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Introduction

Chairman Leahy, Senator Gregg, and other distinguished members of the Committee, I would like to thank you for convening this important hearing and for inviting me to testify. U.S. development assistance has brought dramatic improvements in health, income advancement, and education to much of the developing world in the last 50 years. Average life expectancy in low and middle-income countries increased significantly during this same period. Good public health underpins these advances. Indeed, research findings and country experience have demonstrated an inextricable link between investments in improving individual and collective health status and a nation's economic development and performance. Many of these advances are due, in large part, to your continued support for maternal and child health and reproductive health programs.

USAID has a proven track record that has contributed to impressive reductions in child and maternal mortality and in helping women and couples achieve the size of families they desire in all regions of the world. Our support has helped to reduce under-five mortality in almost 30 countries and maternal mortality in ten countries. USAID-supported voluntary family planning programs have been successful in increasing access to and use of modern contraceptives in all regions of the world. In the process, we have strengthened health systems and built the capacity of developing country institutions to reduce preventable maternal and child deaths and provide basic health services. Your on-going commitment and support for maternal and child health has been and is critically important. As I often remind my staff, it is a great privilege to have work to do which matters, which saves lives of children and mothers, and it is you in the Congress whose compassion and support makes this work possible. And I want to express my great appreciation to you for this.

In talking to you about our work in improving maternal and child health (MCH) and family planning and reproductive health (FP/RH), I would like to focus on five key points:

- * Our programs have a proven record of success.

- * Despite real progress, our work is not done.
- * We have pioneered program approaches and continually develop new interventions that have made and will make a difference in our progress.
- * There are crucial opportunities to accelerate progress.
- * We can take advantage of these opportunities by capitalizing on existing resources and by focusing on key countries.

Maternal and Child Health and Family Planning are often seen as separate and distinct - vertical and disconnected. But USAID is working to integrate our programming to the fullest extent possible, an approach which increases the affordability and sustainability of our global efforts to tackle these important public health challenges. For example, we are making substantial progress integrating our programs for women and children and building consolidated platforms such as antenatal care and community-based distribution approaches for family planning, child vaccinations, and other important health interventions. Most of our missions already support integrated MCH/FP programs and help to build broad-based health systems. These programs strengthen drug management, supervision, community outreach, and other critical systems needed to deliver basic public health services.

In all our health programs, including MCH and family planning and reproductive health, we work to build human and organizational capacity, including taking steps to address the so-called "brain drain." Our programs help strengthen human resources to implement quality health care services through workforce planning, allocation, and utilization; strengthened systems for sustained health worker performance on the job; and training of health professionals. While, as a development agency, we cannot affect recruitment policies of the developed world, we are working on ways to keep health workers in their countries by working with governments on developing appropriate incentives, providing clear and equitable careers paths, and offering continuing education and professional development. Other projects also work to strengthen management systems and increase leadership capacity.

By strengthening and building upon common service delivery platforms, we help to support the specific goals of new high-intensity initiatives like the President's Emergency Plan for AIDS Relief (PEPFAR) and the President's Malaria Initiative (PMI), and therefore advance countries' ability to deliver the full range of health services.

I will talk about MCH and FP in separate sections, but I do so only for ease of presentation, as they are implemented more and more in a fully integrated fashion in country programs.

Using cost-effective tools and approaches, USAID and its international development partners have an unprecedented opportunity to accelerate progress in MCH and family planning, leading to further reductions in maternal and child mortality and unintended fertility.

MATERNAL, NEWBORN, AND CHILD SURVIVAL AND HEALTH

To achieve impact in maternal, newborn, and child health, USAID has consistently applied an approach that focuses on:

- * working with countries having high burdens of maternal and child mortality and malnutrition;
- * developing and delivering high impact maternal and child health interventions such as increasing skilled attendance at birth, control of post-partum hemorrhage, oral rehydration therapy (ORT), immunization, and vitamin A;
- * bringing these interventions as close as possible to the families who need them;
- * supporting results-oriented research to develop new interventions and strengthen programs;
- * monitoring progress; and,
- * strengthening the capacity of countries and communities to save the lives of their own women and children.

Maternal and Newborn Health

The burden of maternal and newborn mortality and disability

Each year more than 500,000 women die of complications of pregnancy and childbirth. Indeed, this is the second most common cause of death of women of reproductive age. While the number of deaths is disturbing enough, it is estimated that an additional 15-20 million women suffer debilitating consequences of pregnancy. Pregnancy-related mortality shows the greatest inequity of all health indicators between the developed and the developing worlds. For example, the one-in-16 chance over a lifetime that a woman in sub-Saharan Africa has of dying as a result of pregnancy is more than 150 times greater than the one-in-2,500 risk of a woman in the United States. In many Asian and Latin American countries, improved national averages often obscure the substantial risk of pregnancy that still remains for women living in poverty.

In addition, 3.7 million newborns die annually, failing to complete even the first month of life. As noted, newborn survival is inextricably linked to the health and nutritional status of the mother before and during pregnancy, as well as her care during labor and delivery. For this reason, USAID's programs always link mother and infant. As we make progress in reducing under-five mortality in general, the deaths of newborns in the first 28 days of life comprise a greater proportion of under-five and infant deaths. Globally, newborn mortality represents over one-third of all mortality among children under age five; however, in countries which have made greatest progress in child survival, newborn mortality can be more than half of the remaining deaths of infants and children. Thus, further progress in child survival must emphasize reduction of newborn deaths as a critically important element.

We have shown that substantial progress can be made in reducing maternal and newborn deaths

Despite the challenges faced in reducing maternal mortality, USAID has helped demonstrate that real progress can be made. Because maternal mortality is normally measured every 5-10 years, the globally-accepted proxy for maternal mortality is coverage at birth by skilled attendants. Across all USAID-assisted countries, skilled attendance has increased from an average of 37 percent in 1990 to 50 percent in 2005; the greatest progress has been in the Asia and Near East region, where coverage has more than doubled, increasing from 21 to 47 percent.

