces. The caravan troupe will be informed in advance of sales points in each area and will be given the objective of helping to increase these distributors' visibility.*

9. ACMS, PSI/W and USAID/GH/HIDN/NUT/CSHGP should revise the logframe and adjust EOP targets.

*ACMS and PSI/W are reviewing the project logframe in light of programmatic changes and will request an adjustment from USAID before the end of 2004.*

10. ACMS should consider if a re-alignment of line items for the remaining period of the grant is necessary, and propose any changes to USAID.

*ACMS is not likely to require a re-alignment of funds between headquarters and field costs, but will need to alter certain line items to reflect programmatic changes since the DIP was approved. ACMS will remain in contact with Tom Hall at USAID to facilitate this.*

11. USAID/GH/HIDN/NUT/CSHGP should consider an extension to the Cameroon program after September 2005 in order to continue the ACMS' communications work and provide for improved coverage and better ways of developing the rural market.

*PSI/ACMS, in collaborating with Plan International and Helen Keller International, is submitting a proposal for a 5-year IMCI intervention in Cameroon, 40% of which would be dedicated to malaria. Under the proposed project, ACMS would scale up nationally, building upon its work in the South, Center and East provinces.*

**WORK PLAN**

<b>Results Hierarchy</b>	<b>Performance Indicators</b>	<b>M &amp; E</b>	<b>Assumptions</b>
<p><b>Goal</b> Reduced incidence of malaria-related mortality and morbidity among children under five and pregnant women in East, Center, and South provinces of Cameroon (the “intervention area”)</p>	<ol style="list-style-type: none"> <li>1 Reduction in all cause morbidity and mortality in children under five</li> <li>2 Reduction in low-birth weight children</li> <li>3 Reduction in malaria incidence among children under five years and pregnant women</li> </ol>	Will not be evaluated at the goal level, due to project duration and lack of appropriate MoH statistical data	
<p><b>Purpose</b> Increased use of ITNs among children under five and pregnant women in intervention area, particularly among the poorest</p>	<ol style="list-style-type: none"> <li>1. Percentage of children under five and pregnant women reported to have slept under a net the previous night increased from estimated 4% to 33% in rural areas; 10% to 33% in urban areas.</li> <li>2. Difference in reported use between 1<sup>st</sup> and 4<sup>th</sup> socioeconomic quartiles decreases by 25%.</li> </ol>	1-2. KAP	<p><b>Political and economic environment remains unchanged or improves</b></p> <p>Mosquitoes do not become resistant to deltamethrin used on ITNs</p> <p>Vector biting patterns do not change significantly</p>

<b>Logframe activities</b>	<b>Responsibility</b>	<b>FY2004</b>				<b>FY2005</b>			
		<b>Jan Feb Mar</b>	<b>Apr May Jun</b>	<b>Jul Aug Sep</b>	<b>Oct Nov Dec</b>	<b>Jan Feb Mar</b>	<b>Apr May Jun</b>	<b>Jul Aug Sep</b>	<b>Oct Nov Dec</b>
<b>IR1: Increased informed demand for ITNs</b>									
<b>OBJECTIVE 1 – INCREASE INFORMED DEMAND FOR ITNS IN THE INTERVENTION AREA</b>									
Finish producing campaigns on retreatment and ITNs as gifts (‘cadeau de valeur’)	ACMS, Panafcom			<b>X</b>					

Produce banners, bumper stickers, plastic bags, keychains to increase visibility	ACMS, suppliers				X				
Order megaphones, costumes, audio equip	ACMS, suppliers				X				
Air 'cadeau de valeur' TV spots/posters	ACMS, CRTV				X				
Produce 2005 calendars	ACMS, suppliers				X				
Air Super Moustiquaire radio jingle	ACMS, CRTV				X				
Hold training workshop for theatre group	ACMS				X		X		
Decorate vehicles to increase visibility	ACMS, suppliers				X				
Distributor marketing contest (increase visibility)	ACMS, distributors				X		X		
Develop 2005 marketing plan	ACMS, partners, PNLP				X				
Rural theatre caravans	ACMS, partners				X	X	X	X	
Air 'retreatment' radio, TV spots, posters	ACMS, CRTV					X			
Conduct LQAS study to determine effect of sales blitzes and comm. campaigns	ACMS, research agency					X			
Develop radio spot to address any major issue brought up through LQAS	ACMS, partners						X		
Air post-LQAS radio spot	ACMS						X		
EOP KAP	ACMS, partners							X	
EOP Evaluation	ACMS, partners, consultants							X	
<b>IR2: Improved equitable access to ITNs</b>									
<b>Objective 2 – Improve equitable access to ITNs in the intervention area</b>									

