USAID
FROM THE AMERICAN PEOPLE

50 Years of Global Health

Saving Lives and Building Futures

YEARS OF

Global Health

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By Tonya Himelfarb

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Any errors or misrepresentation of facts are the sole responsibility of the author under Consultant Project ID #USAID/GH_TH_011513.

Limitations

Given the size and complexity of USAID's support for global health programs, many activities and interventions could not be explicitly covered in this legacy report. Even for those programs included in the document, much of the nuance and detail could not be captured. The author attempted to incorporate a balance of examples and links across regions and countries, but the projects and documents cited in this report reflect only a fraction of the work supported by USAID over the past 50 years. Many more country examples, examples of project impact and records of bilateral and centrally-funded program and project evaluations, assessments and reports are available in the Development Experience Clearinghouse at https://dec.usaid.gov. Descriptions of current health programs across the countries in which USAID works can be found at https://usaid.gov.

Foreword

Administrator Rajiv Shah

Over the last 50 years, the world has made remarkable progress in global health. We have won the fight against smallpox, nearly eradicated polio and dramatically scaled up access to new vaccines. A diagnosis of HIV and AIDS is no longer a death sentence, and the fight against malaria has been renewed with the help of simple lifesaving interventions like bed nets.

As a result, child death has fallen by 70 percent over the last five decades across the world, a rate that we have continued to accelerate even as the global population has grown by more than 1.5 billion people in the last 20 years. In countries like Senegal and Rwanda, child mortality has fallen by more than 8 percent a year, the fastest rate of decline the world has seen in 30 years.

USAID has contributed significantly to the progress made in global health, with investments leading to innovations that now reach millions, saving and improving lives throughout the developing world. From safe injection technologies to oral rehydration therapy, diagnostic tests for anemia and vitamin A deficiency to safe birth kits and new contraceptive technologies, these products are transforming our ability to reach those in greatest need in rural and remote communities.

American global health assistance has saved and improved the lives of millions of children, women and families. I am honored to follow and build on this legacy of leadership and service and deeply grateful for the immense contributions of our talented and dedicated staff across the world. I am constantly impressed by the incredible range of expertise and excellence at our Agency. From our foreign service national staff and foreign service officers to civil service and partners, everyone has an instrumental role in elevating development in our nation's foreign policy and ensuring our efforts are inclusive of the partners we work with and the local communities we serve.

Our legacy in advancing human welfare is impressive but unfinished. Despite incredible success, we know that there are places where progress is far too slow. Every year, 6.6 million children around the world continue to die from causes we know how to prevent. More than 287,000 women die from complications during pregnancy or childbirth. In the developing world, about 222 million women who want to delay or avoid pregnancy are not using a modern method of contraception.

In June 2012, we joined our partners in hosting the Child Survival Call to Action to rally the world behind the goal of ending preventable child and maternal death, and bring about a grand convergence in life expectancy between poor and rich countries in a generation. Since then, more than 170 countries, 200 civil society organizations and 220 faith-based organizations have echoed the call with commitments of their own.

To achieve this goal, women and girls must be protected, empowered and celebrated. This effort begins by investing in girls' education and ending child marriage – essential steps to keeping girls in school and reducing maternal mortality. Educated women are healthier, start families later and are more economically successful. They transfer these benefits to their children – a new generation that is better prepared to contribute to their community.

In the 2013 State of the Union address, President Barack Obama called upon our nation to join with the world in ending extreme poverty in the next two decades. Today, we have new tools that enable us to achieve goals that were simply unimaginable in the past. By pioneering a new model of development that harnesses innovative partnerships to strengthen local capabilities, we can finally end one of the world's most enduring outrages and ensure that children and mothers everywhere survive and thrive.

USAID's Strength: People

Ariel Pablos-Méndez

Assistant Administrator, Bureau for Global Health

For more than 50 years, USAID programs have saved and improved lives around the world, advanced American values, increased global stability and driven economic growth in emerging markets. Our history is a record of our work, a catalog of lessons and a source of pride and inspiration.

USAID began with President Kennedy's vision for foreign assistance, a vision that has been carried out by Agency staff around the world, whose technical excellence and dedication to human advancement and public service improve millions of lives in villages and communities across the globe.

USAID's core strength is people. At the backbone of our work are the people we serve, whose ingenuity, dreams and desires fuel human progress in the midst of hardship. We have made history working together, and we now celebrate it in this volume.

Our strength is our health officers and staff, deployed both at headquarters and around the world, working tirelessly to advance human dignity and global progress, leading the global fight against disease, hunger and poverty.

Our strength is local foreign service national staff working in more than 80 countries throughout the world. These talented experts possess unique local, technical and cultural knowledge and their contributions underpin every success in health and development over a half century.

Our strength is midwives and community health workers, the foundation of any health system, as well as nurses and doctors giving millions access to health care, and, in turn, creating a healthier, safer and more prosperous world.

Our strength is partnerships with community, faith-based and non-governmental organizations whose credibility within communities, and capacity to mobilize significant numbers of volunteers, is the engine of progress in rural communities.

For 50 years, people have advanced global health – helping slash child mortality around the world by 70 percent, ending smallpox and moving polio to the brink of eradication. And these people will drive future success.

In President Obama's 2013 State of the Union speech, he set forth a vision to achieve once of the greatest contributions to human progress in history: an end to extreme poverty. The U.S. Agency for International Development has responded with our Agency's ambitious contributions to that vision. In Global Health, we are working toward Ending Preventable Child and Maternal Deaths and Creating an AIDS-Free Generation – along with our unwavering support for protecting communities from infectious diseases.

We are at a historic moment in human history. We know what works, and we are in a unique position to further reduce child and maternal deaths and virtually eliminate new pediatric HIV infections while keeping families healthy.

By harnessing science, technology, innovation and partnerships to benefit the poorest communities in the world, the global health community can leave an unparalleled legacy in global health in this generation. Our people are foundational to this effort.

I am pleased to share the successes and accomplishments in delivering global health results and working to eradicate extreme poverty that we, as a global health family, have achieved in the past 50 years.

Contents

Acronyms and Abbreviations

ACT	Artemisinin-based combination therapy (for malaria)
AED	Academy for Educational Development
AIDS	Acquired immunodeficiency syndrome
ARVs	Antiretroviral drugs (for HIV and AIDS)
BCC	Behavior change communication
BEST	Best Practices at Scale in the Home, Community and Facilities
CAPRISA	Centre for the AIDS Programme of Research in South Africa
CBD	Community-based distributor; community-based distribution
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
CSM	Contraceptive social marketing
DEC	Development Experience Clearinghouse
DHS	Demographic and Health Survey(s)
DOTS	Directly observed treatment, short-course
DPT	Diphtheria, pertussis and tetanus (vaccination)
E&E	Bureau for Europe and Eurasia (USAID)
FPLM	Family Planning Logistics Management Project
FBO	Faith-based organization
FSN	Foreign service national (employee)
FY	Fiscal year
G2G	Government-to-government
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunizations
GHI	Global Health Initiative
GOBI	Growth monitoring, oral rehydration therapy, breastfeeding and immunizations

HIV	Human immunodeficiency virus
HRIS	Human resource information system
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IEC	Information, education and communication
IPPF	International Planned Parenthood Federation
ITN	Insecticide-treated mosquito net
LSHTM	London School of Hygiene and Tropical Medicine
m4RH	Mobile (phone) for Reproductive Health
MAMA	Mobile Alliance for Maternal Action
MDG	Millennium Development Goal
MDR-TB	Multidrug-resistant tuberculosis
MERS-CoV	Middle East Respiratory Syndrome Coronavirus
MSM	Men who have sex with men
NCDs	Non-communicable diseases
NGO	Non-governmental organization
NHA	National Health Account
NPA	Non-project assistance
NTD	Neglected tropical disease
ORS	Oral rehydration solution; oral rehydration salts
ORT	Oral rehydration therapy
PCV	Peace Corps volunteer
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
P.L. 109-95	Public Law 109-95: The Assistance for Orphans and Other Vulnerable Children in Developing Countries Act (2005)
P.L. 480	Public Law 480: The Agricultural Trade and Assistance Act
PMI	President's Malaria Initiative
PVO	Private voluntary organization

RAPID	Resources for the Awareness of Population Impacts on Development
SOTA	State of the Art technical and managerial training
TAB	Technical Assistance Bureau
TB	Tuberculosis
Three D's	Development, Defense and Diplomacy
TIPAC	Tool for Integrated Planning and Costing
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
U.S.	United States
USAID	U.S. Agency for International Development
USDH	U.S. Direct Hire employee
VCT	Voluntary counseling and testing (for HIV)
WASH	Water and Sanitation for Health
WHO	World Health Organization

A mother and her children receive health care from a nurse in Thailand.

- USAID

I. Introduction and Purpose

Recent decades have witnessed dramatic progress in global health. Smallpox has been eradicated. Global contraceptive prevalence with modern methods has increased from 10 percent in 1965 to more than 50 percent in 2013. Polio remains endemic in only three countries in the world: Afghanistan, Nigeria and Pakistan. Child deaths from diarrhea have been reduced by more than 50 percent since 1990. Deaths from malaria have fallen by more than 25 percent globally since 2000. Globally, maternal mortality per 100,000 live births has declined from 400 deaths in 1990 to 210 deaths in 2010. And HIV has been transformed from a disease that meant certain death to a disease that with the right treatment can be managed as a chronic ailment.

In its 50-year history, the U.S. Agency for International Development (USAID) has had an important hand in these and other crucial advances in global health. In the following pages, you will find a record of its contributions.

Founded in 1961 under the administration of President of the United States John F. Kennedy and evolving from predecessor foreign assistance programs like the Marshall Plan, the Point Four Program and the International Cooperation Agency, USAID was built on five principles that have shaped the Agency's work throughout its history: self-help, long-range planning, long-range commitments, social progress and free world cooperation. With 50 years of hindsight, it is now clear that these principles were instrumental to USAID's success in global health. USAID's strong field presence, coupled with stable funding and sustained commitment, facilitated the application of these principles at the country level. This has allowed staff to closely monitor impact and results, strategically adapt to lessons learned, apply new evidence-based research results and innovate as opportunities arise, all without losing sight of the end goal: improved health outcomes among poor and vulnerable people.

USAID's field presence and decentralized structure have enabled USAID staff to develop a deep understanding of the health challenges in the countries where the Agency works and to build strong relationships that result in culturally, socially and economically appropriate health programming. The technical competence, commitment and passion of both the Washington- and field-based staff, combined with steady funding, have allowed USAID to plan strategically and support long-term investments in health. As a result, USAID has made remarkable contributions to resolving health issues in some of the most difficult and complex environments around the world.

A young girl uses a community water pump installed as part of a development food assistance program in Madagascar. This borehole provides clean water to community members.

- Catholic Relief Services

At the country level, USAID's contributions are seen daily in the increased availability and accessibility of quality health care services, pharmaceuticals and health supplies; in families seeking appropriate health care because they have information and knowledge; in health care workers providing quality health care services because of training and improved skills; in health leaders and managers successfully using data to inform decision-making; in local non-governmental organizations (NGOs) and civil society organizations actively participating in improving health care while playing an active advocacy and watchdog role; and in governments placing increased priority on and investments in ensuring the health of their populations.

At a broader level, USAID's global health programs have promoted profound positive changes in U.S.-partner country cooperative relationships; built goodwill toward the United States; helped mobilize the international community around key global health issues; served as a tool of diplomacy, helping, for example, to stabilize countries emerging from conflict; and contributed to the development of a strong network of public health advocates, implementing partners, academia, foundations and others dedicated to improving global health outcomes.

While USAID's commitment to improving global health outcomes has never wavered, its strategies for achieving its development assistance health goals have adapted over the years to broader U.S. foreign policy interests and domestic political developments; changes in the global environment; the evolving epidemiology of mortality and morbidity in USAID-assisted countries; scientific advances; changes in USAID's organizational structure and lessons learned from 50 years of project implementation. The approaches used by USAID's global health program today are proven, evidence based and cost-effective.

The chief purpose of this USAID global health history legacy report is to describe USAID's key contributions to the improvement of global health over the past 50 years. This report looks first at the establishment of USAID, its organizational structure and how that structure has supported USAID's achievements in global health. It then details USAID's key contributions to global health over each of the past five decades. The full 50-year history of USAID's involvement in each intervention appears in the chapter on the decade in which that intervention was most prominent or achieved the greatest success. Many actors played a part in this impressive story and contributed to the "Key Global Results" that are highlighted at appropriate points throughout this document.

In support of its overview of USAID's key global health contributions, this report provides links to documents, web pages and other sources of technical detail and analysis. This material, although abundant, reflects only a small fraction of the noteworthy bilateral and centrally-funded projects that have created USAID's global health legacy.

Finally, after summarizing some lessons learned, the report offers some thoughts about USAID's future role in global health.

The global health environment today is obviously not what it was in 1961. A larger number of international actors provide development assistance. Economies in low-income countries have been growing, and their domestic spending on health care has been increasing. At the same time, chronic non-communicable diseases pose an ever greater challenge.

Within USAID, the mentoring of incoming staff will be key to passing on institutional memory and experience, as will determining an improved system for dissemination and applying the vast reservoir of information, studies, research results, lessons learned and other documentation on USAID-supported activities.

Meanwhile, USAID's global health program envisions even greater results in the future. With the tools and knowledge available today, extraordinary health outcomes are within grasp. These include eliminating preventable child and maternal deaths and ushering in an AIDS-free generation. There are calls for and movements toward universal health coverage. There are new opportunities for revitalizing family planning. And new technologies offer previously unimagined means of reaching people with health prevention, care and treatment regimens.

USAID, under the guidance and direction of the U.S. Presidential Administration and the U.S. Congress, is already considering the implications of these factors as it develops long-term plans that will ensure the Agency's future contributions are even more productive and effective than those of its first 50 years.

II. Establishment of USAID

Attempts to address global health issues began as early as 1852, when concerns about the disastrous impacts of communicable diseases, primarily cholera, on trade and commerce led to the first International Sanitary Conference in Paris. Similar concerns led to the First General International Sanitary Convention of the American Republics in Washington, DC, in 1902 and to the establishment of The International Sanitary Bureau (125), precursor to the Pan American Health Organization.

A significant precursor organization of USAID emerged in August 1940, when the Roosevelt administration created the Office for Coordination of Commercial and Cultural Relations Between American Republics, which sought to strengthen commercial and cultural ties that would bind Latin American nations to the Allied powers, as world conflict intensified. Renamed as the Office of the Coordinator of Inter-American Affairs and working through one of its subsidiary organizations, the Institute of Inter-American Affairs (IIAA), its efforts began to improve the health and sanitation in generally unhealthy areas where the U.S. government was negotiating to locate military bases. The IIAA also sought to aid and improve the health and general welfare of the people of the western hemisphere by collaborating with Latin American governments. These activities were carried out jointly through bilateral contracts that were administered by Inter-American Public Health Cooperatives in each republic. Andre Luiz Vieira De Campos sums up how the cooperative agreements grew and matured: "In March 1944, the IIAA had 181 North American technicians working in eighteen Latin American countries. Most were physicians, nurses, sanitary engineers, construction engineers, architects, entomologists, and business managers. By June

Jon Kubly/World Vision

President Kennedy signs the Foreign Aid Bill in the Oval Office, August 1, 1962. Onlookers include: Senator Thomas Kuchel, Senator Everett Dirksen, Congressman Robert B. Chiperfield, Congressman Wayne L. Hays, Congressman Francis E. Walter, Congressman Thomas E. Morgan, Congressman Peter Frelinghuysen, Jr., Congressman Cornelius E. Gallagher, Senator George D. Aiken, and Speaker John McCormack.

- Abbie Rowe in the John F. Kennedy Presidential Library and Museum, Boston

1944 another 13,000 nationals of other republics were employed by the program, of whom 600 were qualified technicians working on a range of projects such as malaria control environmental sanitation, hospital organization, dispensaries and health centers, professional training, and health education."

Toward the end of World War II, international development assistance, including global health assistance, became more prominent in the global arena. At the 1944 Bretton Woods Conference, the International Bank for Reconstruction and Development (World Bank), the General Agreement on Tariffs and Trade and the International Monetary Fund were set up, quickly followed by the establishment of the United Nations (UN) and UN system agencies like the United Nations Children's Fund and the World Health Organization. Many of these organizations initially focused on post-war reconstruction, complementing the United Nations Relief and Rehabilitation Agency and other programs providing relief to victims of war. As the need for post-war reconstruction ended, they adapted their focus to support global economic and social development.

Post-World War II also saw a limited number of private organizations engaging in global health-related activities. For example, the Rockefeller Foundation played a key role in fostering the emergence of public health as a discipline, supported the establishment of U.S.-based schools of public health, helped establish a medical college in China that modernized medical education in that country and conducted research into key global health challenges. The Ford Foundation worked in population and demography. Faith-based organizations and missionary groups supported health-related activities to improve the lives of those living in developing countries.

For the United States, international development assistance grew out of the need to stabilize Europe, help rebuild its infrastructure and strengthen its economy following World War II. The Marshall Plan – long viewed as a bold and effective commitment by the United States that produced transformative results – provided financial and technical assistance in this endeavor. Building on this success, President Harry Truman in 1949 proposed the Point Four Program, an international development assistance program, and in 1954, Public Law 480 (P.L.-480), the Agricultural Trade and Assistance Act, was passed, allowing the use of U.S. agricultural surplus to feed the hungry and promote trade.

Between 1952 and 1961, the provision of technical assistance and capital for large projects became an integral part of U.S. foreign policy.

A nurse at a tuberculosis (TB) hospital in Afghanistan, conducts directly observed treatment short course (DOTS) for a TB patient. Since the late 1990s, USAID's TB strategy has been expanding use of DOTS to ensure the completion of TB treatment and to cure and prevent resistance to TB drugs.

- Dr. Said Mirza Sayedi

Projects were administered through precursor organizations to U.S. Agency for International Development (USAID): the Mutual Security Agency, the Foreign Operations Administration and the International Cooperation Administration.

The African independence movements in the late 1950s and early 1960s opened the door to collaboration and foreign assistance with these newly created nations, while significant foreign assistance was provided to Asia and the Middle East, where the U.S. Government had vital strategic interests in the post-World War II era.

In early 1961, U.S. President John F. Kennedy called on all the people of the Western Hemisphere to unite in the Alliance for Progress – "a vast cooperative effort, unparalleled in magnitude and nobility of purpose, to satisfy the basic needs of the American people for homes, work and land, health and schools." U.S. foreign assistance to Latin America grew substantially under the Alliance.

On November 4, 1961, President Kennedy signed the Foreign Assistance Act (122) into law and created USAID by executive order. The newly created Agency was built on five principles that continue to shape USAID today: self-help, long-range planning, long-range commitments, social progress and free world cooperation.

In Fiscal Year (FY) 1962, USAID implemented programs in 83 countries with an appropriated foreign assistance budget of approximately $4.5 billion (nominal dollars) (263). In FY 2012, with the approximately $14.6 billion in development assistance appropriated to USAID, USAID supported development assistance programs in 100 countries. Eighty of them have a Mission while another 20 countries have active programs with no formal Mission. These statistics mask the dynamics over the past 50 years during which time support was extended to several new countries, while others graduated from USAID assistance. Two-thirds of the largest trade partners with the United States were once recipients of USAID assistance. Seven recipients of USAID funding have now achieved donor status themselves.

USAID was the first U.S. foreign assistance organization whose primary emphasis was on long-term economic and social development. To meet this mandate, USAID-supported development programs in many sectors, including agriculture, natural resource management, economic growth, education and democracy and governance. Meeting the world's global health challenges, however, has always been at the core of USAID's efforts to prevent suffering, save lives and create a brighter future for families in the developing world.

While USAID's commitment to improving global health outcomes has remained constant over its 50 years of history, its strategies for achieving its health goals have adapted to changes in U.S. foreign policy, domestic politics, the global health arena, the epidemiology of mortality and morbidity in USAID-assisted countries, scientific knowledge and USAID's organizational structure. Importantly, USAID's evolving strategic approaches also reflect the incredible reservoir of knowledge USAID has accumulated through 50 years of development experience. This USAID global health history legacy report highlights many of the key achievements, evidence-based best practices and lessons learned that have enabled USAID to address global health challenges in a progressively more efficient and effective manner.

USAID's business model provides unique contributions to global health

While the organizational structure of USAID has evolved over its 50 years of existence, core attributes have remained constant. These profoundly affect how USAID does business and achieves success – not only in global health but also across the development spectrum. Unique features that significantly contribute to USAID's ability to succeed include:

FIELD PRESENCE AND DECENTRALIZED STRUCTURE

USAID's strong field presence makes it unique from most donor organizations and is often cited as a reason for USAID's success. When USAID was established, it assumed responsibility for ongoing bilateral health and sanitation projects in 45 countries (142). In 2012, USAID had a field presence in over 80 countries throughout the world, with health officers present in approximately 60 of those countries.

USAID's field presence allows USAID to:

- Develop in-depth knowledge of individual country health challenges and, thus, respond with culturally, socially and economically appropriate interventions;
- Build strong working relationships with counterparts based on trust and respect;
- Respond quickly to changing realities and urgent needs on the ground;
- Rapidly share lessons learned and best practices, promoting south-to-south technical assistance and inter-regional learning;
- Achieve global reach; and
- Establish a cadre of world class implementing partners, institutions and academia.

> "I have seen dozens of U.S. Government structures up close, and in no case do the employees have a greater willingness to do a job and fight for what is worthy . . . the idealism of the vast majority of employees has allowed the Agency to do so much excellent work . . . That idealism – the conviction that we were doing something that needed to be done – is my fondest memory of USAID."
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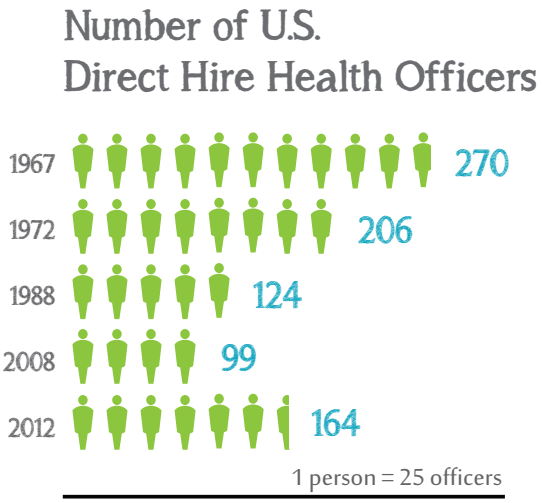
> M. Peter McPherson, USAID Administrator 1981–1987, *Fifty Years in USAID: Stories from the Front Lines, 2012*



various sources

The effectiveness of USAID's on-the-ground presence is enhanced by delegation of authority to the field. USAID missions have a high degree of autonomy to plan and program the funding that is allocated to their respective country programs. This allows for flexibility in adapting programs to country conditions, negotiating directly with country governments on how funding will be allocated and working with and strengthening civil society, especially when the government is unable or unwilling to provide key services.

STRONG TECHNICAL SUPPORT FROM USAID/WASHINGTON

USAID's on-the-ground presence is enhanced by robust technical and strategic support from USAID headquarters in Washington, DC. Since USAID was established, its regional bureaus in Washington have supported their respective field missions. In 1969, a Technical Assistance Bureau (TAB) was formed in USAID/Washington to lead research and development, in collaboration with U.S. universities and international research centers, and to provide cutting-edge technical support to the field. The TAB provided technical support to health and nutrition programs but not to population programs, which were administered under the central direction of the Assistant Administrator of Population and Humanitarian Assistance. In November 1981, a Directorate for Health and Population was established in the Bureau for Science and Technology (a later iteration of the TAB), uniting health, nutrition and population under a single center. In 2002, global health was elevated from a center under a bureau to a bureau itself: the Bureau for Global Health.

USAID's Bureau for Global Health in Washington maintains a professional and support staff of approximately 450 people with strong technical expertise across all of USAID's priority health technical areas. This staff include U.S. Direct Hire (USDH) foreign service officers and civil servants, contractors and fellows. In addition, each regional bureau has key staff devoted to health programming. Field missions utilize headquarters expertise, as well as centrally-funded and-managed projects, to enhance and support their in-country work.

STAFF COMPLEMENT OF COMMITTED TECHNICAL EXPERTS

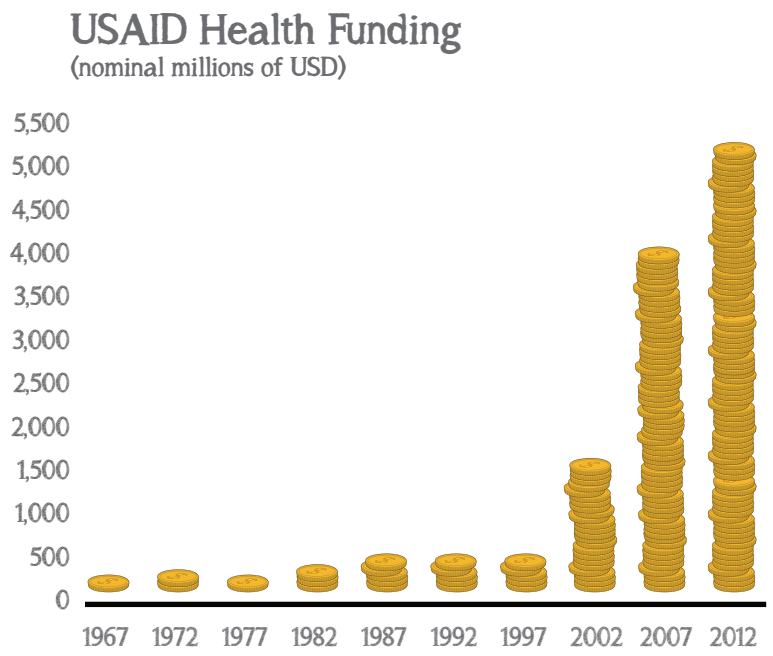
USAID's overall staffing is complex, consisting of USDH foreign service, foreign service limited and civil service employees; direct hire and contract foreign service nationals (FSNs); third-country nationals; several categories of personal service and institutional contractors; and personnel seconded to USAID from other U.S. Government entities. Each category has different levels of authority and responsibility.

USAID employees have more than just technical competence. Their passion and commitment have also been noted. With backgrounds in a broad range of social science and scientific technical disciplines, USAID boasts a highly qualified cadre of individuals dedicated to making the world a better place. A high proportion of USAID's Foreign Service Officers are former Peace Corps volunteers (PCVs), who transfer the same idealism and openness that inspired them to join Peace Corps to their work at USAID. Also, PCVs' experience with grassroots development resonates with USAID's values and helps make returned PCVs effective USAID officers.

In the 1960s, a large number of USAID personnel were posted to Vietnam. As the United States reduced its presence there in the late 1960s and early 1970s, USDH staff declined

A Cusco mother and child sit in a previously typical Andean home with indoor cooking fires.

- Traci Hickson



significantly, and the number of FSNs increased. Downsizing of USDH staff continued through the 1980s, and USAID shifted away from being an agency of USDH technical specialists that directly implemented projects toward an agency responsible for providing policy and strategy guidance and designing and managing grants and contracts. The Reengineering Government movement of the 1990s and the 1995 reduction-in-force accelerated this trend, reducing USDH staffing from over 3,000 to about 2,000.

To compensate for the reduction in USDH technical expertise, USAID increasingly used contract personnel (United States, third-country national and FSN). While USAID's global health program followed this trend, it also benefited from two unique programs that provided critical technical expertise for priority health programs: the Technical Advisors in AIDS, Child Survival, Infectious Diseases, Population and Basic Education (TAACS) program (85) and the Health and Child Survival Fellows Program (142). These programs provided critical senior-level expertise. The latter also brought into USAID junior-level staff who became a valuable pool of potential employees for USAID over the next several years.

In the early 1980s, USAID began sponsoring State of the Art (SOTA) technical and management training for employees in the global health field. These trainings, which are held regionally every two years, are widely recognized as a best practice and help keep field staff technically up-to-date. They also facilitate close and collaborative relations between staff in Washington and those in the field.

In the 2000s, and specifically under USAID Forward, USAID prioritized rebuilding its human resource base, instituting programs such as the New Entry Professional, the Development Leadership Initiative, Global Health Fellows American Association for the Advancement of Science Fellows and Presidential Management Fellows to attract and retain talent (298, 132, 74). By 2012, some 800 new staff had been hired.

USDH Global Health Staff: In line with Agency trends, the number of USDH health officers declined through the 1970s and 1980s but began to increase again late in the 2000s. However, the modest increase was disproportional to increased funding levels being managed by the Bureau for Global Health. In 2012, approximately 12 percent of USAID staff working on global health (164 people) were USDH Foreign Service Officers.

FSN Global Health Staff: USAID's highly qualified technical and support FSN staff work in country missions and are invaluable to the success of USAID-supported global health programs. In addition to providing technical expertise, they provide institutional memory and help to ground USAID-supported health interventions to national, social, economic, cultural and political realities. In 2012, over 700 FSNs were working on global health programs, accounting for approximately 53 percent of all USAID employees working on health. In recent years, increased program emphasis on sustainability and country ownership has translated into ongoing initiatives to increase the levels of responsibility and accountability delegated to FSN staff.

Global Health Contract Staff: Over USAID's 50-year history, contract staff have increasingly become a critical component of the global health staff profile. Contract staff allow USAID to access the expertise needed to effectively oversee an expanding and increasingly well-funded global health program. As of 2012, contractors accounted for approximately 35 percent (450 people) of USAID employees working on global health.

BUDGET

There has been strong bipartisan support for foreign assistance over the years, particularly for global health programs. This relatively secure funding has facilitated long-term planning; the building of long-term, in-country relationships; and the achievement of long-term development goals.

U.S. Government foreign assistance, across all programs – including health, agriculture, democracy and governance, education and others – accounts for less than 1 percent of the federal budget and includes five major categories: bilateral development aid, economic assistance supporting U.S. political and security goals, humanitarian aid, multilateral

economic contributions and non-defense military aid. USAID manages the bulk of the bilateral development aid and a portion of the economic support funds and humanitarian assistance. The Treasury Department handles most of the multilateral aid and the Department of Defense and State Department administer military and other security-related programs (300).

In the 1960s, USAID provided both loans and grants to developing countries. In the 1970s, loans were eliminated and Congress began appropriating USAID's bilateral development funding into different functional accounts. Although these have changed slightly over time, the major accounts are currently Development Assistance, Global Health Programs, Economic Support Funds, Transition Initiatives, International Disaster Assistance, Operating Expenses and Food for Peace.