Most important, although global progress in reducing maternal deaths has generally been slow, ten USAID-assisted countries have achieved average reductions of maternal mortality of 33% over a decade.

Family planning also makes a substantial contribution to saving the lives of women by reducing the number of unintended pregnancies (each of which exposes a woman to risk) and by reducing abortions.

For newborn mortality reduction, USAID funded-research has documented a 33% decline in newborn mortality in Sylhet, Bangladesh with a package of home-based essential newborn care, and a 50% decline in Shivgarh, India with a similar program. Such programs have the potential to produce widespread impact on newborn survival in settings where most births take place at home, and they are now being scaled-up. In large controlled trials, community-based programs for detection and antibiotic treatment of life-threatening neonatal infections have also demonstrated the potential to reduce newborn mortality by almost half. We and other partners are replicating these trials and - if they are successful - will work with countries to apply the results in MCH programs. Neonatal interventions are relatively new in such programs, so we do not yet have examples of national-level mortality reduction. However, very recent analyses suggest

that, as these interventions are scaled-up, we are beginning to see overall declines in newborn mortality at the global level.

This success can be scaled-up through expanding the use of proven, low-cost interventions

Our work demonstrates that many of the major causes of maternal death are substantially preventable and treatable with low-cost interventions. USAID has sharpened its focus on a set of highly-effective interventions targeting specific high-mortality complications of pregnancy and birth - hemorrhage, hypertension, infections, anemia, and prolonged labor. Together, these complications account for two-thirds of maternal mortality. Hemorrhage alone accounts for almost one-third, and USAID has been in the forefront of promoting "active management of the third stage of labor," a highly-effective technique for preventing postpartum hemorrhage.

USAID has recognized that attention to the newborn is essential to success in our child survival programs. Increasing evidence and program experience indicate that we can significantly reduce newborn mortality by combining focused antenatal care, a package of essential newborn care that enhances the survival of all infants, detection and treatment of serious neonatal infections, and community and facility-based approaches to special care for low birth weight babies. These approaches especially target newborn infection and birth asphyxia, which together account for more than 60% of newborn deaths. USAID is presently supporting introduction or expansion of newborn care programs based on these elements in 20 countries.

Accelerating progress

While we have been able to demonstrate important progress in maternal survival in a number of countries, we recognize that sub-Saharan Africa has generally made little progress and represents a special challenge. In response to this stagnation of progress in sub-Saharan Africa, USAID has initiated a new "Safe Birth Africa" initiative to increase skilled attendance at birth, beginning in Rwanda and Senegal. This initiative includes a focus on decreasing financial barriers for families so that they will be more likely to bring expectant mothers for skilled care at birth. It also involves expanding the mandate of frontline providers so that they can perform life-saving measures, along with quality improvement approaches to ensure that good clinical practice standards are systematically applied. USAID plans to expand this work to other high burden countries in order to increase skilled attendance at birth and coverage with life-saving care.

In all countries where maternal mortality is high, as well as in countries where there is wide disparity in birth outcomes between rich and poor, USAID is intensifying its work to spotlight specific life-saving interventions. To expand the use of "active management of

the third stage of labor" to prevent postpartum hemorrhage, USAID launched the Prevention of Postpartum Hemorrhage Initiative in 2002. As of 2006, this approach had been introduced into MCH programs in 15 countries. In support of this intervention, we are working to get oxytocin, the drug that contracts the uterus to reduce bleeding after birth, into single-use UNIJECT injection devices, so that it can be provided by skilled birth attendants to women in peripheral health centers and homes. Because oxytocin is sensitive to heat, we are also exploring a time/temperature index to be put on the oxytocin vial, similar to the Vaccine Vial Monitor, to ensure that medication given to women is potent and that health workers do not unnecessarily discard oxytocin that has not been refrigerated.

In addition to further expansion of essential newborn care at birth, USAID is applying research results on treatment of sick newborns with antibiotics in the community. One step is testing the delivery of antibiotics in UNIJECT devices, so that treatment can be administered easily and safely by frontline-care providers. These newborn activities represent the combination of technical leadership and program application that USAID brings to MCH programs, working in partnership with other donors and recipient countries.

Reversing maternal disability

While our efforts continue to emphasize safe births and prevention of maternal mortality and disability, we are also providing compassionate care for women who suffer the devastating problem of obstetric fistula, a consequence of prolonged labor that can cause a woman to leak urine or feces, often resulting in divorce and social isolation. In 2004, USAID began a program to provide surgical treatment for such women. By the end of 2006, USAID was supporting eighteen fistula repair centers in eight countries of south Asia and sub-Saharan Africa. This support included physical upgrading of centers, training of surgeons, nurses and counselors, and mobilizing more than 5,000 community agents to change norms to delay pregnancy, reduce stigma of affected women, and promote use of family planning and maternity services. Over 2,000 surgeries have been completed.

Child Survival

Let me now turn to the child survival component of our MCH program. This is one of the cornerstone components of USAID's health programming. Arguably, the quantifiable, at-scale results generated by the child survival and family planning programs helped build the confidence that paved the way for later investment in other global health programs, from TB and malaria to HIV/AIDS and Avian Influenza.

The child survival program has a proven record of success, achieved by delivering

high-impact interventions. Twenty years ago, when USAID and UNICEF launched the "child survival revolution" with the support of Congress, an estimated 15 million children under age five in the developing world died from common, preventable diseases each year. Across the developing world, more than one in 10 children did not survive to see their fifth birthday; in some countries, it was one in five. If the same rates of infant and child mortality existed today, the number of deaths would be more than 17 million each year. In contrast, for 2005 WHO and UNICEF estimate the number of children under five who died to have been reduced by more than one-third, to 10.5 million - this is still far too many preventable deaths, but it means that more than six million children's lives are now being saved every year through global child survival efforts.

