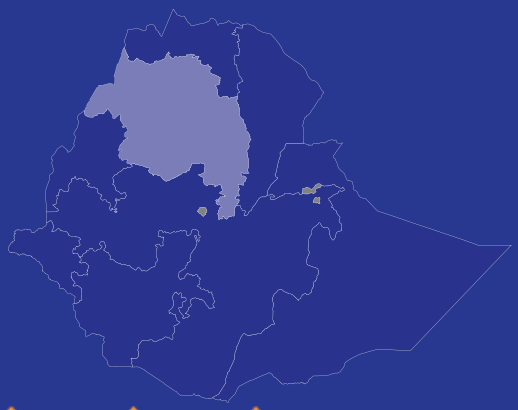
REGIONAL BRIEF



HSFR/HFG End of Project Achievement Highlights - Amhara

The USAID-funded HSFR/HFG project provides technical assistance to the Government of Ethiopia to implement and scale-up health care financing reforms across the country. The goal is to increase access to and utilization of health services through improved quality of health care and reduced financial barriers.

Project objectives are to:

- *Improve the quality of health services*
- *Improve access to health services*
- *Improve governance of health insurance and health services*
- *Improve program learning*

June 2018

THE REGIONAL CONTEXT

Amhara is one of Ethiopia's largest regions; it has 12 zones, three city administrations, and 180 woredas (139 rural and 41 urban). According to the Ethiopian Central Statistics Agency, the region has a projected population of 21.5 million people, about 80 percent of whom are rural farmers.

Two decades ago, Amhara had only nine public hospitals and 140 health centers, which was insufficient to meet the demand of the region's then 14.8 million residents. In addition, service coverage and quality were low. Today, the region has 80 hospitals (5 referral, 2 general, and 73 primary), 847 health centers, and 3,342 health posts.

As in other regions of Ethiopia, Amhara's health care system was unable to modernize and provide quality health services due to many challenges:

- Shortages of specialist doctors and other medical professionals, despite the increased number of health facilities
- Shortages of medical equipment, drugs, and medical supplies
- Inefficient and inequitable use of health resources
- Burdensome, high out-of-pocket payments for health care by the majority of the population at the time of illness
- Lack of standardized health facility user fees that resulted in low resource mobilization and inequitable service provision

To address health sector financing challenges, in 1998 the Federal Democratic Republic Government of Ethiopia approved a health care financing (HCF) strategy that calls for increasing financial resources available for the health sector.

Following the strategy and the prototype Health Service Delivery and Administration (HSDA) proclamation developed by the federal government, the Amhara regional government put in place the required legal frameworks to guide their implementation, including: HSDA Proclamation No 117/2005 and HCF Regulation no 39/2006.

The Health Sector Finance Reform/Health Finance and Governance (HSFR/HFG) project has since 2013 provided technical support to the regional health bureau (RHB), Ethiopia Health Insurance Agency (EHIA) branch offices, woreda administrations, woreda health offices (WorHOs), community-based health insurance (CBHI) schemes, and health facilities in the design, legislation, implementation, and evidence generation of these reforms. Project support included: capacity building such as training the leadership and staff at various levels of the regional government; integrated supportive supervision and mentoring; assistance with adaptation and revision of legal frameworks and implementation guidelines; material support such as provision of motorcycles and computers to CBHI schemes; evidence generation through standardization of data collection instruments and collection, compilation, and analysis of data; and strengthening of governance and networking through review meetings, experience-sharing visits, and high-level conferences and workshops.

Amhara Regional State President, Ato Gedu Andargachew gives recognition awards to best performing zones

MAJOR ACHIEVEMENTS

Health facility governance

The Ministry of Health's health facility governance reform allows for increased health facility autonomy through the establishment of governing bodies at health facilities to contribute to the proper and timely use of facility resources and respond to client needs. Called "governing boards" at hospitals and "management committees" at health centers, these governing bodies are mandated and authorized to ensure that facilities are fully implementing HCF reforms, are offering the best patient care possible, and are functioning efficiently and effectively. This reform is considered critical because its implementation impacts the proper implementation of the other reforms, including the retention and use of revenue collected at health facilities, which is intended to improve quality of services. Key responsibilities of governing bodies include endorsing annual plan and budget allocation, reviewing and endorsing quarterly performance reports, engaging in resource mobilization, facilitating quarterly town hall meetings with community representatives, and any other issues that requires the governing board decision.

HSFR/HFG supported regional government efforts to implement the health facility governance reform and strengthen the leadership and governance practices at health facilities. Project technical assistance included: developing legal frameworks; training in facility governance; monitoring the establishment and functionality of the governing bodies and reform progress; advocating to all relevant stakeholders on the importance of governing bodies; and providing training on the objectives, implementation procedures, and monitoring and review mechanisms of the reform in order to strengthen governing body capacity. In addition, the project organized woreda and regional review meetings to facilitate sharing of best practices and challenges experienced in implementing the reform.

Since HSFR/HFG began, the number of health facilities with functional governing bodies has increased, from 776 in 2013/14 to 891 as of March 31, 2018. During this same period, HSFR/HFG trained 216 management committee members and 174 hospital board members on health facility governance and HCF reform. Of the 825 health centers

implementing the reform, almost all (820) have functioning management committees and of the 66 hospitals with boards, all are functioning. A functioning board is defined as one that meets a minimum of six times a year (half of the expected 12 monthly meetings), that approves the health facility budget at the beginning of the budget year, and that reviews health facility performance at least once a year.

