Exclusive Interview with Ashley Judd on her Memoir: “All That is Bitter & Sweet” 22

USAID AT 50
7 Questions with USAID Administrator Dr. Rajiv Shah 4
Senior U.S. Health Officials Share Insights 12

GLOBAL TO LOCAL

▲ PSI affiliate PACE in Uganda recently procured 7.2 million nets for distribution as part of a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Here, driver Joseph Ssenkooto readies his next shipment. Read about PACE on page 11.
Stay SAFE

...use Elegance female condom

Protects against:
- STIs
- HIV

Good for child-spacing

free your mind...enjoy!

Society for Family Health

UAFC joint programme

Federal Ministry of Health
2 WORLD MAP

4 7 QUESTIONS
Dr. Rajiv Shah, Administrator, U.S. Agency for International Development

6 GLOBAL TO LOCAL
Sustainable Health across the Development Spectrum

11 EVOLUTION OF AN AFFILIATE

12 SENIOR U.S. HEALTH OFFICIALS SHARE INSIGHTS
   • 13 Susan Brems, Ph.D.
     Senior Deputy Assistant Administrator, Global Health Bureau
   • 14 Amie Batson
     Deputy Assistant Administrator of Global Health & USAID’s Deputy of the Global Health Initiative
   • 15 Admiral Tim Ziemer
     U.S. Global Malaria Coordinator, President’s Malaria Initiative
   • 17 Richard Greene
     Director of the Office of Health, Infectious Diseases and Nutrition
   • 18 Robert Clay
     Director of the Office of HIV/AIDS, Global Health Bureau
   • 19 Scott Radloff, Ph.D.
     Director of the Office of Population and Reproductive Health, Global Health Bureau

22 ASHLEY JUDD
“All That Is Bitter & Sweet”

24 TECHNICALLY SPEAKING
Steven Chapman, Ph.D., Chief Technical Officer, PSI

26 WHY SOCIAL MARKETING?
Expert Richard Pollard talks with PSI’s Steven Chapman

27 CONNECTING THE DOTS

28 WORLD POLICY MATTERS
   • 29 Water for the World
     By U.S. Rep. Earl Blumenauer
   • 30 The European Perspective:
     Former UN Envoy in Sudan Jan Pronk

31 MEASURABLE RESULTS

32 FINAL WORD
   • Karl Hofmann,
     President and CEO, PSI

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PSI is a leading global health organization with programs targeting malaria, child survival, HIV, reproductive health and non-communicable diseases. Working in partnership within the public and private sectors, and harnessing the power of markets, PSI provides life-saving products, clinical services and behavior change communications that empower the world’s most vulnerable populations to lead healthier lives. www.psi.org
2011 marks the 50th anniversary of the U.S. Agency for International Development’s establishment to improve global development efforts. www.50.usaid.gov

ACCELERATED MALARIA CONTROL DELIVERS RESULTS
December 2010 marked the end of a decade of accelerated malaria control, with PSI and other Roll Back Malaria partners striving to reach the Abuja targets set in 1999. This effort has resulted in impressive gains in child survival rates, with reductions of up to 50% in malaria-related deaths in a significant number of countries. These gains are largely due to prevention efforts with long-lasting insecticide-treated mosquito nets, which is arguably the most important public health success of the past 10 years. PSI has been at the forefront of this aggressive scale-up effort, delivering approximately 120 million nets and over 50 million net retreatment tabs in more than 30 malaria endemic countries. As the 2015 Millennium Development Goal deadline approaches, PSI stands ready to continue this scale up effort and ensure net coverage and use levels are maintained and millions of lives are saved.

1 CAMEROON TRAINED COMMUNITY HEALTH WORKERS REACH >49,000
With support from the Canadian International Development Agency, 456 community health workers (CHWs) were trained in Cameroon, to cover a catchment area of 9,605 households and 49,168 people. The CHWs distributed oral rehydration salts, zinc and artemesinin combination therapy and referred caregivers for pneumonia treatment for free.

1 EL SALVADOR IUD INSERTIONS
PASMO, PSI’s local affiliate in El Salvador, provided 6,118 intrauterine devices (IUDs) and 283 implants in 2010. These figures build on promising trends in El Salvador where access to family planning is limited.

2 BениN EXPANDING FAMILY PLANNING SERVICES
PSI launched its IMPACT project, which aims to help the Benin government employ USAID’s strategy to expand family planning services and HIV prevention measures among targeted populations in rural and commuter areas.

3 456 TRAINED COMMUNITY HEALTH WORKERS REACH >49,000 PEOPLE

95.7 BILLION LITERS OF WATER TREATED
PSI products – safe water solution, AquaTabs and PUR – have treated 95.7 billion liters of water in more than 32 countries.

95.7 billion liters
**“A TB free Udupi”**

TB DOTS

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**7 INDIA**
**REFER AND SMILE**
Tuberculosis is the largest single cause of adult illness and death from a communicable disease in India (World Bank). “A TB free Udupi” is the vision statement of a TB club formed with PSI support in Udupi district. The TB club comprises patients who are currently undergoing treatment, treated patients and DOTS providers. The club incentivizes referrals of TB suspect cases with its cadre of community volunteers, members and trained health care personnel.

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**4 LAOS**
**PRIVATE SECTOR CLINICS TO PROVIDE TB DOTS**
In Laos, TB represents one of the highest burden diseases (Global Fund). With its first TB case detection and treatment program, PSI uses targeted outreach activities, including innovative strategies such as SMS messaging, to improve case detection. In the next 7 months, PSI/Laos will recruit and enroll 50 private sector clinics to provide TB DOTS through the Sun Quality Health Network.

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**6 UGANDA**
**INCREASING DEMAND FOR FAMILY PLANNING**
PSI’s local affiliate in Uganda, PACE, is shifting consumer perceptions and creating demand for family planning through interpersonal communication, promoting the ProFam social franchise network with women’s groups, and endorsing ProFam services in radio and television spots. In 2010, PACE provided 16,979 intrauterine devices and 8,391 implants.

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**9 DRUG RESISTANCE MIGHT UNDERMINE GAINS IN MALARIA CONTROL**
The spread of parasite resistance to the only effective antimalarial treatment (artemisinin) available at present threatens to undermine the impressive gains in malaria control made over the past few years. The epicenter of this resistance is the Mekong Delta and the Thai/Cambodia and Thai/Myanmar border areas. PSI is currently working with the World Health Organization and other partners to develop and implement comprehensive resistance containment strategies.

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**4 ZAMBIA**
**MIDWIVES TRAIN COMMUNITY MEMBERS ON MISOPROSTOL USE**
Between January and June 2010, SFH, PSI’s Zambian affiliate, distributed 77,280 tablets of Misoprostol for the prevention and treatment of post-partum hemorrhage – the leading cause of maternal death – to 205 public health facilities in 10 rural districts approved by the Ministry of Health. SFH-certified midwives trained 522 facility-based providers and 392 influential community members on Misoprostol use.

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**5 ZIMBABWE**
**PSI HELPS DEVELOP NATIONAL COMMUNICATION ON TB AND HIV**
In Zimbabwe, a country with the 2nd highest tuberculosis (TB) mortality rate in the world, PSI supported the Ministry of Health and Child Welfare in developing a national communication campaign on TB and HIV. Using a combination of mass media and interpersonal communication channels, the campaign aims to: increase awareness about the link between both diseases; increase awareness about TB and symptoms; stress the importance of regular health check-ups and TB screening among people living with HIV; and increase uptake of HIV testing among TB patients.

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Dr. Rajiv Shah was sworn in as the 16th Administrator of the United States Agency for International Development (USAID) on December 31, 2009. Previously, Dr. Shah served as Under Secretary for Research, Education and Economics and as Chief Scientist at the U.S. Department of Agriculture, where he was responsible for safe, sustainable, competitive U.S. food and fiber system, as well as strong communities, families and youth through integrated research, analysis and education. Dr. Shah also held several positions at the Bill & Melinda Gates Foundation, including Director of Agricultural Development in the Global Development Program and Director of Strategic Opportunities. He speaks with PSI President and CEO Karl Hofmann.

Karl Hofmann: Dr. Shah, you are working to make sure USAID projects are moving toward an endpoint; essentially hoping to put USAID out of business in the long run. Is one of the ways in which countries will move toward self-sufficiency in health care provision by increased provision of health products and services through the private sector?

Dr. Rajiv Shah: Absolutely. I believe that global health investments, and development investments overall, are a critical part of keeping our country safe and secure and building an interconnected world that functions well and trades with each other and affords more and more people real opportunities. Because that mission is so important, we’ve really done an exhaustive review and identified an aggressive reform agenda that we call USAID Forward. It defines a set of principles for how we should do development assistance so we can achieve development objectives and, as you put it, put ourselves out of business. Really core to that is this understanding that ultimately our development investments should be replaced by vibrant civil societies, strong private sector activity, and effective, good governance and public service management. In health, a lot of what should follow major development activities is a vibrant private sector that provides health care services in a high-quality, verifiable way to low-income communities, and strong public sector systems that can continue to finance, resource, prioritize and train enough people so that you have a real vibrant and integrated health care system that can stand on its own going forward.