Development funding in each functional account is subject to directives and administration priorities. For example, within the Global Health Programs-USAID account funding, the U.S. Congress provides specific funding levels for health technical areas (malaria, population and reproductive health, tuberculosis, etc.). In addition, there are certain legislative restrictions that apply to all foreign assistance, regardless of account; several of these restrictions are particularly relevant to global health activities.
As illustrated in the graph, the U.S. Government is strongly committed to global health. The marked increase in funding for health programs since the early 2000s is largely due to the U.S. Government's response to the global HIV and AIDS epidemic under the U.S. President's Emergency Plan for AIDS Relief, but it also reflects increased funding for malaria and maternal and child health.

Strategic implementation approaches

Several key implementation strategies make USAID's approach to development assistance unique. The global health program effectively applies the following to ensure program impact and sustainability:

- *Country ownership:* USAID responds to host country needs and embraces "country ownership" as critical to aid effectiveness and sustainable, results-driven development.

- *Addressing country-specific issues:* USAID's decentralized structure allows it the flexibility to assess health conditions in developing countries; create, test, adapt and introduce appropriate products and interventions; and strengthen local health systems. USAID is able to balance technical support for service delivery that meets more immediate needs with capacity building efforts to achieve long-term impact. Openness to new ideas and innovative approaches to addressing country-specific challenges are encouraged.

A Nigerian woman keeps her friend company as she fills gourds with water.
- USAID

- *Grassroots, people-oriented approach:* With its focus on beneficiaries and improving the health and lives of the poor, USAID works at the community level to get services as close as possible to those who need them.

- *Partnerships:* USAID works collaboratively with local institutions, governments, other donors and multilateral organizations, nongovernmental organizations, the private sector and other U.S. Government entities to utilize the strengths of each partner to increase impact.

  - Work with the private sector: USAID is recognized for its strong ties to the private sector. Whereas many development agencies tend to work primarily with public sector institutions, USAID successfully leverages partnerships with the private sector to extend its reach and strengthen private sector health providers.
  - Network of implementing partners: USAID's extensive network of implementing partners allows it to access the best minds, thinking and cutting-edge technologies to advance development impact.

- *Focus on development:* USAID's work in global health is positioned within its overall development portfolio, which includes agriculture and food security; democracy, human rights and governance; economic growth and trade; education; environment and global climate change; gender equality and women's empowerment; global health; science, technology and innovation; water and sanitation; and work in crises and conflict. Working in synergy across this broad development spectrum, USAID's global health program is able to approach complex and multidimensional health challenges from multiple angles simultaneously, leading to a greater positive impact on health outcomes than through health programming alone. Conversely, USAID's long-term capacity building for health, advocacy for community-based approaches and support for health systems strengthening and the decentralization of health services contributes to USAID's democracy and governance objectives.

- *Long-term strategic planning:* USAID takes a long-term view of social and economic development and engages in long-term planning. While planning processes have evolved through the decades, they have consistently included country and sector-level development strategies achieved through packages of development projects. For each project, the goal, objectives, rationale, implementation actions and expected results must be clearly articulated and rigorously supported by project design documents, logical frameworks, social and economic impact analyses, research and monitoring and evaluation plans.

- *Results focus and reporting:* Since its inception, USAID has consistently focused on measuring results and reporting on program impact. In the health sector, this is most clearly illustrated by USAID's Demographic and Health Surveys. These surveys have allowed USAID to quantify the impressive impact of global health investments, which is critical to ensuring continued support for the sector.

- *Evidence-based innovation:* USAID uses the latest evidence to ensure that programs are state-of-the-art and that barriers to implementation are overcome through innovation in technology and delivery. The recent support for Evidence Summits reflects this spirit where professionals from a wide range of development skills review what the current evidence tells us and identified gap for future research support. USAID has been a pioneer in implementation science - taking innovation and research and bringing it to communities to have long-lasting results.

Global leadership, reach and credibility

As the U.S. Government's principal development agency, USAID has advanced science, raised international consciousness and contributed cutting-edge approaches to development. USAID's steadfast vision of improving the lives of the poor and its long-term commitment to the countries in which it works has earned USAID international credibility as a reliable, trusted development partner. Its network of partners and contacts, both globally and domestically, allow USAID to access the best minds, influence development thinking and reach across the world with resources, information and lessons learned.

USAID's Goals

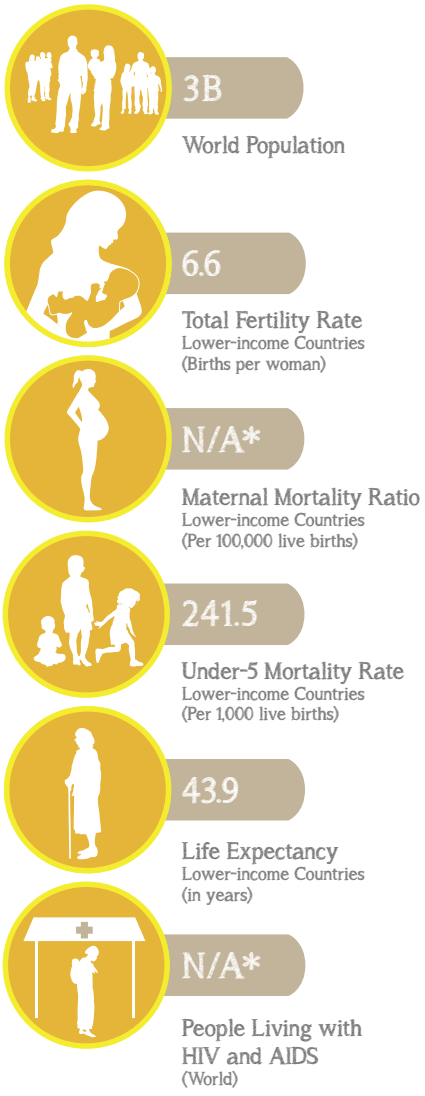
For 50 years, USAID has been guided by the same overarching goals that President Kennedy outlined when USAID was established: furthering America's foreign policy interests in expanding democracy and free markets while also extending a helping hand to people who are struggling to make a better life or recover from a disaster or who are striving to live in a free and democratic country. USAID's global health program is proud of its outstanding contributions to achieving these goals.

“"...My fellow citizens of the world: ask not what America can do for you, but what together we can do for the freedom of man.”

President John F. Kennedy,
Former President of the United States

III. USAID in the 1960s

The Decade of Development



Note: See Annex for data sources, definitions and methods.
*Data not collected at this time

With many countries breaking their colonial ties and achieving independence, the 1960s were a decade of hope and excitement. Independence offered countries the opportunity to leave poverty behind and create a new era of peace and prosperity. The international community stood ready to help, declaring the 1960s the "Decade of Development" and embracing social and economic development with fervor. The United Nations expanded its role, and the World Bank began to lend funds to developing countries for the construction of income-producing infrastructure, such as seaports, highway systems and power plants. The global politics of the Cold War reinforced the international community's desire to alleviate poverty as a strategic tool for building alliances and fighting communism.

In the United States, this global optimism was manifest in the American public's firm support for using international development assistance to help countries modernize. The U.S. Agency for International Development's (USAID's) approach reflected the accepted development theory of the time that equated industrialization with modernization. Thus, USAID's goal, per Rostow's "Stages of Economic Growth," (273) was to assist each developing country to achieve, as quickly as possible, the industrial take-off point, after which growth would continue on its own initiative to benefit the populace. To this end, USAID supported large-scale projects and major investments in infrastructure development, transportation and power. Staff were placed in host country ministries and local organizations to assist in building basic institutions and stimulate reform. USAID's significant investments in agriculture and the dissemination of new agricultural technologies contributed to the success of the "Green Revolution."

During this decade, geopolitics played an influential role in determining the countries in which USAID worked. For most of the 1960s, USAID conducted major development programs in only 30 countries, with 9 of those (Korea, India, Pakistan, Turkey, Nigeria, Tunisia, Brazil, Chile and Colombia) receiving about half of USAID's funding. In addition, USAID participated in security and stability programs in Vietnam, Laos, Thailand, the Congo and the Dominican Republic and provided limited assistance to a few other countries.

In health, USAID's large-scale projects included massive water and sanitation schemes, construction of health facilities and smallpox eradication and measles control. Toward the end of the decade, as the link between population growth and development became an in-

1960s Timeline

1961

USAID established; President Kennedy signs the Foreign Assistance Act

1965

USAID family planning program begins

1966

U.S. Government declares a "war on hunger"

WHO initiates a worldwide smallpox eradication program

USAID begins funding smallpox eradication programs in 20 African countries

1967

United Nations Fund for Population Activities (UNFPA) established

1968

The term "Green Revolution" is coined by USAID's Administrator, William Gaud

> "In the 1960s, USAID produced some of the best and most strategic thinking on development. That's where the thought leadership was in the field."
>
> Interview with Nancy Birdsall, President, Center for Global Development, in USAID *Frontlines,* February 28th, 2010

ternational concern, USAID's involvement in population programs accelerated. Similarly, as concerns with a growing world food crisis increased, USAID intensified its involvement in nutrition activities.

Key USAID Global Health Contributions

SMALLPOX ERADICATION AND MEASLES CONTROL

Key Global Results

- In 1980, the World Health Organization (WHO) declared the world free of smallpox – the first and only disease to be eradicated through a public health effort.
- Measles vaccinations are a routine part of childhood immunizations.

The USAID Story

The optimism of the 1960s was reflected in the belief that, with a small amount of funding, smallpox could be eradicated from the world. In 1966, based on a proposal from the former Soviet Union, WHO launched a global smallpox eradication program with the goal of eradicating the disease within a decade. That same year, USAID with technical assistance from the U.S. Centers for Disease Control and Prevention began supporting a complementary large regional project in Africa to control measles and eradicate smallpox. Some 20 West and Central African countries participated in the USAID project (see map), although this number fluctuated somewhat over the years.

Phase I of the project included one mass smallpox vaccination to inoculate the entire population in the 20 countries and a simultaneous measles vaccination of all susceptible children between the ages of 6 months and 6 years. Between January 1967 and June 1968, approximately 47 million persons were vaccinated against smallpox; 7.6 million children also received measles vaccinations.

Phase II was limited to a maintenance program consisting of smallpox vaccinations for people not vaccinated in Phase I and surveillance. The strategy was later modified to focus on rapid deployment of vaccination teams to areas experiencing a smallpox outbreak.

Thai children receive smallpox vaccinations. Though the little girl in the foreground winces momentarily from the needle stick, she gains protection against a deadly disease. In 1980, the world celebrated the eradication of smallpox.

- USAID

Rapid success of smallpox eradication was facilitated by a new technology. Partially funded by USAID, it adapted the mechanics of U.S. military jet injectors for the application of the smallpox vaccine. High pressure, rather than a needle, was used to force the smallpox vaccine through the skin. Further research eliminated the need for electricity to power the injection device, facilitating vaccination in rural, hard-to-reach areas.

Because of the success of the USAID-funded program and other programs, WHO adapted interventions to eliminate smallpox in Asia and the rest of Africa, and measles vaccinations were integrated into routine childhood immunization programs. The last naturally occurring case of smallpox was recorded in Somalia in 1977. In 1980, WHO declared the world smallpox free.

Lessons learned from the measles control and smallpox mass vaccination campaigns have helped inform USAID, ministries of health and donor-supported vaccination programs against other diseases.

Smallpox Eradication Program
West and Central Africa
(1967–1972)

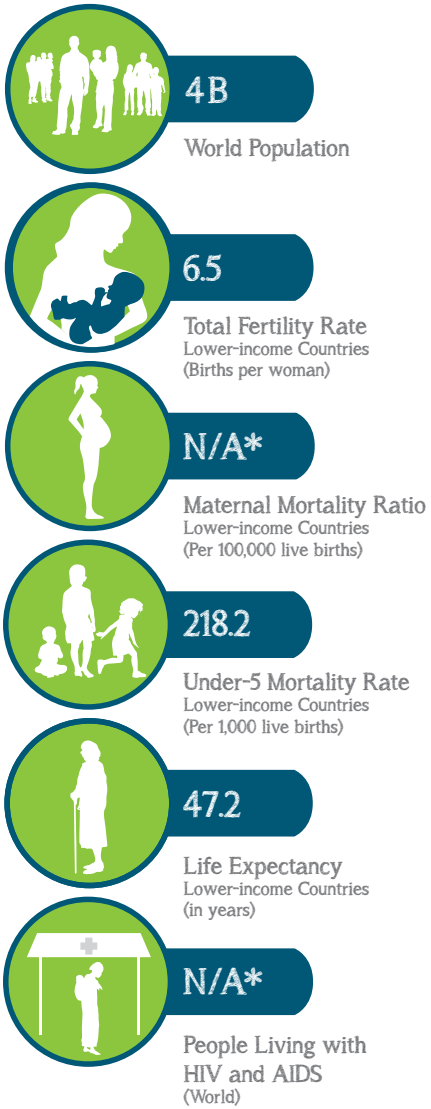
"Health…
is a fundamental human
right and the attainment of
the highest possible level of
health is a most important
worldwide social goal."

Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata,
former Soviet Union, September 6–12, 1978

IV. USAID in the 1970s

Directly Helping the Poor



Note: See Annex for data sources, definitions and methods.
*Data not collected at this time

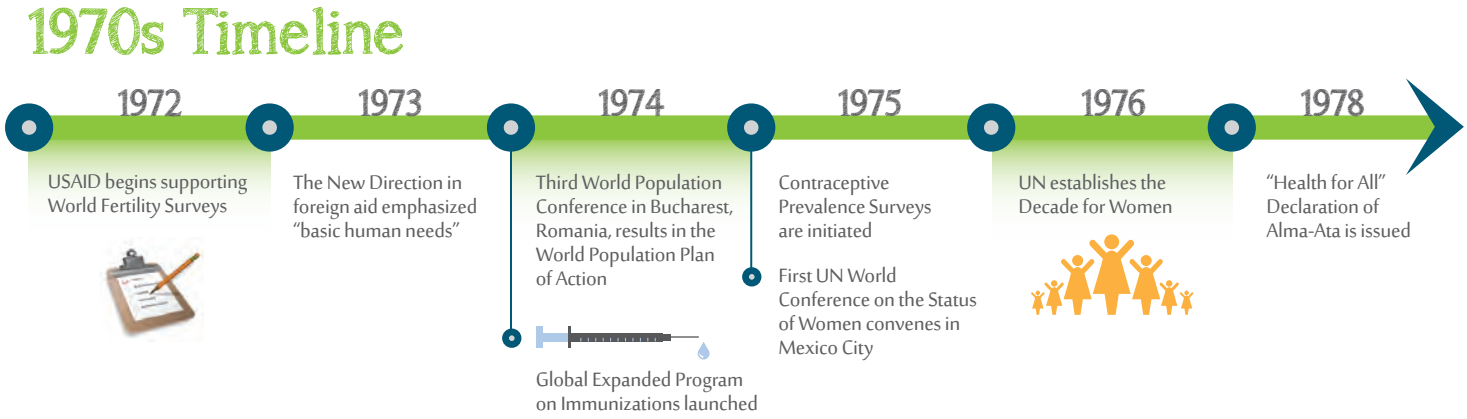
By the 1970s, optimistic expectations for development were fading, and questions grew about whether the prevailing development theory would actually lead to economic growth. This gave rise to the Basic Needs Theory, which promoted development of the poor by addressing basic needs like hunger, education and health. The 1970s was a period of growth for the World Bank, which shifted its focus from large infrastructure to other sectors and greatly increased the size and number of its loans.

During this decade, women in developing countries were recognized as an underutilized resource for change. In 1975, the United Nations' (UNs') first Global Women's Conference elevated the cause of gender equality to the global agenda. Over the next 20 years, the UN convened three additional Global Women's Conferences. These helped unite the international community behind a set of common objectives and plans of action for securing equal access for women to education; employment; political participation; health, nutrition and family planning services; and housing (110).

In the United States, Congress began to question the effectiveness of foreign assistance and, in 1973, passed new legislation emphasizing the need to directly improve the lives of the poor in developing countries. Under the New Directions legislation, USAID shifted from providing technical and capital assistance to supporting governments and organizations. It adopted a "basic human needs" approach that focused on "growth with equity" and expanded basic health, nutrition and family planning services to enhance the poor's productive capacity and long-term employment potential.

Under the New Directions legislation, the grant and loan categories of funding, which had been in effect during the 1960s, were replaced with nine functional accounts aimed at specific development issues. This change gave Congress increased authority to direct foreign assistance priorities. The Percy Amendment to the Foreign Assistance Act of 1961 mandated that U.S.-funded development assistance programs pay particular attention to the integration of women into national economies (286). In 1974, USAID issued its first policy directive on women in development (140).

In the early 1970s, USAID overseas staffing, particularly technical staffing, was significantly reduced, signaling USAID's shift away from direct implementation of projects toward



policy and strategy guidance, project design and management. More resources began to be channeled through multilateral organizations, as well as through non-governmental organizations (NGOs) and other implementing partners.

By the mid-1970s, USAID had clearly defined its approach to implementing the New Directions legislation, as described in its 1975 report to the Committee on International Relations (136) and 1978 policy paper (19). USAID also instituted the use of the Logical Framework to improve planning processes and clearly demonstrate who benefits from USAID assistance (see The Logical Framework: A Manager's Guide to a Scientific Approach to Design and Evaluation, Nov. 1979, [312]).
For health, the New Directions approach was consistent with growing international consensus that health interventions should focus on primary health care. This consensus culminated in the 1978 "Health for All" Declaration of Alma-Ata (108), which urged action by "all governments, all health and development workers and the world community" to protect and promote the health of all people. USAID developed a health sector policy paper (120) that concentrated on four areas:

1. primary health care (basic health, nutrition and family planning services)
2. water and sanitation
3. selected disease control programs
4. health planning

Within these areas, efforts were concentrated on integrated primary health care systems that were low cost and community based.

The Camp David Accords of 1978 altered geopolitics in the Middle East and led to the U.S. Government providing major military, economic, humanitarian and other aid to Egypt and Israel. Whereas economic assistance to Israel was in the form of cash grants, development assistance to Egypt was project driven. This project-driven assistance opened the door to what was to become one of USAID's largest country programs, including a significant health program.

Key USAID Global Health Contributions

FAMILY PLANNING AND REPRODUCTIVE HEALTH

Key Global Results

- Contraceptive prevalence for modern methods in the developing world (including China) increased from under 10 percent in the 1960s to over 50 percent in 2013.
- In developing countries, fertility declined from more than 6 children per woman in the early 1950s to 2.6 children by 2012.
- In the 27 countries that currently receive at least $2 million in USAID family planning and reproductive health assistance, 1 in 10 married women of reproductive age used a modern method of contraception in the 1960s. In 2013, almost one-third of such women in these same countries use modern contraception.

The USAID Story

USAID's leadership and innovative approaches to family planning and reproductive health have led to what is one of its greatest success stories. While interventions began in the 1960s and continue today, the 1970s to mid-1990s are considered the "golden years" of USAID's family planning and reproductive health program (331).

Two major influences led to increased global interest in family planning. First, a social reform campaign to increase access to contraception, initi-

The RAPID Project: Projections and Policy-making

In the 1970s, USAID's Office of Population realized that demonstrating the social and economic consequences of high fertility and rapid population growth to country governments would be key to informing and influencing national population policies. USAID supported development of the Resources for the Awareness of Population Impacts on Development (RAPID) methodology, incorporating visual images to demonstrate the consequences of alternative scenarios of population growth on sectors such as education, health, labor, agriculture and urbanization. Initially, RAPID had to run on a mainframe computer, which constrained its use. However, the advent of the laptop computer in the 1980s allowed the technology to be easily transported around the world. Presentations were tailored to each country, and variables could easily be changed to reflect the impact of different policy decisions. The ability to easily visualize the consequences of continued rapid population growth influenced government decisions on policies and funding for population programs.

Since the 1970s, the RAPID methodology has continued to be refined and applied to other health areas, including maternal and child health and HIV and AIDS.

ated in the United States in the early 1900s, gained momentum, as did similar movements in other countries. Global cooperation began to take place, and in 1946, the International Committee on Planned Parenthood, which evolved into the International Planned Parenthood Federation (IPPF), the largest NGO working in global family planning, was established. This social movement was primarily concerned with women's rights and empowerment, including the right to avoid unintended pregnancies. This right was universally recognized in 1968 at the United Nations' International Conference on Human Rights, which adopted Resolution XVIII, which said: "couples have a basic human right to determine freely and responsibly on the number and spacing of their children and a right to adequate education and information in this respect" (151).

The second influence on the family planning movement related to widespread fears of a "population explosion." In the 1950s and 1960s, three U.S. organizations – the Ford and Rockefeller Foundations and the Population Council – brought together experts and government leaders from around the world at various international meetings to discuss the implications of rapid population growth and high fertility, and developed a consensus about what was needed for the future. In the United States, the 1968 release of Paul Ehrlich's best-selling book, *The Population Bomb*, which warned of mass starvation and social upheavals in the 1970s and 1980s due to overpopulation, heightened fears of a "population explosion." A widespread, general consensus developed that population growth was a major international concern.

During this same period, U.S. foundations and governments in a number of developing nations, concerned about the potential consequences of rapid population growth and high fertility, began using surveys and demographic analysis to better understand population growth. Analyses showed that a substantial proportion of women in developing countries did not want more children but were not using modern contraception methods. The development of two new contraceptives – the oral contraceptive pill and the intrauterine device – raised hopes that effective, inexpensive contraception could be made available to fill this unmet need.

These developments led USAID to move assertively into population programming, launching its first population program in 1965. In 1969, USAID's Office of Population was established to provide leadership, initiative, coordination, technical guidance and assistance in developing and implementing population and family planning activities.

In those early days, population activities, unlike other USAID programs, were not managed by field missions, with support from the Technical Assistance Bureau. Instead, population was a centrally-managed global program, with approximately half of the funding expended through for-profit and non-profit organizations known as U.S. Cooperating Agencies. This central approach was seen as necessary given the political sensitivities of population programs and the lack of interest in many countries for population assistance.

A volunteer worker soothes a young boy's initial uneasiness during a visit to a USAID-funded maternal and child health center in Nigeria.

- USAID

Ten Essential Elements of a Successful Family Planning Program

1. Supportive policies
2. Evidence-based programming
3. Strong leadership and good management
4. Effective communication strategies
5. Contraceptive security
6. High-performing staff
7. Client-centered care
8. Easy access to services
9. Affordable services
10. Appropriate integration of services

Note: Contraceptive security exists when every person is able to choose, obtain and use quality contraceptives whenever needed.

USAID's Commitment to Voluntarism

From its inception, USAID's family planning was guided by a commitment to voluntarism and informed choice. The prominence of each of the three rationales underpinning the program – to enable women and couples to choose the number, timing and spacing of their children; to improve maternal and child health; and to mitigate the consequences of rapid population growth – has shifted over time.

Given the strong bipartisan congressional support for population programming, funding increased dramatically in the first years of the program. Between 1967 and 1974, the budget for the Office of Population grew from $5 million to $125 million – in annual increments of $25 million or more. Funding levels were set by Congress through specific appropriations. Under the first director of the program, USAID's population program embraced a "supply side" approach, focusing on providing condoms and contraceptives. At the time, there was a growing debate (the topic of the 1974 Third World Conference on Population in Bucharest, Romania) over whether decreasing population growth could have a significant impact on economic development or whether economic development was needed first to bring down fertility rates. USAID's Office of Population adopted the position that there was a widespread demand for family planning and that USAID funding earmarked for population programming should focus on meeting that demand.

Throughout the 1970s, in order to meet ambitious goals, USAID initiated a series of innovative family planning interventions that were essentially experimental in nature. These included:

- Working with NGOs and the private sector when country governments had little interest in providing family planning services
- Initiating condom and contraceptive social marketing programs to increase product availability
- Using interactive technologies to enable countries to easily visualize the budgetary implications of different population scenarios and policy choices
- Collaborating with the United Nations Population Fund (UNFPA) to fund the first World Fertility Study and then independently funding Contraceptive Prevalence Studies and Demographic and Health Surveys (DHS) to be able to demonstrate need and impact
- Initiating household/community-based delivery of family planning services
- Developing contraceptive projections and strengthening logistics and supply chain systems to ensure that family planning commodities were available when and where needed
- Funding research on new technologies to expand contraceptive choice, including short-term, long-acting and permanent methods, resulting in the availability of a wider range of contraceptive methods throughout the world

These "experiments" became the backbone of USAID's success in family planning and provided information and lessons learned that continue to inform USAID's approaches to service delivery in every health technical area today.

As USAID's family planning programs ramped up in the late 1960s and early 1970s with these innovative interventions, Asia was virtually the only region of the world with national population policies and programs. USAID began to support the ongoing national program in Korea as well as nascent national efforts in Thailand, Indonesia, the Philippines, Pakistan, Nepal, Singapore, Malaysia, Taiwan, as well as Chile and Costa Rica. The initial results in Southeast Asia were

> "In the 1970s and 80s, USAID family planning programs showed that even in a climate where political, gender, governance and economic growth were not conducive to change, USAID and local champions were able to make family planning in Egypt an international success story."
>
> Chris McDermott, retired Foreign Service Health Officer who served in Egypt, 1999 –2004

positive (Thailand [184], Indonesia [102], Korea [264], case study of four countries [301]).

In South Asia, however, results lagged – particularly in India and Pakistan. In the 1970s, the introduction of community-based family planning services under the Family Planning Operations Research Project in Matlab, Bangladesh, helped prove that family planning uptake and fertility reduction in a very poor country was possible (129) (43).

Early results outside of Asia were mixed. Strong USAID-supported programs emerged in Colombia and several other Latin America and Caribbean countries as well as in Tunisia, but there was little early interest in population programs in Africa. However, during the 1970s and 1980s, in part due to USAID's influence, most developing countries initiated population policies, and USAID support for family planning programs expanded to countries across the world. The early focus on providing only contraceptives softened, and USAID family planning programs became more complex and country specific, emphasizing the role of family planning in improving maternal and child health outcomes.

The 1984 Mexico City International Conference on Population (206) brought changes to USAID support for family planning. At that conference, the United States adopted the Mexico City Policy, which required non-U.S. NGOs to agree, as a condition of receiving U.S. family planning assistance, to neither perform nor actively promote abortion as a method of family planning. The Mexico City Policy was in place from 1984 to 1993 and again from 2001 to 2009. It was rescinded in 1993 to 2001 and has not been in place since 2009.

At the 1994 International Conference on Population and Development in Cairo, Egypt, the development community adopted the 20-year Program of Action, which included a more holistic approach to women's reproductive health needs. The Program of Action was designed to achieve gender equity, improve reproductive health and stabilize population growth. It included a call for universal access to family planning and reproductive health services and for specific measures to advance the economic, educational, legal and health status of women (103).

By the mid-1990s, USAID was supporting family planning programs in 77 countries and providing indirect funding to others through NGOs, such as the IPPF and UNFPA (101). Major efforts in countries as diverse as Egypt (268), (73), (131), (181), (169) successfully helped in reducing fertility rates, lowering abortion rates, ensuring a reliable supply of contraceptives and providing couples with the ability to plan both their family size and the spacing between children (196).

After 30 years of successful involvement in family planning, USAID began to graduate family planning programs in some countries (60). In 2003, recognizing that several countries were becoming eligible for graduation from USAID family planning support based on their modern contraceptive prevalence and total fertility rates, USAID developed a family planning graduation program. It was first applied in Latin America and the Caribbean, with seven countries slated to graduate in a 2–7 year period. Graduation plans helped identify and deal with major gaps, such as contraceptive security. All of the seven countries (Dominican Republic, El Salvador, Honduras, Jamaica, Nicaragua, Paraguay and Peru) have completed graduation.

Community-Based Distribution

Access to family planning services is a problem in many resource-constrained countries where clinic-based national health systems cannot reach poor and rural populations. In the 1970s, USAID's new family planning program recognized the need for innovative programming to achieve its ambitious fertility reduction goals. USAID therefore began to fund research and pilot studies that demonstrated that well-trained community lay persons could successfully distribute family planning information and services. Community-based distribution (CBD) programs that trained people in the community (most often women) to provide door-to-door or locally-based delivery of family planning information and supplies (such as oral contraceptives and condoms) as well as referrals for methods that need a health care worker's participation (intrauterine devices, implants, voluntary sterilization) quickly became a mainstay of family planning programs worldwide. Much of the global rise in contraceptive use is attributed to CBD programs. They also played an important role in empowering women by giving community-based distributors a visible and respected role in communities.

Building on this successful model, USAID's other health sector programs incorporated community-based distribution approaches. In some countries, CBD systems have expanded to provide a full range of essential community health services, including immunization and oral rehydration therapy, HIV and AIDS prevention and treatment, vitamin supplementation, referral for emergency obstetrical care and malaria treatment and insecticide-treated mosquito nets. In some countries, CBD programs have also been integrated with social marketing programs, using community leaders as the main distributors, with very cost-effective results.

As mature programs graduated, USAID support for family planning in other countries continued to achieve significant gains, not only in increasing contraceptive use and reducing unintended pregnancy, but also in promoting economic development. It is now widely recognized that a modest investment in family planning saves lives and improves maternal and child health.

A study in Bangladesh (111) provided evidence that long-term investment in integrated family planning and maternal and child health contributed to improved economic security for families, households and communities through larger incomes, greater accumulation of wealth and higher levels of education.

USAID implements the "Ten Essential Elements of a Successful Family Planning Program" approach and today prioritizes family planning funding for the 24 countries that represent more than 50 percent of the unmet need for family planning (85). USAID remains a leader in family planning, continuing to provide to the developing world 40–50 percent of all donor funding for family planning and 35–40 percent of donor-funded contraceptives. The July 2012 London Summit on Family Planning and the launch of Family Planning 2020 revitalized global interest and commitment to bringing family planning information, services and commodities to some of the most underserved women in the world. Today, as a result of USAID's work in family planning, millions of women and couples around the world are able to choose the number, timing and spacing of their pregnancies, resulting in significant social, economic and health gains for families and communities.

At Bulape Hospital in the Democratic Republic of the Congo (formerly Zaire), a health worker gives family planning talks to groups and individuals. Here, he shows an IUD to one of his clients as they discuss family planning options.