Revenue retention and utilization

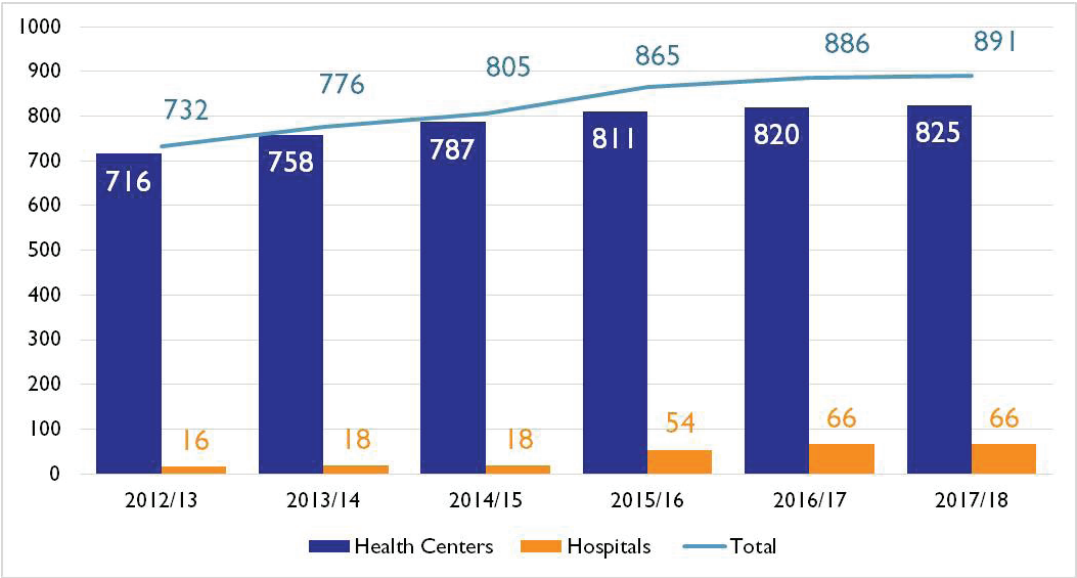
The revenue retention and utilization (RRU) reform allows hospitals and health centers to collect and retain revenue generated at the facility rather than remitting it to the government treasury, and to use this revenue to improve its provision of health services. Revenue sources include consultation fees, sale of drugs and medical supplies through pharmacies, fees for diagnostics and inpatient services, cash and in-kind donations, and revenue from research and training services.

Figure 1 shows that the number of health facilities implementing RRU has steadily increased. This is particularly the case among hospitals, the number of which implementing RRU has more than quadrupled. Today 825 health centers and 66 hospitals retain and utilize their revenue. With HSFR/HFG support, the percentage of health facilities in Amhara implementing RRU increased from 91 percent at the beginning of HSFR/HFG in 2013 to 97 percent at the project end in 2018.

To strengthen the financial management system and capacity to implement HCF reforms, HSFR/HFG worked closely with the RHB in identifying and introducing key HCF positions to the organizational structures at different levels of the health system. This included advocating to the RHBs to obtain Civil Service Bureau approval of the job grading for these positions, and recruiting and deploying qualified personnel. Presently, to coordinate and facilitate HCF reform activities, two health financing officers and one HCF monitoring and evaluation officer have been recruited for the RHB level, and one HCF focal person is assigned to the zonal and woreda level. At health centers, HSFR/HFG also advocated for the recruitment and placement of 335 key finance staff, and today, finance staff have been recruited and trained to manage HCF reforms, including RRU, user fee revision, compiling the costs of exempted health services, and tracking government budget.

In addition, HSFR/HFG provided technical support to finance staff in Amhara in adapting the accounts and other RRU implementation manuals, facilitating the approval of the budget allocated from retained revenue, training key finance staff, and generating data about the progress of the RRU reform. Over the five-year project period, 193 health facility staff have received training in financial management and 611 on HCF.

Figure 1. Number of Health Facilities Implementing RRU

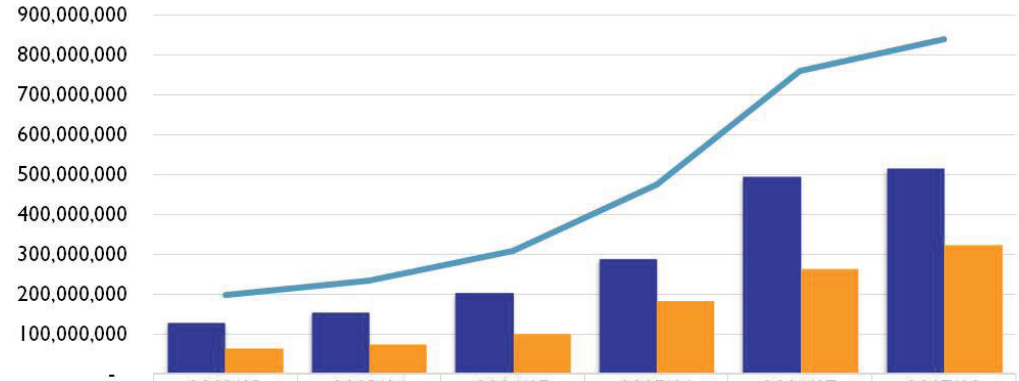


As shown in Figure 2, there has been steady growth in revenue retained at health facilities. In 2012/13, health centers retained 129.8 million birr in revenue; this nearly quadrupled to 516.1 in 2017/18. The amount of revenue appropriated at hospitals also increased dramatically, from 67.9 million birr in 2012/13 to 322.6 million birr in 2017/18. The primary sources of retained revenue for both health centers and hospitals are the sale of drugs and medical supplies and fees for diagnostic services.