KH: You’ve stressed the need for USAID countries to drive economic development through “added-value” activities. Do you consider disease prevention programs to be added-value?

RS: Economic growth should increasingly be the central goal of all of our development efforts because that’s the engine of social improvement that brings better services and better quality of life to the poorest around the world. In health in particular, the investments made to reduce the burden and inequities in global health have huge impacts on economic growth and development. We have a large amount of data that show, for example, investing in malaria not only reduces all-cause child mortality but it frees up hospitals and health systems to treat and serve other patients. Over and above that, it has meaningful impact against economic growth as resources and people are free to engage in more productive activities than of course being sick or ill. What I think is less discussed is the huge toll of malnutrition and child stunting on economic development. We know that 3 percent of GDP in low-income countries is essentially lost to child malnutrition. Then there’s all the unmeasured impact of kids who are never fully able to realize their economic, intellectual and human potential because they suffered from hunger, malnutrition and disease as a child.

When you start saving kids lives and especially young kids, and you reduce child mortality, people then start having less children because they have a higher confidence that their children are going to survive and they start investing more in the health, education, well-being and unlocking the human potential of those fewer children. That’s really the real virtuous cycle that links improved child health to improved economic development.

KH: PSI’s affiliate in Nigeria, the Society for Family Health, became the first locally held Nigerian nongovernmental organization (NGO) to qualify for direct USAID funding. In many countries, that transition from local NGO to receiving direct funding from USAID can take a long time, often due to hurdles like lack of local capacity, insufficient infrastructure and even corruption. How can USAID best address this issue?

RS: Let me first congratulate you and PSI in Nigeria for achieving that distinction because it’s very important and it’s very much the actual vision of success: having strong local institutions that have these broad capabilities. USAID has a proud history around the world of investing directly in local institutions from Bangladesh Rural Advancement Committee in Bangladesh to NGOs in Guatemala and El Salvador, which I just visited. But it is not enough to congratulate ourselves for our past. We are being really aggressive about changing our procurement system so that we can make more direct investments in local institutions right now, everywhere. In Pakistan for example we’ve moved up from 8 to 49 percent of the total assistance portfolio going to local institutions and the Pakistani government. We’re trying to replicate that in many other parts of the world.
KH: USAID celebrates its 50th Anniversary this year. What would you like to see enduring out of the next 50 years?
RS: When President Kennedy created USAID in a letter to Congress, he talked about how development assistance had become disorganized and multifaceted, and we weren’t really living up to our potential to share American ingenuity and innovation, science and technology with the poorest communities and countries in the world. In creating the Agency, he really did launch a great run – those early decades in particular had USAID well-resourced, making real investments in infrastructure and growth, focusing on bringing science and technology to the poorest parts of the world. And we saw huge impact.

We believe that we have a similar opportunity today, and looking forward we want to do many of the same things. This Administration’s very committed to investing in growth, focusing on science and technology, addressing the crisis we currently face in food and hunger, and realizing the next frontier of global health, which I think is linked to immunization, malaria, and new more innovative approaches to both tuberculosis and HIV prevention. Across those areas of work we can save millions of lives, protect and reduce maternal mortality quite significantly, and prevent more than 50 million unintended pregnancies. So we have this huge opportunity to achieve dramatic, quantitatively measurable results, and I just hope we seize that and do everything we can to make those achievements real.

KH: In the past, siloed funding for global health projects has been fairly standard but now the Administration under President Obama has moved forward with the Global Health Initiative (GHI), which talks more about comprehensive health programs and integration and the need to strengthen countries’ own health systems. How do you see reconciling that need to integrate with the need to show real measurable success?
RS: At the end of the day when I think of the GHI, I’m most proud of the fact that in Kenya we have integrated family planning and maternal health services into the AIDS treatment platform of the U.S. President’s Emergency Plan for AIDS Relief.”

“...I’m most proud of the fact that in Kenya we have integrated family planning and maternal health services into the AIDS treatment platform of the U.S. President’s Emergency Plan for AIDS Relief.”

KH: Your new evaluation policy emphasizes transparency, monitoring and reporting on lessons learned. How will we hold local organizations accountable in the same way that we hold organizations accountable at the more macro level?
RS: We need to make sure that whenever we’re spending resources we’re learning something about the impact that spending is having, and we’re getting better based on that learning. Everything doesn’t need to be a big scientific study to observe success or failure; learn from it, and move forward. That is why we’ve made a commitment that all of our projects would be subject to evaluation. Those evaluations, no matter what they say, will be publicly available and from them, we will collectively learn and get better.

KH: You’ve said that USAID plans to graduate at least seven countries from U.S. assistance by 2015. What are the qualifications you anticipate for graduation?
RS: The main graduation criteria has to do with economic growth and development, the evolution of good governance, the ability to connect...
Mr. Abdullah Sellamani prepares boxes of condoms to ship from a PSI warehouse in Dar es Salaam, Tanzania.
The global health community is tasked with delivering fast and effective development assistance to resource-poor countries, while also working to build the capacity within those countries to sustain improvements in health, education, human rights and other development indicators. For years, international nongovernmental organizations (INGOs) have wrestled with finding the right balance between more direct implementation of program activities and longer-term goals of building local capacity to take on greater program responsibility.

Recently, the question of how to encourage long-term sustainability of development programs has come back to the foreground of the development agenda, partly because donors are emphasizing it, and partly because INGOs have their own experiences to share, test and validate. There is no disagreement on why; it’s where, how and when that pose the most difficult questions.

“Too often, our industry is full of incentives designed to prolong our efforts rather than reduce them or enable transitions,” U.S. Agency for International Development (USAID) Administrator Dr. Rajiv Shah told an audience in January. “As a result, handoffs rarely happen.” As part of a suite of USAID reform efforts introduced last year, the agency is placing a renewed focus on local capacity building. This includes accelerating funding to local NGOs and local entrepreneurs. “We must seek to do our work in a way that allows us to be replaced over time by efficient local governments, by thriving civil societies and by a vibrant private sector,” said Dr. Shah.

The U.K.’s Department for International Development, now known as UKaid, will expand partnership agreements with civil society organizations in developing countries, a vision laid out in a 2009 “White Paper.” Perhaps the single most important driver of increased local ownership of health programs is the Global Fund to Fight AIDS, Tuberculosis and Malaria. The specific programs to which $21.5 billion have been distributed since 2002 are developed by the recipient countries themselves – often through a collaboration between national governments and civil society groups. Principals of sustainability and local ownership are built into every grant that the Global Fund approves.

Various INGOs with an on-the-ground presence in the developing world have been working on these issues long before donors began to insist on them. What follows is a brief survey of how four INGOs approach the question of local ownership and capacity building.
FINDING THE CRITICAL PATH TOWARD TRANSITION

The Christian humanitarian organization World Vision applies a uniform paradigm across its programs to promote capacity building. World Vision calls this approach “transformational development.”

“We want to, from the beginning, think about our transitioning out of communities,” says Linda Hiebert, vice president for Program Effectiveness and Integration. “In order to do that we need to establish local partners and build their capacity to be able to sustain the programming.”

The primary platform through which World Vision seeks to implement this model is called the Area Development Program (ADP). This term refers to both the geographical location of World Vision’s work within a country and also to the way in which programs are implemented in partner communities. An ADP typically covers a well-defined geographical area of between 50,000 and 150,000 people. The specific health and education programs for these communities are developed in a collaborative process that includes local and national stakeholders. The ADPs are always locally managed, but overseen by World Vision national offices. An ADP typically receives an up-front commitment of 15 to 20 years, and built into each ADP is the goal of self-sufficiency and self-reliance.

Over the past several years, World Vision has undergone a review of its ADPs to identify some best practices. This process has led to the creation of World Vision’s Integrated Programming Model, which provides both standards for operating and a recommended road map for working with communities. World Vision calls this “the critical path.”

One important element of World Vision’s approach to questions of sustainability is its advocacy work. This happens at the international, national and even very local level. In Bolivia, for example, World Vision is training activists to petition local governments and municipalities for greater health and social welfare resources for their communities. “Local organizations are now both agents of change as well as agents of control,” says Hiebert. “Communities are beginning to do their own negotiations with the local health systems.”

TECHNICAL ASSISTANCE FOR LONG-TERM CAPACITY BUILDING

FHI’s clear emphasis on hard sciences and its evidence-based approach to both research and programs is reflected throughout its work. Over the past 40 years, FHI has evolved from a university-based research center examining contraceptive technologies to a global organization providing technical assistance and capacity building to the health and development sector in the developing world.

