USAID/Zambia
SO3 Close-out Report
1998 - 2004

SO Name: Increased use of integrated child and reproductive health and HIV/AIDS interventions

SO Number: 611-003

Approval Date: December 1997

Geographic Area: Zambia

Total Cost:

- SOAG Total	63,000,000	(Source: P19 09/30/2005, amount obligated)
- PROAG Total	59,000,000	(Source: P19 09/30/2005, amount obligated)
- Field Support Total	49,000,000	(Source: PHN Office Records)
TOTAL	171,000,000	

Principal Implementing Partners:

Bilateral Partners

- **Zambia Integrated Health Programme (ZIHP)**
  Abt Associates, Inc. - ZIHPSYS
  Johns Hopkins University Center for Communication Programs (JHU/CCP) - ZIHPCOMM
  John Snow Research and Training Institute - ZIHPSERVE
  Population Services International (PSI) – ZIHPSOM
- **Churches Health Association of Zambia**

Managed directly by Mission

Sector Program Assistance Agreement (SPA)
Participant Training

Global Health Bureau Projects

Applied Research in Child Health (ARCH)/Boston University
BASICS/John Snow, Inc.
Call to Action Project/Elizabeth Glaser Pediatric AIDS Foundation
Central Contraceptive Procurement
HIV Operations Research (HORIZONS)/Population Council
International HIV/AIDS Alliance
Implementing AIDS Prevention and Control Activities (IMPACT)/Family Health International
LINKAGES/Academy for Educational Development
Maternal & Neonatal Health Project (MNH)/JHPIEGO
MEASURE/BUCEN/US Census Bureau
MEASURE/DHS/ORC Macro
Micronutrient Support Project (MOST)/International Science and Technology Institute
NetMark/Academy for Educational Development
Community REACH/Pact, Inc.
Partners for Health Reform Plus (PHR*plus*)/Abt Associates, Inc.

POLICY Project/The Futures Group International
Population Council
Quality Assurance Project (QAP)/University Research Corporation
Rational Pharmaceutical Management Plus (RPM+)/Management Sciences for Health
The Synergy Project
Training in Reproductive Health (TRH)/JHPIEGO
Child Survival and Health Program Grants:

- Adventist Development and Relief Agency
- Project Concern International (PCI)

Matching Grants:

- Project Concern International (PCI)
- Salvation Army World Service

Technical Assistance to SO3

Technical Assistance in AIDS and Child Survival (TAACS) Program/Center for Development and Population Activities (CEDPA)
Population Fellows Program/University of Michigan
Health and Child Survival Fellows Program/Johns Hopkins University
Population Leadership Program

Background

SO3 was developed with an emphasis on taking an integrated approach to health interventions and supporting the decentralization of the health sector. Rather than continuing USAID's previous "vertical" approach, where separate projects (family planning, child survival and HIV/AIDS) addressed different parts of the health sector, USAID, with its Zambian partners, decided to pursue a broad integration of services while decentralizing to the maximum extent possible. The SO directly addressed Zambia's needs in family planning, child survival, infectious diseases and HIV/AIDS.

In 1997, HIV/AIDS was already having a serious impact on the country. Then, as now, the epidemic threatened Zambia's prospects for sustainable future development as a result of the enormous loss of life among that part of the population in its most productive years, leading to economic disruption from the multiplier effects of an inadequate workforce on supply and demand. The viability of the healthcare system was likewise threatened. The country's formal and informal social support systems were overwhelmed by the need to care for sick family members and for the growing number of AIDS orphans.

Apart from HIV/AIDS, the health status of Zambians was continuing to show other signs of decline. Infant mortality, which had declined in the 1970s, began to rise and was at a level of 109 per 1,000 births in 1996, while the mortality rate for children under five climbed from 174 to 197 per 1,000. Under those conditions, at the time the SO was designed, both infant and child mortality rates were projected to increase further to 129 and 269, respectively, by 2005. In fact, both rates went down.

Not all health statistics were discouraging and progress in the population sector was hopeful. The contraceptive prevalence rate among currently married women in 1996 was 26 percent (14.4 percent modern methods and 11.5 percent traditional), a significant increase from 15 percent in 1992. The most widely used methods were the pill and withdrawal (accounting for 26 percent each of the contraceptive prevalence), followed by the condom (19 percent) and natural family planning (13 percent). Though the population growth rate remained at 3.2 percent, the total fertility rate declined from 6.5 (1992) to 6.1 (1996).