- Judith Brown

COMMODITY PROCUREMENT, LOGISTICS AND PHARMACEUTICAL MANAGEMENT

Key Global Results

- The per person cost of antiretroviral drugs (ARVs) has been reduced from more than $10,000/year in 2000 to $150/year or less in 2012.
- The average cost of a long-lasting insecticide-treated mosquito net (ITN) fell from approximately $5 in 2004 to less than $3.50 in 2012.

U.S. Government Contribution to Commodity-Procurement Global Results

- USAID was the first – and continues to be the largest – bilateral donor for contraceptive commodities.
- In the past 25 years, USAID doubled the number of different contraceptive methods it procures and increased the total value of donated condoms and contraceptives from $32.4 million in 1986 to $107.3 million in 2012.
- Since its launch in 2005, the President's Malaria Initiative (PMI) has filled key commodity gaps in malaria-endemic countries in Africa while realizing cost efficiencies. PMI procured more than 82 million ITNs, 189 million artemisinin-based combination therapies and 62 million rapid diagnostic tests for malaria.

The USAID Story

USAID's leadership in strengthening the institutional capacity of countries to forecast, procure, manage and distribute health supplies and commodities began in the 1960s but was consolidated in the 1970s with the initiation of the first central contraceptive procurement program. This cutting-edge approach responded directly to the World Health Organization (WHO) "health for all" mandate by increasing the availability of contraceptive supplies for the poor. Since the 1970s, USAID's emphasis on supply chain management has led to improved program performance and access to health care services across a broad spectrum of USAID's health technical areas. In addition, it has enhanced quality of care and contributed to more cost-effective and efficient delivery of health services.

USAID's involvement in commodity procurement and supply chain logistics grew out of the population and family planning program's early emphasis on increasing the availability of contraceptive commodities. With no accurate means of forecasting contraceptive needs, country programs often overestimated and ended up with overstocks of USAID-provided commodities. To remedy this situation, USAID's Washington, DC, headquarters began to work with its field missions to revise the way estimated contraceptive needs were calculated. This led to the development of contraceptive procurement tables and logistics management practices that are now integrated into virtually all USAID-supported health programs. In 1970, USAID's global health program initiated centralized contraceptive procurement to ensure contraceptive security for its population programs.

To complement centralized contraceptive procurement, USAID also began to support contraceptive supply management in the 1970s. Initially, the Centers for Disease Control and Prevention provided the needed technical assistance. As population programs expanded and the quantity and variety of contraceptives purchased increased, however, there was a need for additional support. In 1986, USAID awarded the Family Planning Logistics Management (FPLM) project to improve the capability of developing country public and private sector organizations to administer more effective and efficient contraceptive logistics systems. For more reliable forecasting of contraceptive requirements, the project also assisted USAID missions in preparing annual Contraceptive Procurement Tables. The 1989 midterm evaluation of the FPLM project (147) contains additional detail.

Since those initial projects, USAID has continuously supported central commodity procurement and logistics management projects for contraceptives and family planning supplies, malaria commodities and some child survival commodities.

In 2005, under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), USAID initiated the similar, although larger, Supply Chain Management Project for:

- Procurement and delivery of quality HIV and AIDS medicines and laboratory supplies at the best value
- Technical assistance to transform in-country supply chain performance and support health systems strengthening
- Global collaboration for long-term local and international supply chain solutions
- Enhancing country ownership and self-sufficiency

This widely acclaimed project was instrumental in driving down the costs of ARV treatment. It now procures more than half of the ARVs provided under PEPFAR and, in 2012, supported about 3.9 million people on treatment.

Building on decades of expertise in procurement and supply chain management, USAID ventured into cutting-edge interventions to strengthen the regulatory capacity of countries to monitor the quality of medications, operate national drug quality control laboratories, implement drug registration systems and collaborate on international efforts to combat counterfeit drugs, thus helping to ensure patient safety and improved health outcomes. Most recently, USAID became involved in pharmacovigilence and drug quality, initiating activities to monitor and report adverse drug events and investigate their causes.

SOCIAL MARKETING

Key Global Results

- Social marketing was widely adapted to address numerous public health issues.
- Social marketing has achieved positive changes in individual behavior and social norms, resulting in improved health outcomes.

USAID Contributions to Social Marketing Global Results

- In FY 2011, 30 percent of all USAID's contraceptive and condom shipments went to social marketing programs.
- In Bangladesh, the Social Marketing Company manufactures and sells over 210 million oral rehydration salt (ORS) sachets annually, with a cash flow of 80 percent sustainability for its operations.
- New Start voluntary counseling and testing centers test more than 10,000 clients per month for HIV in Zambia and more than 30,000 clients per month in Zimbabwe; more than 250,000 clients in Lesotho have been tested for HIV since the centers were established in 2005.
- In Pakistan, the USAID social marketing program supports 70 percent of the market share for condoms.

The USAID Story

Social marketing, a signature USAID program, incorporates market-based principles into development. USAID first ventured into social marketing in the early 1970s, under its family planning program, as part of the global movement to provide primary health services to all. A 1971 study produced marketing plans for potential contraceptive social marketing projects in two countries, Korea and Jamaica, and led to USAID implementing its first project in Jamaica in 1974.

"Getting product to the customer is not the end. We must look at the patient and treatment outcomes."

Anthony Boni, USAID Pharmaceutical Management Specialist

USAID

Jamaica: USAID's First Condom Social Marketing Project

Initiated in 1974, "Panther" condoms and "Perle" oral contraceptives were targeted at males and females, respectively, in the 14 to 35 age group. Distribution was through the commercial sector and was aimed at pharmacies and general retail stores. Communication activities included mass media, radio, TV and newspapers as well as point-of-purchase displays.

The program was turned over to the Jamaican Government's National Family Planning Board, a division of the Ministry of Health, in 1977. Although there were some initial management difficulties and sales growth stagnated, a mid-1980s evaluation found that the high level of market penetration established under the project had not eroded at that time (124).

Since then, the role of social marketing has broadened to many health technical areas, including child survival, malaria control and HIV and AIDS. The range of products being marketed has expanded to include not only male and female condoms and oral contraceptives, but also oral rehydration salts, insecticide-treated nets, water-based lubricants, voucher booklets and safe water systems.

As social marketing programs matured, the approach further evolved to include the delivery of health services, including a range of family planning, reproductive health and maternal and child health interventions; treatment for tuberculosis and pneumonia; HIV counseling and testing, with referrals for treatment, as appropriate; malaria prevention and treatment; and diarrheal disease prevention and treatment. These services were often delivered through socially-franchised networks of clinics and/or pharmacies, such as Smiling Sun Franchise clinics and Social Marketing Company pharmacies in Bangladesh (84), New Start Voluntary HIV Testing and Counseling Centers in Lesotho, Zambia and Zimbabwe and Child & Family Wellness Shops in Kenya.

Successful social marketing of health products requires good communication strategies. USAID's social marketing partners were at the forefront of behavior change communication (BCC) innovations, adapting technologies used by the private sector to better reach target populations. It is now quite common for theory-driven BCC and social marketing programs to be integrated into wider health programs, as in the USAID-supported Behavior Change and Social Marketing Project in Rwanda (335).

Research and evaluations (288) demonstrate that USAID's social marketing programs have dramatically increased access to affordable, lifesaving products and health care services for the poor. In Cambodia, for example, 517,632 couple years of protection were achieved in FY 2009 through the social marketing of birth spacing products and services, while the social marketing of condoms resulted in an increase in consistent condom use among men and their commercial sex partners from 84.7 percent in 2008 to 95.6 percent in 2009 (240). In addition, 1.4 million safe water disinfectant tablets were distributed through 749 outlets in 7 provinces in Cambodia, providing over 11,000 families with safe water for over 1 year (240).

ORAL REHYDRATION THERAPY

Key Global Results

- By the mid-1990s, it was estimated that more than 750 million episodes of child diarrhea in developing countries – more than half of the estimated 1.5 billion episodes occurring annually – were being treated with oral rehydration therapy (ORT).

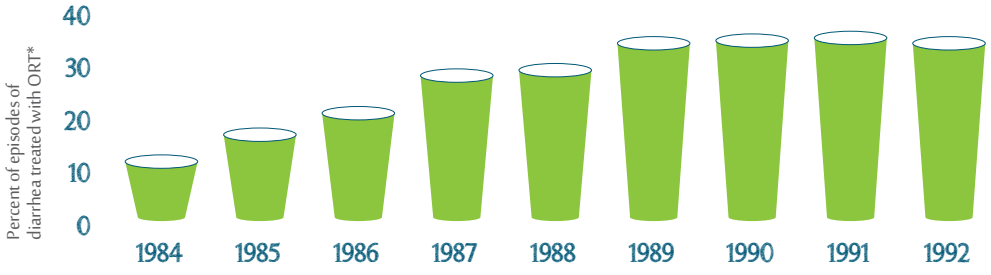
USAID Contributions to ORT Global Results

- By 2005, DHS data indicated that in USAID-supported countries, more than 60 percent of children with diarrhea received ORT.

The USAID Story

Reducing childhood mortality due to diarrheal disease was one of USAID's first challenges. Since standard intravenous fluid therapy could not be easily delivered to sick children in the developing world, USAID was instrumental in creating ORT – a simple technology that has saved the lives of millions of children and adults.

Global Estimates of ORT Use (1984–1992)



*Defined as oral rehydration salts and/or appropriate home fluids

USAID supported scientists at the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) to develop and test a simple sugar and salt solution. When administered orally, this solution provided safe treatment for most cases of severe dehydration – often the result of diarrhea. The ICDDR,B and a sister institution in Calcutta successfully used this solution for adult cholera patients in clinical trials. With USAID support, the ICDDR,B then went on to establish the first large-scale ORT clinical trial at a field hospital in Matlab, Bangladesh.

In the early 1970s, ORT was used on a large scale for the first time when cholera broke out in crowded refugee camps in Bangladesh. Camps using ORT experienced a significantly lower mortality than camps using intravenous fluid therapy, which was limited in supply.

Following this success, USAID supported researchers evaluating the safety and effectiveness of ORT in young children with different types of diarrheal illness. Their work led to prepackaged oral rehydration solution (ORS) that could be reconstituted with water and used by both adults and children, regardless of the cause of diarrhea. In 1975, the United Nations Children's Fund (UNICEF) and WHO agreed to this single formula and began to distribute standard ORS packets globally. In fact, ORS became the cornerstone of the 1978 multidonor-supported WHO Program on Control of Diarrheal Diseases.

Over the next decade, USAID funded pilot ORS programs to promote home ORS use in Egypt, Honduras and The Gambia. In Egypt, as discussed in the Report of the Second Joint Ministry of Health/USAID/UNICEF/WHO review of the National Control of Diarrheal Disease Project (248), strong national political and financial commitment, and ample use of mass media, resulted in a substantial impact on childhood diarrhea mortality. Lessons from Honduras and The Gambia, as outlined in Patterns and Persistence of ORT Use during Intensive Campaigns in Honduras and The Gambia, 1981–1983 (176), led to improved approaches to using BCC, utilizing community-based health care workers, training health workers and providing information and training on the preparation and use of ORT to mothers and community health workers.

By the late 1980s, USAID had helped establish national programs for control of diarrheal diseases in 16 countries as well as a regional program in Central America. Early evidence showed striking reductions in diarrhea-related infant and early childhood deaths. By 1994, it was estimated that international efforts had reduced annual child deaths due to diarrheal dehydration from 4 million to 3 million.

Building on these successes, in the early 2000s, USAID began supporting the development and rollout of complementary interventions that reduce the severity, duration and frequency of diarrheal diseases. Three major outcomes include a refined formulation of ORS, zinc treatment of diarrhea and safe water at the household level (327).

NUTRITION

Key Global Results

- The global prevalence of chronic undernutrition, as measured by stunting in children under the age of 5, has declined 36 percent over the past two decades, from an estimated 40 percent in 1990 to 26 percent in 2011.

USAID Contributions to Nutrition Global Results

- USAID reached more than 12 million children under 5 in FY 2012 through nutrition programs such as micronutrient supplementation, food fortification, anemia reduction and the treatment of acute malnutrition.

The USAID Story

Since 1965, USAID has been at the forefront of international efforts to improve nutritional status in developing countries – an action that is critical to reducing child mortality and accelerating learning, productivity and economic growth. In the 1970s and 1980s, in particular, USAID played a major role in virtually all developments of any significance in nutrition.

USAID's early involvement in nutrition responded to global concerns about a world food crisis and the large numbers of people that were malnourished. This concern was fueled by and intertwined with fears of a population explosion and projections that world population growth would far outstrip anticipated increases in food production, bringing about social unrest and delayed economic development. USAID was called to test various approaches to combat global malnutrition and to help ensure that the basic human need for a nutritionally adequate diet was met.

USAID began investigating the nutritional quality of food and supporting innovations in food technology. In 1969, USAID launched the Food Technology for Development Program (12) that introduced the idea of food fortification, developed and tested specifications for low-cost food supplements and introduced the supplements in several countries. The program also built the capacity of several countries to manufacture their own nutrient-dense "weaning" foods using local commodities.

Beginning in the early 1970s, USAID played a catalytic role in the evolution and development of the multisectoral nutrition movement, helping to increase understanding of the diverse causes of malnutrition and the importance of addressing these causes (324). USAID's groundbreaking work through the Consumption Effects of Agricultural Policies program (198), implemented for more than 15 years in Africa, Asia and Latin America in collaboration with the Department of Agriculture, helped enhance understanding of the important role that agricultural and other economic development policies play in the nutrition of the poor. Several complementary USAID-funded initiatives developed models and methodologies explicitly incorporating nutrition goals into the planning, implementation and evaluation of agricultural research and development programs. The results of this early work continue to inform USAID efforts to improve food security in developing countries. For example, this work influenced the Feed the Future Initiative, launched in 2010, with its focus on multisectoral nutrition as a central programming approach.

Recognizing that increased food availability is only part of the response, in the 1970s USAID also worked to strengthen food utilization, testing the application of commercial advertising techniques and the use of mass media (primarily radio) to promote improved nutrition practices. These tests, representing one of USAID's earliest forays into BCC and social marketing, demonstrated the power of marketing and mass media to promote changes in behaviors, including iodized salt use in Ecuador (171) and home-prepared complementary foods in the Philippines (56).

USAID's nutrition programs consistently prioritized capacity building to enhance host country capabilities. Short-term, in-service and pre-service training through projects such as the Food and Nutrition Technical Assistance Project were integral to investments in nutrition planning, micronutrient research, infant and child feeding, food aid and other interventions. USAID also supported workshops, training materials and train-the-trainer programs that explicitly built capacity in strengthening agriculture-nutrition linkages.

Throughout the 1970s and 1980s, USAID provided vital funding for innovative research to improve understanding of the nature of nutritional deficiencies. USAID's Nutrition Collaborative Research Support Program (68) (156) demonstrated how marginal food intake affected functions such as growth and body size. It also showed how dietary quality influenced school performance, mental and motor development, human milk production and work performance. The program generated new methodologies for assessing households at risk of malnutrition and a set of key indicators for developing highly focused nutrition interventions to improve dietary quality and human performance.

USAID also supported critical research that identified the links between micronutrients and child health and established that micronutrient inter-

> "What understanding of, and commitment to, micronutrients does exist in the world is due in large measure to the Agency's pioneering efforts to have them understood as a key element of public health and to put their universal acceptance and availability within reach."
>
> Review of USAID's Micronutrient Portfolio (241)

ventions were effective, affordable and sustainable (338). USAID-funded investigations in Indonesia, Nepal and India demonstrated that vitamin A deficiency in young children resulted in increased mortality. When studies found that ensuring adequate vitamin A intake could prevent up to one-third of child deaths in developing countries, vitamin A supplementation became the "third engine" of child survival (in addition to ORT and immunizations), driving policies and programs worldwide. USAID sponsored country programs distributing vitamin A capsules to infants and young children and promoted consumption of vegetables and fruits rich in beta-carotene. In addition, USAID promoted vitamin A fortification of P.L.-480 cereal and edible oil commodities as well as staple foods in some countries. USAID's iron research program identified an effective iron fortificant to facilitate the bioabsorption of iron from cereal and legume foods. This fortificant was recommended by WHO for wheat and maize flour fortification. USAID-supported projects, such as MotherCare, reduced iron-deficiency anemia among pregnant women through iron supplementation. A 1997 review of USAID's micronutrient portfolio (241) highlights many of USAID's early contributions in micronutrient research and supplementation, as does the Opportunities for Micronutrient Interventions final report (314).

In the 1970s, USAID was also instrumental in raising international awareness of nutrition issues, providing funding for the establishment of advisory groups such as the International Vitamin A Consultative Group and the International Nutritional Anemia Consultative Group – key forums for scientists, policymakers and program managers from developing and developed countries to exchange information on ways to reduce vitamin A and iron deficiencies worldwide (137). USAID also advocated for the formation of the United Nations Sub-Committee on Nutrition.

In the following decade, as part of the Child Survival Revolution, USAID began to place significant emphasis on promoting breastfeeding and addressing the high rates of growth faltering among 6- to 24-month-olds – a period of vulnerability largely linked to the inadequacy of complementary feeding after the first 6 months of exclusive breastfeeding. The urgency of action in this area was highlighted in a 1995 analysis of 28 research studies. The analysis found that over 50 percent of deaths among preschool children in the developing world were due to the underlying effects of malnutrition (167).

USAID supported studies on breastfeeding promotion, campaigns to increase exclusive breastfeeding, cost-effectiveness analyses of breastfeeding interventions, development of breastfeeding counseling guidelines for HIV-infected mothers and development of the Lactational Amenorrhea Method for family planning. Programs such as the Lactation Management Education Program (167) provided clinical training for health professionals, contributing to the sustained promotion, protection and support of breastfeeding (including maternal nutrition, complementary feeding and the contraceptive effects of exclusive breastfeeding) to improve infant and maternal health.

After nearly 30 years of involvement in nutrition, USAID drew on experience and lessons learned to define the "Essential Nutrition Actions," an operational framework for managing the advocacy, planning and delivery of an integrated package of preventive nutrition actions, including infant and young child feeding, micronutrients and women's nutrition. USAID's rollout of this approach expanded the coverage of these seven key affordable and proven nutrition interventions at health facilities, in communities and through communication channels across

The Seven Essential Nutrition Actions

1. Promotion of optimal nutrition for women
2. Promotion of adequate intake of iron and folic acid and prevention and control of anemia for women and children
3. Promotion of adequate intake of iodine by all members of the household
4. Promotion of optimal breastfeeding during the first 6 months
5. Promotion of optimal complementary feeding that starts at 6 months with continued breastfeeding to 2 years of age and beyond
6. Promotion of optimal nutritional care of sick and severely malnourished children
7. Prevention of vitamin A deficiency in women and children

Asia and Africa. Strategies to deliver the package and promote behavior change included building capacity and mobilizing communities. Because of their effectiveness, the Essential Nutrition Actions were incorporated into the current global Scaling Up Nutrition (SUN) movement and the 1,000 Days Partnership to improve nutrition for mothers and children in the 1,000 days between a woman's pregnancy and her child's second birthday – when better nutrition can have a life-changing impact on a child's future and help break the cycle of poverty.

In the 2000s, USAID was at the vanguard of integrating nutrition assessment, counseling and support (NACS) into HIV and AIDS prevention, care and treatment activities. Further details can be found in the HIV and AIDS section of this report.

Over the decades, USAID's global health nutrition programs collaborated closely with the Food for Peace Office. In 1995, Food for Peace began integrating nutrition into development programming, resulting in Food for Peace developing a strategic plan that focuses on reducing food insecurity and preventing, rather than treating, malnutrition.

COMMUNITY-BASED HEALTH SERVICES

Key Global Results

- Community-based distributors (CBDs) and community health care workers are an accepted and integral part of primary health care delivery systems in many countries throughout the world, providing essential basic health services to vulnerable populations.

The USAID Story

In response to the New Directions mandate to improve the lives of the poor directly, and in line with the Alma-Alta Declaration to prioritize primary health care, in the 1970s USAID's Global Health program initiated groundbreaking approaches to working at the community level. This community-based focus has since become a hallmark of USAID's business model and is frequently mentioned as a critical factor in USAID's success.

To overcome the barriers to accessing health care that existed in most developing countries, in the 1970s and 1980s, USAID experimented with and developed innovative approaches for getting services closer to where people lived (214). While each of the projects was unique, most included some combination of the following activities:

- Building, equipping and/or staffing small, rural primary health care facilities
- Building a cadre of trained community health care workers
- Providing mobile health care services
- Conducting information, education and communication programs via radio and other means of communication
- Providing training and supervision for rural health care workers

Perhaps the grassroots-level approach most identified with USAID is the community-based distributor of family planning. This model evolved into the community-based health care worker approach, with community health workers (CHWs) having much broader responsibilities than family planning alone. CBDs and CHWs, both of whom are usually chosen by their community and then trained to do specialized tasks, play a significant role in preventing unintended pregnancies and in reducing morbidity and mortality in mothers, newborns and children. The use of CBDs and CHWs is further credited with improving the cost-effectiveness of health care systems by reaching large numbers of previously underserved people with high-impact basic services at low cost. The introduction of community-based cadres of health care staff has also helped empower women and increase community involvement in health care.

Given critical and ongoing shortages of highly-skilled health workers worldwide, it is likely that, for the foreseeable future, CBDs and CHWs will continue to be a core component of the health workforce and of primary health care systems in low-resource settings.

BUILDING A CADRE OF STRONG GLOBAL HEALTH IMPLEMENTING PARTNERS, INSTITUTIONS AND ACADEMIA

Key Global Results

- A network of first-class public health institutions in the private sector, non-governmental sector, faith-based sector and academia has emerged in the field of public health.

The USAID Story

Beginning in the 1960s, but accelerating in the 1970s, USAID helped build a strong cadre of implementing partners with expertise in global health. This included research facilities, academic institutions, NGOs, private voluntary organizations (PVOs), faith-based organizations (FBOs), both in the United States and overseas.

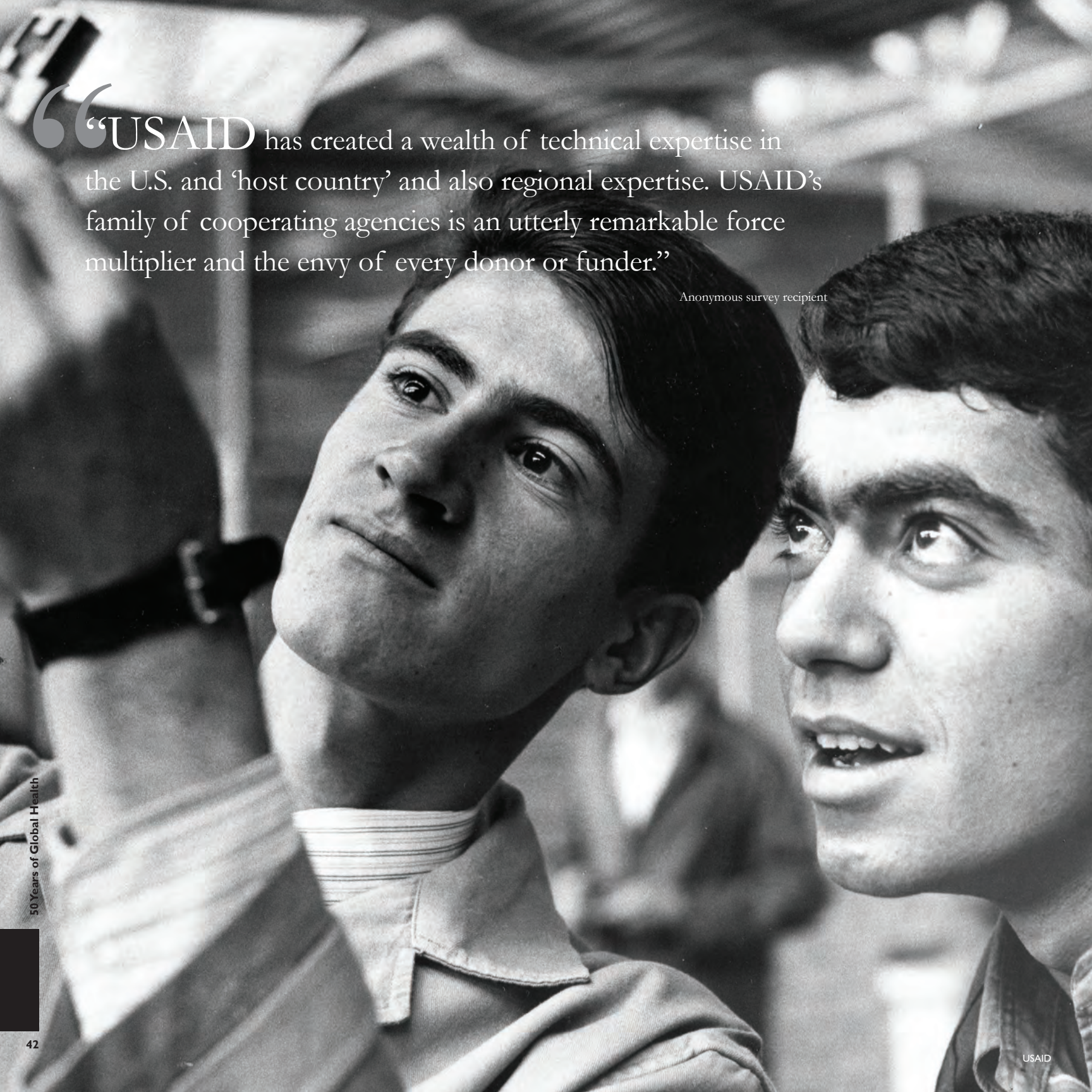
In the 1960s, when USAID primarily engaged in direct project implementation, it initiated what would become long-term, collaborative relationships with universities and research institutions in both the United States and overseas. USAID's growing need for the skills and expertise found in academic institutions and research facilities prompted these entities to strengthen their in-house global health and research capacity so that they could work more closely with USAID and respond to

Building Research Capacity in Bangladesh

One of USAID's greatest contributions to strengthening global health research capacity is its role in supporting the International Centre for Diarrhoeal Disease Research, Bangladesh in becoming a world-class research center. In the late 1970s and early 1980s, USAID financial, technical and organizational support was critical in building the research and technical capacity of this center, enabling it not only to play a pivotal role in advancing oral rehydration therapy but also to continue to conduct research, training, extension and program-based activities to address some of the most critical health concerns in the world today. To help ensure the sustainability of the facility, USAID assisted in setting up an endowment that continues to sustain the institution today (18).

A Bangladeshi mother feeds her infant nutrient-rich food, a measure for treating child diarrhea. Another such measure is oral rehydration therapy, which restores electrolytes and liquids that are lost during diarrheal episodes.

- USAID



"USAID has created a wealth of technical expertise in the U.S. and 'host country' and also regional expertise. USAID's family of cooperating agencies is an utterly remarkable force multiplier and the envy of every donor or funder."

Anonymous survey recipient

USAID

USAID's technical and research needs. With USAID support, the U.S.-based institutions also provided training and mentoring to academic and research institutions overseas, working with scientists and scholars at these facilities to build capacity while also solving public health problems.

In a related move, as the demand for public health specialists grew, in part fueled by growth at USAID, U.S. universities strengthened existing schools of public health and opened new ones. In 1960, there were 12 independent schools of public health in the United States; by mid-2011, there were 46 accredited schools of public health, with at least 19 of them offering concentrations in global health (272).

In the 1970s, as its business model started to shift toward policy, strategy and management, rather than direct implementation of activities, USAID began to channel millions of dollars in funding through U.S.-based private sector and non-governmental sector NGOs and PVOs. To respond to this opportunity, these organizations increased the number and quality of technical experts on staff, expanded the technical areas in which they worked and strengthened their organizational and financial systems to be able to compete and account for USAID funding. Today, the number of strong, highly-qualified, effective and efficient U.S.-based NGOs and PVOs with the technical capacity to contribute to global health improvements is significantly due to their partnerships with USAID.

A similar picture exists in the countries in which USAID works. Given the priority USAID places on working at the community level and the limited capacity of the public health system in many countries to reach the most vulnerable, USAID invested heavily in strengthening the technical and organizational capacity of local organizations so that they could carry out health-related activities

Child Survival and Health Grants Program (1985–present) Saving Lives, Building Capacity and Advancing Community Health

The Child Survival and Health Grants Program began in 1985 as a competitive grants program in recognition of the role of U.S. PVOs in reducing the number of deaths of young children in developing countries. The program combines global implementation with technical assistance and collaboration through the CORE Group, a coalition of more than 70 NGOs and affiliates in 180 countries.

The USAID Bureau for Global Health, through the Child Survival and Grants Program, leverages the development assets and technical "know-how" of diverse U.S. PVOs and their local partners to improve coverage of high-impact maternal, newborn and child interventions in the most marginalized and underserved communities. U.S. PVOs scale up integrated, high-impact interventions, advancing innovation and evidence for community health approaches, strengthening health and community systems and the implementation of policies and ensuring sustainability by developing effective partnerships with and building the capacity of ministries of health, local NGOs and communities. The partnership has strengthened the capacity of 58 U.S. PVOs, as well as governments and civil society in 64 countries, to deliver results and save the lives of millions of children, newborns and women in the most marginalized and underserved communities.

at the community level. In most countries, these local NGOs are the backbone of USAID's health programs.

In the 2000s, USAID placed increased emphasis on reaching out to faith-based organizations to help build their capacity to provide assistance to people in need. USAID established its Center for Faith-Based and Community Initiatives in 2002 to lead this initiative. The center serves as a bridge between small NGOs and USAID, helping to connect FBOs with relevant contacts at USAID, inform them of partnership opportunities and encourage collaboration among organizations. This effort helped expand the cadre of strong implementing partners with which USAID is able to work.

RESEARCH

Key Global Results

- Research has produced multiple new health technologies that have saved millions of lives.
- Research results have influenced governments to develop appropriate policies, guidelines and effective health programs.

USAID Contributions to Research Global Results

- See box on page 45.

The USAID Story

USAID's groundbreaking research contributions have resulted in the development of new technologies, new products and new implementation approaches that helped revolutionize the provision of health care services and were adopted as the standard by many global health programs today. Although USAID's contributions to global health research span all five decades of the Agency's existence, the 1970s was when the research program became more complex, branching into applied research and implementation science. For that reason, this program area is discussed in this chapter.