Measures taken in Amhara facilities to improve the quality of health care service delivery include the following:

- Ensuring the availability of drugs and medical supplies.
- Procuring modern diagnostic and other medical equipment such as CT, ultrasound, x-ray, and anesthesia machines.
- Building examination rooms, maternal waiting rooms, and other buildings.
- Making upgrades (cleaning the compound, painting buildings, and building better communal latrines, etc.) that are part of implementing the federal government's Clean and Safe Health facility initiative.

Figure 2. Retained revenue at hospitals and health centers (birr)



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Health Center	129,808,765	156,266,236	204,941,432	289,868,306	494,128,580	516,122,346
Hospital	67,933,799	77,913,364	102,590,004	184,463,146	265,063,121	322,612,600
Total	197,742,564	234,179,599	307,531,436	474,331,452	759,191,701	838,734,946

Using Retained Revenue to Improve Service Delivery at Felege Hiwot Referral Hospital

Felege Hiwot Referral Hospital has been implementing HCF reforms since 2011. The patient flow there, already high, has increased even more each year since the hospital started implementing the RRU reform and using the retained revenue to provide more and better-quality services. Average retained revenue was 500,000 birr per year when the hospital started implementing the RRU reform in 2011/12. Today, the revenue is more than 100 times that amount: 60 million birr in 2017/18.

Felege Hiwot hospital has used its revenue to procure drugs, medical supplies, and medical equipment, and to renovate buildings. The latest biomedical machines that the hospital has procured are an MRI, fluoroscopy/digital x-ray, Doppler ultrasound, CT scan, dialysis, and electrocardiogram. It also has purchased laboratory equipment to expand its diagnostic and treatment capabilities and improve the range and quality of services it can provide to patients.

Total regional government budget allocation for health

Using national-level Health Accounts findings and regionally generated evidence on facility budget allocations, HSFR/HFG advocated to the RHB and Bureau of Finance and Economic Cooperation to increase government expenditure on health. Over the project period, the amount of government budget allocated to the Amhara health sector has gradually increased, and the region is working toward meeting the Abuja Declaration, which states that 15 percent of the national budget should be allocated to the health sector. Currently, the Amhara region has reached 14 percent and it expects to reach 15 percent by the end of 2018, when newly constructed hospitals begin to function at full capacity (Figure 3).

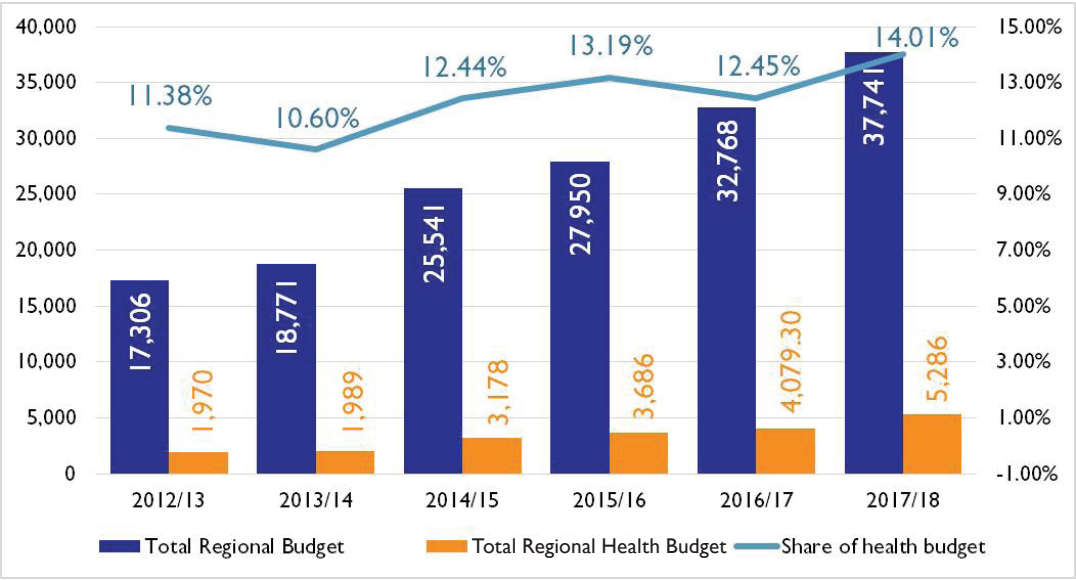
Dips in the share of retained revenue from the total regional health facility budget in two of the five years examined here are due to hospital construction. The costs of construction and procurement of medical equipment, furniture, and other items was high and revenue generated from these facilities was limited because they were not operating at full capacity. This situation started to change in 2017/18, when hospitals began to increase the amount and types of services available.

Community-based health insurance

To address the high out-of-pocket cost of health care, which excluded many Ethiopians from care seeking, and to generate more domestic resources for the health sector in the long term, the Ethiopian government piloted and scaled up CBHI for citizens in the agricultural and informal sectors. CBHI is meeting both its goals: increasing health service utilization by this segment of the population, and it is mobilizing additional health sector funding from domestic sources.

HSFR/HFG supported the Amhara regional government in conducting a feasibility study for CBHI scale-up, developing and adapting CBHI manuals and legal frameworks (directive, bylaws), and designing implementation strategies. The project supported regional and woreda administrations in raising awareness, sensitizing, and mobilizing the community for the uptake of CBHI and enrollment through regional media and community mobilization initiatives. The project provided on-site support during supportive supervision and assisted the RHB in organizing review meetings that were important for reviewing achievements and challenges, and in identifying actions to be taken for key stakeholders in the region.