Over the past 20 years, the United States has committed more than \$6 billion in support of USAID's global child survival efforts. In collaboration with international, national, and private sector partners, this effort has yielded public health successes on an unprecedented global scale:

- * Almost a billion episodes of child diarrhea are treated with lifesaving ORT each year, reducing child deaths from diarrheal disease by more than 50 percent since 1990.
- * More than 100 million children receive a set of basic immunizations each year, and tens of millions more receive supplemental immunizations against polio, measles, and other killer diseases.
- * More than 75 million cases of infant and child pneumonia are taken for treatment by trained health workers.
- * Malnutrition among children under age five has been reduced from one in three to one in four, a 25 percent reduction.
- * The Polio Eradication initiative has saved an estimated five million children from death or paralysis.
- * Half a million children are estimated to have been saved last year alone by micronutrient supplementation programs.

These accomplishments are not attributable to USAID alone. In virtually all countries where it carries out child survival and maternal health efforts, USAID invests its resources in ways that best interact with and leverage the contributions of other donors and of the country itself. Yet, as the attached graphic demonstrates, in almost all the countries where USAID made an average annual investment of at least \$1 million of child survival and maternal health funds each year during 2003-2005, we have seen significant reductions in mortality of children under age five.

Despite real progress, there is still a substantial job left to do.

Sustaining this progress is itself a challenge, especially in the poorest countries with the weakest governments and health systems. A greater challenge is saving the lives of the remaining 10.5 million children who still die each year. As shown in the graph from the 2003 authoritative review of Child Survival in the medical journal *The Lancet*, the causes of most of these child deaths continue to be malnutrition, the common infections of newborns and young children - diarrhea, pneumonia, infections of newborns, and, especially in Africa, malaria - and other life-threatening newborn conditions .

The *Lancet* analysis indicates that over two-thirds of these child deaths are preventable with interventions that are available or in the pipeline, including Oral Rehydration Therapy for dehydrating diarrheal illness; basic treatment of serious infections including pneumonia, malaria, and newborn sepsis; improved nutrition through breastfeeding, better child feeding practices, and management of acute malnutrition; and delivery of micronutrients, especially vitamin A and zinc, which improve children's ability to resist infections or help them fight them off when they occur.

Countries and the global community - with USAID playing an important leadership and program role - have been able to make substantial progress in delivering these high impact interventions. In addition to our substantial contributions to increased global coverage of interventions including immunization and oral rehydration therapy, there are several areas where USAID's contribution has been especially important. One of these is vitamin A. USAID supported a large part of the research demonstrating that vitamin A deficiency was widespread among young children in developing countries, and that preventing or repairing this deficiency could reduce overall mortality among children under age five by about one-fourth. Since then, integrating vitamin A supplementation into maternal, newborn, and child health programs has been one element of our work in most countries, working with UNICEF and the Canadian International Development Agency. One result is that by 2004 (the latest year with complete estimates) almost 70 percent of children in the developing world had received at least one semi-annual dose of vitamin A supplementation, and almost 60 percent had received both doses needed each year for full protection. This achievement, combined with the increasing coverage of micronutrient fortification programs, of which we are also major supporters, means that tens of millions of children are receiving this important nutritional intervention.

Another area worth special comment is breastfeeding, because malnutrition underlies over half of all under-five child deaths. Breastfeeding is one of the highest impact child survival interventions, but improving feeding practices and children's nutrition is one of the most challenging areas of child survival. The global rate of improvement in exclusive breastfeeding of children for the first six months of life is less than one percent annually. However, USAID demonstrated that this challenge can be effectively addressed through a

multi-pronged approach that incorporates community workers, media, health services, and policy changes. Using this approach, seven USAID-assisted countries have made at-scale improvements in exclusive breastfeeding of as much as 10 percentage points a year, well above the global trend. We are now working with partners to apply this experience in additional countries.

A major challenge is that many of the remaining child deaths are occurring in places where existing services often do not reach: in the poorest countries and countries emerging from conflict (like Sudan, Afghanistan, and the Democratic Republic of Congo), in the huge rural areas of countries like India and Pakistan, and increasingly in the slums of the developing world's rapidly growing urban population.

We have new program approaches and new interventions that will make additional impact

Our response to these challenges is not just to do more of the same. Bringing high impact interventions to additional children who need them requires new approaches. One of these is our increasing emphasis on community-based programs, learning from our extensive partnerships with U.S. Private Voluntary Organizations and our experience working with countries that have pioneered these approaches as part of their national program strategies.

One example is community treatment of pneumonia. At the end of the 1990s, our analyses showed that progress in delivering simple oral antibiotic treatment to children with pneumonia - a treatment that research had shown reduces mortality by at least one-third - had leveled off, with only about 50 per cent of children needing treatment actually getting it. The reason was that in most countries, this treatment was restricted to formal health facilities. With the support of USAID and others, a few innovative programs in Nepal, Honduras, and Pakistan had, however, implemented treatment through trained community health workers. In Nepal, this approach more than doubled the number of children receiving treatment for pneumonia, and did so with excellent quality of care. We documented and presented this program experience to international partners including WHO and UNICEF, with the result that this is now the recommended approach to pneumonia treatment for countries where formal health services fail to reach many children. USAID itself has helped introduce this approach in Africa, beginning in Senegal; six additional countries are now implementing this community-based approach, and several others are introducing it.

Similarly, we helped pioneer "Child Health Weeks," which are outreach approaches that bring vitamin A, immunization, insecticide-treated nets, and other health interventions to underserved areas. The aim is to get basic interventions to all children possible now, while building countries' systems and capacities to do so through more systematic approaches in the future.

Our program has also played a key role in developing, testing, and introducing new interventions and technologies that will save additional lives.

One of these is zinc treatment for child diarrheal illness. Research - much of it supported by USAID - has clearly shown that zinc treatment reduces the severity and duration of these illnesses; as a result, zinc is now recommended by WHO and UNICEF as part of the treatment of diarrheal illness, along with oral rehydration. To implement this recommendation, we are supporting introduction of zinc treatment in countries including India, Indonesia, and Tanzania. We are also collaborating with UNICEF and potential zinc supplement producers to assure the availability of safe, standardized, high quality products to supply these new programs.