FHI’s approach to capacity building includes matching its scientific and management expertise to the local needs of the communities in which they work. “FHI has developed a systematic and comprehensive approach to capacity building that contributes to lasting improvements in the health and well-being of the world’s most vulnerable people,” says Al Siemens, CEO of FHI. “Our customized approach is informed by our deep understanding of local context and by the evidence defining best practices.”

FHI works with partners including ministries of health, research institutions, private sector and civil society to improve managerial and administrative systems. Through workshops, exchange visits and mentoring, FHI builds its partners’ skills in areas such as financial management, reporting, grant writing and resource mobilization. They also train local trainers who, in turn, continue to improve knowledge and skills long after FHI experts depart. Through meaningful collaboration, FHI and its partners consistently achieve high-quality delivery of services and research.

FHI’s approach is grounded in the provision of technical assistance, which includes a wide variety of programs like clinical research,
strengthening laboratory standards, and building health management and information systems.

FHI developed the Technical and Organizational Capacity Assessment Tool (TOCAT) to support its capacity building efforts. The TOCAT is used to guide FHI’s partners through each step as they use the tool to assess their financial, administrative, and technical needs and develop plans that increase their capacity to manage programs and deliver quality services over the long term. FHI provides customized assistance as partners develop and implement their action plans, improve services and use of resources, and produce lasting results. This approach has led to a number of successes. Through FHI’s capacity building efforts, it has helped more than 1,000 clinical research sites in 95 countries to improve the way they conduct investigations and report results. In a regional program covering 18 countries in West and Central Africa, FHI supported four institutions to become centers of excellence that provide cost-effective south-to-south technical assistance. Through partnership with FHI, institutions in Cameroon, Burkina Faso, Senegal and Ghana have become the region’s technical leaders in HIV counseling and testing, HIV care and treatment, and services to prevent mother-to-child transmission of HIV. FHI also works closely with ministries of health to bring national programs to international standards. FHI assisted the Government of Tanzania to develop standards and guidelines on HIV/AIDS care and treatment that are now being used across the country. In Zambia, FHI is collaborating with the Ministry of Health to improve the quality of lab services, HIV testing and treatment, and home-based care. These efforts are reaching over 200 health facilities and their surrounding communities.

Looking to the future, FHI and other organizations in the INGO community understand that local capacity building and the successful transition to local ownership of health and development programs will be key. This is a delicate and complex process requiring partnerships and collaboration at all levels. With over 1,400 implementing partners worldwide, FHI is committed to putting the long-term interests of the communities it serves above all else.

Advocacy plays an important role in the work of the International Planned Parenthood Federation. But, as its name suggests, IPPF is not a centralized organization. Rather, it is a collection of member organizations, each of which began as a fully independent organization working in sexual and reproductive health in one of 170 countries reached by IPPF.

“The big advantage of the federation model is that we are responding to local conditions in specific countries,” says IPPF President Dr. Jacqueline Sharpe. “The people working in Iran, Iraq or Afghanistan – those are Iraqis and Iranians and Afghans. They have a vested interest and they understand the culture absolutely and completely.”

Local organizations that seek to join the Federation must undergo a rigorous evaluation process. They must demonstrate that their mission and values align with those of IPPF and they must adopt a constitution that subscribes to IPPF’s code of good governance.

“Membership comes with responsibilities and benefits,” says Dr. Sharpe. Members are expected to work within IPPFs strategic framework, which includes program areas IPPF calls “The Five A’s:” Adolescents and young people; AIDS and HIV; Abortion; Access and Advocacy. Members are then eligible for some financial and technical assistance. The precise level of
this assistance is determined by the context in which the member operates. IPPF’s Mexican affiliate MexFam, for example, is skilled at raising independent funds and receives only a relatively modest portion of its funding from IPPF. Other member organizations, like the Family Planning Association of Burkina Faso must rely more heavily on financial support from the Federation.

Advocacy is also at the heart of IPPF’s work. At the Federation level, it lobbies donor governments and international forums like the United Nations and G20 for increased funding and donor attention to sexual and reproductive health. At the national level, Planned Parenthood associations will press governments to integrate sexual and reproductive health in national budgets. The Planned Parenthood Association of Ghana, for example, successfully lobbied the Ghanaian government to include reproductive health commodities in its 2010 budget and to integrate sexual health into its national health system.

These advocacy efforts, says Dr. Sharpe, are evidence of the effectiveness of IPPF’s diffuse federal model. “You could not want a better advocate for anything than the people who are doing the work themselves.”

MAXIMIZING HEALTH OUTCOMES ALONG A CONTINUUM OF LOCAL OWNERSHIP

In the 67 countries where PSI operates, there is no single template for how to strike the balance between the drive for measurable results and the need for greater local ownership. “It should be an evidenced-based decision, and we shouldn’t be ideological about it,” says PSI CEO Karl Hofmann. “But our premise is that deeper local roots are going to lead to a more sustained health impact.”

In over half of PSI’s country platforms, operations are carried out through a locally incorporated NGO affiliate, each of which benefits from a robust relationship with a wider, global support network: technical expertise, bridge financing, fundraising, research and metrics methodology, financial management and more.

The timing and pace of the move towards greater local governance of PSI’s programs are determined by the local context, with wide consultations between governments, partner NGOs and other local stakeholders. In Nigeria, Uganda and Namibia, PSI programs have evolved to full independence. For example, in 2009, PSI/Uganda supported a transition to a locally governed, locally managed program called the Program for Accessible Health Communication and Education in Uganda (PACE). The newly independent organization works in family planning, HIV, malaria, and other maternal and child health activities, and receives funding from several different donors. PSI serves in a minority capacity on PACE’s governing board and PSI’s global network provides technical assistance, donor relations, foundation funding and logistical support.

In some contexts, however, health outcomes cannot be maximized through the full transfer to local partners. PSI’s program in Southern Sudan, for example, is managed and supported by PSI global staff. In Cambodia, the program is somewhere in between – not yet fully independent but increasingly reliant on strong internal skills and capacity. The Cambodia program is representative of the majority of PSI programs, which fall in the middle of the spectrum and feature some level of PSI control, a steadily decreasing reliance on expatriate staff and an increasing involvement of local board members.

No matter where they fall on the continuum of local governance, PSI affiliates and partners value staying linked to the network, where they can access resources not available to them locally. “We at PACE stand on our own two feet these days, but we still feel like part of the PSI family,” says Dr. Susan Mukasa, director of PACE. “Whenever we need help in improving our health marketing campaigns, for example, we tap into the wealth of technical experience that PSI has to offer – from headquarters, regional offices or other country programs.”

In January, PSI brought together the presidents of the boards of directors of its francophone African programs for a summit in Benin. “Our idea was to show that they are connected to a larger network of PSI partners and that they have things to share with each other and we have things to learn from them,” says Hofmann.

Mark Goldberg is a freelance writer based in Washington, D.C.
On April 1, 2009, PSI/Uganda officially transitioned into a locally registered organization called the Programme for Accelerated Health, Communication and Education (PACE).

**EARLY YEARS OF RAPID GROWTH**

PSI entered Uganda in 1998 with funding from the United States Agency for International Development (USAID) for programs to prevent HIV, unintended pregnancies and malaria. PSI/Uganda also received funding through AIDSMark, a 10-year cooperative agreement funded by USAID and managed by PSI to mitigate the global impact of the HIV epidemic through the social marketing of HIV prevention products and services.

During these early years, PSI/Uganda developed and broadened its programs to include a wide range of products and services. The staff piloted a franchise model, called ProFam, to increase the reach of its HIV programs nationally. ProFam, which still exists today, delivered services through private antenatal clinics to prevent mother-to-child transmission of HIV and through public sector clinics for voluntary counseling and testing. PSI/Uganda scaled up its behavior change communications activities and launched PSI's first basic care package for people living with HIV/AIDS. During this period, PSI/Uganda also expanded its portfolio to address the country's safe water crisis through the social marketing of point-of-use water treatment products.

**SCALING UP PROGRAMS AND INCREASING CAPACITY TO MEET HEALTH CHALLENGES**

By 2005, PSI had been in Uganda for almost a decade, making a measurable health impact on the most vulnerable populations, and it sought to scale up its programs across health sectors.

Donors, realizing that Uganda was a high-capacity country, were starting to fund more local nongovernmental organizations (NGOs) as lead implementers of programs. Transitioning PSI/Uganda into a local NGO would better position it to meet the country's health challenges while acquiring a diversified funding base.

To set the transition in motion, PSI/Uganda invested in developing the capacity of its host country staff through in-country and international trainings. For example, the PSI/Uganda research director spent several months in D.C., which enabled the platform to distinguish itself as one of PSI’s best research platforms in the region. PSI/Uganda also tasked each expatriate technical advisor on the platform to identify, train and mentor local talent.

The efforts in capacity building paid off. By 2009, host country national staff filled every technical advisor position—almost all of them trained by PSI’s technical advisors who formerly filled the position. And when PSI/Uganda transitioned into PACE, its first and current director, Dr. Susan Mukasa, a native Ugandan, was successfully groomed to take on the top management role. PACE also assumed the PSI/Uganda board and its membership.