Figure 3. Amount (millions birr) and percent of Amhara regional budget going to healt



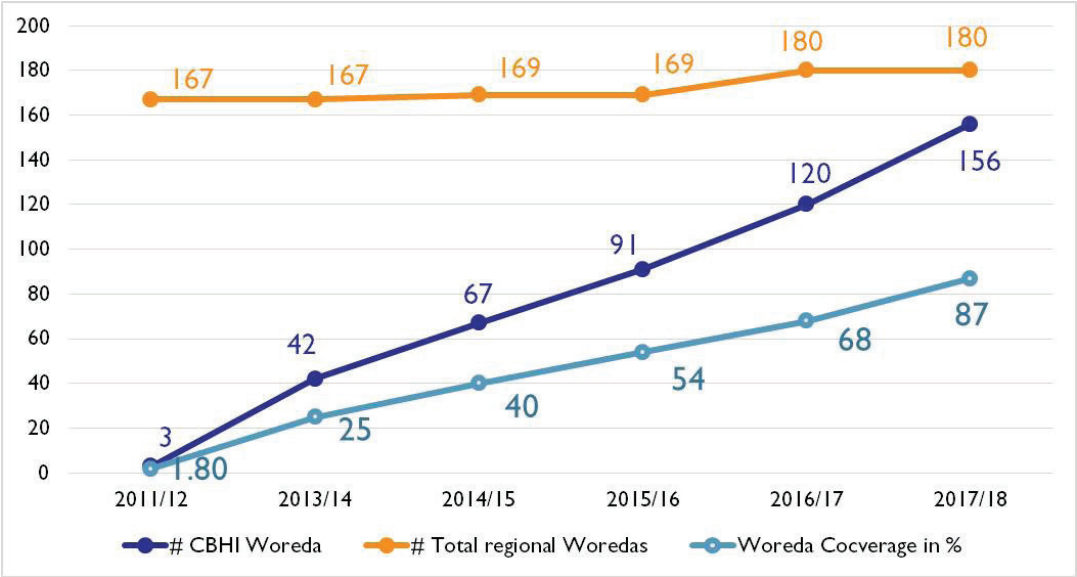
CBHI community mobilization and sensitization event

HSFR/HFG also provided training to RHB, woreda administration, WorHO, CBHI scheme staff, and to woreda and kebele cabinet members on: the concepts, principles, and design parameters of CBHI; CBHI implementation procedures and financial management; and CBHI program monitoring, review, and reporting. More than 12,000 personnel from regional offices; zonal, woreda, and kebele administrations; CBHI executive offices; and health facilities received training. The project also provided technical and financial support to the RHB in disseminating basic information and successes using various communications media such as radio, print, and billboards. Also important, HSFR/HFG assisted in organizing review meetings at the regional, zonal, woreda, and health facility levels and in conducting supportive supervision. As a result, both population and geographic coverage in CBHI increased, substantial financial resources were mobilized, CBHI member utilization at public health facilities increased, and institutionalization of the CBHI program was enhanced.

COVERAGE

CBHI implementation started in 2010 in Amhara, in the three pilot woredas of Fogera, South Achefer, and Tehuledere. Based on its evaluation of the pilot, HSFR/HFG supported the regional government's scale-up of CBHI. By early 2017/18, there were CBHI schemes in 156 of Amhara's 180 woredas (87 percent) (Figure 4). This means the Amhara region has exceeded, two years ahead of time, the Ethiopian government's Health Sector Transformation Plan target of covering 80 percent of woredas by 2020.

Figure 4. Number and percentage of CBHI woredas



There has been steady and tremendous growth in the CBHI enrollment rate during the tenure of the HSFR/HFG project, from 30 percent in 2013/14 to 55 percent in 2017/18 (Figure 5).

The overall proportion of the regional population enrolled in CBHI has also grown, from 10 percent in 2013/14 to 44 percent in 2017/18. The number of indigents enrolled in CBHI has grown from 6.6 to 10.5 percent of total enrolled (Figure 6).

Figure 5. CBHI Membership Net Enrollment Coverage by Year

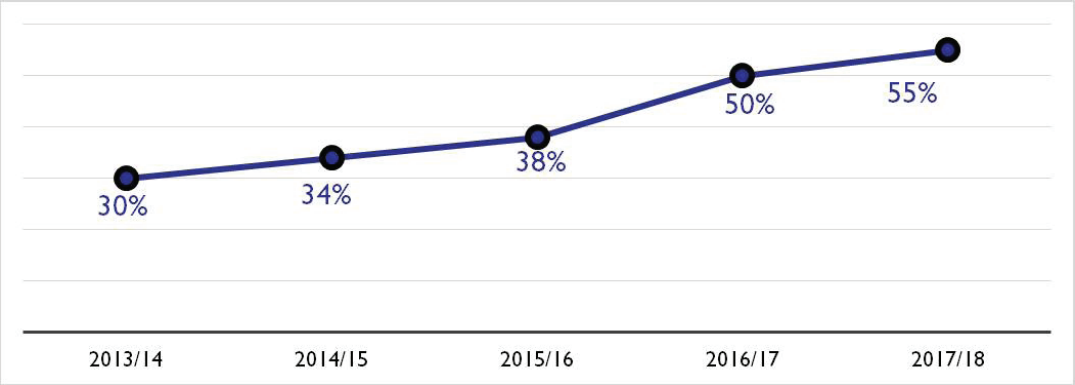
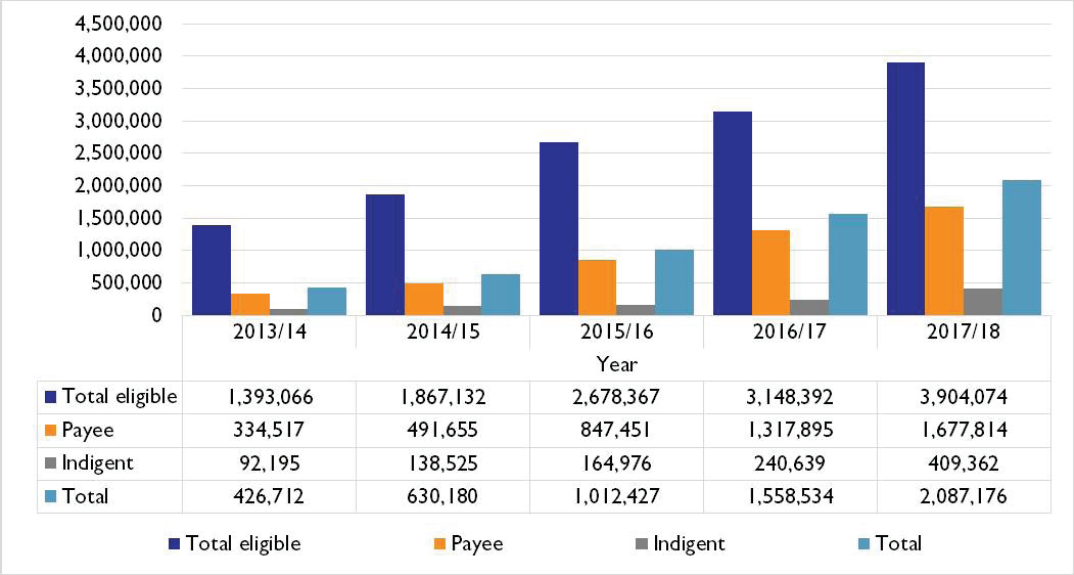