Another example is "point-of-use" (POU) water disinfection technologies. These simple and cheap methods were first developed and used through collaboration of USAID and the Centers for Disease Control and Prevention (CDC) during cholera outbreaks in Latin America in the 1990s. Subsequent research showed that "POU" water treatment can reduce diarrheal and other water-transmitted illnesses by one-fourth or more. Since then, we have collaboratively developed programs for their production and distribution in twelve countries. In some countries, like Indonesia, this is a purely private sector partnership, with the U.S. providing just the technical know-how. In poorer countries like Madagascar and Zambia, we are using social marketing approaches that involve some degree of subsidy to make sure they are available to low-income households (often most impacted by bad quality water). In emergencies - including the 2004 tsunami - these "POU" technologies have played an important part in reducing disease transmission, especially among children. Because over a billion people in the developing world still live without access to safe water, these simple technologies can play an important role in reducing the disease burden on young children.

One other important new intervention is "community therapeutic care" (CTC), an innovative approach to therapeutic feeding and medical treatment of children with acute severe malnutrition in field environments with few human and medical resources. Many families impacted by emergencies cannot reach therapeutic centers, or cannot spare the family members needed to accompany a child in such a center for the days or weeks required to reverse malnutrition. In response, USAID has worked with non-government agencies and international relief organizations to develop this approach for children with severe acute malnutrition. A central innovation of CTC is the use of ready-to-use therapeutic foods such as Plumpy'nut, an energy-dense peanut paste. Plumpy'nut can be safely given by parents in the home, eliminating the need for a prolonged stay in feeding centers. CTC has already been introduced in several African countries as well as in Bangladesh. USAID is now working with WHO and UNICEF to endorse CTC as the standard of care in all countries for managing acute malnutrition.

My testimony on child survival may best be summarized by the following graph.

As I noted early in my statement, global efforts to improve Child Survival now result in the saving of over 6 million children's lives each year. This is a tremendous accomplishment, and one that needs to be sustained. At the same time, authoritative analyses tell us that we can save at least an equal number of those children who still are dying unnecessarily, using the tools and program experience that are already available to us. It is our intention to do our utmost with the resources provided to us to accomplish this important goal.

There is now an important opportunity to accelerate progress in maternal, newborn, and child survival.

During the past few years, we have seen new commitments that we believe can lead to a "second wave" of global effort to improve maternal and child survival. There are new resources appearing from private sector partners like the Bill and Melinda Gates Foundation, from bilateral donors like the U.K. and Norway, and from multilateral partners including UNICEF. One of the largest increases is through funding from the International Funding Facility of the U.K. and Europe for immunization, through the Global Alliance for Vaccines and Immunization (GAVI). The European Union is providing substantial amounts of new funding to several countries to support maternal mortality reduction.

The Millennium Development Goals (MDGs) are stimulating increased international attention to the need for accelerated progress to reach the child and maternal survival goals; this attention is producing new international cooperation, like the inter-agency "Countdown 2015" collaboration to monitor and report on progress toward these goals and the inter-agency "Partnership for Maternal, Newborn, and Child Health." The African Union has recently developed and approved a new "Framework for Accelerated Progress in Child Survival" as well as a new reproductive health regional strategy; work on a similar regional framework for maternal, newborn, and child health is beginning in Asia.

Partly in response to the MDGs, and partly in response to their understanding of the need to accelerate social development, some countries themselves are substantially increasing their own investments in maternal and child health. One impressive example is India, whose Prime Ministerial "National Rural Health Mission" and new second stage Reproductive and Child Health Project represent the commitment of over two billion dollars a year to improved health status among the underserved. There is also increasing public visibility, including ongoing attention by The Lancet to child survival, maternal and newborn health, and global public health in general.

Against this background, we have a strategy to use our existing resources to substantially reduce maternal, newborn, and child mortality and malnutrition in a focused set of high burden countries.

To take advantage of this opportunity, we plan to focus resources on a set of countries which have the highest need, in terms of both the magnitude and the severity of under-five and maternal mortality; that is, countries that have the largest number of preventable deaths as well as the highest rates of mortality. We will focus on countries that have strong commitment to improving MCH and the capacity to program resources effectively, and wherever possible, offer the potential for interaction with other USG investments, including the President's Malaria Initiative and GAVI funding. We believe it is possible to achieve reductions of 25 percent in under-five and maternal mortality in most of these countries by 2011; and in many of them, we also believe it possible to achieve reductions of 15 percent in the number of children who are below weight-for-age.

We will do this by applying our successful lessons from the past and the new approaches and interventions we now have. We will work with countries and partners to identify the most important maternal, newborn, and child health and nutrition problems, and the most important interventions that can be implemented at scale to address those problems. We will support those interventions through appropriate integrated delivery approaches, involving the public health system, private sector providers, NGOs, and community-based approaches. We will identify the best fit of our resources alongside those of other initiatives, partners, and the countries themselves. We will join with countries and partners to monitor progress in terms of improved coverage, and ultimately improved survival, health, and nutrition status. And we will identify and invest in developing the capacity of communities, health systems, and human resources to achieve and sustain progress.

Our belief that such rapid progress is possible is not hypothetical. It is based on the real recent performance of a number of USAID-assisted countries.

Most of these recipient countries are still very poor. Yet they have demonstrated that through commitment to effective programs and to bringing needed services to children and families, rapid progress can indeed be achieved. These achievements, along with those I have already presented in maternal mortality reduction, give us confidence that our continuing work with countries and partners can produce equally important results during the next five years.

Finally, the question comes up of determining when a country is ready to go on its own in MCH, without continued USAID support - the "graduation" question. We plan to approach this process in a phased approach. By looking at past experiences and current

conditions; progress on key indicators including under five and maternal mortality; and such factors as equity of health status, we will develop and apply graduation criteria and analyze each country receiving MCH assistance against these criteria. Based on this analysis, we will identify countries that have strong chances of successfully graduating in the near term. We will then work with the country to focus our program investments and to address institutionalization of health systems, including human resources, financing, drug management, quality improvement, and information systems and evaluation, that will promote sustainable capacity. This process will produce a three- to five-year phase down plan developed with the country. In this way, we plan to have a responsible process for dealing with countries that make good progress, while at the same time keeping our eye on the unmet need of countries with continued high burdens.