As a result, PSI/Uganda was better suited to meet the needs of the population and received grants from the U.K. Department for International Development, UNICEF, Procter & Gamble, the Bill & Melinda Gates Foundation and other foundations to launch new products and restart its family planning program.

**A PARTNERSHIP FOCUSED ON GENERATING HEALTH IMPACT**

PACE remains very connected to PSI. PACE’s affiliation to PSI uniquely positions it to receive a number of services from the global network: support with business development and governance, financial and business services, regional collaboration and knowledge exchange, technical services and capacity building.

“PSI experts are always ready to support PACE staff to improve our skills and capacity when the need arises,” said Dr. Mukasa. “Though we no longer call ourselves PSI or think of ourselves as a local branch office of an international NGO, we believe that we are stronger as part of the PSI network than we would be on our own.”

From January to December 2010, PACE estimates that it was responsible for an 11.9 percent reduction in the burden of disease in Uganda among the health areas in which it specializes. With its local roots and global support from the PSI network, PACE is positioned to continue addressing the health challenges in Uganda.

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**PSI Author:** Jyoti Kulangara, Features Editor, Impact, Washington, D.C.
The United States has a long history of helping people in need, in countries around the world. At times, this has meant helping a nation recover from a disaster or helping families access basic food and shelter to survive. In 1961, with Americans feeling increasing dissatisfaction with the foreign assistance structures that were currently in place, President John F. Kennedy reorganized U.S. foreign aid programs and created the U.S. Agency for International Development (USAID) by executive order.

Since that time, USAID has been the principal U.S. agency to extend assistance to countries recovering from disaster, trying to escape poverty and engaging in democratic reforms. USAID focuses its investments on innovative, cost-effective solutions that save millions of lives and create the conditions so that assistance will no longer be needed, while ensuring that America's long-term national interests are served.

In this section, leading USAID officials speak with Impact Editor-in-Chief Marshall Stowell about the agency’s comprehensive approach to tackling the world’s most serious health challenges and its vision for creating sustainable health systems for future generations. PSI hopes these interviews will further the global dialogue on the impact and importance of U.S. foreign assistance programs.
Susan Brems became Senior Deputy Assistant Administrator in the Bureau for Global Health in July 2010. The Bureau supports field health programs, advances research related to USAID health objectives and transfers new technologies to the field. Before the Bureau, Ms. Brems served as Mission Director of USAID/Angola (2007-2009). She also held the position of USAID Deputy Mission Director in Peru and Nicaragua. Ms. Brems’ career in international development spans 33 years, 17 of which have been with USAID.

**IMPACT:** What are some of the overarching health challenges like malaria, HIV/AIDS, tuberculosis, reproductive health and child survival?

**SUSAN BREMS:** These challenges can be grouped into two categories. Some apply to all technical health areas and some are specific to each health area. Among the overarching challenges, resources are primary. By resources I mean financial, human and technical resources – all of the wherewithal to carry programs into the interior of countries and take them to scale. The other part would be the challenges that are specific to various health areas. For example, in HIV, we’ve been a little bit hamstrung by the lack of a tool kit for prevention; with recent breakthroughs, now that’s moving forward quite a bit.

**IMPACT:** Your Ph.D. dissertation focused on reproductive health of rural women in Brazil. As a leader in the Global Health Initiative – which takes a woman- and girl-centered approach – what are the key activities moving forward that will improve the health of females in developing countries?

**SB:** A common mistake that we make in the field is that we presume a program is woman centered or girl centered by virtue of having females as our target group. To the extent that we can move from seeing women as beneficiaries of programs to employing them in a sincere way in program design, management, supervision, quality control and customer satisfaction, I think then we’ll really have a woman- and girl-centered approach.

**IMPACT:** Using science and technology to develop transformative tools is a principle that defines USAID’s development work. What are other technologies that you are hopeful will provide similar advances?

**SB:** This past year was a banner year, with the success of the CAPRISA 001 clinical trials on a microbicide; this is an area where we’re working intensively. We are looking forward to confirmatory studies that can lead to speedy approval of [tenofovir gel] and then participate in the roll out. There also are new immunization technologies that have been proven for rotavirus and pneumonia, and there are the challenges of scale and financial resources to roll them out. In contraceptives, we have new generations of contraceptives coming online that we’ll continue to support. Double-purpose HIV and pregnancy prevention would be a really wonderful thing for women. So it varies, but I think we have on the horizon a number of successful technologies.

**IMPACT:** According to Transparency International, 40 percent of the poorest countries in the world also rate as the most corrupt. USAID is developing methods to manage and overcome corruption. How can international nongovernmental organizations help ensure that corruption does not stymie delivery of health products and services to the world’s poor?

**SB:** Health development programming, whether it’s in the public sector or with NGOs, can be a wonderful way to work on transparency. As we move more and more towards country ownership, we need to make sure that the systems are in place that ensure good stewardship of financial resources. Therefore, it’s incumbent upon us, as a partner in development, to work with governments and NGOs and to facilitate the work of NGOs with public sector groups and with smaller organizations to build those systems of internal controls.

**IMPACT:** USAID’s approach to maternal and child health includes evidence-based interventions like malaria treatment, safe delivery and treatment of obstetric and newborn complications. What role should the private sector, and social franchising in particular, play in delivering these services to the most hard-to-reach populations?

**SB:** I think PSI and others – and I commend PSI for its leadership in this field – have been wonderful in pioneering a segmented market approach that takes into account that we have heterogeneous populations that vary in their ability to pay for health technologies and accommodates to that. Social marketing addresses access and sustainability at the same time.

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IMPACT: A new Global Health Initiative (GHI) Executive Director, Lois Quam, has recently been named. What will be the organizational relationship between USAID’s Global Health Bureau and the Executive Director?

Amie Batson: Lois sits in the State Department and is reporting to the GHI operations Committee and the Secretary of State. The operations Committee is comprised of USAID Administrator Dr. Shah, Director Frieden of the Centers for Disease Control and Prevention (CDC) and Ambassador Goosby of the Office of the U.S. Global AIDS Coordinator. She is facilitating the day-to-day management of GHI as well as the transition of GHI to USAID leadership in September of 2012.

IMPACT: You have worked at the WHO, UNICEF and the World Bank. How have these jobs prepared you for your current role, especially as one of several principles that guides GHI is to strengthen and leverage key multilateral organizations and global health partnerships?

AB: I’ve worked at UNICEF, WHO and the World Bank. This has helped me in two big ways. One is that I know the skills each of these different agencies bring to the table. We are reaching out to see how we can draw on the World Bank’s strength in health system strengthening or in economic development. Second, I’ve seen how different institutions are structured and seen some of what works well, and what doesn’t and can bring some of that learning into both the U.S. government, and USAID specifically, to see how we might improve the way we do business.

IMPACT: In addition, your work has been focused on improving health systems through the use of results-based financing mechanisms. How will that inform your work with USAID to make developing countries’ health systems sustainable?

AB: Results-based financing is about looking at health in a different way, one based on outputs not inputs. We focus largely on ensuring that all of the pieces that are required are present – the right number of trained staff, adequate vaccine supplies and the right facilities – but we need to make sure all of these pieces work as effectively as possible to produce outcomes. Results-based financing provides a small incentive at the point of care based on outputs. But it’s not an either/or; it’s a question of having that additional incentive to unleash the creativity and energy of the health workers to ensure that at the end of the day the whole continuum of care is realized.

IMPACT: What are the long-term implications on improving the health of people in developing countries if Congress reduces funds for foreign aid programs?

AB: With the H.R. 1 [House Appropriations Committee Continuing Resolution] cuts, USAID health funding would drop by 33 percent from the FY10 levels and by 29 percent from our FY11 requests, so it’s a very significant decline. More than 70,000 children under 5 will perish – 30,000 from malaria, 24,000 from a lack of basic

FOREIGN AID SPENDING

- PERCENT OF FEDERAL BUDGET THE PUBLIC BELIEVES IS SPENT ON FOREIGN AID: 25%
- ACTUAL AMOUNT SPENT BY USAID ON FOREIGN AID: LESS THAN 1 PERCENT
Rear Admiral Tim Ziemer was appointed in June 2006 to lead the President’s Malaria Initiative (PMI), a historic $1.2 billion, five-year initiative to control malaria in Africa. Prior to his appointment, he served as Executive Director of the humanitarian organization World Relief, as a Senior Fellow with the Navy’s Strategic Studies Program at the Naval War College and as Deputy Director for Operations in the National Military Operations Center on the Joint Command Staff.