SO Design Factors

As a result of Zambia's transition to multi-party democracy in 1991, an enabling environment was created which supported the Government of Zambia's (GRZ) efforts to launch a dynamic health reform process designed to provide equitable access to cost-effective quality health care as close to the family as possible. Within this context, there was a major reorientation of policy away from highly centralized vertical programs, towards decentralized, integrated programs.

The GRZ's health sector reform program was a Zambian-created model for decentralization of services and an example of the African leadership that USAID was seeking to promote in order to ensure ownership and sustainability of its development assistance efforts. The health sector was leading Zambian public sector reforms, which were characterized by an emphasis on decentralization, devolution of authority to regional and local levels, and bringing service delivery and management closer to its customers, the Zambian public.

Based on this vision, the Zambia Integrated Health Programme (ZIHP), the cornerstone of SO3, was designed to: 1) create environments conducive to health; 2) disseminate knowledge on the art of being well; and 3) ensure equitable access to an essential package of integrated health care services. The prioritized population, health and nutrition (PHN) interventions to be supported by ZIHP included:

- An integrated adolescent package;
- An integrated promotive/preventive package for woman caring for children;
- An antenatal care package;
- A safe pregnancy package;
- An integrated promotive/preventive package with special emphasis on reproductive health as it related to men; and
- Integrated curative/care packages.

The critical assumptions underlying the SO were:

- The GRZ would continue to pursue its health care reform agenda with the same vigor as in the past;
- The decentralization program would continue to devolve great and great authority, responsibility and financing to the local level; and
- There would be continued progress in privatization and private sector growth.

Sustainability of USAID's interventions was based on the contribution to health sector funding from the Sector Program Assistance agreement, designed to help bridge the gap between the per capita cost of basic primary health care services (estimated at $12 in 1998) and the total GRZ and donor support to the sector at that time of about $4 per capita. USAID also noted that successful implementation of political and economic reforms, particularly those to promote privatization and trade liberalization, would be critical to realizing the health sector's reform goals.

Summary of overall impact at SO and IR level

SO3 achieved significant impact, exceeding the majority of performance targets in all areas of the program.

SO: Increased use of integrated child and reproductive health and HIV/AIDS interventions

The impact of activities under this SO is reflected by:

- An *increase in contraceptive prevalence rate* using modern methods from 14% in 1996 to 22.6% in 2001, exceeding the target established for 2000 of 22%.

- An *increase in condom use* during the last sexual act with a non-marital, non-cohabiting partner from 26% (males ages 15-24) and 20.1% (females ages 15-24) in 1998 to 40.2% (males ages 15-24) and 34.7% (females ages 15-24) in 2003. However, this increase was below the 2003 targets of 46% for males and 42% for females, which the SO felt had perhaps been too ambitious.
- An *increase in the age at first sexual debut* from 16.3 (male) and 16.9 (female) in 1998 to 17.5 (male) and 17 (female) in 2003, meeting the target established for 2003.

IR1: Increased demand for PHN interventions among target groups

Increased demand for interventions among target groups is reflected by:

- *Sustained increased Vitamin A coverage* from 91% in 1997 to 92% in 2004, reaching the goal of maintaining coverage over 80%, the point at which studies have shown a 23% reduction in child mortality.
- An *increase in the percentage of women receiving the standard prevention of mother to child HIV transmission (PMTCT) package* from 10% in 2001 to 37% in 2003, exceeding the target of 35%.

IR2: Increased delivery of PHN interventions at the community level

Increased delivery of interventions at the community level is reflected by:

- An *increase in the number of orphans and vulnerable children receiving support from NGOs and community-based organizations* from 54,000 in 2001 to 232,300 in 2004, exceeding the target of 200,000.
- An *increase in the percent of high-risk sub-populations treated for STIs* has increased from 11.2% for commercial sex workers (CSWs) and 10.7% for long-distance truck drivers (LDTDs) in 2001 to 26% for CSWs and 23% for LDTDs in 2003, exceeding the targets of 15% and 14% respectively.