Figure 6. CBHI Household Membership by Type and Year



	2013/14	2014/15	2015/16	2016/17	2017/18
Total eligible	1,393,066	1,867,132	2,678,367	3,148,392	3,904,074
Payee	334,517	491,655	847,451	1,317,895	1,677,814
Indigent	92,195	138,525	164,976	240,639	409,362
Total	426,712	630,180	1,012,427	1,558,534	2,087,176

In addition to CBHI expanding in terms of the number and proportion of the population enrolled, it has expanded in depth of coverage as measured by enrollment renewal. HSFR/HFG, in collaboration with the Amhara RHB and EHIA offices, continuously conducted follow-up and review meetings in each zone of the region to encourage renewal, and the regional CBHI renewal rate reached 80 percent in 2016/17 and 2017/18, which is in an acceptable range for sustainability (Figure7).

RESOURCE MOBILIZATION AND POOLING

The resources mobilized through CBHI schemes have increased significantly with more woredas implementing the program and an increasing number of households enrolling in schemes.

The major sources of revenue for the CBHI schemes are payee household contributions, the woreda administration's targeted subsidy for poor households, and the federal government's general subsidy for CBHI schemes. Figure 8 breaks down the contributions by source in Amhara region for the first 10 months of 2017/18. The majority (71 percent) came from payee households, followed by the targeted subsidy (19 percent) and the general subsidy (8 percent).

Figure 7. Trend in CBHI membership renewal rate (percent)

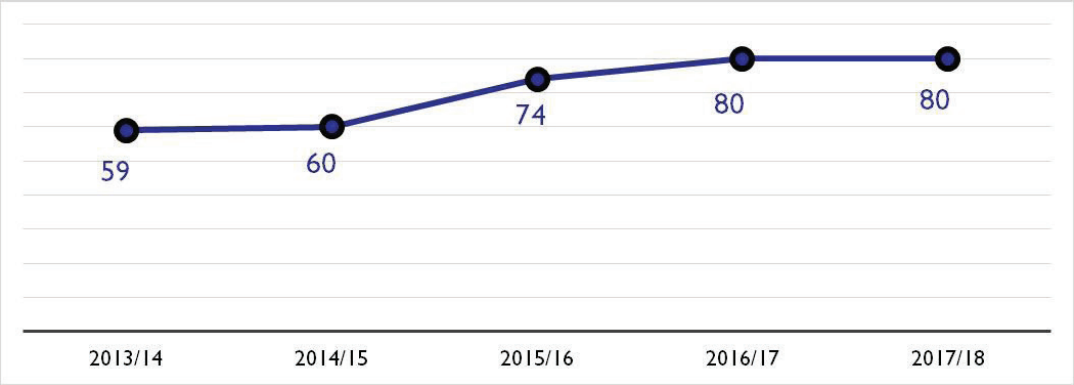
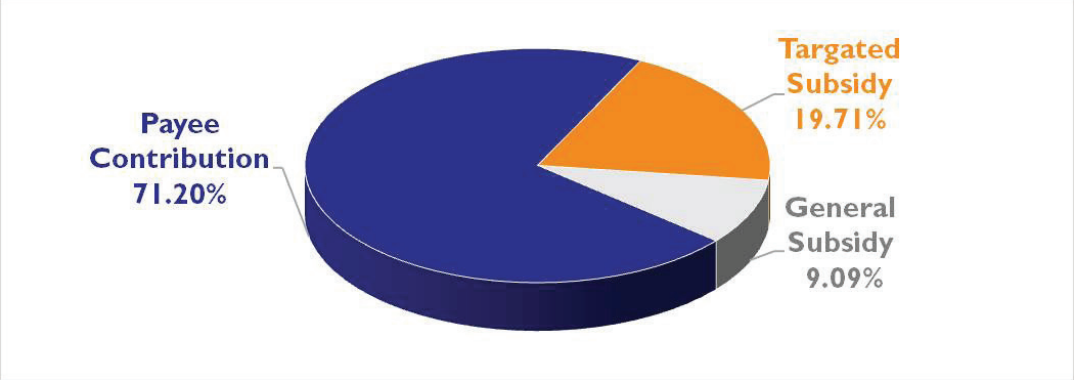


Figure 8. CBHI revenue by share source, 2017/18



The resources mobilized from CBHI schemes in Amhara region have grown remarkably, from 3.5 million birr in 2012/13 to 556.3 million birr in the first 10 months of 2017/18 (Figure 9). Resources mobilized from enrolled paying households alone increased from 2.7 million birr in 2013/14 to over 420 million birr in 2017/18. These increased resources can be attributed to the increased CBHI enrollment as a result of improved awareness and ownership of the program by local stakeholders.