➤ IMPACT: What is the role of the private sector in controlling malaria?
TIM ZIEMER: When discussing the private sector, we have to understand what exactly you mean by private sector. Do you mean licensed pharmacies? Do you mean the private sector that produces nets, anti-malaria drugs, rapid diagnostic kits and insecticides? Or do you mean the mom-and-pop stores that sell tires, cooking oil and anti-malarial drugs? The role of the private sector in all three of those areas is critical. We’re heavily dependent on the private sector to produce and maintain malaria prevention and interventions. In many of the African countries 50 to 60 percent of health services are provided by the private or the faith-based component. However, when it comes to the mom-and-pops, due to the concerns about safety and the existence of pirated anti-malarial drugs, we have to ensure that the drugs are dispensed by appropriate vendors.

IMPACT: Do you think the Affordable Medicines Facility - malaria (AMFm) model can address issues around the availability of artemisinin-based combination therapies (ACTs)?
TZ: The U.S. government is fully supportive of providing safe, effective ACTs at a very low cost to those who need it the most. But when you look at the AMFm model and what it aspires to do and how to get there, it begs a number of questions. The eight or nine countries where AMFm is currently modeled need to produce
To continue working with other donors and technical partners such as the Bill & Melinda Gates Foundation, the U.K. Department for International Development (UKaid), WHO and the four or five countries where the resistance is evident to determine the scope and range of the resistance and the appropriate action needed to confine and reduce the resistance. We are also supporting strengthening of systems to deliver more effective case management of malaria and to improve supply of good quality drugs, as well as research to develop new drugs to treat malaria.

**IMPACT:** What is PMI doing to support the containment of artemisinin resistance developing in Southeast Asia and, longer term, to reduce the risk of resistance developing elsewhere?

TZ: The World Health Organization (WHO) just released a global plan to combat resistance, and the U.S. government is supportive of it. We fund the program in the region and intend to continue working with other donors and technical partners such as the Bill & Melinda Gates Foundation, the U.K. Department for International Development (UKaid), WHO and the four or five countries where the resistance is evident to determine the scope and range of the resistance and the appropriate action needed to confine and reduce the resistance. We are also supporting strengthening of systems to deliver more effective case management of malaria and to improve supply of good quality drugs, as well as research to develop new drugs to treat malaria.

**IMPACT:** What needs to happen over the next five years to achieve the Roll Back Malaria goal of near zero malaria deaths across the globe by 2015? And what needs to happen after that?

TZ: The goal of near zero malaria deaths by 2015 is pretty ambitious. But the fact is that we can do it. We know what causes malaria, we know how to prevent it and we know how to treat it. If we can get the national governments behind their plans, continue to use available resources for effective prevention and treatment we have today, and more importantly, develop a very robust case management program to diagnose fevers, identify malaria and treat it with ACTs, we can get there.

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**IMPACT:** Considering the realities in countries such as Nigeria and the Democratic Republic of Congo, is it a priority to focus resources on malaria elimination?

TZ: None of the 15 countries where PMI works is in the pre-elimination phase. A few countries, like Senegal, are bumping up against pre-elimination. As the country sees the success of its prevention and treatment program and sees sectors or districts nearing a pre-elimination phase, then its national plan has to address that, and we will continue working together.

But when we get to the discussion of elimination, we have to look at the global malaria action plan. At the end of World War II, there were 200 countries that had malaria. Today, we have 104. So we are making progress. The real question is how do we continue to make progress so that we go from a prevention and treatment phase to a sustained control phase and eventually to an elimination phase?

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INTERVIEW WITH

RICHARD GREENE
DIRECTOR OF THE OFFICE OF HEALTH, INFECTIOUS DISEASES, AND NUTRITION AT USAID

Richard Greene began his career as a Peace Corps Volunteer in Côte d’Ivoire in 1978. After taking a job with USAID in 1984, he spent 15 years overseas in places like Sudan, Cameroon and Bangladesh. Mr. Greene has been principally recognized for his work on the President’s Malaria Initiative (PMI).

IMPACT: Nutrition is a key component of four Millennium Development Goals (MDGs): reducing poverty and hunger; reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other diseases. How have the MDGs helped motivate the U.S. government to make child nutrition programs a top priority?

RICHARD GREENE: The MDGs have helped put global health development on the map by setting clear targets and documenting progresses that have been achieved. Nothing persuades people that health is a good investment more than documenting successes.

IMPACT: USAID Administrator Dr. Rajiv Shah has stressed the important role that innovation should play in achieving America’s global development objectives. What are some of the promising innovations in your program areas?

RICHARD GREENE: If you look at neonatal mortality, we have a number of innovations such as the Gentamicin antibiotic used by community health workers and the cream Chlorhexidine that can be put on the umbilical cord to prevent infection. For pneumonia, we have a birth dose of vitamin A that can reduce mortality in newborns. We continue to develop and scale up these innovations in countries in order to reduce the burden of disease and mortality.

IMPACT: Much of the reform efforts underway at USAID seek to promote local capacity building. What are examples of programs that are markedly moving local organizations toward full ownership?

RICHARD GREENE: In our malaria program, PMI, we work with more than 140 faith-based and local organizations. Sometimes they help deliver services or run health clinics in Africa where there is no formal public health system. Other NGOs will do information and advocacy. Almost any development activity that USAID supports can be done by local organizations if their capacity is present.

IMPACT: You’ve noted the American public’s skepticism of funding development programs overseas when there is need at home. How do you make the case to Americans and to Congress in the face of budget cuts that funding for health programs in the developing world is critical?

RICHARD GREENE: First, the public thinks that we spend about 10 to 15 percent of our budget on international development when we only spend about 0.3 percent of a percent. Second, investments in programs such as avian and pandemic influenza and tuberculosis (TB) will prevent these diseases from spreading to the U.S. And third, I think we all believe that producing allies and helping developing countries develop is good diplomacy.

IMPACT: How do you see approaches like social marketing and social franchising fitting into the U.S. government’s strategy to provide affordable health products and services in developing countries, particularly in regard to cost-efficiency?

RICHARD GREENE: Almost any low-cost public health intervention where people are willing to pay a few cents can be socially marketed. Particularly in urban areas, [social marketing] can be a very good development tool.

IMPACT: USAID values integration and collaboration in order to more efficiently meet global health goals. In what ways does your division collaborate with other agencies’ leadership, working to prevent and treat nutrition, maternal and child health, and infectious disease?

RICHARD GREENE: We can’t achieve anything without collaborating with other development partners. When we go into a country, we may be the biggest donor but we depend upon the Global Fund. We depend on other governments. We depend on the World Bank to provide investments. Our ability to establish coalitions and collaborative work and activities is critical to our success.

IMPACT: Malnutrition exacerbates the burden of infectious diseases, such as TB and HIV/AIDS. Thus, improving nutrition interventions is vital to the success of infectious disease programs. What is the role of education and behavior change in preventing malnutrition and subsequently infectious disease?

RICHARD GREENE: Behavior change is critical. Children are malnourished because mothers do not understand the need of dietary diversity, frequent feedings, exclusive breastfeeding for the first six months, good weaning practices or the need for micronutrients. It’s not enough to give a mother an insecticide-treated bed net. She has to understand that everybody has to sleep under the net, not only during the rainy season when there are a lot of mosquitoes, but also during the dry season when the mosquitoes aren’t so apparent. Behavior change and education are critical to all of our health programs.

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Robert Clay is the Director of the Office of HIV/AIDS in the Bureau for Global Health at USAID. In his role, he is leading the office through the second phase of the President’s Emergency Plan for AIDS Relief (PEPFAR), which is being implemented under Global AIDS Coordinator, Ambassador Eric Goosby.

**IMPACT:** This year marks the 30th anniversary of the first diagnosis of HIV. What do you think have been the greatest successes and failures in the last 30 years in efforts to fight the disease?

**ROBERT CLAY:** Without a doubt, the greatest success in efforts to fight HIV has been the rapid expansion of access to life-saving anti-retroviral treatment (ART). After seven years of ART scale up, about 5 million people are on treatment in poor and middle-income countries around the world. This is an incredible success story. ART is not just saving lives, it is preserving the social fabric for families and communities. But there are more than 33 million people living with HIV who will eventually need treatment and about 2.6 million new infections each year, roughly double the number of new patients who initiate ART. The math does not add up. We will never get ahead of the epidemic unless we turn off the tap of new infections.

So our greatest challenge lies in prevention. While we have had some successes in prevention, especially in concentrated epidemics such as in Brazil, India and Thailand, when it comes to the generalized epidemics in Southern and East Africa that bear the greatest global burden of disease, the progress is mixed. In my own view, however, it is not that prevention has failed in generalized epidemics, but that it has not been fully tried, at scale, with a systematic, data-driven approach and interventions of adequate coverage and quality. We must intensify our prevention efforts, and we must do better than we have done over the last 30 years.

**IMPACT:** What HIV prevention interventions do you consider the most challenging to achieve impact with, and why?

**RC:** The broad area of structural interventions remains largely underdeveloped and is a major gap in advancing combination prevention. I’m speaking especially with respect to generalized epidemics. There is a better understanding of the role of structural interventions in creating an enabling environment to address the needs of most-at-risk populations in concentrated epidemics. There are indications that intervening structurally in generalized epidemics could have a big pay-off. Take for example the World Bank-funded study of cash transfers for young women in Malawi. Although the results have yet to be published or replicated, the cash payments appear to have altered the context of risk by influencing the young women to choose younger male partners who were less likely to be HIV-infected, thereby reducing HIV incidence by about half.