As an indication of the priority USAID has consistently placed on research, a centrally-funded research program was formally initiated at USAID in 1962, less than 1 year after USAID was established. In contrast to the country-specific efforts being carried out in the field, the centrally-funded research program sought answers to an array of problems that cut across nations and regions. In the early years, the research was primarily funded through grants and cooperative agreements with U.S. universities and government agencies and, less often, under contracts to universities in developing countries, private agencies and foundations or other international development organizations. Scientific research was complemented by operational research efforts that provided critical information for adapting research results to the local context for effective dissemination. Research results also played a critical role in policy dialog and reform efforts, helping USAID to work with country governments to make evidence-based policy decisions and develop and implement appropriate guidelines.

In the 1960s and 1970s, much of USAID's health research focused on malaria and the search for a malaria vaccine, but research on health planning, health labor force, human nutrition, food processing and food fortification were also funded. With its significant investments in family planning and contraceptive research, USAID played a key role in the development, refinement and introduction of every contraceptive method available in the developing world, including fertility awareness methods, contraceptive implants and intrauterine devices (302) (174).

Over the next two decades, USAID supported groundbreaking research studies that helped inform approaches to implementing the concept of primary health care by examining comprehensive and integrated rural family health care, comparing vertical vs. horizontal health care programs and looking at the effect of distance and location on utilization of health services. These included the Development of Integrated Family Planning, Nutrition and Health Services study in Narangwal, Punjab, India (66), carried out by the Johns Hopkins University; the DANFA Comprehensive Rural Health and Family Planning Project in Ghana (61), carried out by the University of California, Los Angeles; and the Patterns of Health Utilization in Upcountry Thailand study by Mahidol University, Bangkok (63). These research studies were complemented by several case studies on rural primary health care (57).

USAID's global health program also supported efforts to adapt, design, develop and advance innovative health technologies and diagnostic tools for use in low-resource settings. More than 30 years of support for the investigation and evaluation of a wide variety of health technologies resulted in several technologies being applied at the global level, including Uniject, a prepackaged, low-cost, prefilled disposable syringe that is now being used to deliver different lifesaving products (118). Diagnostic equipment developed with USAID support included a less expensive field binocular microscope for diagnosis of malaria parasites and bacteria and a battery-operated hematology analyzer for the detection of malaria parasites. USAID's continued leadership in research is currently breaking ground in the new hybrid field of multipurpose prevention technologies for unintended pregnancy, HIV and other sexually transmitted infections.

Illustrative USAID-Supported Research Contributions to Global Health

SAVING WOMEN AND CHILDREN

Maternal Health: USAID introduced and expanded the Active Management of the Third Stage of Labor to prevent postpartum hemorrhage in women and is expanding the results to the community level, including the use of misoprostol by community health workers.

Child Survival: Zinc Supplements: USAID-supported research built the evidence base that led to WHO and UNICEF signing a 2004 agreement revising the protocol for using zinc supplements to treat diarrhea.

Family Planning: USAID has been involved in the development or enhancement of every modern contraceptive that is currently widely available in the world. USAID-supported research resulted in the availability of a wider selection of contraceptives globally, including long-acting contraceptives and female barrier methods. USAID continues to research a number of new technologies, including a contraceptive vaginal ring that allows women to determine when to start and discontinue use.

Nutrition: USAID-supported research established the evidence base leading to the discovery that 2¢-worth of vitamin A given to children every 6 months could reduce child mortality by 34 percent and the severity of diarrhea and malaria. USAID's support of this research on vitamin A deficiency as well as its support of research on anemia prevalence and large-scale food fortification resulted in production of fortified sugar, cooking oils and/or flours in several countries.

INFECTIOUS DISEASE

Malaria: USAID has supported malaria vaccine research since 1965. Two separate studies provided proofs of concept of vaccines against both the blood and liver stages of malaria parasites. New drug research resulted in the development of a dispersible pediatric formula and the submission of two new and novel antimalarial drugs for regulatory approval. USAID research demonstrated the efficacy of insecticide-treated mosquito nets for malaria prevention.

HIV and AIDS: The Centre for the AIDS Programme of Research in South Africa 004 trial in 2010 provided the first-ever proof of concept that a microbicide, Tenofovir 1-percent vaginal gel, could safely and effectively reduce the risk of sexual transmission of HIV (human immunodeficiency virus) from men to women. USAID supported the development of packaging for nevirapine, allowing this key drug for the prevention of mother-to-child transmission of HIV to be administered at home.

Tuberculosis: USAID supported clinical trials on tuberculosis drug regimens that confirmed that a 6-month course of treatment with a specific set of drugs was more effective than an alternate 8-month course with other drugs. These results are now included in the International Standards of Care for TB Treatment.

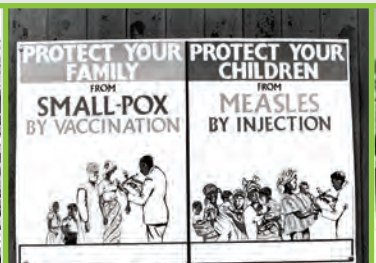
Emerging Pandemic Threats: USAID has supported cutting-edge research to characterize existing and potential pandemic threats and better understand ecological factors and human practices that contribute to the spillover of animal diseases into human populations. The lack of this information has hampered the ability to predict, prevent and respond to the emergence of new diseases with pandemic potential.

OTHER

Project Implementation Approaches: Research on the impact of village-level health care workers and the effectiveness of community-based care confirmed the feasibility of this approach, which has been rolled out worldwide for multiple health interventions and incorporated into policy guidance.

Health Technologies: A single-use, automatic self-destruct syringe, which prevents the reuse of soiled syringes and needles, has the potential to interrupt the transmission of hepatitis B and C, HIV and AIDS (acquired immunodeficiency syndrome), Chagas disease and malaria. Vaccine vial monitors (indicators placed on vaccine vials that show if vaccines should be discarded due to heat exposure) are now being used by the United Nations Children's Fund for poliomyelitis vaccine. New technologies now also make it possible for traditional birth attendants and midwives to provide safe care and home delivery by using kits that include strips to detect protein in urine, low-cost delivery kits and color-coded scales that identify low birth weight infants.

Photos from USAID



"There can be no keener
revelation of a society's soul
than the way in which
it treats its children."

Nelson Mandela,
Former President of South Africa

Sustainable Development

4.8B

World Population

6.1

Total Fertility Rate
Lower-income Countries
(Births per woman)

N/A*

Maternal Mortality Ratio
Lower-income Countries
(Per 100,000 live births)

183.7

Under-5 Mortality Rate
Lower-income Countries
(Per 1,000 live births)

51.9

Life Expectancy
Lower-income Countries
(in years)

N/A*

People Living with
HIV and AIDS
(World)

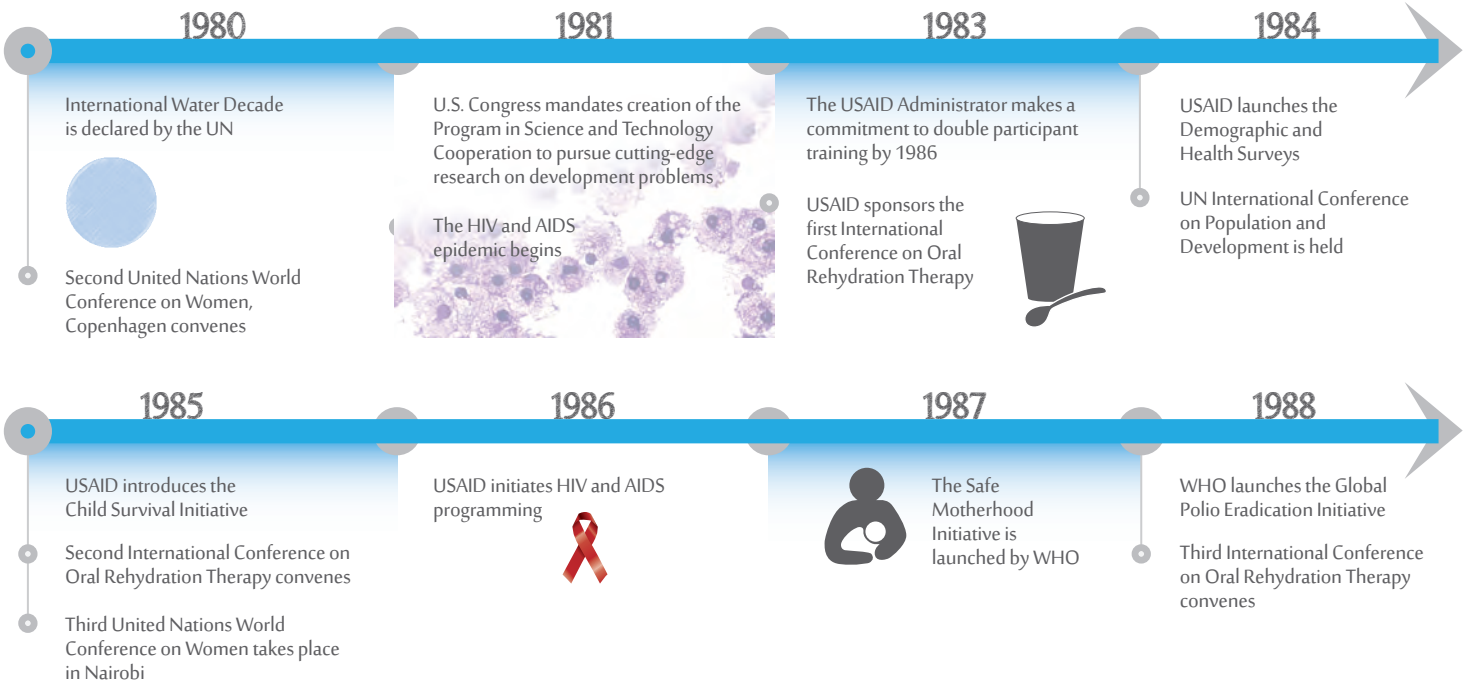
Note: See Annex for data sources, definitions and methods.
*Data not collected at this time

In the 1980s, [illegible] [illegible] [illegible] [illegible] [illegible] dimension to economic development, leading the United Nations to adopt the Human Development Index and to publish the annual Human [illegible] [illegible] [illegible] local capacity and leadership; and promoting market-based principles to restructure policies and institutions. As policy dialogue assumed a more impor- [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] the implementation of development programs and the political processes that influenced them.

During the 1990s, the U.S. Government's "reinventing government" movement strove to [illegible]

[illegible] attention to tuberculosis (TB).

1980s Timeline



on this shift and in December 1982 launched the Child Survival Revolution, helping to elevate its global credibility (313). The Safe Motherhood Initiative, launched in 1987 by the World Health Organization (WHO) in Nairobi, also grew out of this shift toward selective primary health care.

Also by the mid-1980s, global controversy had arisen over family planning programs, including whether not family planning was coercive and whether reducing population growth actually contributed to development. This led to a shift in focus from "population programs" to "meeting the unmet need for family planning."

Events in Eastern Europe and the crumbling of the Soviet Union toward the end of the 1980s and into the early 1990s led to the 1989 establishment of the Bureau for Europe and New Independent States at USAID (later renamed the Bureau for Europe and Eurasia or E&E) to assist former Eastern Europe and former Soviet-bloc countries in transitioning to democracies with open, market-oriented economic systems and responsive social safety nets. Health programming was an integral part of this equation.

Key USAID Global Health Contributions

MATERNAL AND CHILD HEALTH

Key Global Results

- In the past 50 years, infant and child death rates in the developing world were reduced by 70 percent.
- The number of under-5 deaths worldwide fell from 16.9 million in 1970 to 6.6 million in 2012, with over 100 million children's lives spared in our generation.
- Immunization programs prevented close to 3 million child deaths annually from measles, neonatal tetanus and tuberculosis.
- Full diphtheria, pertussis, tetanus (DPT3) immunization rose worldwide from 37 percent in 1980 to 82.9 percent in 2011. In 1980, less than 5 percent of children in developing countries were immunized against measles, diphtheria, pertussis, polio and tuberculosis; in 2000, almost 75 percent were protected against these diseases.

Africa Child Survival Initiative

Combatting Childhood Communicable Diseases Project provided assistance to 13 African nations between 1982 and 1993 to strengthen public health capacity and reduce under-5 morbidity and mortality through three interventions (immunizations, case management of diarrhea and malaria case management and prophylaxis in pregnancy) and four support strategies (health information systems, training and supervision, health education and operational research).

These 13 countries made great progress in improving the quantity, quality and effectiveness of immunizations; developing programs for the control of diarrheal disease; and creating malaria control policies (5).

- Since the launch of the Global Polio Eradication Initiative in 1988, the global number of polio cases has been reduced by over 99 percent. Now polio is endemic in only three countries (Pakistan, Nigeria and Afghanistan) compared to 145 countries before the initiative began.
- In least-developed countries, maternal deaths per 100,000 live births declined from 810 in 1990 to 410 in 2012.

USAID Contributions to Maternal and Child Health Results in 24 Priority Countries

- Maternal mortality declined at an average rate of 5 percent per year – more rapidly than the global average.
- Attendance at birth by a skilled provider increased from 26.9 percent in 1990 to 50.0 percent in 2012.
- Newborn mortality rates declined 33 percent from 1990 to 2011.
- Deaths of children under 5 were reduced from 7.7 million in 1990 to 4.8 million in 2011.
- DPT immunization rose from 41.6 percent in 1990 to 59.8 percent in 2012.
- Between 2000 and 2010, there was an 18 percent decline in pneumonia and diarrheal deaths among children.

The USAID Story

USAID is recognized worldwide for its outstanding contributions to maternal and child health. Although it began supporting child health programs in 1975, it was not until the launch of the USAID Child Survival Initiative in 1985 and the addition shortly thereafter of maternal health to that initiative that maternal and child health truly gained a prominent position in USAID's global health portfolio.

The Child Survival Initiative represented an evolution from the comprehensive primary health care approach of the 1970s, which did not yield the improvements in coverage that were anticipated. The new approach, outlined in the December 1986 USAID Policy Paper: Health Assistance (115), focused on the provision of selected child survival interventions that would provide the basis for building up more comprehensive primary health care systems over time. The focus on selected interventions was viewed as a more cost-effective and direct means of improving child health and preventing mortality. USAID's selective approach was based on proven, evidence-based technologies that significantly reduced child morbidity and mortality – particularly oral rehydration therapy (ORT) and immunizations – while also promoting other key preventive interventions, such as breastfeeding, birth spacing to reduce the number of high-risk births, treatment of acute respiratory infections and malaria control and treatment. The mix of interventions was tailored to the country situation.

USAID launched a significant effort to improve global immunization coverage in the mid-1980s, beginning a long history of investments in various approaches to supporting the improvement of national vaccination programs. As primary health care evolved during the 1970s and 80s,

Vitamin A

USAID-supported research demonstrated that vitamin A supplementation can substantially reduce child mortality in vitamin A-deficient populations. Vitamin A programs are now under way in 50 countries. Indonesia, which reported in 1978 that 13 of every 1,000 children under the age of 5 suffered from night blindness, is now free of nutritional blindness due to vitamin A deficiency. In Central America, because of a vitamin A sugar fortification program, childhood blindness has been prevented in more than half a million children.

An infant is vaccinated with Uniject, a prepackaged, low-cost, pre-filled syringe that is now used around the world, thanks in part to USAID support and investigation.

- PATH/Carib Nelson

USAID's approach to immunization would also evolve, heavily influenced by the child survival revolution, a period when the global community struggled to define a framework that incorporated the essence of the Alma-Ata Conference with selective primary health care.

Eventually, what became known as the "twin engines" approach, a selective focus on two high impact interventions – immunization and oral rehydration therapy – would characterize USAID's child survival programs. However, as the strategies used to accelerate coverage improvements during the 1980s began to lose their momentum during the less favorable international economic climate of the 1990s, USAID began to re-evaluate its approach and move toward a systems strengthening concept. At the turn of the 21st century, and with pressure of measurable mortality and morbidity reduction goals to better quantify the impact of foreign assistance, the Agency slowly moved toward more easily measured inputs and away from the longer term systems strengthening activities that had characterized its work for much of the previous two decades. This approach emphasized simple, proven technologies, more partnerships with public and private sector organizations, and greater transfer of funds to vertical disease programs with short-term impact. Investments such as polio eradication and vaccine purchase through the GAVI alliance became funding priorities for the Agency.

USAID launched three global projects to provide technical assistance for the implementation of its child survival activities. The Technologies and Resources for Child Health (REACH) project supported the expanded program on immunization and acute respiratory infections. The Technology for Primary Health Care (PRITECH) project supported diarrheal disease control programs and increased the use of ORT. The Communication and Marketing for Child Survival (HealthCom) project provided information, education and communication (IEC) support to child survival programs. The key elements in these and other child health and nutrition interventions were later combined into a single global leadership and technical assistance contract, the Basic Support for Institutionalizing Child Survival (BASICS) Project.

By the end of the 1980s, the magnitude of maternal mortality (in 1980, more than half a million women died during pregnancy, childbirth or in the 42 days after delivery – a global maternal mortality rate of 442 per 100,000 live births) and the risks women face during pregnancy and childbirth began to draw global attention, and USAID expanded its child health activities to include maternal health. USAID's maternal health efforts focused on reducing maternal mortality and promoting maternal health by supporting cost-effective approaches to improve pregnancy and reproductive health services, increasing the utilization of essential obstetric services and improving quality of care through training and quality assurance programs. USAID promoted behavioral change to ad-

Scaling Up Immunization

Immunization programs represent one of the great public health success stories for USAID, which has provided technical and commodity assistance to more than 100 countries in support of child immunization programs. This assistance has been directed at increasing demand for immunization services, training health workers, strengthening planning capacity, improving the quality of services delivered and upgrading vaccine logistics. As a result of these efforts by USAID and other partners, full diphtheria, pertussis and tetanus immunization has risen worldwide from 37 percent in 1980 to 82.9 percent in 2011.

To bring more attention to immunizations and to generate greater resources, USAID participates in the Global Alliance for Vaccines and Immunization and the Vaccine Fund and collaborates with private sector groups such as the Bill & Melinda Gates Foundation. Through these mechanisms, USAID has stressed the introduction of new technologies such as vaccine vial monitors and safer injection equipment, increased use of underutilized vaccines against hepatitis B and *Haemophilus influenzae* type b and promoted vaccination against pneumonia and rotavirus, two major causes of death in developing countries.

Community Health Workers in Nepal Reduce Child Mortality

In the villages of Nepal, where most people live without access to health care, USAID supported the training of 46,000 female community health volunteers to deliver basic health care. These women made Nepal the first country to deliver vitamin A supplements every 6 months to 3.5 million children nationwide (ages 6 months to 5 years), preventing at least 12,000 child deaths annually.

Female community health volunteers are also trained to detect childhood pneumonia, treat mild cases and refer severe cases and patients who do not respond to treatment to health facilities. Some volunteers also teach mothers about maternal and child health, provide basic family planning services and make referrals for malaria and other infectious diseases.

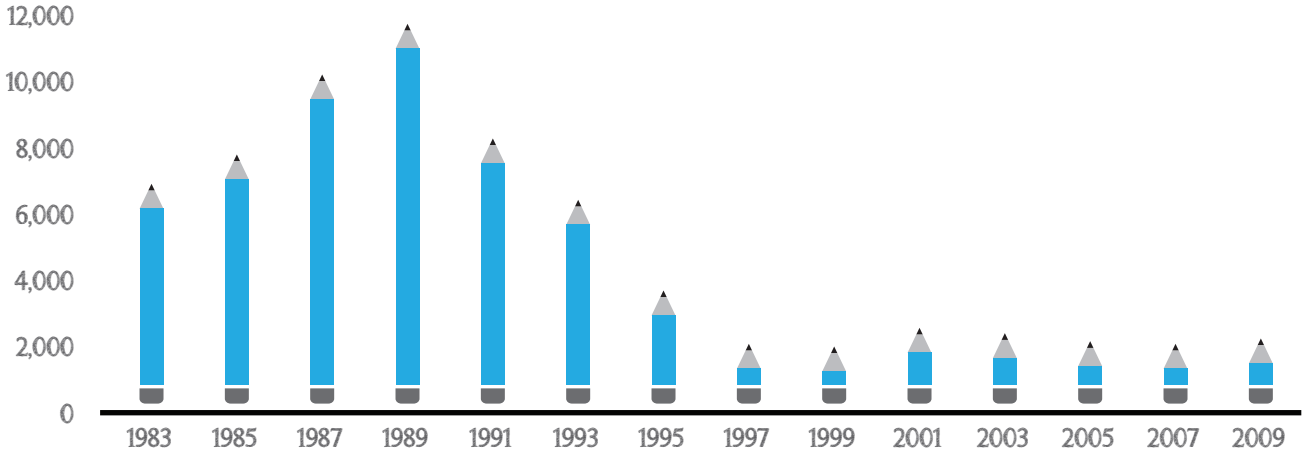
dress harmful traditional practices such as restricting nutrient-rich foods during pregnancy and speeding labor with potentially harmful local herbs, and it trained birth attendants, nurses and midwives in clean and safe birthing techniques. USAID also supported tetanus toxoid immunization of pregnant women to prevent neonatal tetanus (172) (36).

Since the late 1980s, maternal and child health programs were the mainstay of many USAID health programs in the field, saving the lives of countless mothers and children. These programs offer textbook examples of USAID's success in melding evidence-based, cutting-edge technologies with innovative project implementation approaches to achieve high-impact results. The story of USAID support in Nepal, where female community health workers were used to reduce child mortality, is a prime example of using a community-based approach to disseminate new technologies (77). Egypt's National Control of Diarrheal Disease Project, which focused on two key interventions – ORT to control severe diarrhea and an expanded program of immunizations against the six major communicable childhood diseases – demonstrates the power of USAID's strong partnerships with governments to take implementation of proven technologies to scale (325) (266).

USAID's numerous contributions to maternal and child health are well documented in Saving Lives Today and Tomorrow: A Decade Report on USAID's Child Survival Program 1985–1995 (276) and Two Decades of Progress: USAID's Child Survival and Maternal Health Program (327) as well as in various Reports to Congress (297) (21). Additional information is available on USAID's involvement in poliomyelitis (230), acute respiratory infections (3), control of diarrheal disease (55) and childhood blindness.

A boy enjoys handwashing, a key practice for preventing illnesses such as diarrheal disease and respiratory infections.
- USAID

USAID Academic Training in the United States, All Sectors and Degree Levels
(1983–2009)



Note: "Academic" = Training for more than 6 months
Source: USAID TraiNet

Although dramatic progress in maternal and child health was made in the mid-1980s to the 2000s, in the 2000s, an estimated 7 million children were still dying each year from preventable causes, particularly in sub-Saharan Africa and South Asia. In response to this unacceptably high mortality rate for children under 5 years of age, UNICEF and USAID, in 2012, launched the *A Promise Renewed* campaign to end preventable child death (83).

The vision for the campaign is that every country should reach an under-5 mortality rate of 20 or fewer child deaths per 1,000 live births by 2035. To implement this campaign, USAID developed a detailed roadmap and entered into more than 50 partnerships. The campaign was initiated in June 2012 during the Child Survival Call to Action conference in Washington, DC, which was convened by the Governments of the United States, India and Ethiopia in collaboration with UNICEF. Conferences in both India and Ethiopia followed in early 2013. Since that time, several more countries have joined the movement and launched country events, and more are scheduled in the future.

WATER, SANITATION AND ENVIRONMENTAL HEALTH

Key Global Results

- The proportion of people using an improved water source rose from 76 percent in 1990 to 89 percent in 2010.
- Between 1990 and 2010, over 2 billion people gained access to improved drinking water sources, such as piped supplied and protected wells.

The USAID Story

Although USAID's work on water and sanitation began two decades earlier, it was in the 1980s, the International Water Decade, that USAID's water and environmental health programs became more complex and were integrated into its global health programming.

South Korea: The Minnesota Project

"... the Minnesota Project should deserve to be one of the most successful cases of helping a nation's health care system in the world's history. No one would doubt that the project served as a cornerstone for laying the current health care system in Korea, which is now competing with global leaders in health care. I would like to take this opportunity to express again my gratitude to USAID and all the people concerned." – Dr. Chin Soo-hee, Minister of Health and Welfare, in New York at the Korean Health Care Banquet, March 2011

Initiated in 1954 by the U.S. Agency for International Development's predecessor agency, the Minnesota Project (or Seoul National University Cooperative Project) is widely credited with transforming South Korea's public health education and research systems. Through a contract with the University of Minnesota, more than 70 Seoul National University staff attended 3-month to 4-year trainings at the University of Minnesota. Numerous other staff received in-country training and support from the 11 University of Minnesota faculty members who went to South Korea as technical advisors. As a result, a new path for medical students was developed (clerkship, internship, residency), new teaching methods were introduced and the active learning process stimulated creative thinking. Over the next several decades, those staff trained in Minnesota continued to exert considerable influence over developments in the medical field. Today, the Republic of Korea is a world leader in medical research and technology.

A girl in South Korea "opens wide" during a dental checkup.

- USAID

Early USAID-supported water and sanitation projects focused on irrigation and large hydropower and dam projects. USAID missions had U.S. direct hire engineers on staff to implement these infrastructure projects, and USAID headquarters staff included several engineers who provided technical assistance to the field. Much of the large infrastructure work was concentrated in urban areas. Rural water and sanitation efforts focused on small-scale community and household interventions.

Many of USAID's large infrastructure programs in the 1960s and 1970s were implemented in the Middle East. These USAID-supported initiatives included, among others, large potable water and sanitation projects in major and secondary cities in Egypt; construction and rehabilitation of water and wastewater treatment facilities throughout Jordan; and construction of a financially self-sustaining wastewater treatment plant in Drarga, Morocco (188). USAID also supported a large municipal water and sewerage program in Brazil (343) and helped provide water and sewerage facilities to urban populations in East Pakistan (236).

The early programs were often accompanied by significant training, including U.S.-based participant training and institution building efforts. Over time, the large investments in water and sanitation infrastructure development were complemented by projects that addressed governance of water resources (247) (180), scientific research on water and sanitation (114), data management (113) and other areas associated with the efficient and effective provision and utilization of potable water. Today, water-related programs continue to be a significant part of USAID assistance in the Middle East.

When USAID shifted its global health focus to basic human needs, its water intervention also shifted – from large infrastructure projects to

community water and sanitation, with some emphasis on community organization. For the most part, USAID provided low-cost hardware (e.g., pumps, pipes) and supported its operation and maintenance to improve a community's water supply, while the community assumed responsibility for maintenance and repairs.

In the 1980s, USAID expanded its water portfolio to address environmental health issues, adding activities related to waste management through the construction of low-cost latrines as well as hygiene promotion. By this time, shifts in USAID staffing were taking place, and USAID was employing fewer engineers and technical staff who could directly implement water and sanitation programs. Technical assistance to missions was therefore provided through central projects overseen by staff in Washington. The most significant of these was the Water and Sanitation for Health (WASH) Project (1981–1994) (347), which provided technical assistance in more than 85 countries.

> "Participant training is considered by many to be one of AID's most important contributions to international development. USAID participants provide the knowledge and skills needed to implement and carry on USAID-supported development projects long after AID and other donors leave. Many host country leaders of government, industry, technology, education and science are drawn from the ranks of USAID participants."
>
> Audit Report 85-08, December 1984

WASH evolved considerably during its period of implementation, from a focus mainly on hardware to the implementation of cutting-edge approaches for ensuring community participation and management and for achieving sustained behavior change. The key WASH legacy to the environmental health field was the articulation of a rigorous process for engaging communities and ensuring the sustainability of investments in water supply and sanitation.

In the 1990s, USAID made a concerted effort to further expand its environmental health program through the Environmental Health Project (1994–2004) to address health topics such as urban air pollution and lead exposure. However, when central strategic objectives were established in 1994, none was established for environmental health. Subsequently, resources for environmental health began to decline and environmental health and hygiene activities increasingly became integrated into maternal and child health activities, with a focus on health impact rather than broader environmental health issues. To achieve health impact objectives, USAID's water and sanitation portfolio adopted an integrated package of technological, social and behavioral interventions that looked not just at access through improved hardware but also at the enabling environment (willingness to pay, the role of women, community-based ownership and decision-making) and behavior (sustained/correct/consistent use, handwashing, etc.).

In the 2000s, USAID's water and sanitation programming continued to evolve. The part that focused on improving health outcomes through household and community use of water was firmly ensconced in the Bureau for Global Health and Agency health activities. It emphasized the reduction of diarrheal diseases for both improved child survival and the improved health of people living with HIV and AIDS by promoting three key hygiene practices: handwashing with soap, safe feces disposal and safe storage and treatment of household drinking water (133). Efforts to address broader water and sanitation issues, including those focused on utility service provision in urban areas and broader issues of water resource management, were disbursed throughout other USAID bureaus and sector programs.

At the 2002 World Summit on Sustainable Development, the U.S. Government agreed to a global target on sanitation and subsequently launched several new partnerships and initiatives, including the Water for the Poor Initiative (348). This initiative worked in partnership with others to launch the International Network to Promote Household Water Treatment and Safe Storage.

The 2005 Water for the Poor Act provided a $300 million soft earmark for foreign assistance-supported water activities and served as the impetus to USAID to increase support for environmental health issues

in Africa. USAID's response is articulated in its new Water and Development Strategy (340), which steers USAID's water programs toward two of the most important human needs for water: health and food.

PARTICIPANT TRAINING: INVESTING IN FUTURE LEADERS

Key Global Results

- The training of thousands of professionals helped build leadership and technical capacity in countries throughout the world.

The USAID Story

Recognizing that local universities were often not equipped to train people in the skills needed for rapid economic recovery and development, the U.S. Government, under the Marshall Plan, began to sponsor academic and technical training in the United States or in a third country for citizens of developing countries. In the 1980s, USAID's emphasis on building local capacity and leadership capability led to increased investment in participant training.

The participant training program grew rapidly in the early 1980s and peaked toward the end of the decade. Technical training was generally short term, while academic training provided long-term opportunities for advanced academic degrees in the United States or in a third country.

Over a period of almost 50 years, USAID supported nearly 68,000 international students in long-term U.S. degree programs across all sectors (47). Each year, some 300–400 technical specialists received USAID support for degree programs in the United States in family planning, nursing and other public health fields.