Develop proposal to increase funding for commodities (PSI) and discuss w/ potential donors	ACMS				X	X				
Hold sales blitz in Yaounde	ACMS, partners					X				
Sales blitz in rural and peri-urban areas, Center	ACMS, partners						X			
Sales blitz in rural and peri-urban areas, East	ACMS, partners					X				
Sales blitz in rural and peri-urban areas, South	ACMS, partners						X			
Begin systematically approaching private-sector companies	ACMS, partners						X	X	X	
Push sale of retreatment kits before retreatment campaign	ACMS, partners					X				
Lobby for sale of retreatment kits through health centers	ACMS, MOH, WHO					X	X	X	X	
<b>IR3: Strengthened sustainability of ITN and CS programming</b>										
<b>Objective 3 – Increased capacity of partner organizations to sustain ITN programming in Cameroon</b>										
Hold strategic planning exercise for ACMS	ACMS						X			
Hold annual review workshop for MOH, partners following MTE results	ACMS, partners					X				X
Hold partner policy meeting	ACMS, partners						X	X	X	
Lobby to rescind taxes and tariffs on nets to facilitate in-country source of nets	ACMS, MOH, WHO, partners					X	X	X	X	
Identify means of procuring insecticide locally	ACMS					X	X	X	X	
<b>OBJECTIVE 4 – INCREASED PSI CAPACITY IN MCH/CS</b>										
Release PSI profiles, ITN CDs	PSI					X	X	X	X	
Yearly marketing plan for MCH department	PSI					X				
Publish project materials on The Wave (web page for all country offices)	PSI					X	X	X	X	

## 2005 PROJECTED BUDGET EXPENSES

National Social Marketing Project Cameroun  
 USAID/GH/HIDN/NUT/CSHGP  
 CA # HFP-A-00-02-00043-00

### PROJECT YEAR THREE (2004-2005) BUDGET

	Description	Cumulative USD Billings	USD Budget	USD Variance	Year 3 2004-2005 Projected Expenses	Total New Budget	Variance
<b>Headquarters costs</b>							
	Personnel:	72,608.50	132,287.00	59,678.50	47,288	<b>119,896.50</b>	-12,391
	Fringe Benefits:	32,052.80	44,932.00	12,879.20	17,969	<b>50,022.24</b>	5,090
	Supplies:	1,160.69	0.00	(1,160.69)		<b>1,160.69</b>	1,161
	Indirect Charges:	131,410.82	235,700.00	104,289.18	84,182	<b>215,592.92</b>	-20,107
	Travel:	26,247.28	0.00	(26,247.28)		<b>26,247.28</b>	26,247
<b>Headquarters costs:</b>		<b>263,480.09</b>	<b>412,919.00</b>	<b>149,438.91</b>	<b>149,440</b>	<b>412,919.63</b>	0.63
<b>Field costs</b>							
	Personnel:	77,184.75	204,448.00	127,263.25	80,162	<b>157,346.75</b>	-47,101
	Fringe Benefits:	80,652.26	172,721.00	92,068.74	96,860	<b>177,512.26</b>	4,791
	Travel:	55,536.71	96,187.00	40,650.29	45,828	<b>101,364.71</b>	5,178
	Equipment:	16,585.27	10,720.00	(5,865.27)	2,436	<b>19,021.27</b>	8,301
	Contractual Services:	18,959.49	11,680.00	(7,279.49)	21,552	<b>40,511.49</b>	28,831
	Other Direct Costs:	211,487.03	391,262.00	179,774.97	179,774	<b>391,261.52</b>	0
<b>Field costs:</b>		<b>460,405.51</b>	<b>887,018.00</b>	<b>426,612.49</b>	<b>426,612</b>	<b>887,018.00</b>	0.00
<b>TOTAL</b>		<b>723,885.60</b>	<b>1,299,937.00</b>	<b>576,051.40</b>	<b>576,052</b>	<b>1,299,937.63</b>	

#### Notes:

#### Headquarters costs

- Personnel is decreased due to overestimated support costs.

- Fringe is increased to account for higher fringe rate in 2004-2005 than when budget was prepared.
- Supplies increased to account for equipment purchased through and billed by PSI/Washington.
- Indirect cost decreased to reflect decreased Personnel costs.
- Travel increased to account for travel costs booked and billed by PSI/Washington.

**Field costs**

- Personnel is decreased because of delays during first year of project and sharing of salaries with other projects.
- Fringe is increased to allow for sales bonuses.
- Travel is increased to enable Project to better reach rural areas and do sales blitzes to open new sales points.
- Equipment is increased to provide audio equipment to increase visibility in rural areas.
- Contractual services are increased to provide sufficient funding for EOP evaluation and packaging, which were under budgeted.
- Other direct costs remain the same although the project will increase communication spending to fund rural theater caravans

**FORM 424a**  
**SECTIONS D & E**  
(as required for annual reporting)

- FORECASTED CASH NEEDS								
		Total for 3rdYear	1st Quarter	2 Quarter	3rd Quarter	4th Quarter		
13.	Federal	\$576,052	\$144,013	\$144,013		\$144,013	\$144,013	
14.	NonFederal	\$0	\$0	\$0		\$0	\$0	
15.	<b>TOTAL</b> (sum of lines 13 and 14)	\$576,052	\$144,013	\$144,013		\$144,013	\$144,013	
SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT								
(a) Grant Program		FUTURE FUNDING PERIODS (YEARS)						
		(b) First		(c) Second	(d) Third		(e) Fourth	
16.	CSHGP					\$576,052		\$0
17.	0							
18.	0							
19.	0							
20.	<b>TOTALS</b> (sum of lines 16- 19)							\$0