Family Planning and Reproductive Health

The United States is firmly committed to promoting the reproductive health and well-being of women and families around the world. Over the years, USAID has become the acknowledged leader in implementing the U.S.'s global voluntary family planning assistance program. Our portfolio of interventions strongly emphasizes method choice and includes a mix of contraceptives that are country appropriate and can include long-acting methods, injectibles, and fertility awareness options, sometimes known as natural family planning. We are fully committed to informed choice and to ensuring that family planning users know the risks and benefits of the method they choose. USAID supports these contraceptive options with a range of activities to advance service delivery, the quality of the medical care and counseling, and the effectiveness and sustainability of family planning programs. Our work includes helping to create an enabling environment for family planning programs, support for research on improved contraceptive methods, training of health care providers, and helping nations create a commodities logistics system.

Since our program began in 1965, the use of modern family planning methods in the developing world, excluding China, has increased by a factor of four, from less than 10 percent to 42 percent. In the 28 countries with the largest USAID-supported programs, the average number of children per family has dropped from more than 6 to 3.4. Moreover, abortion rates have declined in Eastern Europe and Eurasia. Using Romania as an example, abortion was the primary method of family planning through the early 1990s, with women having as many as four abortions in their lifetime. When modern contraceptive use more than doubled between 1993 and 1999, the abortion rate decreased by 35 percent and abortion-related maternal mortality dropped by more than 80 percent.

USAID's program is unique in a number of ways: it is comprehensive in its support (with activities ranging from contraceptive development, to community-based delivery of FP/RH services), it works through multiple channels of delivery (including private sector

and NGO sector -- while other donors tend to focus on public sector and increasingly on basket funding), and it has on-the-ground health experts that direct, oversee, and manage bilateral activities. We have pioneered program approaches and continually develop new interventions that will accelerate progress.

- * Our efforts have made family planning services accessible to people in hard-to-reach areas. These include door-to-door distribution, clinic-based services and employee-based programs.

- * USAID introduced contraceptive social marketing. These programs privatize contraceptive distribution and marketing, using the commercial pharmaceutical sector to reach more people at lower cost, decreasing countries' dependence on the donor community for supply and distribution of affordable commodities.

- * We support the world's largest information/education programs that use in-country media and local entertainment outlets, performers, and groups to educate millions of people about contraception, child care, and health.

- * USAID created and standardized the largest repository of fertility and family health information, the Demographic and Health Survey, which is used by policy makers and program managers in developing countries and the donor community to assess impact and make informed decisions about program design and management.

- * We are noteworthy the donor community in developing new and improved contraceptive methods and supporting research to improve existing contraceptive technology. These innovations provide couples in developing countries with superior and safe methods of family planning. Americans also profit from USAID-supported improvements, such as the introduction of low-dose oral contraceptives and the female condom.

- * USAID has always given high priority to providing contraceptive supplies and related assistance in logistics and quality assurance. USAID provides 50 to 70 percent of all contraceptive assistance in the developing world and nearly all logistics management assistance.

We have successfully graduated numerous countries and others with mature programs are on the road towards graduation from family planning assistance, allowing us to respond to countries where unmet need is still critical. Currently we are strategically shifting family planning resources towards sub Saharan Africa. The FY2008 budget request targets 43 percent of family planning resources to the region.

Graduation of several countries from U.S. government assistance for family planning also

is an indicator of USAID's success. In addition to the overall measures of lowering fertility and high levels of contraceptive use across income groups, successful graduation from family planning assistance requires that a number of specific elements are in place, including national commitment to family planning, adequate financing for programs, contraceptive security, sustainable leadership and technical skills, availability of high quality information, appropriate engagement of the private sector, and attention to access of underserved populations.

The Asian countries of Indonesia, Thailand, and Turkey have graduated from family planning assistance. Egypt will graduate by 2010. In Latin America, Brazil, Mexico, Colombia, and Ecuador are no longer receiving family planning assistance. Family planning programs in the Dominican Republic, Jamaica, and Paraguay are on track to graduate from USAID family planning assistance in the next few years. In Europe and Eurasia, programs in Kazakhstan, Kyrgyzstan, Moldova, Romania, Russia, and Uzbekistan have successfully increased contraceptive use and thereby reduced abortion.

As the world's largest bilateral donor, USAID delivers assistance in more than 60 countries through bilateral and regional programs. Each year, U.S. reproductive health programs deliver services to more than 20 million women, including clinical services as well as non-clinic based approaches to deliver services to the hard-to-reach. The Agency works directly with hundreds of non-governmental organization partners, the majority of which are foreign NGOs, to provide technical assistance to family planning programs at the local level. Assistance is also provided through U.S.-based universities, and private sector companies and organizations.

Despite our strong record of achievement, our work is not done. Women's health burden remains great:

* More than 500,000 women die annually from maternal causes, almost all of them in the developing world. Family planning helps reduce maternal mortality by reducing unintended pregnancy and the perceived need by many to resort to abortion, as well as by ensuring that the proper spacing is achieved between wanted pregnancies.

* Of these annual pregnancy-related deaths worldwide, about 13% (or 78,000) are related to complications of unsafe abortion. The United States believes one of the best ways to prevent abortion is by providing high-quality voluntary family planning services and providing assistance to prevent repeat abortions through the use of family planning. As a result, USAID-supported family planning programs in Eastern Europe have resulted in significant declines in abortion as contraceptive use has increased.

Unmet need continues to be a challenge.

There remains a great need - and desire - for family planning. While more than 400 million women in the developing world are now using family planning, there are an estimated 137 million with an unmet need and 64 million using traditional, rather than modern, contraceptive methods.