IR3: Increased delivery of PHN interventions by the private sector

Increased delivery of interventions is reflected by:

- *Sales of "Maximum" brand male condoms increased* from 4.7 million in 1993 to 13.3 million in 2004, exceeding the target of 12 million.
- *Sales of "SafePlan" oral contraceptives increased* from 182,000 in 1997 to 712,500 in 2004.
- *Sales of insecticide treated nets (ITNs) increased* from 2,238 in 1998 to 272,701 in 2004. However, 2004 sales fell short of the target of 320,000 for that year.
- *Sales of "Clorin" (home water treatment solution) bottles increased* from 3,558 in 1998 to 1.78 million in 2004, exceeding the target of 1.66 million.

IR4: Improved health worker performance in the delivery of PHN interventions

Improved health worker performance is reflected by:

- *Maintenance of an 80% or higher rate of correct diagnosis and treatment of childhood illness* in target areas.

IR5: Improved policies, planning and support systems for the delivery of PHN interventions

- *Numerous critical health policies for institutional and human resources development developed, revised, approved and or/submitted to* Cabinet including the Nurses and Midwives Act; education and training for health; health care financing; nutrition; reproductive health; malaria; child health and HIV/AIDS Act and Multisectoral HIV/AIDS/STD and TB.

Significant changes in the Results Framework during the life of the SO

No major changes were made to the SO or IRs during the period 1998-2004. However, as the program was refined, the PMP was changed several times. In 2000, the IR indicator: "cost sharing of revenues" (percent of user fees spent on non-administrative health care in demonstration districts) was dropped, as

the cost of collecting this information was deemed to be too high. In 2002, two other indicators were dropped. The indicator "new family planning acceptors" was replaced with "couple years of protection" to better reflect USAID/Zambia's contribution to family planning, although this was also ultimately dropped as the Ministry of Health chose not to collect and present family planning data in this form. The indicator "diagnosis and treatment of STI" was also dropped because the SO had no program in this area at the time.

In 2003, SO3 dropped two indicators, "coverage of fully vaccinated children" and "persons diagnosed and treated in hard to reach areas." The first indicator was dropped because USAID's level of support to the Expanded Program for Immunization was so small that an indicator in this area was not appropriate. The second indicator was dropped due to difficulties in collecting representative information that would demonstrate USAID's contribution in the program area.

In 2002, Zambia was selected as a focus country for the President's PMTCT Initiative and designated as a Rapid Scale-up country for HIV/AIDS. As a result the SO was required to add new HIV/AIDS indicators to the PMP: "median age of sexual debut", "percent of women receiving PMTCT services," "OVCs reached by community based programs," and "STI treatment among high risk sub-populations."

Summary of activities used to achieve the SO and their major outputs

Health Systems Strengthening

- Technical assistance through the USAID-funded ZIHP project has led to increased capacity in policy development and financial management; improved Ministry of Health annual planning at all levels of the health system; stronger health management information systems (HMIS); enhanced drug and medical supply logistics; and improved quality of service delivery.
- Strengthened health worker performance has been an integral component of USAID's SO3 portfolio. USAID's partners have helped to build capacities in competency based training and curricula review and development. Nurses, midwives, and providers of HIV/AIDS services have benefited from pre-service and in-service training and stronger supportive supervision systems.
- USAID's Sector Program Assistance (SPA) agreement helped to accelerate Zambia's health reform program impact by focusing resources at the district and lower levels to increase access to and quality of basic health services and sector systems.

HIV/AIDS

- USAID strongly encouraged the scale-up of voluntary counseling and testing (VCT) sites (supply side) combined with outreach and media campaigns to increase demand for these services. As of 2004, there were 250 VCT sites throughout the country (compared to 42 in 2001) and a total of 139,402 clients received services in FY04, up from 3,929 in 2001.
- USAID's partners have helped to dramatically increase the availability of home based care for people living with HIV/AIDS. By FY04, psychosocial and community support, income generating activities, and referral systems reached nearly 8,000 people. These activities make a significant difference in the quality of life for people living with HIV/AIDS.
- Implementing organizations have also greatly scaled up support to orphans and vulnerable children (OVCs) in 130 communities, reaching 232,300 in FY04 through grants to local organizations. Activities included income generation, education, psychosocial and economic support.
- Condom social marketing and increased use of condoms have been important components of USAID's program. Total condom sales in FY04 were over 13 million. Not only does this activity contribute to increased access to contraceptive services, it also plays an important role in curtailing the transmission of STIs and HIV.
- Activities targeting youth included media campaigns such as the Helping Each Other Act Responsibly (HEART) campaign, radio shows and the youth newspaper, "Trendsetters"; sports camps; school-

based programs; faith-based retreats; community dramas; and the use of peer educators/promoters. These activities have helped to increase the age of sexual debut.