To enhance the cash collection process and protect it from misappropriation, HSFR/HFG technical support included following up the timely closing of book of accounts, submission of financial reports, and auditing of financial activities.

HEALTH SERVICE UTILIZATION

A primary goal of CBHI is to increase people's utilization of health services. To facilitate this, CBHI schemes enter into contractual agreements with public hospitals and health centers to provide services to beneficiaries.

At the beginning of HSFR/HFG, 29 health facilities were contracted in Amhara. Today, 739 facilities are under contract, vastly expanding the accessibility of health care. Rising rates of health service utilization reflect this. As Figure 10 shows, utilization by CBHI beneficiaries more than doubled from 0.25 annual visits per capita in 2013/14 to 0.55 in 2017/18 (data from two quarters). This is mainly attributable to the increased number of households enrolled in CBHI, who no longer have to pay fees out of pocket at the time of service provision.

Figure 9. Resources mobilized through CBHI contribution and subsidy (birr)

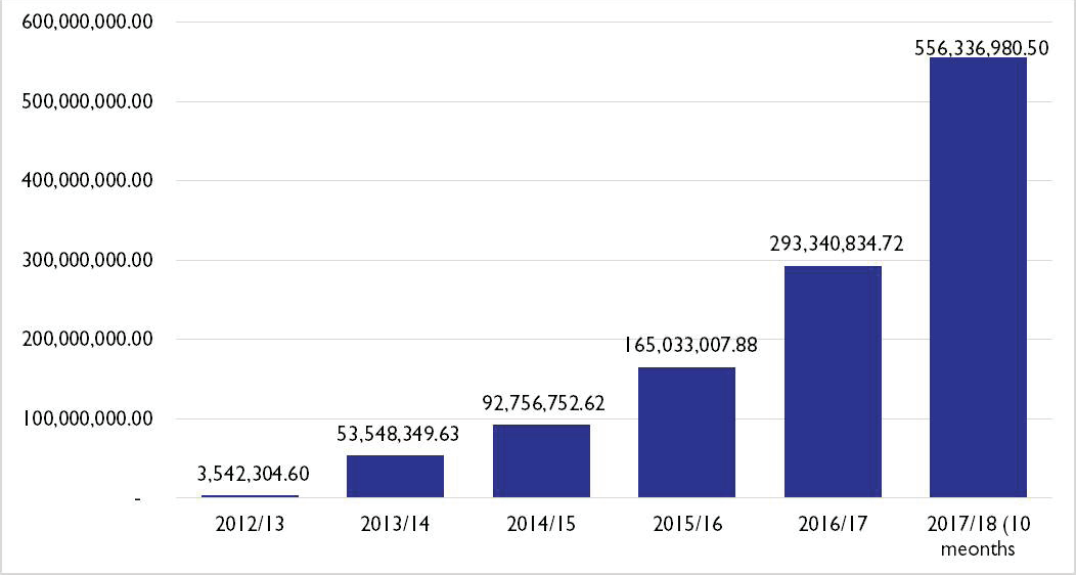
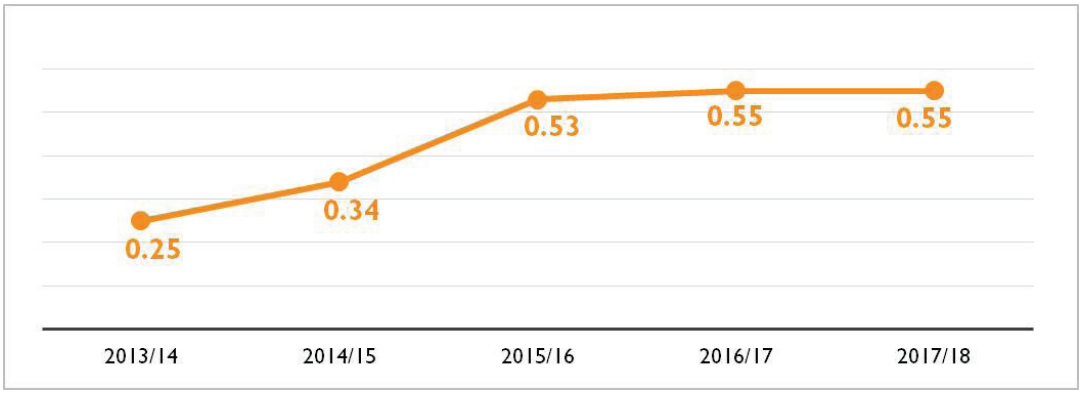


Figure 10. CBHI beneficiary per capita annual visits



CBHI INSTITUTIONALIZATION FOR SUSTAINABILITY

To help ensure CBHI sustainability, HSFR/HFG provides technical support for institutionalization of CBHI through creation of permanent organizational structures at the regional, zonal, and woreda level. Technical support to RHBs and EHIA branch offices includes assistance in defining practicable design parameters for CBHI; advocating to the regional human resources and civil service bureau to encourage buy-in to the organizational structure, and jointly monitoring CBHI program implementation with the RHB, woredas, and EHIA. When activities are planned jointly, available budgets from the RHB, woredas, EHIA, and HSFR/HFG are set with full knowledge of all stakeholders; implementation is a joint responsibility and report development is a shared task. This has greatly contributed to building the capacity of government counterparts.