Unmet need is particularly great in Africa. There, nearly half of the world's maternal mortality occurs and on average only 15 percent of married women use contraceptive methods. The desired fertility in the region is considerably lower than actual fertility, which remains high at 5-7 children per women in most countries. Although demographic and health surveys reveal that a high proportion of women and men-well more than half in many African countries-said they wanted to wait at least two years before having their next child or that they had the size family they wanted, there were, in fact, nearly 39 million unintended pregnancies in Africa between 1994 and 2000-clear evidence of the need for family planning. In too many African countries, attention to family planning has declined and donor and government funding has stagnated.

There are significant opportunities to accelerate progress.

Though family planning is primarily viewed through the prism of women's health, research has shown that the women themselves view family planning in broader terms. They believe that having smaller families and spacing births not only improves health, but increases opportunities for education as well as for greater domestic and community involvement. Their instincts are right - women are critical to achieving development goals.

The impact of family planning on children's lives often is not considered. More than 10.5 million children under the age of 5 die every year in the developing world. Many of these deaths can be reduced by expanding access to family planning. Births that are spaced too close together, too early, or too late in a woman's life decrease both the mother's and infant's chances for survival. Children born too close together face increased risk of contracting and dying from infectious diseases and can suffer high rates of malnutrition. By helping women space births at least 3 years apart and bear children during their healthiest years, family planning could prevent many of these deaths. Research done in 2003 has shown that if women had not had any births at intervals less than 24 months, almost two million deaths to children under age 5 could have been averted. Additional deaths also would have been averted if mothers had spaced births at least 36 months apart.

The education of women is critical. Research has shown a strong link between girls' literacy and many other development objectives. Women who start families before age 20 are less likely to finish school than those who wait even a few years. Early and frequent childbearing can limit women's education. The importance of family planning in

allowing women to stay in school goes beyond the women themselves. Mother's education is an important predictor of children's educational attainment and therefore of their future earnings. Conversely, education also improves use of family planning services. Studies show that women with as little as 2 or 3 years of formal schooling are significantly more likely to use reliable family planning methods than women with no formal education.

Employment allows women to earn income, which increases life options and involvement in the community. Family planning users often are more likely than non-users to take advantage of work opportunities. In addition, high levels of female labor force participation and higher wages for women are associated with smaller family size. As women enjoy greater economic opportunities and as family income rises, they spend more money on the education and nutrition of their children, continuing the cycle of opportunity. This in part explain why micro-finance is such a powerful tool today in development, both economic and social development.

Working with key international partners, family planning has now come to embrace a broader mandate.

- * Ensuring that family planning is introduced into policies, programs, and services whenever there is a natural link. At the country level, this aims to ensure that there are no missed "good" opportunities.
- * Recognizing that program development is situation specific, USAID will draw on the best current programmatic evidence to determine priority interventions and conduct further research to identify the best approaches that can be scaled up.
- * Programming for impact: underscoring that opportunities and challenges differ in each country, local data and experiences will be used to help determine which approach to strengthening family planning will have the greatest impact.
- * Exploring strategies to reduce the large inequities - among the poor and hard to reach - in family planning access, method choice, and information among population subgroups.
- * Promoting national ownership and responsibility for the strengthening of family planning services despite current shifts in priorities and economic environments.
- * Ensuring optimal allocation of resources and strengthening of technical and managerial capacity as prerequisites for sustainable family planning programs.
- * Multisectoral approaches: strengthening linkages between health and other sectors

so as to make use of all available entry points and opportunities to introduce family planning and address unmet need.

USAID also has several special initiatives that broaden our work beyond "bread and butter" family planning programs. Among them:

- * Reproductive health programs can be effective partners in HIV/AIDS prevention in developing countries. Incorporating education and counseling to promote condom use and other HIV/AIDS prevention methods in reproductive health programs can contribute to the fight to stop the spread of the epidemic. In addition, research shows that adding family planning into programs for the prevention of mother to child transmission of HIV (PMTCT) can greatly reduce the number of orphans while saving the lives of thousands of women and children.

- * Slowing the rate of population growth gives nations time to develop sustainable solutions to other development challenges. Access to reproductive health programs can contribute to preserving the world's endangered environments by conserving scarce resources. Currently, more than 505 million people live in areas already experiencing chronic water shortages, a number that is expected to increase to 2.4 billion in the next 20 years. In addition, in the past 3 decades, growing populations have caused 10 percent of the world's agricultural land to be lost due to residential and industrial needs. When reproductive health and family planning information are widely available and accessible, couples are better able to achieve their desired family size. This not only directly impacts the well being of families, but also contributes to both better management and conservation of natural resources.

- * The Office of Population and Reproductive Health has other special initiatives that address women's health and status in society in innovative ways. These include working to bring about the abandonment of female genital cutting; increasing male involvement in family planning; gender violence; health equity which is how to ensure the poorest of the poor receive our services and programs; the reproductive health of refugees; the availability and sustainability of health commodities including contraceptives and condoms; and repositioning family planning as attention and resources to this crucial health intervention are sometimes neglected because of the understandable focus on such pressing health concerns as HIV/AIDS.

We can take advantage of these opportunities by capitalizing on existing resources and by focusing on key countries.

USAID must address the great unmet need for family planning that continues to exist by:

- * Maximizing access to good-quality services;

- * Emphasizing communication;
- * Focusing on men as well as women;
- * Increasing our efforts to reach the very poor.

Also, family planning programs can develop better links with other services for new mothers and young children. Making common cause among such programs should be efficient because unmet need is concentrated among women who are pregnant unintentionally or who have recently given birth. We are developing approaches to address high levels of need in the poorest countries of the world. I have spoken of the profound need to expand our programs in Africa. Significant need also continues to exist in low contraceptive prevalence countries in Asia, such as Afghanistan, Cambodia, northern India, Pakistan, and Yemen, where prevalence is below 25 percent. In Latin America, USAID is concentrating its family planning resources in Guatemala, Bolivia, and Haiti where contraceptive use ranges from 22 to 35 percent.