Family Planning

- Social marketing of condoms and oral contraceptives has had a significant positive result on access and use of contraceptives. Increased access to a wider choice of contraceptives will help ensure that Zambians have the ability to plan the size and timing of their families.
- Support for family planning mass media and information, education and communication (IEC) campaigns have not only helped to provide valuable information to clients, but have also helped to increase skills in provider counseling.
- In order to broaden contraceptive choice, USAID provided commodity support and technical assistance and training to introduce the Norplant implant to the public sector. USAID also supported the introduction of the injectable contraceptive, Depo Provera to the public sector.

Maternal Health

- USAID has been a staunch supporter of maternal and neonatal health services. Beginning in 1998, USAID promoted the development of a post-abortion care (PAC) training package. As of 2004, PAC services were available in seven out of nine provinces and 66% of the 8,000 PAC clients seen in FY04 started a modern family planning method after receiving counseling.
- Technical assistance to increase health worker knowledge and skills in emergency obstetric care has played a vital role in increasing access to quality maternal health services.
- USAID's assistance to increasing PMTCT services directly enabled 60,367 women to receive services through 75 sites in FY04 (compared to 2002 when 946 women received care in six sites). These activities have contributed significantly to reducing the number of infants born with HIV and to prolonging the life of mothers.

Child Survival

- USAID's ongoing support for Vitamin A supplementation has resulted in maintained coverage of over 80% of children aged 6-59 months, the recommended coverage needed to achieve significant reductions in child mortality. Zambia has seen a 50% reduction in vitamin A deficiency, from 12% of children surveyed in 1997 to 5% in 2003. This is in part attributable to the success of the national vitamin A supplementation program over the past six years and is likely to be a significant factor in the decline in under-five mortality.
- Another major success has been USAID's assistance to promote vitamin A supplementation for all domestically produced sugar and its recent efforts to increase supplementation of maize meal. Zambia was the first country in the region to fortify all domestically-produced sugar. After seven consecutive years, the sugar supplementation program is self-sustaining.
- The initial support to the vitamin A program also helped to institutionalize national semi-annual Child Health Weeks. In addition to vitamin A supplementation, catch-up immunizations, deworming, growth monitoring, antenatal care services, and re-treatment of bednets are offered during these focused service weeks.
- USAID plays an important role providing clean water to millions of Zambians through the socially marketed home water treatment product, Clorin. Initially marketed as a product to be used during the rainy season when cholera is a danger, Clorin was promoted as a year-round product and sales rose from 3,558 in 1998 to over 1.78 million in 2004. In addition, information, education and communication messages concerning safe drinking water and sanitation were disseminated to communities throughout Zambia, helping to prevent diarrheal and other waterborne diseases.

Infectious Diseases

- USAID and its partners have provided comprehensive assistance to Zambia's malaria program, including investing in building the capacity of the National Malaria Control Center.
- Social marketing of insecticide-treated bednets expanded from 2,238 in 1998 to272,701 in 1994. USAID's approaches included targeting hard-hit provinces, the most vulnerable (pregnant women and children under five) and the commercial sector.
- USAID assisted the Ministry of Health to develop and implement the national malaria-in-pregnancy prevention program which includes intermittent presumptive treatment of pregnant women, an intervention that will reduce morbidity and mortality during pregnancy.
- During this period, USAID supported the Ministry of Health to change the first line treatment from chloroquine, which had become minimally effective due to widespread drug resistance, to Coartem. Zambia was the first country in the region to make this change.
- USAID also provided technical support in planning, training, evaluation and safe use of pesticides for the roll-out of the national Indoor Residual Spraying program.