Although formal evaluation of the effectiveness of participant training and its impact on host country development is limited (101), there is broad consensus both within and outside of USAID that participant training was one of USAID's most important contributions to development. It is believed that the benefits of U.S.-based participant training are both significant and sustained over a long period of time. These include:

- Building educated, enlightened new leaders for a country
- Exposing emerging leaders to U.S. values and attitudes that will positively influence future directions of their country
- Promoting new knowledge, skills and attitudes
- Building a greater understanding of how public health contributes to gains in economic development
- Building a favorable attitude toward the United States
- Paving the way for productive relationships at the country level that will facilitate USAID success in the country
- Strengthening graduate programs with in-country universities by supporting state-of-the-art education
- Fighting communist expansion (1970s)

NON-PROJECT ASSISTANCE

Key Global Results

- USAID's experiences offered valuable lessons on how to provide direct support successfully to governments and promote policy reform.

The USAID Story

As policy dialog and policy reform gained prominence in the 1980s, USAID experimented with providing non-project assistance (NPA) or

The Kenya Health Care Financing Program

The Kenya Health Care Financing Program, initiated in 1989, provided $9.7 million in non-project assistance to three organizations – the Ministry of Health, Kenyatta National Hospital and the National Hospital Insurance Fund – and included $5.3 million for technical assistance. The project ran into problems immediately when the premature introduction of user fees for health care services (one of the key elements of the policy reform agenda) created a public and political backlash. As a result, outpatient fees were suspended. USAID-supported technical assistance identified specific problem areas and developed a plan to reintroduce fees over a 2-year period. The original registration fee was reintroduced as a treatment fee, other fees were introduced, and some existing fees were adjusted. By the end of the project, user fees were accepted, and the new financing system provided significant revenue for use at the facility and district levels to improve quality of services and to replace declining government funding. The impact of the user fees on the most vulnerable, however, remained controversial.

This poster was designed for a media campaign in Albania that promoted modern contraceptive methods.

performance-based assistance directly to governments (currently called government-to-government or G2G) to achieve policy reform goals. NPA was expected to address several perceived disadvantages of project assistance by building government, capacity to plan, manage and account for resources; ensure the ownership and sustainability of project-funded activities; and benefit those most in need.

NPA policy reform efforts were often aimed at privatization, economic liberalization, budgetary reallocation or public-sector decentralization within a specific sector and generally had conditions and benchmarks tied to the release of funds. For health, USAID designed NPA projects as sector assistance programs with two objectives: the direct transfer of financial resources to the host government and support for specific policy reforms to address policy and resource constraints, sector productivity, performance or output. The first health sector NPA project was initiated in 1986 in Niger (96). Others followed in Ghana, the Philippines, Ecuador, Chile, Nigeria and Botswana.

Key lessons learned include:

- Policy dialogue, and the ownership of the policy by both the government and donor is critical.
- Policy reform and institutional capacity building are complex and labor intensive and require realistic timeframes to see results.
- Combining technical capacity building with NPA is often critical in the successful implementation of policy reforms, given host country institutional weaknesses.
- Good data are necessary for good policy development and are required to help inform the design of an NPA activity.
- Monitoring and evaluation must be central to any policy reform activity and decisionmakers need to use findings to make course corrections as needed.
- Strong donor coordination is critical in building consensus around key issues to support a uniform policy reform agenda.

USAID's experience with NPA and the lessons learned are further discussed in Non-Project Assistance and Policy Reform: Lessons Learned for Strengthening Country Systems, November 2012 (199); Policy Paper No. 12: The Use of USAID's Non-Project Assistance to Achieve Health Sector Reform in Africa: A Discussion Paper (282); Partnering for Policy Change and Performance: USAID's Nonproject Assistance in Population and Health (88); NPA: Salient Themes and Issues (197); Health Sector Reform in Africa: Lessons Learned (72); and A Brief Review of NPA and USAID Experience (33).

DEMOGRAPHIC AND HEALTH SURVEYS

Key Global Results

- More than 90 countries in Africa, Asia, Europe and Eurasia and Latin American and the Caribbean now have nationally-representative data in the areas of population, health and nutrition that are being used for program monitoring, evaluation, policy development and decision-making.

- Many countries now "own" the Demographic Health Survey (DHS) process, funding it from their national budgets.

The USAID Story

Initiated in 1984, the DHS is widely acclaimed as one of USAID's most important contributions to global health. The term most often heard in describing the DHS is "the gold standard." Indeed, the DHS provides the most accurate country-specific health-related data available over time. This information is used to identify and analyze problems, plan appropriate responses and monitor impact. No other development sector has this type of quality information.

The DHS grew out of the population and family planning movement. Early pioneers of that movement recognized the need to systematically collect data on a global basis to demonstrate impact. This information was critical for program planning, budgeting and implementation as well as for reporting results to Congress. Between 1972 and 1984, USAID and the United Nations Population Fund (UNFPA) joined forces to implement the World Fertility Survey in 41 countries. These surveys looked at fertility and mortality, as well as some child health indicators. When they proved to be very expensive, USAID began to fund more narrowly focused fertility and family planning surveys called Contraceptive Prevalence Surveys, which were carried out in 36 countries over the next 9 years.

In 1984, USAID merged World Fertility Surveys and Contraceptive Prevalence Surveys into the new DHS program, significantly expanding the scope of the surveys beyond population and contraception topics to collect information on reproductive health, maternal health, child health, immunizations, maternal mortality, child mortality, malaria and nutrition. Later, special focus modules on HIV and AIDS, gender-based violence, youth, etc., were added to meet country-specific needs for data. Building on two decades of DHS work, the Government of Bangladesh developed an innovative approach to converting DHS data into lay language in several "policy briefs." These were used with policymakers and their constituents as advocacy tools on key health issues needing increased attention and funding.

To date, the DHS program has collected, analyzed and disseminated accurate and representative data on population, health, HIV and AIDS and nutrition through more than 300 surveys in over 90 countries. While early Demographic and Health Surveys were primarily funded by USAID, many other donor and multilateral organizations now support these surveys, as do many country governments. USAID is placing increased emphasis on building local capacity to plan and fund implementation of the DHS.

INFORMATION, EDUCATION AND COMMUNICATION AND BEHAVIOR CHANGE COMMUNICATION

Key Global Results

- The importance and effectiveness of communication in changing knowledge, attitudes and behavior leading to improved health outcomes has been well established.

- IEC and behavior change communication (BCC) are routinely integrated into health programs across all health technical areas.

USAID Contributions to IEC and BCC Global Results

- An integrated radio communication project in Nepal and a nationwide television campaign in the Philippines increased the adoption of family planning and use of family planning services among those previously not using contraception; in the Philippines, a 6.4 percent increase in use of modern contraceptives was recorded after a 5-month campaign, representing 348,695 new users.

- Mozambique's Tchova Tchova program to encourage culturally appropriate gender relations and strengthen participants' ability to take action against harmful gender norms that could place both men and women at higher risk of HIV exposure had a significant and positive effect on gender equity; couple communication increased and only 2 percent of participants reported having more than one sex partner.

The USAID Story

Through its groundbreaking work in IEC and BCC, USAID demonstrated the importance of addressing the social dimensions of health, along with its medical, biological, economic and structural dimensions, to achieve sustainable health impact.

In the 1980s, USAID aggressively incorporated IEC approaches into its global health programs, with the goal of giving people information on the availability and benefits of various health interventions, assuming they would then adopt better health-seeking behaviors. As this approach matured, USAID recognized that education and information are a necessary but insufficient condition for changing individual behaviors. Behavior change also requires a supportive environment and specific focus on behaviors. Thus, IEC grew into BCC, which seeks to build that supportive environment as well as provide information and education. IEC and BCC activities seek to inform, influence and motivate individuals as well as community, institutional and public audiences to change their behaviors on important health and development issues.

USAID's first large venture into IEC took place under the family planning program through the Population Communication Services project (281) (223), but IEC was rapidly adopted by other health technical areas.

By the 1980s, child survival initiatives such as the Mass Media and Health Practices Project (170), HealthCom I and II (349) and Basic Support for Institutionalizing Child Survival I and II were all making use of USAID's growing body of IEC and BCC expertise. Similarly, malaria programs, tuberculosis interventions, nutrition programs and HIV and AIDS activities (AIDSCOM [210]) integrated IEC approaches. Communication interventions included the use of mass media (radio, television, newspapers), graphics (leaflets, wall charts, calendars, comic books, billboards), community theater, folk art and special events. These were complemented by interpersonal communication messages, often conveyed through trained community-based distributors or by community health care workers, peer educators or school programs. Messages were presented in many ways so that people of various levels of education could benefit.

Over time, proven BCC methodologies and materials were developed and disseminated (349) (274), and cost-effectiveness was evaluated (283). Critical lessons learned were incorporated into new, increasingly complex projects, such as C-Change, Health Communications Partnership and the Health Communication Capacity Collaborative.

An early challenge to BCC activities was the difficulty in evaluating impact and attributing behavior change to a BCC intervention, given the multidimensional social facets of health behaviors. Multiple studies now exist, however, demonstrating the impact of BBC interventions.

A longitudinal survey in the 1980s evaluated programs in Honduras and The Gambia to promote the correct mixing and administering of oral rehydration therapy to prevent and treat infant diarrhea. The survey found that the BCC interventions significantly contributed to correct treatment (97). Another BCC study in the 2000s in Madagascar demonstrated increased exclusive breastfeeding practices, from 29 percent to 52 percent, within a 10-month period. And a 2000 evaluation of "Tsha Tsha," a South African TV drama that explored relationships, intimacy and respect, found that young adolescent viewers were more likely to practice HIV preventive behaviors than non-viewers (150).

In June 2013, USAID further advanced the evidence base for behavior change when it convened the Population-Level Behavior Change Evidence Summit for Global Health in Washington, DC (226). This summit brought together experts from around the world to determine which evidence-based interventions and strategies would support a sustainable shift in health-related behaviors in populations in lower- and middle-income countries to reduce under-5 morbidity and mortality.

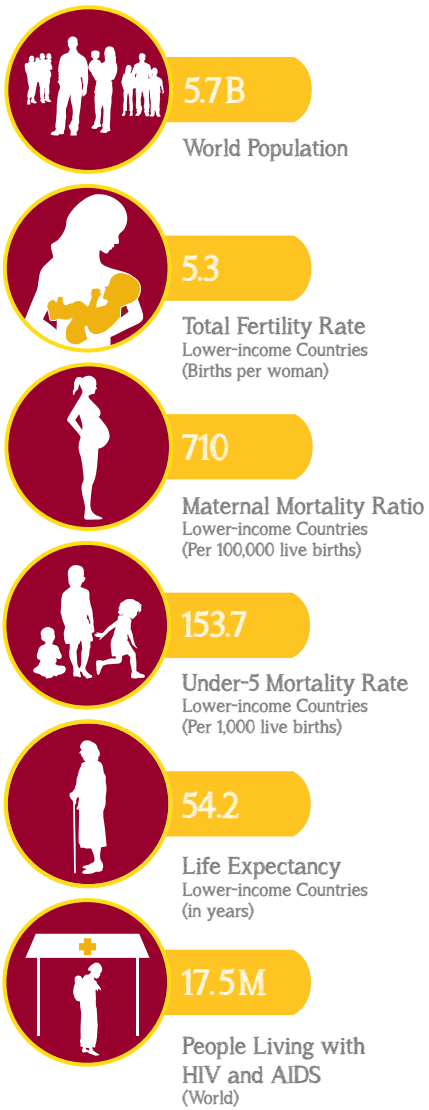
The IEC/BCC field continues to evolve, and USAID is at the forefront of using and adapting new technologies to promote social behavior change and to integrate behavior change messaging into social marketing and other types of programs. For example, the Mobile for Reproductive Health (m4RH) Project (237) developed a set of text messages on family planning methods that users can access via their mobile phones. In 2 years of operation in Kenya and Tanzania, the m4RH approach reached more than 70,000 users. Another innovative program, carried out through the Mobile Alliance for Maternal Action public-private partnership, is discussed in the Partnership section of this report.

"... sustainable development will make an enormous difference for the United States. It's the difference between having partners with whom we can tackle common challenges, from drugs and disease to the environment, and failed states that are thrown into tragic chaos."

President William J. Clinton,
Former President of the United States

VI. USAID in the 1990s

Sustainable Development



Note: See Annex for data sources, definitions and methods.

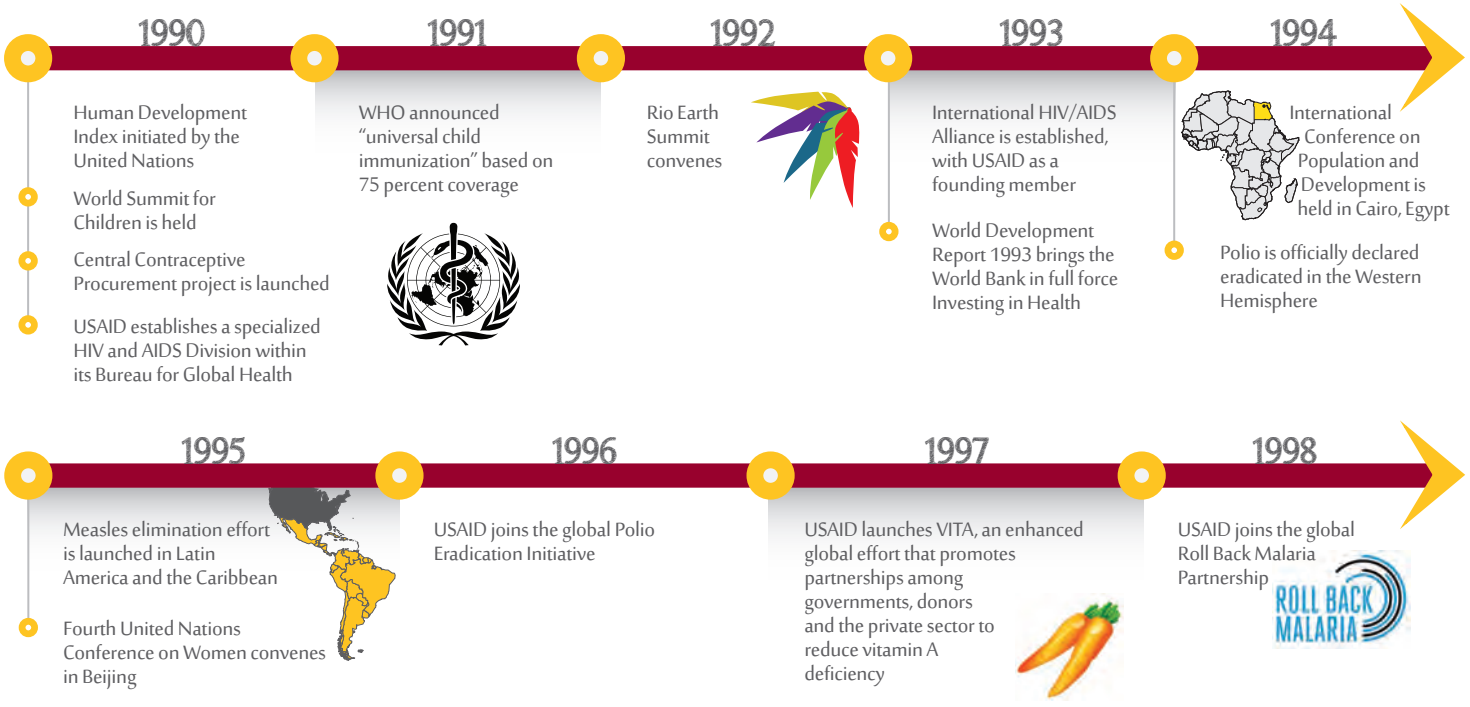
In the 1990s, there was a backlash to the structural adjustment programs of the 1980s, which many believed had interrupted development in some countries and had a negative effect on health. Some in the development community began to focus on measuring well-being through the options open to a person rather than through the income or goods they receive. This approach added an ethical dimension to economic development, leading the United Nations to adopt the Human Development Index and to publish the annual Human Development Report. Sustainable development, or economic development that meets the needs of the present without compromising the ability of future generations to meet their own needs, also gained prominence.

In the United States, with the end of the Cold War, the role of development assistance as a tool of foreign policy was under discussion. Some argued that its role should be to expand trade, while others pushed for a major ramp-up to promote democracy. By the end of the 1990s, the U.S. Agency for International Development (USAID) listed sustainable development as its top priority, with a focus on helping countries improve their own quality of life, including improved health.

During the 1990s, the U.S. Government's "reinventing government" movement strove to create a government that worked better and cost less, leading to extensive internal reforms for USAID. Budgets were reduced, 26 overseas missions closed, new missions opened in high-priority Eastern Europe and the former Soviet Union, and a major reduction in force resulted in the termination of some 30 percent of USAID's direct hire Foreign Service and civil service employees. In response to these changes, USAID shifted additional resources into partnerships with institutional contractors and non-governmental organizations. For USAID's health sector, this included the Technical Advisors in AIDS, Child Survival, Infectious Diseases, Population and Basic Education Program and Health and Child Survival Fellows programs.

In the health sector, the global development community embraced health sector reform, particularly the decentralization of health services. Malaria made a resurgence. A better understanding of the magnitude of the HIV and AIDS epidemic on economic development and global health spurred increased action to contain this deadly disease, as well as increased attention to tuberculosis (TB).

1990s Timeline



Key USAID Global Health Contributions

TUBERCULOSIS

Key Global Results

- Between 1995 and 2011, 51 million people were successfully treated for TB.
- The Millennium Development Goal of a 50 percent reduction in TB mortality by 2015 is on target and should be reached.

USAID Contributions to TB Global Results

- Between 1990 and 2011, TB mortality decreased by 35 percent and TB prevalence by 37 percent in USAID priority countries.
- More than 1.5 million people with TB were successfully treated in USAID priority countries in FY 2012.
- In FY 2012, in USAID priority countries, the number of patients with multidrug-resistant TB (MDR-TB) who initiated therapy more than doubled from the previous year, with more than 44,000 patients starting treatment.

USAID has been a global leader in the international fight to address the public health challenge of TB since initiating a TB program in the mid-1990s, when the HIV and AIDS epidemic resulted in increased attention to TB. From its inception, the USAID program focused on scaling up high-quality services to diagnose and treat TB.

Initially, USAID focused on expanding its HIV portfolio to include TB-related activities that minimized HIV-associated morbidity and mortality. Using seed funding from the HIV program, USAID partnered with the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) on an operations research project in seven

The Stop TB Strategy

1. Pursue high-quality DOTS (directly observed treatment, short-course) expansion and enhancement.
2. Address TB-HIV co-infection, MDR-TB and the needs of poor and vulnerable populations.
3. Contribute to health systems strengthening based on primary health care.
4. Engage all care providers.
5. Empower people with TB and communities through partnerships.

sub-Saharan African countries. The focus of this joint project was delivering TB care through community-based TB-HIV care.

In 1998, the U.S. Congress authorized USAID TB-specific funding, and USAID developed a TB strategy to provide quality technical assistance to countries, expand the directly observed treatment, short-course (DOTS) strategy, develop and roll out new drugs and diagnostics and promote international collaboration to address the global TB epidemic.

Also in the late 1990s, USAID and other partners drafted a Global Action Plan for TB, with support from WHO and CDC. The plan became the basis for the STOP TB Initiative. Shortly after, in 2000, the global health community launched the Stop TB Partnership to galvanize support for TB control. The U.S. Government, with USAID as the lead, became a prominent member of the partnership and supported its First Global Plan (2001–2006). This plan emphasized increased case detection and improved treatment success rates in high-burden countries to ensure proper TB diagnosis and treatment by providers in both public and private sectors, quality management of MDR-TB treatment; expanded integration of TB-HIV programs, strengthened community involvement in TB care and support for MDR-TB surveillance.

When the U.S. Congress passed the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis and Malaria Reauthorization Act in 2008, U.S. funding for TB prevention, diagnosis and treatment programs increased substantially. This Act mandated U.S. Government support for the ambitious objectives of the Global Plan to Stop TB 2006–2015, which seeks to halt and begin to reverse TB incidence, primarily through support for training of health care providers; necessary services and commodities; and appropriate treatment, with a particular focus on MDR-TB.

In 2010, on World TB Day, the U.S. Government released a new TB strategy (155). The strategy provided a framework for the U.S. Government to accelerate implementation of proven, cost-effective interventions to prevent the further spread of TB, susceptible and resistant TB and MDR-TB and to reduce TB-associated morbidity and mortality. Building on USAID's strong foundation of support for improved TB programs in a number of countries, the U.S. Government committed to:

- Accelerate detection and treatment of TB for all patients, including children
- Scale up prevention and treatment of MDR-TB
- Coordinate with U.S.-Government HIV efforts under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) to expand coverage of interventions for TB-HIV co-infection
- Improve the overall health systems where USAID works

To implement this interagency effort, USAID works closely with the Office of the U.S. Global AIDS Coordinator at the Department of State, which leads the U.S. Government response to TB-HIV co-infection as part of PEPFAR (342), and with CDC as the key agency responsible for U.S. TB prevention, control and elimination activities.

Measuring Impact

The President's Malaria Initiative (PMI) is carefully measuring the contribution of malaria control efforts to declines in mortality in PMI focus countries. Three impact evaluations have been completed to date in mainland Tanzania, Malawi and Angola. By 2015, evaluations will have been carried out in all 15 original PMI focus countries.

The findings of the mainland Tanzania impact evaluation documented a 45 percent reduction in all-cause mortality among children under 5 between 2000 and 2010, due in large part to the scale-up of malaria control interventions. These results have been further supported by the findings of the 2012 Tanzania Malaria Indicator Survey, which showed a 47 percent reduction in malaria prevalence from 18 percent in 2008 to 10 percent in 2012.

Rapid diagnostic test kits are one of the key tools that have helped reduce malaria deaths among children under 5.
- PATH/Mike Eisenstein

Managing the quality, affordability and delivery of anti-TB drugs is vital to both successful treatment of individuals with the disease and to the success of TB programs overall. As a leader in drug management, including procurement, supply chain logistics, selection and quality assurance, USAID applies its expertise to improve TB drug management at the global, national and regional levels. USAID has also been crucial to the success of the Stop TB Partnership's Global Drug Facility, which provides quality-assured drugs to countries in need.

MALARIA

Key Global Results

- Malaria-specific mortality rates have decreased by 25 percent since 2000.
- Reported malaria cases fell by more than 50 percent between 2000 and 2010 in 43 of the 99 countries with ongoing malaria transmission.

U.S. Government Contribution to Malaria Global Results through the President's Malaria Initiative

- In FY 2012, PMI protected more than 50 million people with insecticide-treated mosquito nets (ITNs) and/or indoor residual spraying and distributed more than 43 million treatments of lifesaving drugs to targeted populations.
- Declines in mortality rates among children under 5 years of age have been documented in 12 of the original 15 focus countries receiving support from PMI; these declines ranged from 16 percent in Malawi to 50 percent in Rwanda.

The USAID Story

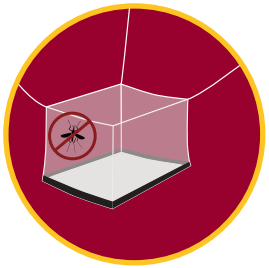
The U.S. Government has been at the forefront of malaria control efforts since it began supporting programs in the 1950s, but it renewed this leadership in the 1990s when chloroquine resistance emerged.

In the late 1950s, the United States provided large-scale technical assistance to 19 national programs and financial and technical support to the original malaria eradication efforts of WHO; the Western Hemisphere's part of WHO, the Pan American Health Organization; and the United Nations Children's Fund (UNICEF). In line with WHO's 1955 worldwide malaria eradication policy, the U.S. Government supported malaria eradication programs that relied heavily on the application of DDT (dichlorodiphenyltrichloroethane), which had helped to eradicate malaria in the United States and parts of Europe. U.S. programs were concentrated in Latin America and Asia, with limited funding going to Africa despite its high burden of disease.

When USAID was established, administration of ongoing malaria eradication programs became the responsibility of USAID regional bureaus (165).

However, in the late 1960s, it was decided that WHO should take greater responsibility for in-country administrative and technical advisory services,

Malaria Interventions



Insecticide-treated mosquito nets

Research shows that high ownership and use of ITNs reduce all-cause mortality in children under 5 by about 20 percent and malarial infections among children under 5 and pregnant women by up to 50 percent.

Indoor residual spraying

Indoor residual spraying is the organized, timely spraying of an insecticide on the inside walls of houses or dwellings. It kills adult mosquitoes before they can transmit malaria parasites to humans.

Intermittent preventive treatment for pregnant women

An estimated 25 million or more African women become pregnant and are at risk for malaria. Intermittent preventive treatment involves the administration of at least two doses of an antimalarial drug to a pregnant woman, which protects her against maternal anemia and reduces the likelihood her baby will be born underweight.

Diagnosis and treatment with lifesaving drugs

Artemisinin-based combination therapies are the most effective and rapidly acting drugs currently available for treating malaria.

and USAID began to withdraw U.S. Government technical staff from overseas programs (285). By 1976, USAID was supporting malaria eradication programs only in Haiti, Nepal, Ethiopia, Indonesia and Pakistan.

Malaria eradication programs initially achieved stunning results. By the end of the global malaria eradication campaign in 1969, many in the public health community believed that malaria was under control. In Latin America, over 56 percent of the population in malaria-affected areas was free of the disease by 1964. In Asia, the highly malarious Terai area of Nepal became one of the most productive parts of the country following malaria eradication efforts in the late 1950s and 1960s. However, several factors, including complacency, premature termination of programs, lack of adequate technical and financial support, resistance to pesticides and failure to integrate malaria programs into the overall health system, led to a resurgence of malaria, particularly in Africa. By the late 1980s, studies indicated that 90 percent of the world's malaria cases and 85–90 percent of malaria-related deaths, occurring predominantly in children under 5, were in Africa. Studies also indicated growing resistance to chloroquine, the standard antimalarial drug treatment. Furthermore, USAID-funded studies carried out in several countries indicated that a large share of household income was being used for malaria treatment, posing a severe economic burden on the poor (158). In response, in the 1990s, USAID began supporting malaria interventions as part of integrated child survival and maternal health programs.

Under the U.S. Government's renewed focus on malaria, USAID made major contributions to the development of new malaria prevention tools by providing funding to support the initial testing of ITNs. When trials showed that ITNs could reduce the frequency of malaria by up to 50 percent, USAID initiated innovative programs to expand production and distribution of ITNs in African countries. Through social marketing initiatives such as the NetMark Alliance (40) and public-private partnerships (49), complemented by subsidies for the most vulnerable, USAID was able to both reduce costs and increase availability of ITNs so that even the poorest families could afford them.

USAID's efforts to strengthen malaria treatment, conducted in collaboration with CDC and other partners, focused on evaluating alternative drugs and helping countries change their malaria treatment regimens from chloroquine to sulfadoxine-pyrimethamine. By the end of the 1990s, however, the continued emergence and spread of resistant malaria strains required further action, and in the following decade artemisinin-based combination therapies (ACTs) were adopted as the preferred treatment for malaria in Africa. USAID was instrumental in validating the use of ACTs through its support for the largest clinical field trials ever held in Africa.

A girl shows her delight with a new insecticide-treated mosquito net that will protect her against malaria. In 2012, USAID provided over 50 million people with these nets.

- Maggie Hallahan

Antimicrobial Resistance

Although drug resistance has long been recognized as a threat to treatment outcomes, it was not until the late 1980s and early 1990s that it became a significant concern. Recognizing the potential impact of resistance on global health outcomes, USAID raised global awareness of the issue and worked closely with WHO to develop the landmark 2001 WHO Global Strategy for Containment of Antimicrobial Resistance, which provides a framework of interventions to slow the emergence and reduce the spread of antimicrobial-resistant microorganisms.

In 1998, USAID joined the Roll Back Malaria Partnership, launched by WHO, UNICEF, the United Nations Development Program and the World Bank, to provide a coordinated global response to malaria. At this time, increased congressional support for malaria programs led to USAID becoming the world's largest funder of malaria interventions. The U.S. Government remains the world's largest malaria donor through its funding to the President's Malaria Initiative (PMI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Building on USAID success in malaria control, President George W. Bush announced the establishment of the President's Malaria Initiative, a $1.2 billion effort to aggressively scale up malaria prevention and control interventions so as to reduce malaria mortality by 50 percent in 15 African countries by 2010. An expanded PMI strategy was developed to achieve Africa-wide impact by halving the burden of malaria in 70 percent of at-risk populations (approximately 450 million people) in sub-Saharan Africa. PMI now works in 19 countries in sub-Saharan Africa and the Greater Mekong Subregion in Asia. This interagency initiative, led by USAID and implemented with CDC, is focused on scaling up proven malaria control interventions (see infographic on page 66).

In addition to PMI focus countries, USAID malaria funding also supports control efforts in three other African countries as well as one regional program in Latin America.

To supplement support for implementation of malaria control activities, USAID has also made significant investments in malaria-related research since 1965 through the USAID-funded Malaria Vaccine Development Program (166). Indeed, malaria vaccine research was one of the first large-scale global health research projects to be undertaken by USAID, and for many years, the USAID program was the major global effort devoted to developing vaccines to decrease illness and death due to malaria. In the early years, the program consisted entirely of research efforts to identify promising approaches. As the knowledge base grew, the program progressively shifted toward testing the approaches identified by the earlier work through producing and testing investigational vaccines.

In recent years, USAID's continued support for malaria vaccine development has been expanded to include support for malaria drug development research to accelerate the viability of appropriate treatments in developing countries. This support has led to the approval and use of new treatments for malaria (262).

To complement vaccine and drug development research, PMI supports operational research focused on program-relevant questions to help guide program investments, make policy recommendations to national malaria control programs and target interventions to increase their cost-effectiveness. PMI's operational research studies explored topics such as mosquito net durability; the effectiveness of combining interventions, such as indoor residual spraying and insecticide-treated mosquito nets; and the effect of insecticide resistance on insecticide-treated mosquito net effectiveness.

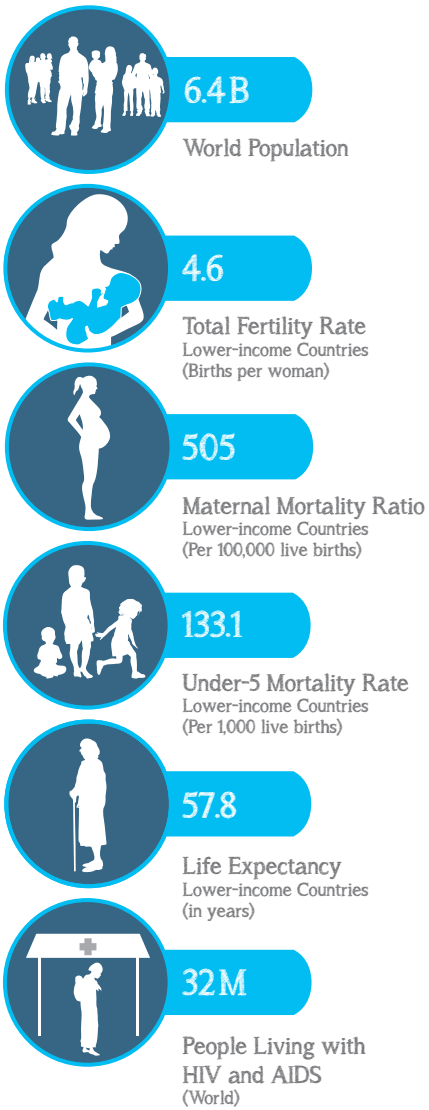
“Development is a lot cheaper than sending soldiers.”