Studies suggest that the renewal rate is an important indicator of scheme sustainability. Therefore achieving a reasonable renewal rate is one task on which the project and key implementers worked hard. It demands continuously raising awareness of the importance of CBHI and satisfying members. In Amhara, success is evidenced in the growth of the renewal rate from 59 to 80 percent.

A second indicator of CBHI program sustainability is having strong financial management practices. HSFR/HFG trained the CBHI executive team so it could support improved financial management at the regional, zonal, and woreda level. The project helped the RHB outline the CBHI audit manual. Once the manual was developed, CBHI audit training was provided to woreda finance and economic cooperation offices. Based on this support, the financial performance of more and more CBHI schemes is being audited, from 59 schemes previously to the current 86 schemes. It is encouraging that auditing is being institutionalized since this practice discourages fraud or embezzlement of resources mobilized by CBHI.

The third indicator that points to the sustainability of an insurance scheme in general is the claims ratio – the ratio of beneficiaries' medical expenses covered to the total finances generated by the scheme. The ratio should be less than one. In Amhara, a significant number of CBHI schemes are maintaining a healthy claims ratio of less than one. Currently only five of the approximately 130 schemes that have started covering health cost of their beneficiaries have a claims ratio of greater than one.

HSFR/HFG and key implementers including the RHB and zonal health departments have initiated the creation of zonal-level CBHI pools. The regional legal framework has been finalized and issued to zones for implementation, and training on it provided. Having more people in a single pool, such as at the zone rather than the woreda level, expands the pool of resources available to pay claims. In this way, it increases risk sharing and solidarity among CBHI members and woredas and therefore enhances the sustainability of the CBHI program.

Creation of zonal pools is planned for June 2018 and they are anticipated to start operating on July 1, 2018. The three pools are in East Gojjam, South Wollo, and Oromia nationality zones, with 353,926, 410,383, and 73,144 CBHI member households, respectively.

Fee waivers

A major goal of Ethiopia's HCF reforms has been to expand availability of basic services and minimize financial barriers to access for the poor. This includes waiving user fees to ensure that the poorest (indigent), who are not able to pay the fees, do not have to pay for services offered in the public health system. Woreda administrations are usually responsible for identifying, screening, and certifying fee waiver beneficiaries, as well as allocating adequate budget to cover their health service expenses. This arrangement entitles the beneficiaries to fee-waived health service without jeopardizing the financial position of the health facilities providing the services.

STRENGTHENING THE FEE WAIVER SYSTEM

HSFR/HFG supported RHBs and woreda administrations to implement the fee waiver program with technical assistance, training, mentoring, and supportive supervision. HSFR/HFG trained officials at regional, zonal, and woreda levels on the socioeconomic and political significance of serving the poor. Technical assistance was given to RHB experts and woreda cabinet members on fee waiver beneficiary selection, issuing fee waiver identification cards, entering into health service delivery and reimbursement of cost agreements with health facilities, allocating budget for the program, and reimbursing health facilities for services delivered.

Amhara achieved standardization of the fee waiver system, which improved access to health care services by its poor residents. Fee waivers now are provided throughout the region. In woredas with a functioning CBHI program, the local administrations pays the CBHI contribution for indigent households so that they can become CBHI members; in woredas without a CBHI scheme, the woreda government reimburses indigent household health visit expenses.

As shown in Figure 11, the number of fee waiver beneficiaries in Amhara has almost doubled, rising from 915,493 in 2012/13 to over 1.75 million – 8.2 percent of the total regional population – thus far in 2017/18. The number of beneficiaries in non-CBHI woredas has declined significantly because there are many fewer such woredas. Out of total number of fee waiver beneficiaries, 89 percent are from CBHI woredas/town administration and the rest are in non-CBHI woredas/town administrations.

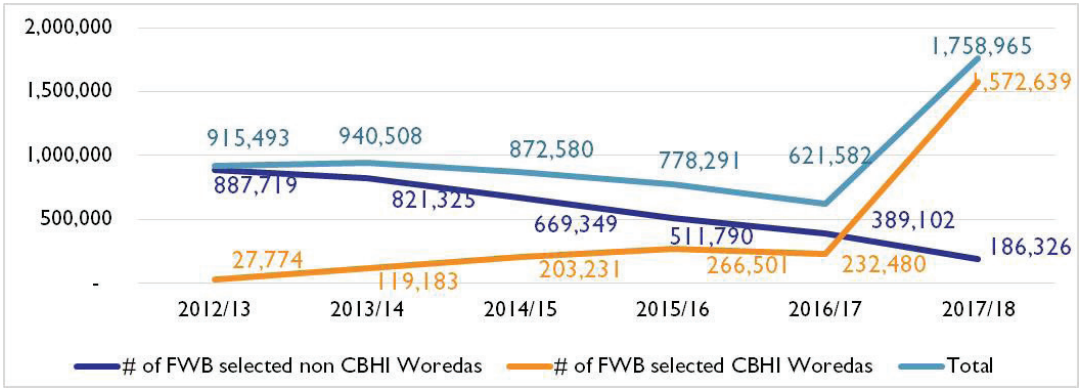
SELECTING FEE WAIVER BENEFICIARIES

Figure 4 also shows that the number of fee waiver beneficiaries declined from 2013/14 until 2016/17 due to woreda claims of inadequate budget to cover fee waivers. To avoid this in the future, the revised CBHI scale-up regulation and directive decreed that woredas should target at least 10 percent of the population as fee waiver beneficiaries/ indigent and cover their contributions to CBHI schemes to improve equitable health services to the poorest. As a result, the number of fee waiver beneficiaries selected increased dramatically in 2017/18. The total number of fee waiver beneficiaries in non-CBHI woredas continued to decline but this was because more and more woredas have started implementing CBHI.