Prospects for long term sustainability of impact and principal threats to sustainability

The prospects for long-term sustainability of impact are good in view of the substantial progress made under the SO and the investments it represents in Zambia's health system. USAID's commitment to health systems strengthening and health worker capacity building has helped to greatly improve the chances for long-term impact. As above, with USAID's assistance, there is now an annual planning process at all levels of the health system, a functioning Health Management Information System, critical policies in place, strengthened knowledge and skills among health workers delivering services, wider availability of insecticide-treated bednets and other products that protect health, increased knowledge among the public of health issues and actions, etc. All of these gains are imbedded in the tools provided to the Ministry of Health and the increased capacity of management and technical staff.

The specific SO3 intervention designed to promote sustainability, the Sector Program Assistance (SPA) agreement, did provide $8 million in critical funding for the operating expenses of health services at the district level and below. However, it did not reach it's Life of Project ceiling of $20 million, which was dependent on USAID receiving $10 million in additional funds from Washington which weren't made available. Nonetheless, USAID's SPA made an important contribution. Without support for the day-to-day running of health services, USAID's investments made through more traditional projects would be compromised. For example, USAID may be able to upgrade the knowledge and skills of a physician so that they can provide improved emergency obstetric care. However, if none of the necessary drugs and equipment are available, or if there is no electricity in the facility, their ability to apply their new skills is challenged. In recognition of this, USAID extended the SPA through 2010 in order to continue to invest in health sector basic costs.

However, there are threats to the sustainability of SO3 efforts as well as those of the current USAID/Zambia PHN program, SO7. First, the economic climate of the country has not improved to the level expected and the health sector continues to be heavily dependent on donor funding. At the same time, a number of key health sector donors are moving to budget support, which creates additional uncertainty in donor funding. There is also a severe human resource crisis and Zambia is unable to attract or retain the health care professionals that it needs to deliver services throughout the country. While some progress can be made on this through human resource management and training reforms, ultimately the country will need the resources to be able to offer attractive compensation packages to civil service employees. Finally, HIV/AIDS has continued to overwhelm the health system, drawing both human and material resources away from other critical health priorities.

Key Lessons learned

Lessons learned from SO3 were applied to the design of the current PHN SO7.

- The Sector Program Assistance Agreement, which provides resources designated for the health sector based on GRZ performance on health reforms, has been a successful effort in strengthening health services at the district and lower levels and is a critical complement to project based assistance.
- A focus on health systems strengthening supports long term sustainability of critical population, health and nutrition interventions.
- Long-term commitment and ongoing support of critical child health interventions such as vitamin A supplementation resulted in institutionalization of the intervention, consistently high coverage levels, increased program sustainability, and a reduction in vitamin A deficiency.
- Resources targeted towards specific health interventions such as VCT, PMTCT, OVCs and home based care can achieve dramatic results in demand and coverage.
- Involvement of the private sector is a powerful tool to increase access to PHN services. Keys to this success have been expansion of commercial sector outlets through social marketing, involvement of Employer Based Agents (EBA) and traditional healers.
- NGOs, CBOs and FBOs can play an important role in service delivery for hard to reach populations and linking communities to the District Health Management Teams (DHMT).
- The design of the Zambia Integrated Health Programme (ZIHP), with four individual awards (three COAGS and a contract) operating as one program, required a large investment in time for coordination and joint planning and reporting. In addition, the institutional cultures of the organizations involved and the personalities of the four Chiefs of Party were critical to its success. A different mix of grantees or Chiefs of Party might not have been as successful.
- A demonstration district approach, while initially attractive because of the opportunity to test the integrated approach to interventions in a limited number of districts (12), ultimately created equity issues with the Ministry of Health, who wanted more districts to benefit. In many cases, ZIHP was able to scale-up successful programs to other districts. However, in others, project budgets did not support scale-up.
- Greater focus on reaching rural populations was needed for all interventions.
- An unplanned influx of increased resources in one area, HIV/AIDS, required adding more partners mid-Strategy and made it difficult, if not impossible, to maintain the integrated approach of ZIHP. SO3 ended up with a vertical HIV/AIDS program implemented by multiple partners outside of ZIHP. The design of SO7 specifically sought to consolidate the program.

SO 3: Performance indicators

Indicator 1: Contraceptive Prevalence Rate (modern methods)

Women of reproductive age are defined as women aged 15-49 years. Modern contraceptive methods currently used in Zambia, during the time frame of this Strategic Objective, include condoms, oral contraceptives, intrauterine devices (IUDs), injectables, Norplant, diaphragm/foam/jelly, vaginal foaming tablets and female/male sterilization.