However, USAID's targeted countries, particularly those in Africa, face a number of challenges in their quest to meet the family planning needs of its population. Among these are weak health systems, poor access to family planning commodities, the non-involvement of men in family planning interventions, and inefficient utilization of resources.

We also must employ interventions that will ensure family planning remains on the agenda of all sectors and continue improving access to all services. Other interventions include strengthening national capacity for sustainable programs, strengthening community participation, addressing family planning needs of vulnerable populations, and conducting operations research.

BUILDING CAPACITY WHILE SAVING LIVES

Our programs are aimed at achieving impact in saving the lives and improving the health of mothers and children. At the same time, we are a development agency - we therefore believe that everything we do should also build the capacity of countries and people to improve their own situations. To do this, our program investments aim to build integrated, sustainable approaches and develop key components of the health systems countries need to deliver all basic health services. Let me touch on several specific areas of particular importance.

Integration

As I noted in my introduction, we recognize the important positive connections among voluntary family planning and birth spacing, good maternal care, and child health and nutrition programs in terms of health outcomes for women and children. To achieve

these synergies, and at the same time build strong and cost-effective platforms for broader primary health care services, we implement integrated maternal-child health and family planning programs in almost all countries where we work.

One example is the delivery of antenatal, delivery, and post-partum care services. We know that good antenatal care - including promotion of adequate nutrition and anemia prevention, detection and treatment of infections and complications, and planning for adequate care at birth - can have important positive effects on outcomes for both women and their babies. It is also an important opportunity to begin discussing family planning options for women who want to delay a future pregnancy, which will help preserve their health and that of their infants. In areas where malaria is prevalent, we promote antenatal care as a key opportunity to provide antimalarial treatment and promote use of insecticide-treated nets, protecting women from anemia and illness, and protecting their unborn children from the low birth weight caused by maternal malaria infection. In high HIV environments, antenatal care is one of the best opportunities to offer testing and counseling services and identify mothers requiring anti-retroviral treatment or prevention of mother-to-child transmission of HIV (PMTCT). High quality care at delivery is one of the most critical interventions for the survival and health of mothers and newborns; it prevents or resolves life-threatening complications and provides essential immediate care to newborns who need it. It also provides a key opportunity for PMTCT. We are now increasingly extending care into the post-partum period, allowing for the detection and treatment of serious maternal and newborn complications and better promotion of breastfeeding and essential newborn care. This post-partum period is also one of the most important opportunities to counsel women in voluntary family planning methods. Thus, in practice, our MCH-FP programs are delivered holistically, giving greater impact, greater sustainability, and greater support for other important health programs.

The same is true for the community-based program approaches that we support in areas where formal health services cannot meet all basic health needs. We support outreach programs that often deliver multiple interventions including immunization of mothers and children, vitamin A and iron supplements, insecticide-treated bednet distribution, and antenatal care. We support community health worker and social marketing programs that often deliver family planning advice and commodities, condoms and information for HIV prevention, oral rehydration, and increasingly treatment for malaria and other child illnesses. We support programs for women's groups that promote family planning, breastfeeding and child nutrition, and birth planning; these groups often engage in income-generating and micro-finance activities that enhance their effectiveness and influence in their communities.

Such integrated approaches reap the benefits of synergies among specific interventions and parts of our health programs. They also maximize the potential for sustainability by making the most effective use of each contact of services with families.

Strengthening Health Systems

Achieving impact while investing in health systems is challenging, given the low levels of resources available in most countries with high fertility and mortality, and thus the huge number of potential claims on additional resources. As has been seen in some countries where a broad focus on health systems has replaced a clear focus on health outcomes (Zambia in the 1990s, Ghana recently), investment in systems not linked to outcomes will not necessarily improve the survival and health of women and children. USAID is recognized as a major contributor to approaches that strengthen key elements of health systems, while doing so in ways that link these investments to outcomes. Our efforts have made important contributions in several critical dimensions of health systems, including:

* Quality improvement - USAID has been a global leader in the application of modern quality improvement approaches to health and family planning programs in developing countries. The Agency's "Maximizing Access and Quality" initiative has impacted every country we assist and has even further reach. For example, quality improvement approaches have led to the development of a Global Handbook that documents protocols and best practices for family planning services. This document, which has been translated into eight languages, is published by the WHO and is used by USAID funded programs in more than 60 countries through WHO's reach. Quality improvement approaches have led to the development of "standards of care" for maternal and child health services and the use of these standards to measure and improve quality of services. These approaches are being used to improve basic services, such as reducing delays in management of life-threatening obstetric complications and improving care of severely ill children; in hospitals in Nicaragua, this approach reduced child deaths from malaria by 86 percent, from diarrhea by 57 percent, and by pneumonia by 38 percent.

* Drug and commodity supply and logistics - USAID is a major supporter of systems that provide, distribute, and track contraceptive commodities and other essential public health commodities. Last year, shipments for contraceptives and condoms were provided to 52 countries and additionally, many of these countries also received anti-retroviral drugs and diagnostics. Additionally, technical assistance pharmaceutical management and/or supply chain strengthening was provided in at least 39 countries. For maternal and child health, where most drugs and commodities are parts of routine health systems, efforts have focused on making MCH drugs parts of "tracer" systems that evaluate the functioning of overall logistics systems by tracking the availability and use of selected drugs. For new products, like zinc for treatment of diarrhea, USAID works with the U.S. Pharmacopoeia to develop quality and manufacturing standards needed to allow international procurement by UNICEF and countries, and also works with manufacturers to assure adequate quantity and quality of products required by programs.

* Financing - USAID worked with WHO and the World Bank to develop "National Health Accounts," tools that for the first time allow country governments and their partners to see all the resources available for health - not just from government, but from donors and from families themselves. These important decision-making tools are now being utilized in approximately 70 countries, with direct USAID assistance to 26 of these. Another important area of USAID engagement is support for "risk pooling" approaches that remove cost barriers to care. One important approach is technical assistance to community-based insurance plans, or "mutuelles," which is an innovative way to finance health care in Africa. These community-based plans now exist in about a dozen African countries; in Rwanda alone, where USAID is providing assistance, by 2006 there were over 300 community-based plans serving over 3.1 million people (or 40 percent of the population).