FINANCING FEE WAIVERS

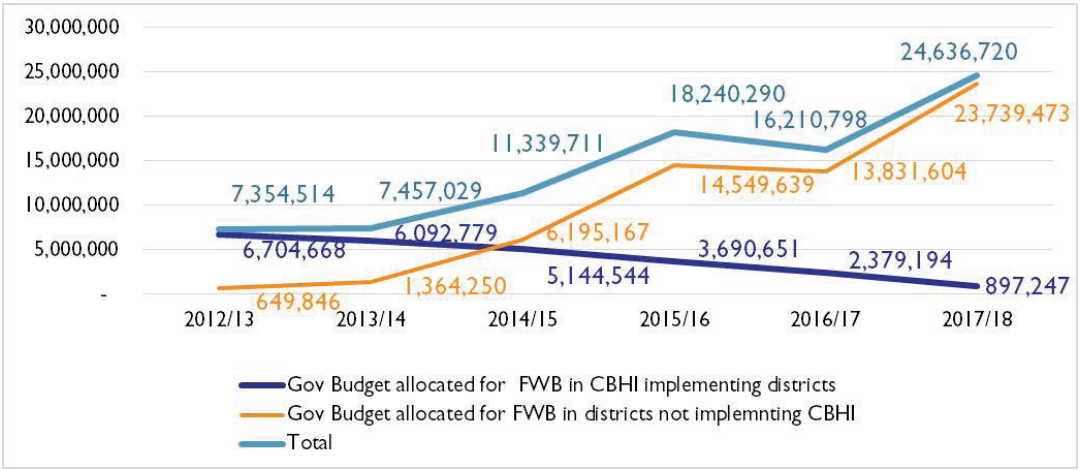
HSFR/HFG continuously advocated to woreda officials on the importance of allocating sufficient budget to reimburse facilities for services they provide to fee waiver beneficiaries in order to ensure more equitable health service provision. This resulted in the government budget allocation increasing at the woreda and regional level over time as the number of fee waiver beneficiaries selected also grew. As shown in Figure 12, this increment was especially remarkable in 2017/18 because of revisions made to the CBHI contribution rate following the ratification of the CBHI legal frameworks.

Figure 11. Trend in the number of fee waiver beneficiaries



Note:
FWB = fee waiver beneficiaries

Figure 12. Government budget allocation for fee waiver beneficiaries (birr)



Exempted health services

The Ethiopian HCF strategy calls for regions to standardize a package of critical public health services that public health facilities provide free of charge to the entire population. These include maternal health services (ante- and postnatal care, delivery, etc.), immunization for children under five years, treatment of tuberculosis patients, and HIV/AIDS diagnosis and treatment services. Government and donors are expected to cover the cost of these services, but for many years, regional and woreda authorities failed to allocate adequate budget for this.

In response, HSFR/HFG advocated to the regional government to support health facilities with budget earmarked to sustainably finance the exempted health services. Accordingly, the regional government set aside a considerable budget to cover some of the costs incurred by health facilities and to provide drugs and medical supplies to ensure the sustainability of the health services. The project regularly generates evidence on service utilization and associated costs so that local governments apportion the earmarked budget among health facilities across the region. Based on HSFR/HFG advocacy in the region, annually an average 150 million birr was allocated for health facilities directly from the regional government to pay for exempted health services. But this budget covers only part of the expenses and additional effort is required.

Experience-sharing and policy workshops

To strengthen support for and implementation of HCF reforms, HSFR/HFG supports dissemination of implementation experiences and lessons learned. The project facilitates experience-sharing events at which it and other stakeholders, such as the RHB, and zonal and woreda administrations, present facts about the positive outcomes and impacts of implementing the HCF and CBHI initiatives.

Three national-level experience-sharing and policy workshops, four inter-regional experience-sharing visits, and two intra-regional experience-sharing and policy workshops were held in Amhara. There also have been woreda-level events. They have resulted in stakeholder consensus for HCF and CBHI scale-up.

LESSONS LEARNED

Key lessons learned from the implementation of HCF reforms in Amhara are as follows:

- Willingness and commitment of political authorities to implement HCF reforms is a must. To ensure this, strong and continuous advocacy by the Ministry of Health is essential; it should start at the regional level and continue down to lower-level administrative units.
- HCF reform implementation cannot be done by the health sector alone; it requires involvement of other sectors, in particular, the Ministry of Finance and Economic Cooperation and its branches at the regional, zonal, and woreda level.
- Objective criteria to select the truly poor as fee waiver beneficiaries is a challenge since wealth ranking is difficult to do in developing countries. Therefore, community targeting (selection with community consensus) is the best option for selecting the poorest households.
- Capacity building on financial management and auditing for the CBHI executive team, health facility finance staff, and woreda finance auditors is vital to ensure accountability and avoid fraud and abuse of retained revenue and resources generated by CBHI schemes.
- Institutionalization and ownership by the government is a prerequisite to sustain HCF and CBHI activities.
- Improvements in health service delivery quality is needed to sustain CBHI renewal.

Recommended citation: HSFR/HFG Project. June 2018. *HSFR/HFG End of Project Achievement Highlights - Amhara.* Rockville, MD: Health Finance and Governance Project, Abt Associates

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services.
The HFG project is a six-year (2012-2018), $209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.
The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

Cooperative Agreement Number:
AID-OAA-A-12-00080
Agreement Officer Representative Team:
Scott Stewart (GH/OHS) sstewart@usaid.gov
Jodi Charles (GH/OHS) jcharles@usaid.gov

Abt Associates
www.abtassociates.com
6130 Executive Boulevard
Rockville, MD 20852