Indicator 2: Condom Use (M=male, F=Female)

Percent of urban residents who report using condoms during their last sexual act with a non-regular sex partner, desegregated by males/females ages 15-24 and 15-49. Changing sexual behavior is not an easy task and in a high prevalence country like Zambia, most sexually active adults with any risk behavior are already infected, that is the adult population is "saturated" with HIV infection. As a result, attention should increasingly be focused more on young people who are not yet sexually active or who are just embarking on their sexual lives, but not necessarily negating the adult population. Therefore, establishing norms of safe behavior among young people early on may be much easier than changing norms of unsafe

behavior in older propel. Because of this emphasis on safe behavior among young people, condom use among 15-24 year olds is a critical indicator to help track program performance on young people's behavior change.

Indicator 3: Median Age at First Sexual Debut
Delaying the age at which young people first have sex is a critical program goal. Clearly young people are protected from infection by abstaining from sexual intercourse. Hoover, evidence has shown that a later age at first sex also reduces susceptibility to infection per act of sex, at least for women. This indicator therefore measures the age by which half of the adolescent population is sexually active – and this is obtained by linear extrapolation between the two points where the median is crossed. An upward shift in the indicator suggests that programs promoting abstinence among young people are working.

Evaluations and special studies

USAID Reports and Assessments

- Population Health and Nutrition Sector Assessment, USAID/Zambia, October 2002.
- ZIHP Midterm Assessment, Zambia Integrated Health Programme (ZIHP), May 2001.

Partner Evaluations

- Zambia Integrated Health Programme - An Overview, Zambia Integrated Health Programme, October 2004.
- ZIHP - Impact Evaluation of Service Delivery and IEC Interventions, Zambia Integrated Health Programme, May 2004.
- Community Partnerships Case Study Report, Zambia Integrated Health Programme, October 2004.
- Increasing PHN interventions in underserved areas of Zambia through partnerships between DHMT and NGOs, Churches Health Association of Zambia, October 2004.
- Language Uses and Reading Comprehension Among Literate Zambians: Findings from a 2002 Survey, Zambia Integrated Health Programme, June 2003.
- Evaluation of the Training in Reproductive Health (TRH III) Project, JHPIEGO, January 2003.
- External Review of the Maternal and Neonatal Health Program, JHPIEGO, October 2003.
- Annual/Semi-Annual/Quarterly Reports, Zambia Integrated Health Programme and Churches Health Association of Zambia, 1998, 1999, 2000, 2001, 2002, 2003, 2004.
- Report on the formative assessment for the Zambia Cross Border Initiative, Family Health International, September 2003.

Instrument close out reports

Prepared per ADS 202.3.8 for bilateral contracts, grants and cooperative agreements.

Key contacts

USAID/Zambia
Population, Health and Nutrition Office
Phone: +260-1-254303
Fax: +260-1-254532

Barbara Hughes, PHN Director
Email: bhughes@usaid.gov

Bilateral Partners

Churches Health Association of Zambia (CHAZ)
Plot Number: 9306 Ben Bella Road
PO Box 34511, Lusaka, Zambia
Telephone: +260 1 229 702/237 328
Fax: +260 1 223 297

ZIHPCOMM
Johns Hopkins University Center for Communication Programs (JHU/CCP)
111 Market Place, Suite 310
Baltimore, MD 21202-4024
Telephone: (410) 659-6300
Fax: (410) 659-6266
www.jhuccp.org

ZIHPSERVE
John Snow Research and Training Institute
1616 North Fort Myer Drive, 11th Floor
Arlington, VA 22209
Telephone: (703) 528-7474
Fax: (703) 528-7480
www.jsi.org

ZIHPSOM
Population Services International (PSI)
1120 19th Street, NW, Suite 600
Washington, DC 20036
Telephone: (202) 785-0072
Fax: (202) 785-0120
www.psiwash.org

ZIHPSYS
Abt Associates, Inc.
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814-5341
Telephone: (301) 913-0500
Fax: (301) 652-3618
www.abtassoc.com

Global Partners

ADRA
Adventist Development and Relief Agency
12501 Old Columbia Pike
Silver Spring, MD20904-6600
Telephone: (301) 680-6380
Fax: (301) 680-6370
www.adra.org