**IMPACT:** How is your office contributing to efforts to build the evidence base for behavioral prevention interventions?

**RC:** There is already substantial evidence from intervention research, both domestically and internationally, that behavioral prevention interventions work to reduce HIV risk behaviors. As part of USAID’s agency-wide mandate to reinvigorate evaluation, the Office of HIV/AIDS is planning to further increase support for rigorous impact evaluation to further expand this evidence base. In the future, however, I expect evaluation efforts to give greater emphasis to assessing the impact of “prevention packages” that include a combination of biomedical, behavioral and structural interventions, recognizing the importance of both the contribution of individual interventions, and the interactions and synergies between them.

**IMPACT:** USAID values integration across health areas to more efficiently meet global health goals. What key integration approaches
Interview with

Scott Radloff, Ph.D.

Director of the Office of Population and Reproductive Health, Bureau for Global Health at USAID

Scott Radloff heads the Office of Population and Reproductive Health at the Global Health Bureau. In 2008, he was a patron of USAID’s public-private partnership with Johnson & Johnson and the World Wildlife Fund, which was the first major global development alliance to focus on an integrated approach to tackling population, health and environmental issues.

**Impact:** The Global Health Initiative (GHI) was introduced nearly two years ago and promised a renewed focus on women and girls. In what ways has GHI encouraged greater access to family planning services?

**Scott Radloff:** GHI includes family planning as one of its goal areas, so it elevates family planning in priority along with maternal and child health and so it’s gaining attention in USAID programming. In addition, GHI puts an emphasis on partnerships, so we’ve been able to enter into partnerships with multilateral and bilateral donors around the world and to work in concert to improve access to family planning services. For example, we’ve been engaged in partnerships with various donors including the alliance for reproductive, Maternal and newborn health, which is an alliance that brings together the resources of several donors including the U.K. Department for International Development, Australian Agency for International Development and the Bill & Melinda Gates Foundation. Through that alliance, we’ll be able to generate additional resources for family planning and maternal and newborn health, and to better coordinate those resources.

**Impact:** USAID Administrator Dr. Rajiv Shah has stressed the important role that innovation should play in helping to achieve America’s global development objectives. What are some of the promising innovations in reproductive health and family planning?

**Scott Radloff:** We have supported for over ten years the development of a new contraceptive device called ‘depo in uniject’. It takes the injectable contraceptive and places it in a single device attached to a needle that can be given subcutaneously. That will enable the injectable contraceptive to be administered by community health workers at the community level. We’ve also invested in a product that is a one-year hormonal ring. It’s similar to the ‘NuvaRing’ that’s available in the U.S., but it’s a one-year ring that would be the first method that would be woman-controlled and would provide effective protection for one year. It can be delivered to a woman in her community, and she will be able to stop using it whenever she wants to become pregnant.

**Impact:** What role can the private sector play in providing reproductive health services and products in developing countries?

**RC:** USAID, as the premier development agency, has always advocated for integration as an essential strategy to address the health and development needs of the populations that we serve. We advocate for smart integration which requires a strategic review of different program(s) to identify opportunities, fill gaps to increase efficiency and effectively meet the needs of clients. USAID does not use one specific integration approach; rather, we adjust our approach based on the different contexts and needs for each country. Most recently, PEPFAR, with USAID as a key agency, released integration guidance to support the linkage of prevention of mother-to-child transmission with maternal, newborn and child health services.
SR: Well, when we talk about strengthening health systems in developing countries, we talk about the whole system. It's the government systems and it's the private and nongovernmental organization (NGO) providers of services, so a vibrant and effective health system is one where all of those actors are playing a role. And we know that as countries advance, the role of the private sector expands as people are better able to afford services. Roles change, and we see a very important role for NGO and private sector involvement, increasingly so over time.

IMPACT: In recent years, many in the development community have seized upon the “Girl Effect”—the idea that investing in girls and adolescent women will have a compounding effect on other development goals. Are there specific programs that USAID supports to help attain the “Girl Effect”?

SR: We know that girls have a high unmet need for family planning or high risk for unintended pregnancy, so we need to find creative ways of reaching them with information and services.
and by doing so, we can help them stay in school and pursue careers. Traditionally, we’ve been supporting programs that provide information and education to girls and adolescents – family-life education programs in schools is one example; educating counselors who can talk to their peers about family planning, HIV and other reproductive health issues is another. I think as we go forward, we’re going to see more use of communication tools like cell phones and look at new technologies for better reaching youth with information about family planning and protection from sexually transmitted diseases.

**IMPACT:** The world population will reach 7 billion in 2011, a milestone that will significantly impact our climate and the sustainability of our planet. How might family planning and reproductive health play into that issue?

**SR:** Well, the fact that we’ve reached 7 billion in a little over 12 years, I believe, shows you that we have an increase in population that needs family planning services. So just to maintain current levels of contraceptive use, you have to increase access by 3 percent a year. To make progress, we have to do better than that in the fast-growing developing world.

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**1980s**

- **Family planning programs expand to address such critical issues as maternal/child health and population and the environment.**

- **1982**
  - USAID issues a policy paper stating that family planning programs will be based on fundamental principles of voluntarism and informed choice.

- **1984**
  - President Reagan announces the “Mexico City policy,” a regulation that prohibits non-U.S. nongovernmental organizations receiving USAID population assistance funding (either directly or through sub-awards) from using their own or other non-USAID funds to promote abortion as a family planning method.

- **End of 1980s**
  - USAID recognizes a “resource gap” between the cost of population programs and donor/public sector funding; USAID engages the private sector to meet the growing need.

**1990s**

- **USAID stresses quality of life issues, including women’s needs, and also recognizes the need for male involvement in family planning. As the decade progresses, young people’s needs also receive increasing attention.**

- **1993**
  - President Clinton rescinds the Mexico City policy.

- **1995**
  - USAID launches its five-year FOCUS on Young Adults reproductive health program.

- **1998**
  - Congress enacts the Title X amendment, reaffirming and elaborating voluntary standards for family planning projects.

- **1999**
  - World population tops 6 billion.

**2000s**

- **The Office of Population & Reproductive Health (Pop/RH) becomes part of the newly established Bureau for Global Health.** The focus of Pop/RH work remains constant, but there are new emphases on contraceptive security and combating HIV/AIDS through family planning. Male involvement and, through the new YouthNet program, the reproductive health needs of adolescents and young adults remain important program areas.

- **2000**
  - USAID announces a policy recognizing female genital cutting as “a harmful practice that violates the health and human rights of women and hinders development.”

- **2001**
  - President Bush reestablishes the Mexico City policy. The policy does not restrict organizations from providing post-abortion care or from treating injuries or illnesses caused by legal or illegal abortions.

- **2002**
  - The Office of Population/Reproductive Health formally established a Population-Environment program in response to legislative language in the FY02 Foreign Operations Appropriations Act, stating that an unspecified portion of funds allocated for family planning and reproductive health should be used “in areas where population growth threatens biodiversity or endangered species.”

**2009**

- President Barack Obama rescinds the Mexico City policy.

- Under the GHI the number of USAID FPRH priority countries is expanded from 13 to 24 to reflect overlapping priorities and synergies with MCH.

**2010**

- USAID partners with DPDH, AusAID and the Gates Foundation to create the Alliance for Reproductive, Maternal and Newborn Health. The Alliance will work to accelerate progress in averting unintended pregnancies and reducing maternal and neonatal mortality.

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**WATCH THE INTERVIEW WITH SCOTT RADOFF AT WWW.PSI.ORG/IMPACT6.**
everything in Mumbai is extreme: the heat, the traffic, the noise, the crush of human bodies everywhere. And nothing I’ve done or seen could have prepared me for what passed for a housing compound in the depths of Dharavi, the sprawling area made internationally famous in the film Slumdog Millionaire. We were surrounded by dozens of squealing children as soon as we parked the car. I emerged at the opening of a tiny, dark tunnel running between two shanties from which a tiny figure in a bright sari materialized. It was Nasreen, the 16-year-old daughter of Kausar, one of PSI’s peer educators, who lived at the other end of this ghastly passageway. It was entirely black, no light source at all, about 18 inches wide and less than 6 feet high. The uneven cement was wet from an unseen water source. Was it sewage? I hunched down, let my eyes adjust, and held Nasreen’s hand as she escorted me into the reality of this “apartment” complex that accommodates 10,000 people. Our route twisted and turned unexpectedly, I never got my bearings. The sounds of people living their lives was all around us, animated conversations, a TV blaring (there is more jerry-rigged electric around here than I’ve ever seen, it’s amazing none of it catches fire), babies crying. The children who had been at the car when I arrived would crazily appear in cracks in the tunnel along our way, popping out of crevices so small I hadn’t thought they were passageways, yet from floor to ceiling the narrow, dark space would impossibly fill with faces. It was like being in a nightmare version of a fun house at the fair, the type where you are constantly jolted by unexpected, unwelcome surprises...but there is very little fun at this fun house.