Robert Gates,

Former U.S. Secretary of Defense

VII. USAID in the 2000s

Development, Defense and Diplomacy



Note: See Annex for data sources, definitions and methods.

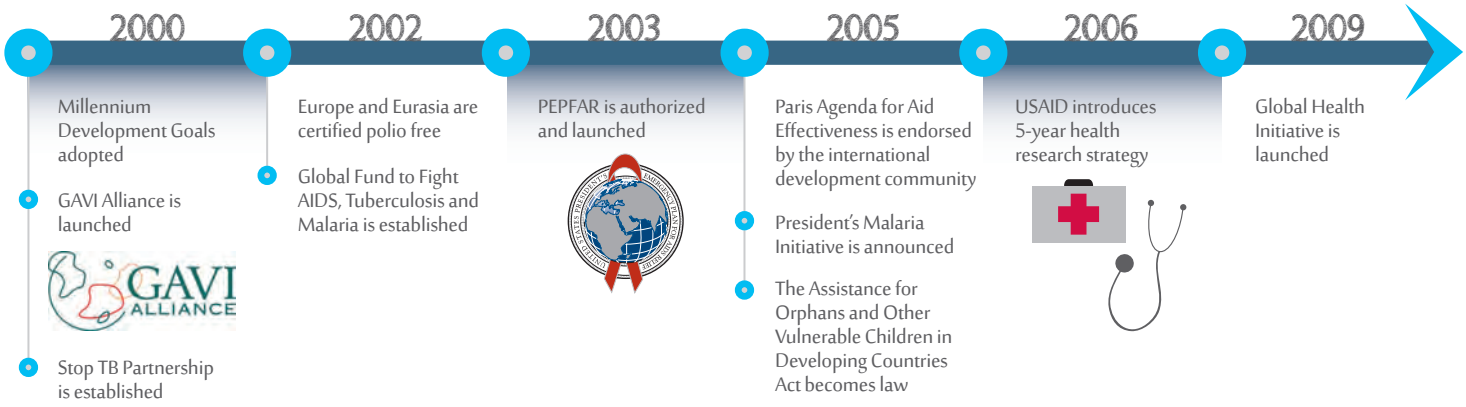
Several key events helped shape the international development community's thinking, priorities and approaches to development during this decade.

- International commitment to the United Nations Millennium Development Goals (MDGs) – three of which focus directly on health – raised international awareness and mobilized donors and country governments around a set of common goals – but also contributed to a focus on single diseases.
- The 2002 Monterrey Consensus (187) focused increased attention on the role of recipient countries and the effectiveness of aid rather than on the level of foreign assistance.
- The establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (309) in 2002 provided increased attention and funding for these diseases and brought about increased coordination among donors.
- Several large foundations, such as the Bill & Melinda Gates Foundation and the William J. Clinton Foundation, emerged as key players in development, and the private sector increasingly embraced corporate social responsibility; while undergoing these changes, they have augmented available resources for development and created new opportunities.

For the United States, following the terrorist attacks of September 11, 2001, the U.S. National Security Strategy identified the "Three D's" as vital to U.S. security interests – diplomacy, defense and development. In response, the U.S. Agency for International Development (USAID) began working in the war-torn countries of Afghanistan and Iraq, helping to rebuild government, infrastructure, civil society and basic services (health and education), and reengaged in Pakistan. Under very difficult circumstances, USAID applied its proven development model, improved the lives of those affected by conflict and built relationships that strengthened diplomatic efforts.

In 2006, USAID released its Policy Framework for Bilateral Foreign Aid (229). This document recognized USAID's new role as one of the cornerstones of U.S. national security and presented a new direction for the Agency that focused on transformational development –

2000s Timeline



the promotion of far-reaching, fundamental changes in governance and institutions, human capacity and economic structure that would allow countries to sustain economic and social progress without depending on foreign aid. To help ensure that foreign assistance was used to further foreign policy goals, in January 2006, the Director of Foreign Assistance Office (F) was created within the U.S. Department of State to oversee USAID, the Department of State and other foreign assistance programs. USAID accordingly closed its office responsible for overall budgeting and development policy.

In the health sector, the launch of two single-disease initiatives, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (2003) and the President's Malaria Initiative (PMI) (2005), brought increased U.S. Government funding and attention to these two global health challenges, while the signing of Public Law 109-95 (P.L. 109-95), The Assistance for Orphans and Other Vulnerable Children in Developing Countries Act (2005) raised the profile of children in adversity. These initiatives promoted a whole-of-government approach to increase the impact of U.S. Government investments. The 2009 Global Health Initiative (GHI) sought to bring PEPFAR and PMI, the single-disease initiatives, and other global health-related programming together again through the application of seven core programming principles. To ground GHI's strong focus on maximizing results, GHI set aspirational goals in eight broad health areas.

Key USAID Global Health Contributions

HIV AND AIDS RESPONSE

Key Global Results

- Twenty-five countries have seen a 50 percent or greater drop in new HIV infections since 2001. Half of all reductions in new HIV infections in the last 2 years have been among newborn children – showing that elimination of new infections in children is possible.
- Deaths due to AIDS-related causes fell 25 percent from 2005 to 2011. In sub-Saharan Africa, the number of AIDS-related deaths declined by nearly one-third during the same period.
- More than 8 million people living with HIV have access to antiretroviral therapy. The number of people with access increased by 63 percent from 2009 to 2011.

U.S. Government Contributions to HIV and AIDS Global Results through PEPFAR

- The U.S. Government has contributed more than $7 billion to the Global Fund to Fight AIDS, Tuberculosis and Malaria.
- Over 46.5 million people have received HIV testing and counseling through PEPFAR programs; 11 million have been pregnant women.

A Miraculous Transformation in Afghanistan

After the fall of the Taliban in 2001, Afghanistan's health system was near collapse, with little coverage for preventive or curative health services. The impact was clear: Many of this country's health indicators were among the worst in the world. In 2001, the infant mortality rate was estimated at 165 per 1,000 live births, and the under-5 mortality rate was estimated at 257 per 1,000 live births. The maternal mortality ratio was as high as 6,507 per 100,000 births in some parts of the country.

The Ministry of Health identified a Basic Package of Health Services that would have the biggest impact on reducing morbidity and mortality: maternal and newborn health, child health and immunizations, nutrition, communicable diseases (TB and malaria), mental health, disability and essential drug supply. It then developed a plan to ensure that these services were offered at all four levels of health facilities. Community health workers were to deliver some of the most essential components of the package.

USAID collaborated with the World Bank, the European Union and other donors to support the plan – with stunning results. A nationwide survey conducted in 2010 found that between 2002/2004 and 2010 deaths per 1,000 live births fell from 257 deaths to 77, and under-5 mortality per 1,000 live births fell from 172 to 97. During this same period, antenatal care coverage increased from 16 percent to 60 percent, and maternal mortality per 1,000 births declined from an astonishing 1,600 deaths to 327.

- Of the women who received PEPFAR-supported HIV testing and counseling, 750,000 also received antiretroviral drug prophylaxis, allowing approximately 230,000 infants to be born HIV free.
- Antiretroviral treatment has been provided to 5.1 million men, women and children living with HIV.
- More than 15 million people, including 5 million children in adversity, have received care and support.
- Approximately 2 million medical male circumcisions have been performed worldwide.

The USAID Story

USAID has been on the forefront of the HIV epidemic for nearly 30 years, since the virus was first discovered in the 1980s. It was in the 2000s, however, that this technical area became the largest in USAID's global health portfolio. As of 2010, nearly 1,000 USAID staff members worked on HIV and AIDS issues; 80 percent were in the field. USAID currently administers and implements more than half of all PEPFAR programs.

USAID established its first AIDS programs in 1986 – just 2 years after the virus had been isolated and identified. As there were no effective drug therapies to treat people living with HIV at that time, programs that addressed surveillance of the epidemic and promoted behavior change and condom use were considered the most viable way to respond effectively to this global public health crisis. Therefore, in the early years, USAID's HIV and AIDS response primarily consisted of prevention and care programs, with a focus on Africa, where the epidemic was most concentrated. Employing the lessons learned in addressing other global disease challenges, USAID initiated innovative HIV and AIDS prevention activities that educated people about the disease, increased their understanding of risk behaviors and began to break down the stigma and discrimination surrounding the disease. USAID supported condom social marketing for HIV prevention through programs such as AIDSMark, providing people with access to a lifesaving HIV prevention commodity (4).

USAID's care activities built on decades of work at the community level to support home-based care and train community-based volunteers to help those affected by the disease (12).

In 2000, USAID launched its first programs for the prevention of mother-to-child HIV transmission. If the mother receives the full package, such interventions have proven to be up to **98 percent** effective.

PATH/Mutsumi Metzler

GHI Principles

- Promote women, girls and gender equality
- Encourage country ownership/leadership
- Strengthen health system and program sustainability
- Leverage and strengthen key multilateral organizations, global health partnerships and the private sector
- Foster strategic coordination and integration
- Improve metrics, monitoring and evaluation
- Promote research and innovation

USAID recognized that human rights were key to fighting HIV and AIDS. The Agency supported the formation of support and advocacy groups of HIV-positive people, worked to reduce stigma and discrimination and was at the forefront of promoting recognition for the rights of the lesbian, gay, bisexual, transgender, intersex population (98) (69) (105). Utilizing its strong community links, USAID mobilized religious leaders and faith-based organizations to fight against HIV and AIDS in countries such as Tanzania (156) and St. Kitts and Nevis (317). USAID also supported the development of simple HIV rapid tests, revolutionizing HIV testing.

As new HIV infections continued to increase at an alarming rate, USAID's HIV and AIDS program expanded, with funding increasing from $1.1 million in FY 1986 to $433 million by FY 2001. To support growing HIV and AIDS programs in the field, USAID's Washington, DC, headquarters established a specialized technical office focused on HIV and AIDS. USAID also became one of the founding members of the International HIV/AIDS Alliance – a global partnership of nationally based organizations working to support community action on AIDS in developing countries. This partnership was instrumental in the establishment of the Joint United Nations Programme on HIV/AIDS (UNAIDS), the UN agency responsible for strengthening and supporting an expanded response to HIV and AIDS.

When USAID-supported studies indicated in 1995 that increasing access to voluntary counseling and testing (VCT) could lead to a reduction in risk behaviors, USAID ramped up VCT programs, incorporating its expertise in behavior change communication and developing innovative approaches to making VCT more available, such as mobile testing and socially marketed VCT. Today, HIV counseling and testing is a standard element of the global response to HIV and AIDS.

In 1997, working with UNICEF and UNAIDS, USAID called the world's attention to the tragedy of AIDS orphans and began to provide global leadership in caring for orphans and other children affected by and infected with HIV. USAID supported community-based programs that helped ensure these children received the care, protection and services (including education, food, nutrition, shelter, protection, health care, livelihood opportunities and psychosocial support) they needed to grow into contributing members of society (175).

In 2000, USAID sponsored research by the U.S. Bureau of the Census on the demographic impact of AIDS. The findings alerted the public of the disease's devastating reach and helped mobilize the world's response. In that same year, USAID initiated some of the first prevention of mother-to-child transmission programs.

Around this same time, in response to early studies indicating that male circumcision could reduce the risk of HIV infection by at least 50 percent, USAID held its first international meeting on male circumcision. More than 150 experts from around the world met to discuss the feasibility of using male circumcision to prevent the spread of HIV. USAID pioneered investigations into the cultural acceptability, feasibility, safety and cost-effectiveness of medical male circumcision in curbing rates of infection, launching pilot programs in Zambia (296), Haiti, South Africa and Swaziland. Results of the pilots all pointed in the same direction – men were interested in having this procedure performed and the procedure could be delivered safely and efficiently. This was the beginning of a process that would eventually make medical male circumcision a significant part of USAID's HIV prevention program – and a PEPFAR priority. As part of this process, USAID developed innovative means of expanding uptake of and access to voluntary medical male circumcision through the use of behavior change communication, the provision of mobile services and task shifting.

In his 2003 State of the Union address, U.S. President George W. Bush asked the U.S. Congress to authorize $15 billion over 5 years to address the urgent and severe crisis of HIV and AIDS globally. This request, which was authorized a few months later through the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003, but is best known as PEPFAR, became the largest investment any donor had made for combating a single disease. Reauthorization of the Act in 2008 extended the U.S. Government's commitment to global HIV and AIDS programs for another 5 years and authorized up to an additional $48 billion for AIDS, malaria and tuberculosis (TB).

With the launch of PEPFAR, USAID's involvement in HIV and AIDS programming increased significantly in both size and scope. USAID funding increased from $1.3 billion in FY 2004 to $3.4 billion in FY 2012. A constant flow of new research results made this a rapidly evolving field. USAID's ability to successfully transfer evidence-based interventions for use in real world, low-resource settings enabled it to quickly respond and shape how HIV and AIDS programs are implemented today.

For example, USAID utilized its expertise in reaching and working with vulnerable groups to analyze the social and economic challenges faced by key populations, such as men who have sex with men (MSM) in Anglophone Caribbean (190) and Europe and Eurasia, and develop innovative programs to reach these key groups with HIV and AIDS services in countries such as China (91) and in the Caribbean (53).

Capitalizing, too, on its strong relationships with partner countries, USAID used epidemiological data to develop tools to help governments and non-governmental organizations (NGOs) identify and reach out to the real drivers of the HIV epidemic, even when these groups had little political support. Such groups included injecting drug users, MSM, transgender people and commercial sex workers.

USAID was at the forefront of promoting the integration of nutritional assessments, counseling and support into HIV prevention and care activities (65). The Agency championed the use of complementary and therapeutic feeding for malnourished AIDS patients. This included support for the development of appropriate products and formulations. Building on its decades-long history of involvement in the promotion of breastfeeding, USAID actively supported research into breastfeeding and HIV transmission, participated in the development of international guidelines and rapidly translated both into on-the-ground programming that prevented the transmission of HIV from mother to child (138).

With a proven history of successfully working in procurement and logistics, in 2005, USAID launched the Supply Chain Management System Project, which has provided more than $750 million in HIV and AIDS

With USAID's leadership, the U.S. Government has adopted an interagency action plan to address the needs of children in adversity, such as this Ugandan girl.

- Robin Hammond for World Education/Bantwana Initiative

Orphans and Vulnerable Children

USAID leadership in responding to issues related to the millions of children left orphaned and vulnerable by the HIV and AIDS epidemic began in 1997 when USAID, with UNICEF and UNAIDS, released Children on the Brink, the first in a series of reports about children orphaned by AIDS. Since then, based on the principle that children are best off in a family and community setting, USAID has worked through PEPFAR to strengthen families to provide for children's needs; organize and resource civil society to identify and assist children and families at risk and provide safety nets; and build capacity in governments to ensure strong welfare and social protection services.

commodities, such as antiretroviral drugs, rapid test kits and male circumcision kits. This project saved over $700 million by pooling procurements of generic AIDS drugs and reduced shortages and stock-outs of commodities that caused dangerous interruptions in therapy for patients (278).

To complement its HIV and AIDS prevention, care and treatment programs, USAID engaged in health systems strengthening activities and supported research on the development of products to prevent HIV infection and transmission, including research into vaccines and microbicides. USAID supported a game-changing Centre for the AIDS Programme of Research in South Africa (CAPRISA) study, which, in July 2010, provided the first proof-of-concept that a vaginal microbicide could safely and effectively reduce the risk of heterosexual transmission of HIV from men to vulnerable women. Shortly thereafter, Science Magazine named the CAPRISA study one of the top 10 breakthroughs of 2010 (149).

In November 2012, PEPFAR released the PEPFAR Blueprint: Creating an AIDS-free Generation (219), which outlined PEPFAR's planned contributions to this ambitious goal. The blueprint emphasizes the principles of scaling up prevention, treatment and care services; shared responsibility among the full range of stakeholders in the HIV and AIDS response; focusing on women and girls to increase gender equality in HIV services; ending stigma and discrimination against people living with HIV and AIDS as well as key populations who contribute to the HIV epidemic; and adapting to and adopting new science and evidence for both effective implementation of interventions and capturing cost-saving efficiencies.

CHILDREN IN ADVERSITY

Key Global Results

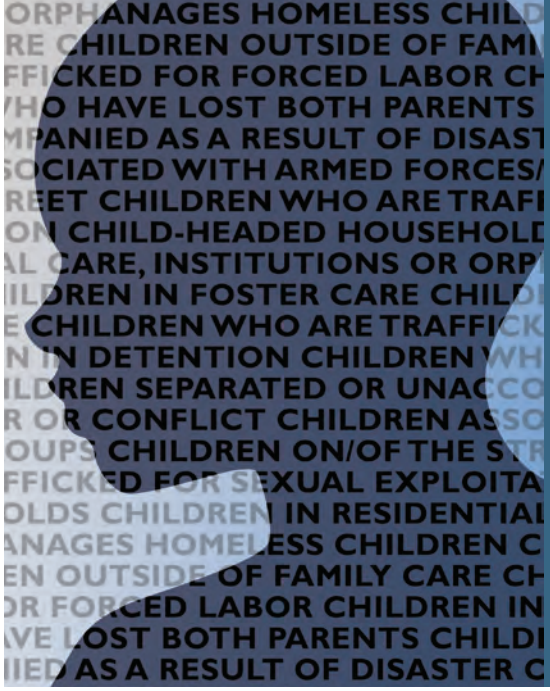
- Overall improvement rates in child well-being almost doubled in the first decade of the 21st century.
- Fifty million more children were in primary school in 2005–2010 than in 1995–1999.
- The number of underweight children dropped by 36 million from 1995–1999 to 2005–2010.

USAID Contributions to Children in Adversity Global Results through P.L. 109-95

- USAID led the interagency process to develop a comprehensive, whole-of-U.S. Government Action Plan to address the needs of children in adversity.
- The evidence base on reducing risks for vulnerable children developed through USAID program and research activities influenced the development of the U.S. Government Action Plan on Children in Adversity.

The USAID Story

While providing assistance to children in adversity has always been part of the USAID mission, it was in 2005, with the signing into law of Public Law 109-95, The Assistance for Orphans and Other Vulnerable Children in Developing Countries Act, that USAID's Bureau for Global Health assumed an interagency leadership role in addressing the critical needs of highly vulnerable children.



U.S. Government Action Plan on Children in Adversity: A Framework for International Assistance (2012–2017)

Objective 1 **Build strong beginnings:** The U.S. Government will help ensure that children under 5 not only survive, but also thrive by supporting comprehensive programs that promote sound development of children through the integration of health, nutrition and family support.

Objective 2 **Put family care first:** U.S. Government assistance will support and enable families to care for their children, prevent unnecessary family-child separation and promote appropriate, protective and permanent family care.

Objective 3 **Protect children:** The U.S. Government will facilitate the efforts of national governments and partners to prevent, respond to and protect children from violence, exploitation, abuse and neglect.

USAID's early support for orphans and other vulnerable children was primarily carried out through its humanitarian assistance programs. These programs provided assistance to children as part of their response to those affected by conflict, natural disasters and other tragedies. For example, in the 1970s, significant effort was placed on assisting victims of the Vietnam War, including orphans and displaced children (95). The 1984 report, 20 Years of Response (326), highlights U.S. Government efforts to assist children and families affected by drought, earthquakes, tornadoes, floods, conflict and other causes during the first two decades of USAID's history.

Recognizing that children required special attention beyond what was already provided, in 1989, USAID established the Displaced Children and Orphans Fund (70) to provide care, support and protection for the special needs of children at risk, including orphans, unaccompanied minors, children affected by armed conflict and children with disabilities. For the past 25 years, this fund has provided critical global support that strengthened the capacity of families and communities to address the physical, social, educational, economic and emotional needs of children in crisis. The Displaced Children and Orphans Fund was among the first to recognize and respond to the orphan crisis emerging from the HIV and AIDS pandemic, supporting an assessment of the growing orphan problem in Uganda in 1991 as well as projects to assist children affected by AIDS in eight countries.

In the late 1990s, USAID expanded its HIV and AIDS portfolio to more comprehensively include programs to mitigate the impact of HIV and AIDS on those infected and affected by the pandemic, including orphans and vulnerable children. Soon thereafter, several programs that specifically provided assistance to children in adversity were initiated in countries such as Zambia, Uganda, Rwanda and South Africa (255). Since that time, USAID has continued to provide leadership in responding to the needs of children in adversity, programming the majority of PEPFAR funding allocated for orphans and other vulnerable children and reaching more than 4 million children in 2012.

As the AIDS orphan crisis deepened and the number of children made vulnerable by conflict and other causes increased, in 2005, President George W. Bush signed into law P.L.109-95: The Assistance for Orphans and Other Vulnerable Children in Developing Countries Act to promote a comprehensive, coordinated and effective response on the part of the U.S. Government to the world's most vulnerable children. Prior to P.L.109-95, U.S. Government efforts to assist vulnerable girls and boys in low- and middle-income countries often focused on single vulnerability cohorts and categories, such as children affected by HIV and AIDS, children in emergencies or children in the worst forms of child labor, including those who have been trafficked. Although such efforts produced substantial benefits, they represented a fragmented response. P.L.109-95 promotes coordinated, multifaceted action that helps ensure that children in adversity benefit fully from policies and services.

Under P.L. 109-95, USAID is the lead of an interagency effort in more than 100 countries. This effort includes over 30 offices in 7 U.S. Government departments and agencies: the Departments of Agriculture, De-

Villagers gather around a recently renovated clinic in Tanzania that serves over 1,800 people and provides outpatient services.

U.S. Navy photo by Mass Communication Specialist 1st Class Jonathan Kulp/Released

National Health Accounts Lead to Major Adjustments in Government Allocation of Funding

National Health Accounts (NHAs) are used in more than 100 countries by policymakers to review resource allocation patterns in the public and private sectors. NHAs provide information to assess the efficiency of current resource use and to provide options for health care reform. Because of the information provided by NHAs, policymakers are better able to identify health system problems and opportunities for improvement, develop and select the optimum allocation strategy and monitor impact and adjust policies.

Since the early 1990s, USAID has been at the forefront of promoting the development and use of NHAs as an integral part of health information systems. This focus began in India, where USAID supported the application of the established Organization for Economic Co-operation and Development system of health account methods to look at household expenditures on health. USAID quickly expanded it to other regions (28). Experience led to the development of a more comprehensive NHA methodology that includes all sources of health spending (government, donor and household). In 2001, USAID collaborated with the World Bank and the World Health Organization to publish Guide to Producing National Health Accounts.

Over the past 20 years, USAID has worked with more than 17 countries to facilitate both the production and use of health resource tracking data, including those reported in NHAs, to strategically plan for future needs, prioritize essential health services, develop health workforce management capacity, strengthen health information systems and ensure the availability of quality-assured medicines.

Through its promotion of and support for NHAs, USAID has helped ensure that both its own investments and those of partner country governments lead to better health outcomes for the populace.

fense, Health and Human Services, Labor and State; USAID; and Peace Corps. USAID's Bureau for Global Health is the locus of P.L. 109-95 leadership and management and the home of the U.S. Government Special Advisor for Children in Adversity, a position mandated by the Act. In March 2012, the Special Advisor also became Senior Coordinator to the USAID Administrator for Children in Adversity.

In 2011, U.S. Government interagency partners actively began to establish whole-of-government guidance and a strategy for children in adversity. The process was informed by a U.S. Government Evidence Summit on Protecting Children Outside of Family Care. As published in December 2011 in The Lancet, at this summit senior U.S. Government interagency leaders committed to establish guiding principles and a U.S. Government strategy for assistance to vulnerable children.

Building on this commitment, an interagency team worked collaboratively to develop the first U.S. Government Action Plan on Children in Adversity. The Action Plan is grounded in evidence that nations benefit from investing wisely in children. The Action Plan integrates internationally recognized, evidence-based good practices into its international assistance initiatives for the best interests of the child.

USAID further demonstrated its commitment to the Action Plan's objectives by establishing a Center of Excellence for Children in Adversity with responsibility for coordinating programs throughout USAID that address children's issues. USAID's programming for children is currently channeled through more than 10 different offices.

HEALTH SYSTEMS STRENGTHENING

Key Global Results

- Universal health coverage, consisting of financial protection from high out-out-of pocket health spending, expanded population coverage and widening service coverage, was embraced by the World Health Assembly in 2010 and the UN General Assembly in 2012 as a health systems strengthening goal.

USAID Contributions to Health Systems Strengthening

Global Results

- An integrated primary health care system is successfully functioning in several former Soviet states, and residents are using the health system again.

- Country capacity to identify data needs and to collect, analyze, interpret and use health information for decision-making and monitoring and evaluation through the Demographic Health Surveys (DHS) now exists.

- More than 80 countries have conducted health resource tracking using the USAID-supported National Health Account (NHA) methodology.

- In more than 17 countries, USAID facilitated both the production and use of health resource tracking data, including National Health Accounts, to plan strategically for future needs, prioritize essential health services, develop health workforce management capacity, strengthen health information systems and ensure the availability of quality-assured medicines.

- Health workforces are better planned, trained, managed and supported due to access to accurate data provided by USAID-developed human resource information systems (HRIS). Currently, iHRIS software supports 475,000 health workers in 12 countries.

The USAID Story

While health systems strengthening only became a well-defined, cross-cutting health priority for USAID in the decade of the 2000s, USAID's 50 years of leadership in striving to build systems that would ensure and sustain health gains is well established. Many of the first USAID-supported activities to address specific parts of the health system have already been discussed, including the interactive RAPID technologies that led to health policy reform; the DHS that provided quality data to inform decision-making; assistance for drug and commodity procurement and logistics management to ensure a reliable source and distribution of essential health commodities; training and capacity building in health planning, finance and management; and support for health sector reform, including integration and decentralization.

One of USAID's first attempts to establish that good health delivery systems could deliver low-cost services to large populations began in the 1970s in response to the "health for all" mandate. The Development and Evaluation of Integrated Delivery Systems for Health, Family Planning and Nutrition Project (65) in Thailand demonstrated that integration of services was feasible and provided valuable information, later integrated into USAID's health systems strengthening work, on the role of community participation in strengthening a health system (130). Recognizing the importance of building developing countries' ability to systematically track the magnitude and flow of their health spending, USAID played a key role in advancing the NHAs through development of a NHA Producer's Guide in close collaboration with WHO and the WB; its advancement in tracking spending in priority areas (e.g., child health, reproductive health, malaria, HIV and AIDS); and supporting locally-led NHA for the first time among 32 countries (62 rounds of NHAs) since 1997.

A health worker from USAID-supported Marie Stopes International provides outreach to remote areas in Zimbabwe to ensure access to contraception.

- Dana Allen

Reforming Soviet-Style Health Systems

In 1993, USAID pioneered efforts in several countries to reform the traditional Soviet-style health system model into a modern integrated primary health care/family medicine model based on health systems strengthening principles and techniques. Early challenges in Russia and Ukraine helped inform more successful endeavors in Albania, Armenia and Kyrgyzstan. For example, USAID provided technical assistance in close partnership with the Governments of Kazakhstan, Kyrgyzstan and Uzbekistan to comprehensively reform and restructure the health service delivery and financing systems at both national and local levels. The conceptual foundations for the reforms were clearly articulated in a program report (34), and successes in the initial 10 pilot sites led to an expansion of the activity (Zdrav Reform Project [355], [200]). A 2011 comprehensive assessment of USAID's years of pursuing the integrated primary health care/family medicine approach in this region documented the experience; assessed the strengths, weaknesses, opportunities and threats; and provided recommendations regarding future IPHC/FM programming (80). This assessment was complemented by Empowering Health Care Consumers in Europe and Eurasia (78), an innovative examination of the region's experience with motivating health care consumers to take more responsibility for their health, with recommendations for how USAID and other donors could increase the effectiveness of their assistance in this area.

In response to development trends of the 1980s that focused on structural adjustment, health sector reform and sustainable development, USAID engaged in several cutting-edge activities aimed at ensuring that an appropriate level of resources was allocated to health, the benefits of publically-delivered health services were equitably distributed, and resources were used as efficiently as possible. Building on the findings from investigations and country studies that it funded (see illustrative list below), USAID helped strengthen the financial base of health systems around the world.

- Cost Recovery by Government Hospitals in LDCs: A Key Element in Strategy to Increase the Commitment of Resources to Primary Health Care (294)
- Health Zones Financing Study in Zaire (31)
- Pricing for Cost Recovery in Primary Health Care in Guinea (164)
- Economic Analysis of Segments of the Public Health Sector of El Salvador (90)
- Burundi: A Study on the Financing of the Health Sector (271)

The lessons learned from these interventions led to one of USAID's major contributions to strengthening health care finance: the development of National Health Accounts, a tool that is now widely used by national governments to inform policy-making and resource allocations (see box).

In the early 1990s, as health sector reform gained importance in global public health, USAID's Global Health program engaged in several cross-cutting health systems projects. The Partnerships for Health Reform Project focused initially on implementation of improvements in health policy, management, financing and health service delivery, but its focus later expanded to include developing and strengthening health information and infectious disease systems, HIV and AIDS and community participation. Significant efforts in countries as diverse as Egypt, Malawi, Jordan, Zambia (107) and Ghana led to improved access to health services (265).

The countries in Latin America and the Caribbean, in particular, embraced health sector reform. By the mid-1990s, virtually all of them had initiated or were considering health sector reform. USAID supported decentralization and other health reform efforts in several countries in this region through the Latin America and Caribbean Regional Health Sector Reform Initiative (14) and also collaborated with the Pan-American Health Alliance to develop methodological guidelines for monitoring and analyzing reforms (267).

In the former Soviet Union, USAID championed the reform of the traditional Soviet-style health system into a modern, integrated primary health care/family medicine approach while helping to fill gaps left by the demise of the Soviet system.