Human Resources and "Brain Drain"

One challenge which faces virtually all of our health programs is the movement of trained health care providers away from developing countries and into more developed countries--commonly referred to as the "brain drain."

As a development agency, USAID has little influence on the policies of wealthy countries that receive emigrating health professionals, the demand side of this issue. Our strategy in this area focuses on retaining trained providers in their countries' health systems, the supply side of the issue.

The in-country factors affecting the healthcare human resource supply are more than a shortage of workers or absentee-ism due to training. Low salaries and poor working conditions drive workers to other types of employment even within their own country. Weak human resource management systems do not support workers. The recruitment, deployment and promotion of workers are often politicized and not performance-based. Additionally, an inappropriate alignment of the workforce means that tasks are often assigned to the wrong types of workers causing overly burdensome workloads.

USAID is actively engaged in multiple efforts within countries to increase retention and contribute to greater worker productivity. Specifically, in almost every country where USAID has programs, USAID is developing and/or strengthening in-service training systems to provide workers with the knowledge and skills needed to do their jobs; often utilizing innovative learning approaches, such as distance learning and self-directed learning, in order to minimize the time workers are out of post for training. USAID is collaborating with Ministries of Health to strengthen supervision systems so that they provide positive support to workers, and is instituting quality improvement methodologies that encourage workers to take an active role in ensuring the quality of the services they provide.

Keeping workers on the job is essential to increasing the number of workers. In five African countries, several approaches are being tested and implemented in USAID programs, including: piloting financial and non-financial incentives; developing clear and equitable careers paths; offering continuing education and professional development. There has been an increased retention of workers in Ghana, Namibia and Uganda with improvements to the working environments and benefits such as transportation reimbursements.

Improved management and modern quality improvement approaches are affordable and have the potential to improve dramatically the way health systems manage their human resources, helping to retain workers. USAID provides support for workforce planning and rationalization in six countries. Human resource (HR) managers are assisted to develop the skills needed to scan and analyze HR data, determine relevant policy questions, and make policies to ensure that workers with appropriate skills are available when and where they are needed. In several countries, HR Directorates in Ministries of Health are being strengthened through training of key staff and through secondments of HR experts who then share their knowledge and skills so as to create strong HR managers. In a number of countries, USAID is assisting MOHs, licensing and certification bodies, private-sector organizations and other stakeholders to develop the human resource information systems they need.

Sustainability

Sustainability of MCH and family planning programs is a critical goal of USAID. To this end, we aim to:

- * Increase funding by host governments of national MCH/FP programs.
- * Increase diversification and long-term funding of MCH/FP activities by donors and international organizations.
- * Improve the quality of national MCH/FP activities and establish critical masses of health workers competent in MCH/FP interventions.
- * Achieve high and sustained national coverage rates for MCH/FP interventions.
- * Reduce inequities in access to health care and in health outcomes.
- * Involve community, voluntary and private sector organizations in MCH/FP activities at national, district and community levels.

With progress on each of these elements, MCH/FP programs will become more effective

and sustainable. More importantly, national leaders, health managers, and the general population will expect and demand effective, nationwide MCH/FP programs and will help to make this happen. There will also develop an international mandate that no country will suffer stock-outs of essential MCH/FP commodities. This has already occurred for child vaccines. Finally, national governments and international donors and organizations will be judged by the quality and coverage of their MCH/FP programs.

There is now evidence that USAID, other donors, and national governments are helping to make important progress on all these key elements of sustainability. For example:

- * There is evidence that host government contributions to MCH/FP programs have increased in real dollar terms over the past ten years.
- * Coverage rates for key MCH/FP interventions are steadily increasing. For example, the worldwide coverage for the third dose of the DPT vaccine is 74% and for vitamin A is over 50%.
- * There are major new commitments of international partners to MCH/FP and some new funding mechanisms that promise long-term support for the sub-sector.

Complementary Funding and Global Development Alliances

USAID funds have complemented over \$4.6 billion from partners to advance development objectives worldwide.

USAID provides leadership in the Reproductive Health Supplies Coalition (RHSC), a coalition of 21 members - multinational organizations, bilateral and private foundation donors, low and moderate income country governments, civil society, and the private sector - that works to increase political commitment and public and private financial resources, as well as more effective use of resources to ensure sustained access to quality reproductive health supplies through public, private, and commercial sectors.

USAID supports the Global Alliance for Improved Nutrition (GAIN) to accelerate micronutrient fortification programs globally and to mobilize the private sector to deliver fortified products to the poor. The Alliance includes 14 governments ; three donors; the United Nations; the private sector including Proctor and Gamble, Unilever, Danonoe, and Heinz; development agencies such as the World Bank; education and training institutions; and civil society. The Alliance has supported 15 national food fortification programs projected to reach 446 million people.

Between FY2001 and FY 2006, USAID contributed \$352.5 million to GAVI as one of the largest government donors representing nearly 20% of GAVI's funding. Since GAVI's

inception in 1999, the Gates Foundation combined with a variety of donor governments has contributed a total of \$1.9 billion.

CONCLUSION

USAID sees improved health for the world's poorest people not only as a moral imperative but also as a pragmatic investment of U.S. funding for peace, security, and world-wide economic growth. USAID-supported MCH/FP programs have a proven record of success which is helping to save lives and build health systems. Our support has helped to reduce under-five mortality in almost 30 countries and maternal mortality in ten countries. USAID-supported family planning programs have been successful in increasing access to and use of modern contraceptives in all regions of the world. We now have program approaches and new interventions that will allow us to build on these successes and make additional progress. We also have valuable experience in delivering these interventions and approaches in a fully integrated and cost-effective manner at district, health center, and community levels so that these life-saving services can be affordable and sustainable. With the continued support of Congress, we will be able to contribute to further gains in maternal and child health and family planning throughout the developing world. Thank you for your support.