Eventually, Nasreen and I arrived at a crude wooden ladder, which we climbed up into the two tiny rooms she shared with her HIV-positive mother and her brother. Incredibly, this was a duplex affair, one hovel stacked on top of the other, once the horizontal space ran out. I was speechless at the poverty of their living space, which Nasreen had spiffed up by plastering recent newspapers soaked in flour and water over the corrugated tin walls.

When Kausar found out she was HIV-positive in 1999, the doctor told her, “There are drugs, but you cannot afford them, and you’ll be dead in five years anyway.” Indignant, she ripped her test result paper in half and slapped him across the face. He pressed charges. In court, she spoke on her own behalf. “Have I raped someone? Killed? Stolen? Kidnapped? What have I done?” The judge saw things her way, and demanded the doctor pay her a small fee in damages. Hence, a spitfire of an HIV activist was born. Kausar now works for PSI escorting other HIV-positive patients when they go to doctors and coaching them through their care.

Kausar has a very charismatic faith and credits God for her strength. When troubled, she prays for 30 minutes then “goes out and gets the job done.” She prayed for me, a long, intent, sincere petition that culminated in a joyous series of alleluias. Like Lucy in Guatemala, and so many others I had met, she transformed her life through service to others. It was deeply moving to me.

I was told how, during their hard times, when Kausar was so sick from AIDS, Nasreen scrounged for her family to stay alive. She begged. She worked. Eventually, she herself went so hungry, a teacher finally reached out to her, learned the story, and personally gave her money for food. A lovely girl, Nasreen wants to be a doctor. I braided her hair, undid it, and braided it again, just to be able to nurture her more. The sweetness of the moment was almost unbearable. Before I left, we had a little talk about our bodies, because Kausar admitted that she hadn’t ever discussed sex with her nearly adult daughter.

Nasreen leaned into me, holding my hand (she grabbed it back if I ever released hers) listening. I said to her, “Your body is beautiful and sacred, do you believe me when I say that?” (Yes.) You are beautiful and sacred, do you believe that about yourself? (Yes.)

I came to India for Nasreen.
ASHLEY JUDD

became a global ambassador for PSI in 2002 and joined as a Board Member in 2004. Through her work, she has discovered the need for a holistic, balanced approach to conquer human rights, global health and social justice atrocities, and she has worked to bring PSI and partners together to address complex public health issues that affect women and other vulnerable populations around the world.

Ashley visited Washington, D.C., while promoting her new memoir in April, and sat down for an interview with Marshall Stowell, Editor-in-Chief of Impact magazine. Marshall has joined Ashley on nearly all of her 13 PSI trips across Africa, Asia and Latin America. Together, they talked about what they had witnessed in the slums, brothels and war-torn countries.

Watch “India’s Hidden Plague,” a documentary following Ashley Judd’s mission to fight HIV/AIDS in India.

www.snagfilms.com/films/title/indias_hidden_plague

Follow Ashley Judd on Twitter @AshleyJudd.

Ashley Judd and Marshall Stowell on stage at the 6th and I St. Historic Synagogue in Washington, D.C. Watch the full conversation online at www.psi.org/impact6.
In early February, while Chrestien Yemeni was working for PSI’s affiliate, the Cameroon Social Marketing Association (ACMS), he attended a workshop on innovation. The pressures on him were clear to see. He was repeating “yes, right away” into his mobile phone in one hand. In the other hand was a coffee cup and pulling down his shoulder, a work bag.

Five years ago, PSI was already working at a very large scale in more than 60 countries around the world. Today, we are nearly double the size. For Chrestien, in his sixth year at PSI, his workload is bigger too, and a lot more complicated.

Chrestien is the 21st century knowledge worker on the front lines of global health, facing enormous, complicated, never-before-solved-before challenges, limited resources and difficult contexts.

He and his supervisor, Jean-Chrétian Youmba, are in their second year leading one of PSI’s newer and potentially very critical activities – piloting a high-profile project delivering treatments for malaria and diarrheal-induced dehydration through village health workers in Eastern Cameroon. The project is a hydra – with epidemiology, supply chains, evaluation research, training, partnerships, and behavior change of providers and caregivers as its heads. Its donor, the Canadian International Development Agency, wants to know whether large numbers of community-based health workers and caregivers can administer these treatments in a manner that reduces child mortality. Cheaper, better, faster.

Leading this initiative would test the training, skills and stamina of anyone. It requires that Chrestien develop solutions never before tried at scale, and work under time and financial pressures a long drive away from his home.

Chrestien has a master’s in public health. He is the 21st century knowledge worker on the front lines of global health, facing enormous, complicated, never-before-solved-before challenges, limited resources and difficult contexts.
Steven Chapman leads PSI's efforts to improve the effectiveness, cost-effectiveness and equity of its interventions. He manages PSI's Technical Services team, which consists of about 50 experts in five departments: Malaria and Child Survival; Sexual, Reproductive Health & TB; Research & Metrics; Social Marketing; and Learning and Performance.

PSI/Burundi staff teaches a full classroom of students about the importance of drinking safe water.

health and came to PSI with more than a decade of experience that made him a gifted trainer, coach and manager. However, these credentials, in and of themselves, are not enough.

For everyone in PSI today, this is arguably the case. Chrestien is the 21st century knowledge worker on the front lines of global health, facing enormous, complicated, unsolved challenges, limited resources and difficult contexts. How, really, can PSI enable him to do his job?

Finding the answer to that question is what Steven Honeyman, director of PSI’s Learning and Performance department, his team, and many across PSI seek everyday in our organization-wide learning initiative. Capacity building has long held a prominent position in international development. There are manuals, toolkits, theories, websites, books, workshops, networks, e-this, m-that, projects, programs, agencies and high-level goals dedicated to it. There is no shortage of learning about learning.

Why is it then that learning about learning is turning into one of the most valuable initiatives in PSI today? Because it appears when and only when PSI succeeds at learning, Chrestien Yemeni can do his job.

Chrestien’s most important contact with learning in PSI came when he won a place in our six-week Malaria and Child Survival Associates training. The training was instituted by Desmond Chavasse, PSI’s vice president for Malaria and Child Survival, and Ricki Orford, now PSI’s country representative in Malawi, who realized that short-term technical assistance was not able to meet the growing needs of PSI’s country programs, which were going through the long and expensive problem-solving phase leading up to the launch and first months of a new health intervention.

When Chrestien completed the training two years ago, he returned to Cameroon with the latest knowledge of what works in child survival and a set of problem-solving and management skills, allowing him to knit together partners and intervention components from research to supply chain management.

When Chrestien or other associates need key documents, they look for them on an internal website that the Learning and Performance team manages with PSI’s Information Services department. Chrestien communicates with other associates and child survival experts through an in-house version of Facebook and takes courses through PSI’s e-learning site, which are both new Learning and Performance applications. Every two years, PSI takes stock of tools, approaches and experiences that Chrestien and his colleagues have had and then works to fill in gaps. This stock taking, called the platform assessment tool, is an important outcome of the Dutch-funded Results Incubator, a learning and regional HIV social marketing initiative in Southern Africa led by PSI’s Agai Jones.

From time to time, we still ask Chrestien to participate in a workshop, on the condition that it will make his busy life easier. The one he attended in February was held to transfer the same innovation techniques that Apple or Google uses to ACMS. The aim here was to get teams to come up with novel solutions to problems. The hope is that PSI staff, like Chrestien, will benefit.

Chrestien is now a full-time Malaria and Child Survival associate based in Nairobi. He will be providing technical assistance to other PSI programs for the coming year while receiving mentoring from other PSI Malaria and Child Survival specialists.

What are we learning about learning? Twenty-first century knowledge workers like Chrestien Yemeni and hundreds of others across the PSI world need it, right now.
As PSI prepared to attend the 2nd World Non-Profit & Social Marketing Conference in April, Chief Technical Officer Steven Chapman sat down with Richard Pollard. Mr. Pollard co-authored “Review of DfID Approach to Social Marketing,” an influential 2003 evaluation of social marketing that introduced the idea of the total market approach. He is now an international consultant in social marketing who specializes in the total market approach to social marketing.

**STEVEN CHAPMAN:** What is a total market approach in social marketing?

**RICHARD POLLARD:** It looks at the total market in any given country—in our case, the market primarily for health products and services. A market has two sides: the demand side, where the consumer is; and the supply side. In commercial marketing, suppliers are very clever at finding groups of consumers with various needs, wants and expectations and offering to them brands, packaging and so forth, that appeal to each of these groups. In social marketing, we recognize the need to understand all these aspects of a distorted market and how we can shift toward demand-driven approaches rather than supply-driven approaches. There are many complex issues involved in looking at the whole market, and we need people who can do that. Social marketing professionals and the social marketing field is a very good place to start.