In the 1990s, USAID led in applying quality improvement approaches to health and family planning programs in developing countries. Through its support for operations research, USAID raised international awareness and demonstrated the importance of quality improvement in strengthening health systems. USAID provided technical assistance at the national, regional/district and facility levels to introduce and implement clinical guidelines and standards, quality monitoring and assessment methods, continuous quality improvement and training and job aids. These interventions contributed to improved patient satisfaction and reductions in mortality (242).

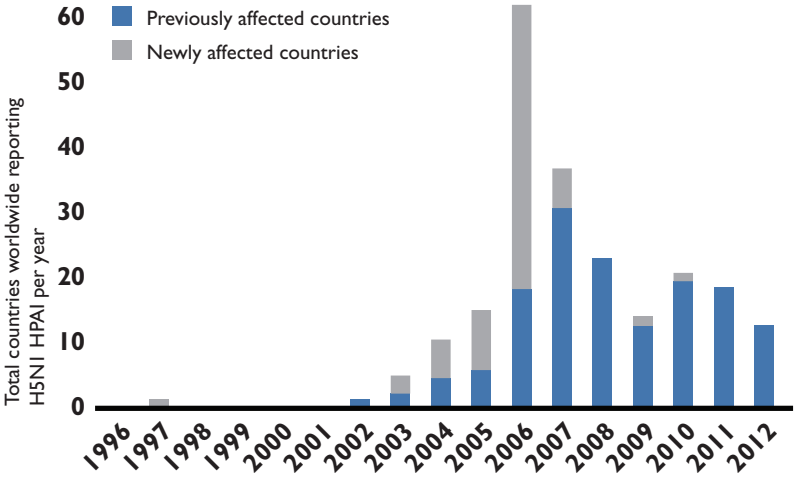
By the early 2000s, there was growing discontent in some quarters of the global development community with "sector reform." Increased focus was placed on health systems. The 2000 World Health Report (322) presented a strong argument for increased investment in health systems, and WHO's six building blocks (82) provided a common definition of health systems strengthening as well as a framework for action. Later, a handbook of indicators and measurement strategies was developed to help demonstrate the impact of health systems strengthening activities (186). USAID actively contributed to the global discussion on health systems and the development of benchmarks – and was a major supporter of WHO's Health System Strengthening Division.

In the 2000s, USAID supported ongoing health systems strengthening investments (DHS, supply chain management and quality assurance) and initiated new activities, such as the Partnerships for Health Reformplus (75), Data for Decision Making Project (92) (62), Health Systems 2020 Project (121) (195), Management and Leadership Program (32) and Capacity Projects (304), to strengthen both specific and broader aspects of health systems. These projects were instrumental in strengthening human resources for health; developing and testing different approaches and tools to increase the use of epidemiologic, economic, demographic and other types of needed data for formulating and implementing public health policies and programs; increasing the availability of information for decisionmakers through new technologies, such as mapping with geographic information systems (208); developing an open source human resource information system (134); and building capacity to plan, manage and govern health facilities and systems. The unifying theme across these interventions was to make information more transparent so that decisionmakers could make better decisions.

Health Workforce Planning

USAID works to ensure that the health workforce is planned, trained, managed and supported. USAID developed a human resource information system (HRIS), using open source software through the iHRIS Suite Software, to obtain accurate data on the health workforce, assess human resource problems, plan effective interventions and evaluate those interventions. The iHRIS software currently supports 475,000 health workers in 12 countries.

Countries Reporting H5N1 Avian Influenza



Source: WHO, OIE report
Each affected country had at least one outbreak or case of poultry, wild birds or humans.

To build on long-standing investments in strengthening health systems and to ensure that future investments were "smart," in 2012, an Office of Health Systems was established within USAID's Bureau for Global Health to act as USAID's center of excellence and focal point for leadership and technical expertise in health systems strengthening. An Agency-wide Health Systems Strengthening Network was also established to connect the USAID health community globally for health systems strengthening matters, technical exchanges and dialogue on health systems strengthening.

Many of USAID's contributions to health systems strengthening are discussed in more detail in the October 2009 Sustaining Health Gains – Building Systems, Health Systems Report to Congress (299). Additional thinking on the subject can be found in Complexity and Lessons Learned from the Health Sector for Country System Strengthening (30). Future challenges for health systems strengthening include universal health coverage, as discussed in the last section of this report.

PANDEMIC INFLUENZA AND OTHER EMERGING THREATS

Key Global Results

- Between 2006 and 2012, the number of countries reporting the presence of H5N1 avian influenza decreased from 53 to 11, and the global number of both poultry outbreaks and human cases caused by H5N1 avian influenza decreased by more than 70 percent.
- Since 2009, routine surveillance for microbes with pandemic potential has been initiated in wildlife (20 countries), human populations (10 countries) and domestic animals (3 countries).
- Since 2009, more than 200 novel microbes have been identified and are being assessed for pandemic potential.

USAID Contributions to Pandemic Influenza and Other Emerging Threats Global Results

- During 2010–2013, USAID, in collaboration with CDC and WHO and other international partners, provided technical, operational, or commodity support to Bangladesh, Bolivia, Cameroon, China, Democratic Republic of the Congo, Gabon, Republic of the Congo, Saudi Arabia and Uganda for the investigation of and response to 18 infectious disease outbreaks in animals and people.
- USAID-supported capacities, platforms and partnerships had been rapidly adapted for use in responding to the H1N1 influenza pandemic in 2009 and the emergence of the Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and H7N9 avian influenza in 2012 and 2013, respectively.

The USAID Story

Since 2005, USAID has actively responded to the dangers posed by emerging pandemic threats. The dual goal of USAID's Pandemic Influenza and Other Emerging Threats program is to (1) minimize the global impact of existing pandemic influenza threats such as H5N1 avian influenza and (2) preempt the emergence and spread of future pandemic threats.

USAID's work in this area began in 2005 as H5N1 avian influenza began rapidly spreading from Southeast Asia to other regions. USAID strengthened the capacities of more than 50 countries to monitor the spread of H5N1 avian influenza among wild bird populations, domestic poultry and humans; mount a rapid and effective containment of the virus when it is found; and prepare to mount a comprehensive response in the event a pandemic-capable virus emerges.

USAID's efforts contributed to dramatic downturns in reported poultry outbreaks and human infections and to a dramatic reduction in the number of countries affected. At the peak of its spread in 2006, avian influenza had been reported in 53 countries across three continents. By 2012, only 11 countries were affected. Five of these countries (Indonesia, Vietnam, China, Bangladesh and Egypt) continue as the primary reservoir of

the virus, accounting for more than 95 percent of all reported outbreaks involving either poultry or humans.

In 2008, USAID broadened its avian influenza program to focus on detecting and responding to other emerging diseases of animal origin that posed significant public health threats. This change reflected USAID's assessment of several factors: the majority of new diseases in humans (including HIV and AIDS and H5N1 avian influenza) since 1940 have originated in animals; the rate of disease emergence from animals has been increasing; and this trend will undoubtedly continue, given increasing animal-human interactions due to land use changes and increases in animal production – both of which are a direct consequence of growing human populations.

In 2009, USAID responded to the H1N1pandemic, deploying more than 40 million doses of the H1N1 vaccine and related ancillary materials (syringes, needles, etc.) to more than 60 countries. USAID also supported a global laboratory network to monitor impact of the H1N1 virus as it spread around the world, with a special focus on upgrading the surveillance and laboratory capacities of 26 countries in West and Central Africa and Central and South America, where such capacities were previously nonexistent. Finally, USAID heightened community-level readiness to mitigate the effects of the virus through nonpharmaceutical interventions in 28 countries in Africa and Asia, using a coalition of the International Federation of Red Cross Societies, UN partners, military authorities, the private sector and NGOs.

USAID's ability to quickly and effectively mobilize its technical, programmatic and financial resources in support of the H1N1 pandemic response demonstrated the value of having capacities in place that can be adapted for new threats.

In 2009, USAID launched the Emerging Pandemic Threats program, a suite of capacity building investments designed to give earlier insight into the emergence of new public health threats and enhance country-level capacities to mitigate their potential impact. In collaboration with the CDC, Department of Defense, WHO and the Food and Agriculture Organization, USAID expanded surveillance to monitor wildlife and domestic animals for potential pandemic threats; enhanced preservice training for public health, animal health and related programs; strengthened in-service field epidemiological training; strengthened laboratory capability to address common infectious disease threats in animals and people; broadened ongoing efforts to prevent transmission of H5N1 avian influenza and other pandemic threats; and strengthened national capacities to prepare for the emergence and spread of a pandemic.

The Emerging Pandemic Threats portfolio drew heavily on experiences and lessons acquired in addressing threats posed by H5N1 avian influenza. Its strategic approach builds on the understanding that the future well-being of humans, animals and the environment are inextricably linked. Promoting the principle of "One Health," this approach spans animal and public health as well as environmental and conservation communities. It targets the promotion of policies and the strengthening of skills and capacities critical for both minimizing the risk of new disease emergence and sharpening the ability to limit the social, economic and public health impact of new diseases, and it uses a "risk"-based approach to target investments where the likelihood of disease emergence is greatest. At the country level, USAID partners work with governments and other key partners to strengthen country-level capacities for routine infectious disease detection and outbreak response. These efforts significantly refined understanding of the "drivers" that underlie disease emergence and established important new partnerships and platforms

Public-Private Partnerships Accelerate Disease Control

Since 2006, four companies – GlaxoSmithKline, Johnson & Johnson, Merck and Pfizer – have donated more than $4.2 billion worth of drugs to 19 countries supported by USAID's NTD Program. A new 2012 commitment from Merck will allow USAID to begin scaling back the purchase of praziquantel, a drug used to treat schistosomiasis, and therefore commit larger portions of USAID funding to country-level interventions.

In early 2012, USAID joined the London Declaration on NTDs, a historic partner-driven effort to accelerate progress toward eliminating and controlling NTDs. Leaders from the Governments of the United States, United Kingdom and United Arab Emirates, 13 pharmaceutical companies, the Bill & Melinda Gates Foundation, the World Bank and other global health organizations announced their support for eliminating certain NTDs by 2020. USAID is leveraging funding from the United Kingdom and coordinating country-level commitments to expand programs into the Democratic Republic of the Congo, Ethiopia and Nigeria.

for timely and effective detection, control and prevention of future threats.

The success of USAID's Pandemic Influenza and Other Emerging Threats program was validated by the rapid response to H7N9 avian influenza in China following its emergence in 2013. China was able to contain the H7N9 virus within a few months, preventing its spread throughout the country and to neighboring nations by using capacities, platforms and partnerships that USAID had helped develop for H5N1 avian influenza. In contrast, the general lack of these capacities, platforms and partnerships in the Middle East has slowed efforts to contain MERS-CoV since it emerged in 2012.

NEGLECTED TROPICAL DISEASES

Key Global Results

- More than 727 million people received treatment for at least one neglected tropical disease (NTD) in 2011.
- More than 40 countries have developed integrated plans for NTDs.
- Drug donations continue to expand, with companies donating an average of 1.4 billion treatments each year to those at risk.
- WHO released the first-ever NTD Roadmap for Implementation, setting targets through 2020 for the global control, elimination and eradication of 10 NTDs.

USAID Contributions to Neglected Tropical Disease Global Results

- Since FY 2006, the NTD program has reduced the risk of disease in more than 364 million people through the delivery of more than 820 million NTD treatments.
- In FY 2012, USAID supported the delivery of 231 million treatments and leveraged more than $1 billion in drug donations. To date, approximately $4.2 billion in drugs have been donated to USAID-supported national NTD programs.

Community drug distributors use color-coded sticks to determine proper treatment dosages. A person whose height falls within the yellow area would, for example, need three doses.

- RTI International

Unilever and Others: Global Partnership for Handwashing with Soap

Partners

- Public sector – World Bank (Water and Sanitation Program), United Nations Children's Fund (UNICEF) and USAID.
- Private sector – Unilever, Procter & Gamble and Colgate-Palmolive.
- Non-governmental organizations – Academy for Educational Development (AED) (now FHI 360).
- Academia – London School of Hygiene and Tropical Medicine (LSHTM).

Challenge

Diarrheal disease and respiratory infections contribute to the high incidence of early death among children in less-developed countries; incidence of these diseases can be significantly reduced with proper handwashing with soap.

Response

In 2001, Unilever, Proctor & Gamble and Colgate-Palmolive joined a public-private partnership to lower the incidence of diarrheal disease in the developing world. Based on hygiene studies, the initiative sought to lower the incidence of diarrheal disease by as much as 35 percent through the use of soap and proper handwashing. Unilever provided the partnership with soap products for distribution in Peru, other South American countries and Vietnam.

Partner Contributions

World Bank, UNICEF and USAID offered their knowledge on public health and development, along with financial resources. Technical assistance and research-based findings came from LSHTM and AED. Unilever, Proctor & Gamble and Colgate-Palmolive brought their marketing skills and soap products to the global campaign.

Result

Thousands of young lives were saved from diarrheal disease. The partnership helped strengthen public health systems, an essential development objective in communities. The soap companies expanded their reach into new markets, increased demand for their products, established important ties to key government agencies and NGOs and demonstrated their commitment to socially responsible causes (157).

- In the 24 countries supported by USAID's NTD program, 24 million people are no longer at risk of acquiring blinding trachoma, and 34.4 million people are no longer at risk for lymphatic filariasis.
- Between FY 2006 and FY 2012, USAID provided $301 million in support to NTD control and elimination.

The USAID Story

Since the early 2000s, USAID has provided global leadership and support in demonstrating that national-scale coverage through an integrated approach to NTD control is both feasible and cost-effective. For seven of the most common NTDs, there are safe and effective drug therapies that can be delivered to eligible individuals in an affected community once or twice a year for control and/or treatment. Using its experience with mass immunizations, community-level responses and scale-up of national health programs, USAID provides funding to supplement governments' budgets to distribute these drug therapies safely and effectively, scale up treatment to reach national coverage and work toward control and/or elimination of these diseases.

To address the need for a geographic evidence base for targeting specific areas with the right quantity and type of drugs to eliminate and control NTDs, USAID supports disease mapping around the world. In 2012 alone, USAID supported disease mapping in 223 districts in 7 countries. USAID also builds country-level and global capacity and supports global coordination for NTD reduction, including through the Onchocerciasis Elimination Program of the Americas, which aims to eliminate river blindness in the Western Hemisphere by 2017. As a result of USAID's assistance, many of the countries receiving USAID NTD support have begun to document the control and elimination of NTDs in their populations.

USAID was also instrumental in developing key NTD training and monitoring and evaluation tools, including the Tool for Integrated Planning and Costing (TIPAC) (323). Adopted as the WHO standard, the TIPAC helps users estimate the costs and funding gaps of a nationwide NTD program.

This child is one of the 486 million people who receive fortified food and condiments through GAIN, which receives direct support from USAID.

- USAID

Global Alliance for Improved Nutrition (GAIN)

Food fortification is a proven way for public and private sectors to join in ending nutrition deficiencies for a sustainable solution. USAID has been working to fortify foods for four decades and continues to accelerate and expand food fortification programs as one of the most effective, long-term strategies to reduce micronutrient malnutrition. USAID and CDC are working together to improve monitoring and evaluation systems to ensure public health impact in this area.

Through GAIN, a partnership of governments, international organizations, non-governmental organizations and more than 600 private sector companies, USAID directly supports the fortification of staple foods and condiments with iron, iodine, vitamin A and other micronutrients. When at scale, these programs are expected to reach over 486 million people in 19 countries with fortified foods, such as corn meal, wheat flour and soy sauce.

Fortification is cost-effective. Every $1 spent on vitamin A fortification returns $7 in increased wages and decreased disability. A dollar spent on iodized salt returns $28; iron fortification, $84 (153).

The Rapid Funding Envelope for HIV and AIDS, Tanzania

The Rapid Funding Envelope for HIV and AIDS is an innovative partnership between the Tanzania Commission for AIDS, the Zanzibar AIDS Commission, nine bilateral donors and one private foundation. Established in 2002 to enable local civil society institutions to participate fully in the national multisectoral response to the AIDS epidemic, the Rapid Funding Envelope provides grants to Tanzanian nonprofit civil society organizations, academic institutions and civil society partnerships for essential, short-term projects aligned with the National Policy on HIV and AIDS and the National Multi-Sectoral Strategic Framework. As of October 2009, the Rapid Funding Envelope had made 166 grants totaling approximately US$ 22.1 million. Innovative grant results include:

- Development of HIV education materials in Braille
- Food security provided to people living with AIDS
- Legal advice imparted for wills and inheritance
- New HIV voluntary counseling and testing sites
- Communication to at-risk youth through community theater
- Development of a curriculum to train pharmacists on dispensing ARVs
- Scale-up of a holistic approach to AIDS care
- Evaluation of the impact of HIV and AIDS on elderly Tanzanians

PARTNERSHIPS

Key Global Results

- USAID partnerships have improved the coordination of global health initiatives.
- These partnerships have also achieved effective and efficient use of funding.

The USAID Story

Public-Private Partnerships, Global Development Alliances and Corporate Social Responsibility

Strong partnerships with the private and non-governmental sectors are a unique USAID strength. Believing that some of the best development outcomes occur when the public and private sectors join forces, USAID forges strong partnerships with a wide range of private sector organizations. By leveraging the valuable resources and innovative approaches of these partners, USAID increased the reach and impact of its development initiatives.

While USAID began to work with the private sector as early as the 1960s, the free-market emphasis of the 1980s led USAID to significantly ramp up its collaboration with the private sector for the delivery of health services. USAID's Kenya mission launched the Family Planning in the Private Sector Project in 1983 (173), and USAID's Bolivia mission initiated the Self-Financing Primary Health Care Project that same year (279); and USAID's Jamaica mission designed the Private Sector Promotion of Family Planning Project the following year (178). Meanwhile, USAID's headquarters in Washington, DC, developed and launched the Technical Information on Population for the Private Sector (160) and supported projects under the Enterprise Programs (307) to help host country businesses recognize the benefits to firms of providing reproductive health services to their employees.

In the early 2000s, for-profit corporations' shift toward corporate social responsibility coincided with USAID's focus on shared responsibility and reaching new partners. Several new public-private partnerships and

An outreach worker, supported by USAID, provides home care services to an HIV-positive patient in Nepal.

- USAID

global development alliances were formed over the next few years to address specific development objectives. These partnerships were seen as a win-win for both parties: Business partners valued USAID's matching funds, local knowledge, development expertise, networks and the credibility available through these alliances, while USAID appreciated the resources and long-term sustainability that businesses, foundations, NGOs, universities and other private sector partners brought to development programming. A sampling of the alliances includes:

- In Indonesia, USAID partnered with an Indonesian company, PT Tanshia Consumer Products, to develop, produce and distribute a new, low-cost chlorine water treatment product.

- In Zambia, agriculture and mining companies partnered with USAID to bring HIV and AIDS prevention and treatment programs into the workplace, scale up HIV and AIDS services for their employees' families and extend those services to the communities where these businesses operate.

- In Nicaragua and Honduras, USAID partnered with Green Mountain Coffee Roasters to integrate maternal and child health activities into agriculture and food security initiatives already included in their social investment strategy.

- In Uganda, USAID and its NGO partner, Text to Change, worked with companies to disseminate health information through an interactive short message service program.

- In Colombia and Ecuador, USAID partnered with Kimberly-Clark to strengthen maternal and child health messages that were disseminated to pregnant women and new mothers through the company's Huggies® regional, direct-to-consumer outreach program.

- Globally, USAID collaborates with Pfizer's Global Health Fellows program to deploy company employees, free of charge for up to 6 months, to nonprofit organizations working on HIV and AIDS.

Collaborating with the Global Fund to Fight AIDS, Tuberculosis and Malaria –

Examples from South, Southeast and Central Asia

In countries such as China, Thailand and those of the Central Asian Republics, the Global Fund is the largest HIV donor. Under PEPFAR, USAID programs have been particularly effective at coordinating closely and leveraging the Global Fund's large resources.

For example, in the Central Asian Republics, USAID-PEPFAR follows a two-pronged approach with the Global Fund. First, it provides expertise to help Global Fund-financed programs function more effectively. Second, it assists recipient countries to become and remain eligible to receive Global Fund grants. Through this strategy, both U.S. Government and Global Fund resources reach more people in need.

USAID-PEPFAR programs in Thailand and India, with technical assistance-based models of programming, follow similar approaches. They provide technical assistance to the national governments to ensure quality implementation of Global Fund HIV grants at the provincial and local levels. Again, this approach improves efficiency, quality and reach of resources, allowing more people to receive lifesaving support.

- Globally, USAID partnered with Johnson & Johnson, the United Nations Foundation, mHealth Alliance and BabyCenter to form the Mobile Alliance for Maternal Action (MAMA) (168). MAMA delivers health messages on family planning, antenatal care, birth preparedness, nutrition, immunization, hygiene and infection prevention and the treatment of diarrhea and pneumonia in infants via mobile phones to expectant and new mothers.

- Through the American International Health Alliance, USAID supported more than 125 health partnerships in 25 countries in Europe and Eurasia that covered a broad range of health issues.

- Through Saving Mothers, Giving Life, USAID unites leaders in the global health field from the public, private and NGO sectors to help save women's lives, particularly during pregnancy and childbirth.

To complement its collaboration with private sector companies, USAID also actively supported the establishment of business councils to promote antidiscrimination workplace policies and services. For example, in Mexico, USAID promoted the establishment of a national business council by 24 major U.S. corporations in Mexico to reduce the stigma of HIV and AIDS.

Additional information on USAID's global health partnerships can be found in Building Alliances Series: Health (38), Evaluating Global Development Alliances (148), Doing Good Business: HIV/AIDS Public-Private Partnerships (71) and at 4th Sector Health (100).

Implementing Partners

USAID works in close partnership with an impressive pool of implementing partners. For decades, USAID played a strong role in building the global health capacity of a wide array of U.S.-based and international for-profit, research, academic and non-governmental and faith-based organizations. USAID and the world are now reaping the benefits of that investment. These organizations play a critical role as key implementing partners, directly implementing the majority of USAID-supported global health programs.

Since the 2000s and the increased focus on country ownership and sustainability, USAID has intensified its efforts to build the technical, financial, organizational and advocacy capacity of indigenous organizations so that they can directly receive U.S. Government funding, better compete for other sources of funding and advocate to governments on health issues.

Civilian-Military Cooperation in Cambodia

In Cambodia, the U.S. Government formed an interagency Civil Military Working Group, chaired by the Department of State, with representation from USAID, the Department of Defense, CDC, Peace Corps, the Public Affairs Office and the Regional Security Office, to ensure interagency coordination for military and military-related training, exercises and aid.

Under the auspices of this group, USAID collaborates closely with the Department of Defense to implement several activities. For example, USAID mobilizes non-governmental organization partners to assist Department of Defense teams to provide health education and manage patient flow during Medical Civic Action Projects. USAID also coordinates site selection, meets with Provincial Health Department leaders and local authorities and provides on-the-ground assistance for the Department of Defense's Humanitarian Assistance activities, such as constructing clinics and schools. USAID was critical in the success of the Department of Defense's 2012 Pacific Partnership for Cambodia, mobilizing civil society and civilian partners. This 3-week, $3.3 million multilateral military medical and humanitarian assistance mission built three health centers, provided primary care services to almost 13,000 patients and performed 218 surgeries.

Faith-Based Partners

Faith-based partners (FBO) have played a key role in the USAID program. Starting in the 1980s with the Child Survival Grants Program, the outreach to HIV-affected populations, family planning service delivery and strenthening countries' malaria programs, FBOs have played a key role in delivering results. They often reach communities that are not reached through the public sector and provide quality care that sets the standards for others. FBOs have been critical in helping change behavior and setting new community norms for health. More recently, FBOs have been an active member of a Promised Renewed, committing to 10 key child survival behaviors to focus their work on.

Key International Public Health Organizations

Complementing its work with the private and non-government sectors, USAID's strong partnerships with key international public health organizations were instrumental in advancing global health goals. These partnerships fostered synergistic strategies, promoted global health standards and leveraged financial and technical resources.

At the global level, joint agendas such as the Millennium Development Goals and the Paris Declaration on AID Effectiveness fostered global commitments and standards of practice. USAID's coordination with organizations such as WHO, Global Alliance for Vaccines and Immunizations, the World Bank, UNICEF, the United Nations Population Fund, UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria galvanized action and resources to meet these global commitments and address major global health concerns.

An important offshoot of these alliances was the emergence of key foundation partners, like the Bill & Melinda Gates Foundation and the William J. Clinton Foundation, and private philanthropists, non-governmental and faith-based organizations and new transnational diasporas at the global level. USAID uses its technical leadership to facilitate coordination and advocacy to improve health and development globally.

The global coordination is reflected at the regional and country levels. USAID works with partners to set joint agendas and programs of action on issues such as policy reform and combating specific diseases (e.g., the Amazon Malaria Initiative and the Mekong Malaria Initiative). A key aspect of country-level coordination is leveraging resources to increase reach and impact and ensure more effective and efficient use of resources.

Interagency collaboration

USAID's commitment to the whole-of-government approach as a means of ensuring that financial and human resources are used as effectively as possible began in the 1960s, with its close and collaborative relationship with the U.S. Public Health Service (now the Department of Health and Human Services). In particular, USAID collaborated closely with the CDC, one of several agencies operating under the Department of Health and Human Services. Over the decades, USAID frequently contracted CDC for its technical expertise, and the two agencies often collaborated on health-related research, evaluations of infectious disease problems and epidemiological work.

In the 1990s, in collaboration with the CDC, USAID began funding the Field Epidemiology and Laboratory Training Program for malaria and tuberculosis. This collaborative relationship continues today. USAID funds the adaptation of the program to country needs as well as the participation of local epidemiologists in the program, while the CDC conducts the actual training. In 2011, USAID and the CDC signed a new agreement to accelerate efforts to control and eliminate neglected tropical diseases. (141).

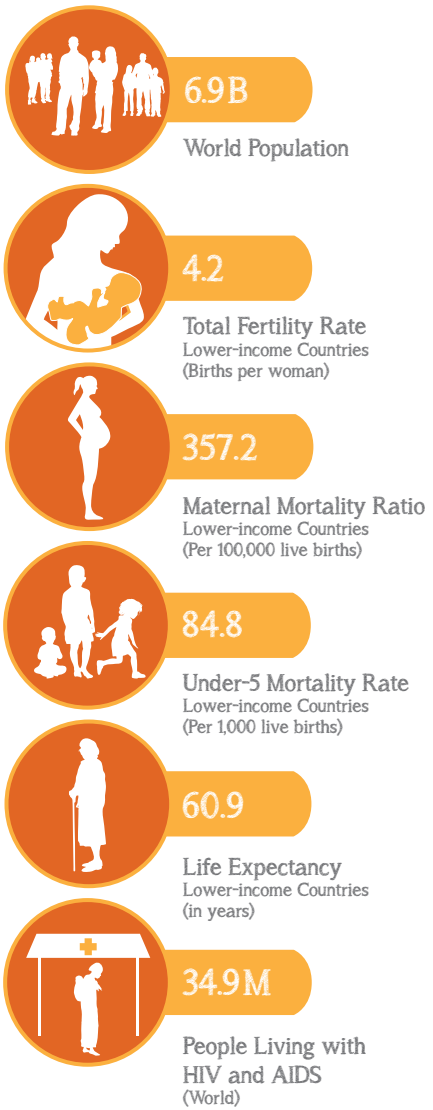
In the 2000s, under the various Presidential Initiatives, the collaborative process became more formalized and expanded to include additional U.S. Government entities (PEPFAR includes seven main U.S. Government implementing agencies; PMI is overseen by an advisory group made up of representatives of eight U.S. Government entities; and GHI is led by three core U.S. Government agencies). The collaborative interagency relationships, from headquarters to field, are guided by common principles, overarching guidance, joint strategic planning and standardized methods of reporting on results.

“Looking at these issues as a businessman, I believe that investing in the world’s poorest people is the smartest way that our government spends money.”

Bill Gates,

Chairman, Microsoft Corporation and Co-Chair and Trustee of the Bill & Melinda Gates Foundation

USAID Forward



Note: See Annex for data sources, definitions and methods.
Maternal Mortality Ratio: Data are only available for 2010.
Under-5 Mortality Rate, Life Expectancy and Total Fertility Rate: Data are for 2010–2012.

In the 2010s, the continuing global recession led to fiscal austerity, and the international development community began to accelerate the shift and increase emphasis on country ownership and aligned donor investments with host country priorities. This concept was reflected in the idea of "shared responsibility" or working together inclusively, with each partner owning its part and sharing in the responsibility of reaching a goal (212). Interest in cost-efficiency and cost-effectiveness also increased. In the health sector, HIV and AIDS, malaria and tuberculosis continued as the dominant global priorities, and there was increased recognition of the role of non-communicable disease in public health.

For the U.S. Agency for International Development (USAID), the May 2010 National Security Strategy, the September 2010 Presidential Policy Directive on Global Development (233) and the December 2010 Quadrennial Diplomacy and Development Review led to the development of a new USAID Policy Framework 2011–2015 (349). The Policy Framework operationalized the Presidential Policy Directive and Quadrennial Diplomacy and Development Review and described an agenda for the institutional reform of USAID, known as USAID Forward (330), which placed increased emphasis on transforming development through science and technology, strengthening monitoring and evaluation, working closely with local partners and rebuilding or reforming several USAID internal practices (procurement, human resources, policy and planning, and budget management). The Agency's ability to aggressively implement some of the reforms was constrained by flat budgets and delayed budget approvals.

USAID's Bureau for Global Health applied the Agency's new policies, directives and initiatives specifically to global health and issued USAID's Global Health Strategic Framework, FY 2012–FY 2016 (332) that articulated USAID's five technical and one cross-cutting core global health priorities and strategic approaches. To help achieve these goals, a new Office of Health Systems was established within USAID's Bureau for Global Health, elevating health systems strengthening to the same level as the eight technical elements. In response to the Global Health Initiative (GHI), efforts to promote cost-effectiveness and renewed interest in integrating health services, the Bureau for Global Health developed a process for assessing when integration made sense. Known as Best Practices at Scale in the Home, Community and Facilities (BEST), the process was applied to develop BEST action plans in 28 countries.

2010s Timeline

In late 2012, the Office of Global Health Diplomacy was established in the Department of State to guide diplomatic efforts to leverage diplomacy in support of GHI's principles and goals.

Key USAID Global Health Contributions

EVALUATIONS

Key Global Results

- Countries are successfully using data and strategic information for policy-making, planning and resource allocation.