International HIV/AIDS Alliance
Queensbury House
104-109 Queens Road
Brighton BNI 3XF, UK
Telephone: 44-12-7371 8900
Fax: 44-12-7371 8901
www.aidsalliance.org

Applied Research in Child Health (ARCH)
Boston University
715 Albany Street
Boston, MA 02188
Telephone: (617) 414-1260
www.international-health.org

NetMark
Academy for Educational Development (AED)
1825 Connecticut Avenue, NW
Washington, DC 20009-5721
Telephone: (202) 884-8000
Fax: (202) 884-8400
www.aed.org

Community REACH
PACT, Inc.
1200 18th Street NW, Suite 350
Washington, DC 20036
Telephone: (202) 466-5666
Fax: (202) 226-5669
www.pactworld.org/reach

Partners for Health Reform Plus (PHRplus)
Abt Associates, Inc.
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814-5341
Telephone: (301) 913-0500
Fax: (301) 652-3618
www.abtassoc.com

IMPACT
Family Health International
2111 Wilson Boulevard, 3rd Floor
Arlington, VA 22201
Telephone: (703) 516-9779
Fax: (703) 516-9781
www.fhi.org

LINKAGES
Academy for Educational Development (AED)
1825 Connecticut Avenue, NW
Washington, DC 20009-5721
Telephone: (202) 884-8000
Fax: (202) 884-8400
www.linkagesproject.org

Maternal & Neonatal Health Project (MNH)
Training in Reproductive Health (TRH)
JHPIEGO
1615 Thames Street, Suite 200
Baltimore, MD 21231-3492
Telephone: (410) 614-2288
Fax: (410) 614-6643
www.mnh.jhpiego.org
Telephone: (410) 955-8558
Fax: (410) 614-3458
www.jhpiego.jhu.edu

MEASURE/BUCEN
International Programs Center
U.S. Bureau of the Census (BuCen)
Washington Plaza 2, Room 309
Washington, D.C. 20233-8860
Telephone: (301) 457-1444
Fax: (301) 457-3033
www.census.gov

MEASURE/DHS
Macro International (ORC Macro)
11785 Beltsville Drive, Suite 300
Calverton, MD 20705-3119
Telephone: (301) 572-0200
Fax: (301) 572-0999
www.macroint.com

Rational Pharmaceutical Management Plus (RPM Plus)
Management Sciences for Health
Washington DC Office
4301 N Fairfax Dr., Suite 400
Arlington, VA 22203
Telephone: (703) 524-6575
Fax: (703) 524-7898
www.msh.org

POLICY Project
Futures Group International
1050 17th Street, NW, Suite 1000
Washington, DC 20036
Telephone: (202) 775-9680
Fax: (202) 775-9694
www.tfgi.com

Population Council
4301 Connecticut Avenue, NW, Suite 280
Washington, DC 20008
Telephone: (202) 237-9400
Fax: (202) 237-8410
www.popcouncil.org

Project Concern International (PCI)
3550 Afton Road
San Diego, CA 92123
Telephone: (858)279-9690
Fax: (858) 694-0294
www.projectconcern.org

Quality Assurance Project (QAP)
University Research Corporation
7200 Wisconsin Avenue, Suite 500
Bethesda, MD 20814-4204
Telephone: (301) 654-8338
Fax: (301) 941-8427
www.urc-chs.com

Micronutrient Support Project (MOST)
International Science and Technology Institute
1820 North Fort Meyer Drive Suite 600
Arlington, VA 22209
Telephone: (703) 807-0236
Fax: (703) 807-0278
www.mostproject.org

Call to Action Project
Elizabeth Glaser Pediatric AIDS Foundation
1140 Connecticut Avenue NW, Suite 200,
Washington, DC 20036
Telephone: (202) 296-9165
Fax: (202) 296-9185
www.pedaids.org/

Salvation Army
World Service Office (SAWSO)
615 Slaters Lane
Alexandria, VA 22313
Telephone: (703) 684-5528
Fax: (703) 684-5536
www.salvationarmy.org

The Synergy Project
Global Health and Development Strategies Division
Social & Scientific Systems, Inc.
1101 Vermont Avenue, NW, Suite 900
Washington, DC 20005
Telephone: (202) 842-2939
Fax: (202) 842-7650
www.synergyaids.org