The USAID Story

In January 2011, USAID released a new Evaluation Policy (81) that reaffirmed its commitment to quality program evaluation. Since its inception, USAID has used evaluation findings to inform decisions, improve program effectiveness, be accountable to stakeholders and support organizational and global learning. The new policy, recognizing that evaluations are fundamental to success, builds on USAID's rich tradition of evaluations and updates standards and practices to address contemporary needs.

To complement its evaluations, USAID engages in the routine collection of strategic information, collected according to monitoring and evaluation plans tailored to capture the progress and performance of each project/program that is reported annually to Congress.

TECHNOLOGY AND INNOVATIONS

Key Global Results

- New technologies are being adapted for use in low-resource settings to improve the effectiveness and efficiency of health development efforts.

USAID Contributions to Technology and Innovations Global Results

- USAID is introducing and scaling up GeneXpert, a new diagnostic technology that facilitates diagnosis of drug-resistant tuberculosis (TB) and TB associated with HIV infection. USAID supported the rollout and implementation of GeneXpert in 14 countries through procurement of over 80 machines and associated test kits.
- USAID is supporting the completion of studies required for U.S. Food and Drug Administration approval of the 1-year contraceptive vaginal ring.
- USAID is assisting the rollout of chlorhexidine, a new intervention proven to reduce neonatal infection and mortality when applied to the umbilical cord within hours of birth.

The USAID Story

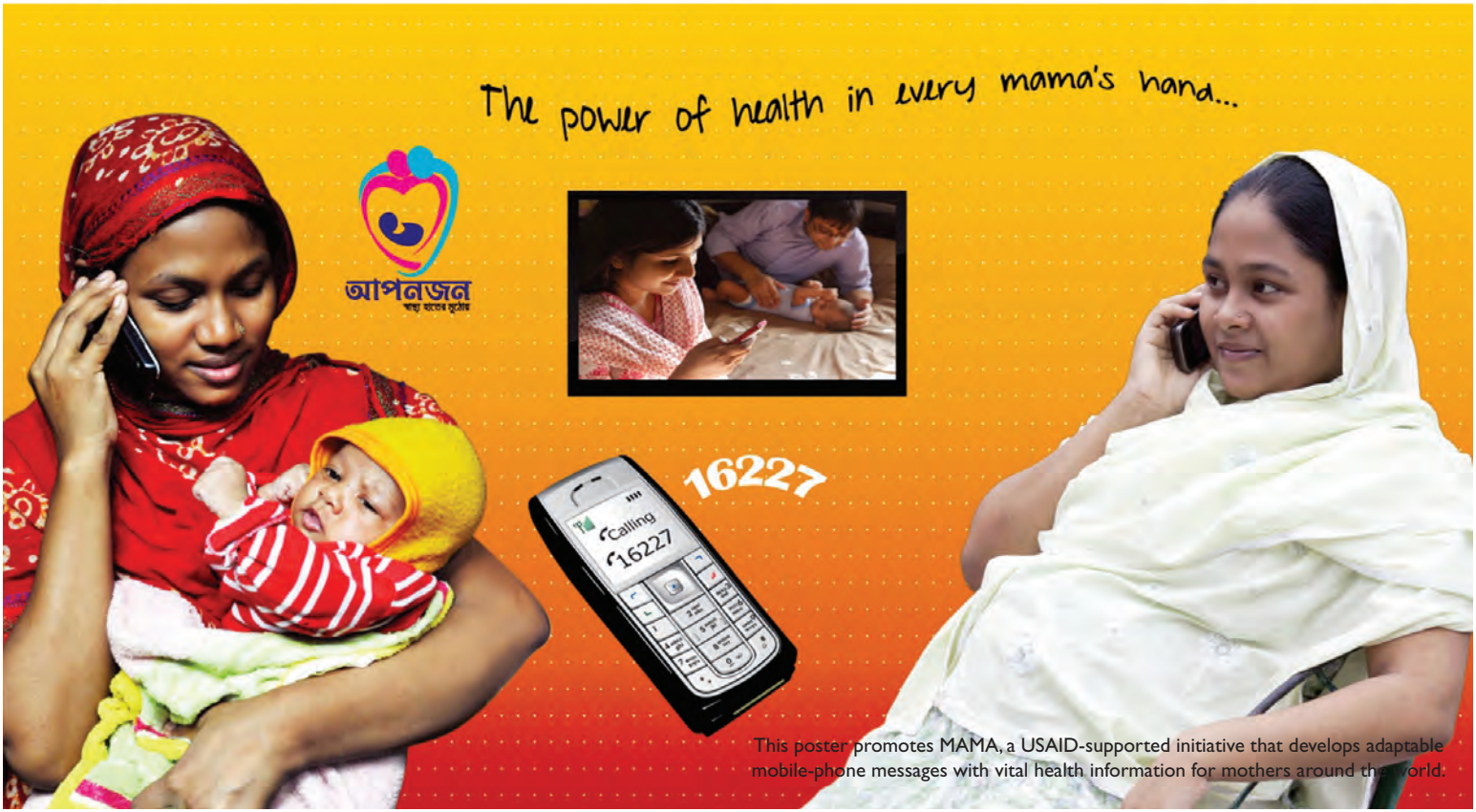
USAID is widely recognized for its ability to apply science, technology and cost-effective innovation to produce powerful public health outcomes. The RAPID project, discussed in the 1970s section of this

eHealth/mHealth

From 2006 to 2011, the number of mobile cellular subscriptions in the developing world increased from 1.62 billion to 4.52 billion. The growth in Africa was even more dramatic, more than tripling during that time period from 129 million to 433 million (International Telecommunications Union). This exponential growth has made the once-unthinkable now inevitable: instantaneous and inexpensive human-to-human interaction and electronic data transfer, available anywhere in the world at any time.

Through its support for eHealth (information and communications technology in support of health care systems) and mHealth (mobile aspects of eHealth, particularly mobile phones), USAID leverages the power of the mobile revolution to improve the lives of women and their families and strengthen health systems. eHealth/mHealth has the potential to significantly improve health care by increasing the demand for quality health services; strengthening the capacity and efficiency of health care providers; creating opportunities for remote patient monitoring and care; collecting data; and enabling health care managers to make better-informed, more timely decisions.

By deploying integrated eHealth/mHealth programs at scale, patients will be directly and individually empowered to improve their knowledge, change their behavior and contribute to improving the health of their families and communities. And through multidonor efforts like the Health Informatics Public-Private Partnership and the Mobile Alliance for Maternal Action, USAID is striving to achieve health impact while simultaneously supporting a core set of global best practices, calling for improved coordination, country ownership, openness, shared tools and evaluation.



This poster promotes MAMA, a USAID-supported initiative that develops adaptable mobile-phone messages with vital health information for mothers around the world.

document, is an early example of USAID using emerging computer technologies to inform population policy and funding decisions. Since then, USAID has promoted simplified drug treatments, new vaccines, oral rehydration therapy, long-lasting insecticide-treated mosquito nets, micronutrient supplementation, voluntary medical male circumcision and many other technological advances to significantly improve health outcomes for millions of people.

As promising health advances continue to emerge, USAID is moving the field of implementation science forward by engaging in an intricate process of systematically evaluating these advances for safety, impact, cost-effectiveness, cultural acceptability, responsiveness to and recognition of gender norms, inequities and human rights before determining whether and how to scale them up. At the same time, USAID is driving new technologies and promising practices, supporting research and engaging in field work that results in improved knowledge and innovative practices.

The expansion of information and communications technology, and mobile phones in particular, has the potential to significantly influence the delivery of health services by increasing expectations and demand for quality health services; providing opportunities for greater efficiency, transparency and accountability; helping ease the global lack of human resources for health by shifting a range of tasks to lower-level providers and training and mentoring them via phones; and creating new options for remote service delivery. Already, new technologies are being used to help community health workers access more highly trained health workers for advice on how to deal with health issues they confront. Similarly, new technologies are being used in distance learning programs. USAID is exploring how to best embrace eHealth to further its mission as well as how to most effectively partner with the private sector entities that drive this technology.

A Romanian mother nurses her infant. USAID supported Romania's family planning efforts for over 15 years, then graduated the country from such assistance in 2006. Now, community organizations in Romania's 11 largest cities coordinate, implement and provide family planning services within their regions.
- World Bank

In 2012, USAID established the Center for Accelerating Innovation and Impact in the Bureau for Global Health to fast-track the development, introduction and scale-up of priority global health interventions. This center will promote and reinforce innovative, business-minded approaches and solutions for important health challenges, convening industry experts and academic thought leaders to inform thinking. To apply these forward-looking practices to USAID's health investments, the Bureau for Global Health invests seed capital in the most promising ideas and cuts the time it takes to transform "discoveries in the lab" to "impact on the ground" (139).

In 2011, USAID, the Government of Norway, the Bill & Melinda Gates Foundation, Grand Challenges Canada and the U.K. Department for International Development joined together to launch Saving Lives at Birth: A Grand Challenge for Development (275). The program provides seed money and transition funding for innovative ideas that can leapfrog conventional approaches in three areas: (1) technology, (2) service delivery and (3) "demand side" innovation that empowers pregnant women and their families to practice healthy behaviors and to be aware of and access health care during pregnancy, childbirth and the early postnatal period, especially the first 2 days after birth.

PROGRAM GRADUATION AND SUSTAINABILITY

Key Global Results

- Countries that were previously recipients of donor funding have emerged as new donor nations.

USAID Contributions to Program Graduation and Sustainability Global Results

- USAID graduated and phased out of 34 health sector programs, including 24 family planning programs.

The USAID Story

In the 2010s, USAID is at the forefront of successfully "graduating" mature health programs from donor assistance, with an eye to sustainability. From early years, individual health project designs were required

to address issues of sustainability. Evaluations and studies such as A Synthesis Study of the Factors of Sustainability in A.I.D. Health Projects (161) provided information on what made projects sustainable. However, little was written on how to successfully graduate or phase out complex health sector elements, sector programs or entire country programs. There was also little recognition of the difference between graduation, which takes place once certain thresholds of development or intended results have been achieved, and phase out, which refers to a withdrawal of USAID involvement without plans to turn over the activities to another institution to continue implementation.

The first transition of health programs took place in the 1970s and included the family planning program in South Korea. Family planning and/or other health programs transitioned in several other countries in the 1990s (Tunisia, Thailand, Botswana, Costa Rica, Colombia and Mexico) and the early 2000s (Brazil, Ecuador, Turkey and Morocco). Some of these transitions were graduations; others were phase outs.

Recognizing the need to proactively manage the transition process, in 2004, the Office of Population and Reproductive Health created a working group to analyze the experience of recently graduated countries (60) (50) (280). This group was tasked with developing criteria and a technical approach for graduation and updating the list of countries scheduled for graduation. The working group's Technical Note of August 16, 2006, (unpublished), defined threshold criteria for graduation as well as steps for countries approaching the threshold levels.

Graduation from family planning assistance is currently predicated on an assessment of self-sufficiency and sustainability that is initiated when a country reaches a threshold of modern contraceptive use of 50 percent and a total fertility rate of three children per woman. Based on these criteria, USAID's family planning program developed a graduation and phase-out plan that is currently being implemented, primarily in the Latin America and the Caribbean region (29).

Other USAID health element programs undertook similar strategic reviews to narrow their focus and identify priority countries. They are now in the process of carrying out graduation and phase out plans.

In 2012, USAID's Bureau for Global Health began documenting lessons learned from the graduation and phase out of health programs in Graduation and Phase-out in the Health Sector: What Have We Learned? This document will be used to facilitate the incorporation of best practices and lessons learned into health program graduations. A companion document, Five Steps Towards Implementing a Deliberate Health Sector Element Phase-Out, identifies key steps in developing and implementing a 1−3 year phase out strategy.

A community health worker in Peru, uses a flipchart to teach a mother of a child under 2 about best practices in maternal, neonatal and infant health and nutrition. The flipchart is one of seven that were created with USAID support to help community health workers with their monitoring and reporting.

- L.Cabello. (Future Generations Peru future.org)

IX. Lessons Learned

Research and interviews conducted during the development of this document revealed consensus on the key factors contributing to U.S. Agency for International Development's (USAID's) successes:

- *Field presence:* As discussed in the introduction to this document, USAID's field presence, with its highly talented U.S. and foreign service national employee staff, is widely considered to be one of the most critical factors in USAID's remarkable story of success. Living in partner countries and working side-by-side with program beneficiaries allow USAID's dedicated American employees to build the partnerships and knowledge base required to respond appropriately to country needs. Employing some of the most capable and knowledgeable local experts grounds USAID's interventions while also building country ownership and sustainability.

- *Sustained commitment with adequate resources:* USAID was established with long-term development objectives in mind. Attainment of these objectives requires long-term relationships and a continued commitment with adequate resources. USAID has been fortunate to enjoy continued bipartisan support for foreign assistance, especially for global health programming, which has allowed it to engage in this type of long-term commitment and planning. As a result, USAID is viewed by most partner governments, non-governmental organizations (NGOs) and private sector entities as a trusted development partner.

- *Strategic, data-driven approach within a broader development framework:* The value USAID places on long-term planning, including sector studies, gender analyses, logical frames and results frameworks, coupled with the use of evaluations, surveillance results and strategic information, allow USAID to design and implement responsive global health programs tailored to a country's needs. Continuous monitoring and evaluation allows up-to-date data to inform decisions and the way forward. Because global health is positioned within a broader development mandate in most countries, health programs benefit from, and contribute to, other USAID-supported interventions in education, economic growth, environment and democracy and governance.

Employing some of the most capable and knowledgeable local experts grounds USAID's interventions while also building country ownership and sustainability.

- *Focus on results:* USAID's global health program concentrates on improving health outcomes, and the Agency has refined several approaches to ensure that all projects have impact.

  - Focus on implementation and implementation science: USAID's experience in examining what it takes to get new health practices adopted within the context of diverse populations, cultures, political systems and limited resources is critical to its success in adapting new technologies and implementation approaches. By adapting those low-cost tools that have been proven to have the greatest impact and then scaling them up within a country context, USAID has been able to ensure the effectiveness and efficiency of its funding.

  - Community-level focus: By focusing on bringing interventions as close as possible to the people who need them, USAID has ensured that its efforts improve the lives of the most vulnerable.

  - Increase access to services: To ensure that people have access to services, USAID works with ministries of health to strengthen systems and to decentralize services, NGOs and faith-based organizations for advocacy and to reach those populations not reached by government and the private sector to improve quality and reach. This inclusive approach to partnering has expanded the scope and impact of USAID programming and has helped maximize the effective use of funding.

  - Geographic focus: USAID's recent focus on a limited number of key countries is credited with increases in efficiency, cost-effectiveness and success. For example, by focusing maternal mortality programs on the 24 countries that contribute over 77 percent of the maternal deaths worldwide, child survival programs on 24 countries that account for over 70 percent of child deaths and family planning programs on the 24 countries that represent over 50 percent of the unmet need for family planning, USAID is able to reach the maximum number of people with its limited resources.

- *Partnerships:* The fact that USAID works with countries in a strong partnership based on respect and mutual accountability allows USAID's other strengths to shine and produce results.

While USAID's Global Health program has enjoyed unprecedented successes, inevitably there are things that could have been done better and obstacles that need to be overcome to achieve better results. As a learning organization, USAID is eager to identify those areas where improvements can be made and to take action to correct them. Several areas of improvement were identified during the course of this project.

- *The importance of building a new cadre of staff:* Efforts to increase staffing under USAID Forward are a welcome opportunity to address chronic shortages of in-house expertise. Good mentoring is needed to prepare these new stars. Because many senior officers, who could provide requisite mentoring, are retiring, it is important to develop an alternative system of mentorship.

- *The need to document and learn from the past:* The priority USAID has placed on documenting its development experiences has varied over time, and there are many examples of success. While most projects undergo midterm and final evaluations, the wealth of information and lessons learned emanating from USAID's vast network of programs and projects is difficult to capture in a way that can be used to systematically inform future project designs and interventions. The Development Experience Clearinghouse contains a wealth of information, as do the websites of implementing partners. However, better systems – particularly ones that use the new technologies available today – are needed for ensuring that this information is utilized. In March 2013, USAID's Global Health program made a major contribution to information sharing with the launch of Global Health: Science and Practice, a no-fee, open-access journal. This journal was developed for global health professionals, particularly program implementers, to have their experiences and program results validated by peer reviewers and to share them with the greater global health community.

- *The need to evaluate and document success and graduation:* USAID's Global Health programs have graduated several countries from element-specific assistance and some from health programming assistance more broadly. USAID has not systematically evaluated what happens when its assistance ends, either in individual health elements or across the entire health portfolio. As health indicators in more countries improve, moving toward the goals of ending preventable child and maternal deaths and fostering an AIDS-free generation, it will be important for USAID to learn from past graduations to appropriately plan for and monitor graduation from health assistance at both the element and health program levels.

- *The value of interagency relationships:* USAID is a strong supporter of the whole-of-government approach. Adjusting to this new approach, however, has been a challenge for USAID as well as other partners, particularly when "lanes" of responsibility have not been clearly defined and when there has been a perceived overlap in the areas in which the different government agencies work. USAID needs to continue to work across the U.S. Government on developing the open and transparent approach to collaboration that is needed for interagency efforts to reach their full potential.

- *Development is USAID's central mission:* USAID takes pride in its holistic approach to health and the way it positions global health within its broader development mandate. Any opportunities for improving the way USAID's Bureau for Global Health works with the non-health sectors should be encouraged. Prospects for adapting the Best Practices at Scale in the Home, Community and Facilities approach, which focuses on integrating family planning, maternal and child health and nutrition programming, to non-health sectors should be explored.

Fish are a valuable source of protein, and USAID has helped establish fish hatcheries at the Parwanipur Research Station in Nepal

- USAID

X. USAID's Contributions

The programs, projects and implementation approaches discussed in this report highlight U.S. Agency for International Development's (USAID's) vast contributions to the global health field over the past 50 years. In the 100+ countries in which USAID has worked during that period, these noteworthy contributions have translated into tangible and measurable impacts on the health and lives of everyday people. In these countries, USAID's legacy is visible daily through:

- Quality health care services that are available and accessible
- Affordable pharmaceutical and health supplies that are available when and where needed
- Families seeking appropriate health care services, based on accurate knowledge
- Children reaching their fifth birthday
- Trained and skilled health care workers offering quality health care services
- Families planning the timing and number of children they want
- Health systems that respond to the needs of the populace
- Health leaders and managers with the training and qualifications to successfully perform their duties
- Local non-governmental organizations (NGOs) and civil society organizations actively participating in improving health care
- Governments placing increased priority on ensuring the health of their populations
- Leaders with the ability to focus on results and use data to inform decision-making processes


“Poverty does not belong in civilized human society. Its proper place is in a museum. That’s where it will be.”
Mohammad Yunus, Founder and Managing Director of the Grameen Bank

Following the 2011 floods in Pakistan, USAID provided assistance to help the many who faced dire shortages of clean drinking water, leading to outbreaks of acute diarrhea. Here, flood-affected villagers carry water pots on their heads near a makeshift camp.

- AFP PHOTO/ASIF HASSAN

More intangible legacies of USAID's presence in these countries and across the globe include:

- Profound positive changes in U.S.-host country cooperative relationships
- Goodwill toward the United States, with USAID recognized, even in the most remote areas, for its good work and positive impact on people's lives
- Success in using health as a tool of diplomacy, including success in using USAID's health contributions to help stabilize countries emerging from conflict
- An international community mobilized around key global health issues
- Strong linkages with partners in both the United States and other countries
- The presence of a strong network of public health advocates, implementing partners, academia, foundations and others – all dedicated to improving global health outcomes

Within the United States, USAID's legacy is evident in strengthened domestic public health programs and organizations, including the schools of public health at several universities and USAID's impressive NGO/faith-based organization and for-profit implementing partners, as well as in the large and growing cadre of public health professionals serving our country.

Jane and her husband are HIV positive, but their children are HIV free and healthy. With antiretroviral medication, these loving parents will be able to care for their children and watch them grow into adults.

- Elizabeth Glaser Pediatric AIDS Foundation

XI. Thoughts for the Future

New Horizons Emerge

As the U.S. Agency for International Development (USAID) enters the future, it must build on its past success and adapt to changing economic, demographic and epidemiological realities by:

- *Responding to the economic transition of health:* There has been an unprecedented growth in per capita gross domestic product over the past 50 years, accompanied by dramatic gains in health worldwide. While domestic spending on health in low-income countries has increased, a significant growth in out-of-pocket expenditures has inequitably affected the poor. USAID will need to reassess its role in this new environment to ensure a focus on development and equity goals, as well as build country systems.

- *Ending preventable child and maternal deaths:* Significant success has been achieved in reducing maternal and child mortality rates, and there is renewed global commitment to bringing an end to preventable child and maternal deaths. USAID, in partnership with key international and private sector organizations, is leading *A Promise Renewed.* USAID will need to find an appropriate balance of financial and human resources for supporting this movement.

- *Achieving an AIDS-free generation:* Building on past successes and landmark scientific advancements, the possibility of an AIDS-free generation is truly within sight (17). New HIV infections and AIDS-related deaths are on the decline, and national health systems have been strengthened to deliver a broader range of essential health services to the populations they serve. Partner countries are increasingly assuming central leadership in coordinating their HIV and AIDS response. In September 2012, the Office of the U.S. Global AIDS Coordinator issued the PEPFAR Blueprint: Creating an AIDS-Free Generation (219), which laid out a roadmap for achieving this goal. As one of the main implementing agencies for the U.S. President's Emergency Plan AIDS Relief, USAID will play a significant and evolving role in achieving an AIDS-free generation.

- *Promoting universal health coverage:* In December 2012, the United Nations adopted a resolution on affordable universal health coverage. This resolution urged member states to develop health systems that avoid significant direct payments at the point of delivery

and that have a mechanism for pooling risk to avoid catastrophic health care spending and impoverishment. The United States supports the resolution and believes that it articulates an important goal. In the countries where USAID works, learning how to best assist countries to better manage their own health care systems to achieve universal health coverage will be a high priority.

> "The goal of an AIDS-free generation may be ambitious, but it is possible with the knowledge and interventions we have right now. And that is something we've never been able to say without qualification before. Imagine what the world will look like when we succeed."
>
> Former U.S. Secretary of State Hillary Rodham Clinton, November 8, 2011

- *Revitalizing family planning:* USAID is a core partner in the Family Planning 2020 global partnership to support the right of women and girls to decide, freely and for themselves, whether, when and how many children they want to have. The initiative aims to enable 120 million more women and girls to access family planning information and services by 2020. Family Planning 2020 is an outcome of the 2012 London Summit on Family Planning. At the summit, more than 20 governments made commitments to address the policy, financing, delivery and sociocultural barriers to women accessing contraceptive information, services and supplies. Also at the summit, donors pledged an additional $2.6 billion in funding. As new donors are welcomed into this space, USAID's technical expertise will be critical to advance programming and foster new partnerships.

- *Addressing shifts in the global disease burden:* There is a global shift under way from communicable toward non-communicable diseases (NCDs). NCDs, injuries and environmental hazards are now the leading causes of death in all regions of the world except for Africa, where the majority of USAID health programs are located. USAID will need to consider the implications of this for future programs.

- *Changing demographics:* In many developing countries, a large percentage of the population is under 15 years of age. As these youth mature, their need for age- and disease-appropriate health services will expand. At the same time, aging populations create demands for different types of health and support services. Health systems will be challenged to provide quality services to these two growing, yet diverse, sets of health service consumers. USAID will build on its experience in working with youth and in building health systems to help countries meet this challenge. The October 2012 release of the USAID Youth in Development Policy (354) is a positive step in strengthening youth programming, participation and partnership and in defining how to mainstream and integrate youth issues across USAID initiatives and operations.

- *Graduating programs and providing ongoing support to graduates:* As USAID increasingly focuses its efforts on countries with high disease burdens, it will need to make several policy decisions regarding phase-out and ongoing monitoring/support. Issues requiring specific policy determinations include whether it is better to graduate countries from assistance element by element or as a whole program and what criteria should be used to make this determination; the type of support USAID should provide to countries during phase-nout, graduation and postgraduation or phase-out; and whether USAID would increase support to a country after it graduates if circumstances change, including identification of changes that would trigger renewed or increased support.

- *Using technology and innovations to work more efficiently and effectively:* In an era of declining resources, USAID will need to devise additional innovative approaches and make use of new technologies to do things at lower cost without reducing impact.

- *Working within a new donor environment:* The number of international actors providing development assistance has increased dramatically in the 50 years of USAID's existence. Internationally, several aid recipients have emerged as donor nations. In addition, there has been a significant increase in collaborative, coordinated action by key public international organizations like the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, the Global Alliance for Vaccines and Immunizations, the World Bank, the United Nations Children's Fund and the Joint United Nations Programme on HIV/AIDS to address major global health concerns. Furthermore, key foundation partners, like the Bill & Melinda Gates Foundation and the William J. Clinton Foundation, as well as private philanthropists, non-governmental and faith-based organizations and new transnational diasporas, have become more engaged in global

health. Finally, the role of the private sector in public health has increased. While each creates new streams of funding and new opportunities, USAID will need to consider how it can most effectively achieve global health impact in this new environment.

Conclusion

Despite many remaining health challenges, USAID will continue to advance global health priorities over the next several decades. USAID will tackle lingering issues and realign assistance within the context of emerging opportunities.

Given the changing environment, the future offers USAID the opportunity to transition its assistance in response to the economic growth transforming many of the countries with which it works. The nature of the assistance may shift. As incomes improve, people will spend more on health, and governments will be encouraged to spend more on health as a percent of gross domestic product. Ministries will become more sophisticated and will be able to provide essential social services themselves. Similarly, increased demand for policies and programs serving the emergent middle class, including the provision of health insurance schemes or universal health coverage, will provide opportunities for the private sector to invest more in health. Through cross-sector advocacy, programmatic integration and enhanced partnerships with new ministries (such as the ministries of finance, development and justice), parliaments and national leaders, USAID can play a pivotal role in harnessing transitions for better health. Particular attention will be paid to systems strengthening, health financing, national accountability and governance in the context of achieving health priorities as well as fostering country ownership of both programs and results. USAID should collaborate with donors, partners and implementers to continue to lead discussions and work in these emerging areas.

To capitalize on these opportunities, USAID will need to further focus support on technical assistance and partnering with new players while reducing emphasis on service delivery, which has been the source of some of the Agency's greatest accomplishments. USAID will also need to make the investment case regarding increased government spending on health from national budgets. In addition, USAID must ensure that increased emphasis on these new areas does not lead to an erosion of gains made over the past decades. Furthermore, USAID will need to ensure that policies and programs continue to reach the community level. Some of the shifts in USAID scope and focus will include emphasizing equity and pro-poor policies within market-driven health services; continuing to monitor gains made by involving civil society in promoting better health governance and accountability; instituting appropriate regulation of the private sector to ensure quality services; and balancing investments in the unfinished agenda with the emerging priority of NCDs.

There is no doubt that the coming decades will be just as exciting – and just as challenging – as the past 50 years. USAID's resilience and ability to reinvent itself as it reaches out to new partners will ensure the continuation of impressive contributions to global health as well as improved health outcomes for future generations.

Universal Health Coverage

The goal of universal health coverage (UHC) is to ensure that all people obtain the health services they need without suffering financial hardship. Various models of health coverage have evolved over the years from the German model of employment-based social protection to U.K.'s tax-based National Health Service to various public and private sector-based systems.

As low-income countries grow into middle-income status, health spending grows, making basic care affordable but often through unregulated private provision, paid out-of-pocket with mixed quality, inefficiency and inequity. National Health Accounts show that half the total health spending in Africa is paid out-of-pocket; in South Asia, it is 80 percent, leading globally to 150 million episodes of catastrophic health expenditures annually, pushing 100 million people back into poverty.

UHC is about reorganizing – rather than increasing spending – through private or publicly financed prepaid, risk-pooling systems, which are associated with better health outcomes for mothers and children. Mobilizing and reorganizing domestic resources and building the local institutional capacity to do it well are increasingly important in priority countries to build modern health systems, ensuring equitable and sustainable development in health. Successful examples include Ghana, Mexico and Thailand. More countries are making progress, some as part of the Joint Learning Network for Universal Health Coverage, following the World Health Report 2010.

Annex

Methodology for Developing the Health History Legacy Project Report

This global health history project was prepared for USAID's Bureau for Global Health by Tonya Himelfarb, under the guidance of Khadijat Mojidi, project manager, and a 13 member advisory committee. The consultation was carried out between February and August 2013 and was informed by:

- A **desk review** of documents produced by USAID and its implementing partners, international partners and global health development experts. The consultant made ample use of the Development Experience Clearinghouse, websites of implementing partners and multilateral organizations and other Internet sources. A bibliography of documents is provided and links to many information sources are included in the document itself.

- **Key informant interviews:** The consultant interviewed 26 current and former USAID health officers.

- **Online surveys:** The consultant developed four questionnaires on Survey Monkey and disseminated them out to retired or former USAID health officers, representatives for key implementing partners, Foreign Service nations and representatives from multilateral and bilateral organizations. The results provided some insights for some of USAID key contributions across the decades in global health.

About the Data

Sources

Data for life expectancy at birth, under-5 mortality rates, maternal mortality ratios and total fertility rates were downloaded from the World Bank databank (http://databank.worldbank.org/).
Population data (live births, total population and women 15–49) were downloaded from the U.S. Census International Database site (http://www.census.gov/population/international/data/).

HIV and AIDS data were downloaded from the 2013 UNAIDS spreadsheet "HIV Estimates with Uncertainty Bounds" from the 2013 Report on the Global AIDS Epidemic (http://www.unaids.org/en/dataanalysis/knowyourepidemic/).

Definitions

Low-income countries were defined by the 2013 list of low-income countries from the World Bank: http://data.worldbank.org/about/country-classifications/country-and-lending-groups#Low_income.

The World Bank assesses countries annually and assigns them into groupings (low, lower-middle, middle, upper-middle, high) based on gross national income per capita using the World Bank's Atlas method (see http://data.worldbank.org/about/country-classifications).

The World Bank databank does not have country income classifications for every year in the database. As such, it assigns low-income status across all points in time to all countries that are currently labeled as low-income countries.

Methods

We used U.S. Census Bureau population data to weight the indicators by the appropriate annual population (live births, female population aged 15–49, total midyear population). We calculated a straight average for the 10-year period spanning each decade across the weighted annual averages to generate an estimate for each indicator for the decade.

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