**SC:** What metrics are used to define whether social marketing is pursuing a total market approach successfully?

**RP:** The first metric looks at subsidies. The markets we are dealing with are primarily distorted by the level of subsidies being given either through the public sector, nongovernmental organizations (NGOs), social marketing or even subsidies given to the commercial sector. We need to find a better way to target subsidies and establish programs that move consumers away from subsidized products so that we open up a dynamic market for the commercial sector to exploit at mass-market prices. The most important factor to track is whether subsidies are properly allocated.

**SC:** Many social marketing projects are managed by NGOs. Should these NGOs help grow commercial market share? Should these NGOs sell products for a profit?

**RP:** This is an interesting subject that comes back to the issue of distorted markets. There’s no reason why a social marketing organization shouldn’t, for example, have its own brands and therefore sell its own products. But is that subsidy being well allocated? Are they being well placed? At the same time, the social marketing organizations are under pressure to cross-subsidize. There’s an argument that says if we’re really going to implement the total market approach, then we need to look at these issues within this broader context.

**SC:** In your view, what is the best way to organize a social marketing program based on a total market approach?

**RP:** It’s a matter of what our social marketing programs are for. If we go back historically, donors want you to come out with low-priced products and are funding you to do that. We will judge your success based on the number of commodities that you manage to sell. Now that’s quite a reasonable strategy, but again it’s a strategy that needs to mature. And why does it need to mature? It needs to mature because we’re seeing today a remarkable growth in economic development in many countries and thus higher demand that is often met through subsidies, and we can’t sustain that approach any more.

I see social marketing expertise as the core expertise that is needed to develop total market approaches. We place less of an emphasis on segmented approaches to program management and funding but more of an emphasis on national, total market approaches, especially with the emphasis on Millennium Development Goals. And as the future of social marketing and social marketing management includes providing the sources to evaluate and even manage total market approaches, I think donor interest in social marketing will increase rapidly. But again, we’ve got to be careful that we don’t come up with strategies that are actually distorting the market even more.

**PSI ATTENDS**

The 2nd World Non-Profit & Social Marketing Conference

At the core of PSI’s work is its commitment to markets. PSI uses social marketing approaches to address perhaps the toughest challenge faced by global health organizations: sustaining programs over the decades it takes to solve the world’s major health issues. For more than 40 years, PSI has worked to achieve positive health impact, and sustains this impact over time by using social marketing approaches that make it easier for populations to access products, services and information that address the priority contributors to a country’s burden of disease.

At the 2nd World Non-Profit and Social Marketing Conference in Dublin, April 11-12, thought leaders and practitioners from across the world brought together their expertise from such areas as the behavioral sciences, strategic communications, health promotion, policy development and advocacy, and social marketing. PSI and affiliate staff, including Steven Chapman and Dr. Mannasseh Phiri, country representative for PSI’s Zambian affiliate Society for Family Health, attended the conference. Dr. Phiri, a native Zambian, gave the keynote address titled, “Social marketing in the Developed and Developing Worlds: Time for (Ex)change?”

He called for bringing social marketers from the developing world into the global conversation, publicizing social marketing programs and sharing the expertise of social marketers around the world.
A shwini, an 18-year-old garment worker in Bangalore, contracted tuberculosis (TB) several months ago. Factory workers like Ashwini tend to be at high risk of TB infection due to overcrowding and poor ventilation in their working and living spaces.

It was on the job that Ashwini met members of PSI’s Project Connect. With funding from the U.S. Agency for International Development, Project Connect conducts a workplace program on HIV/AIDS and TB. As part of the program, PSI’s interpersonal communication (IPC) agents conduct one-on-one sessions on TB awareness, symptom recognition, and treatment counseling. IPC agents screen clients and refer any worker experiencing chronic cough, fever and other TB symptoms for testing to the nearest Designated Microscopy Centre, which is affiliated with India’s Revised National Tuberculosis Control Program (RNTCP). At the center, the client is tested for TB, and those who test positive immediately start treatment.

Ashwini, along with 13 of her colleagues with TB symptoms, was referred to the nearest diagnostic center where she tested positive for TB. She first underwent counseling on the importance of treatment adherence and then began Directly Observed Therapy Short-course (DOTS) treatment. DOTS is the internationally recommended strategy for TB control. In the DOTS strategy the treatment is given under direct and supportive observation to ensure the right drugs are taken at the right time for the full duration of treatment.

PSI’s Project Connect program has worked to create local understanding and awareness around TB within the garment worker community. In addition to counseling, IPC agents work with company management to ensure that suspected TB positive clients are given permission to visit the diagnostic center for treatment and follow-up appointments during office hours.

In India, strong partnerships among the National TB Program and the Ministry of Health and Family Welfare, local nongovernmental and community-based organizations, and the private sector are proving key to moving toward global targets to reduce TB burden in the country.

Local organizations and the government have worked together to create new TB policies which are supported by programming that seeks to change provider and client behavior. And the private sector is increasing its role in the efforts.

India has the largest private health sector in the world. Data suggests that 6 percent of all patients referred for TB diagnosis and testing are referred by the public sector, whereas up to 80 percent of outpatient care is provided by the private sector. PSI/India works with private providers to strengthen TB service delivery.

In Ashwini’s case, the nearest TB treatment provider was more than five kilometers away. Since she needed treatment every day, she was worried that she wouldn’t be able to adhere. PSI worked with factory management and the RNTCP to place a treatment provider on the company premises.

PSI is also including public and private providers in trainings, and involving local communities by facilitating the creation of TB clubs in rural areas to reduce stigma against the disease.

Ashwini is now in her last month of treatment, and she is scheduled for a final test soon. She is among hundreds of other garment workers currently accessing counseling and DOTS treatment services. “If TB-infected people get the same type of support that I received, we can definitely stop TB,” she said.

PSI Author: Katie Wallner, Consultant, Sexual, Reproductive Health & TB, Washington, D.C., and Project Connect team, India

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WORLD TUBERCULOSIS DAY 2011

> MARCH 24 IS WORLD TUBERCULOSIS DAY, where the world recognizes an often-overlooked disease that kills up to 6,000 people every day. The day commemorates when Dr. Robert Koch in 1882 announced that he had discovered the cause of tuberculosis, the TB bacillus. At the time of Koch’s announcement in Berlin, TB was rampant throughout Europe and the Americas, causing the death of one out of seven people. Koch’s discovery launched the path towards diagnosing and curing TB. With tuberculosis programs in 12 countries, PSI and its partners are using a range of innovative approaches to stem the spread of the disease and help individuals all over the world.

**FISCAL YEAR 2012 BUDGET REQUEST: THE STARTING POINT TO IMPROVING HEALTH WORLDWIDE**

“The fiscal realities we face require hard choices,” U.S. President Obama noted when he delivered his annual budget request to Congress on February 14, 2011. The Obama administration took a critical look at where it gets the most value for its money, and global health programs emerged as a priority in its Fiscal Year 2012 budget request.

The budget request for the Department of State and U.S. Agency for International Development included $8.7 billion for the components of the President’s Global Health Initiative, including programs to address HIV/AIDS, reproductive health, tuberculosis and other health challenges in the developing world.

The ongoing support for global health is in line with the Administration’s intent to focus investments where the U.S. has a comparative advantage over other donors and can achieve maximum impact, a path outlined in the Administration’s review last year of foreign assistance programs. The U.S. has a history of bipartisan leadership in successfully promoting health worldwide, dating to the early days of the President’s Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, TB and Malaria almost a decade ago.

Additionally, as noted in the budget request, global health and other development initiatives are powerful tools of U.S. national security, because the productivity associated with healthy communities is a stabilizing factor around the world. Past and present U.S. military leaders, including Secretary of Defense Robert Gates and Chairman of the Joint Chiefs of Staff Admiral Michael Mullen have heralded the role that development programs play in keeping America secure.

The President’s budget request each year is always just a starting point. Congress will spend the months ahead evaluating the elements of the request. Global health advocates and Administration officials will support that process by presenting evidence to reinforce the President’s conclusion that saving and improving lives internationally is cost-effective and has far-ranging positive impacts for U.S. taxpayers.

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**European Union Commitment to Millennium Development Goals**

The European Union (EU) has made the achievement of the Millennium Development Goals (MDGs) among its highest priorities, and it now appears ready to provide the most committed and needy countries with “an MDG initiative amounting up to €1 billion to foster progress toward” the MDGs, according to the European Commission. This initiative is offered to all African, Caribbean and Pacific Group of States (ACP) countries and consists of two components: one of €300 million reserved for “good performance” and a second of €700 million open to all ACP countries. This initiative should help increase the momentum to the policy dialogue on MDGs.

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**Changing Lives, Delivering Results**

The U.K. Department for International Development, now branded UKaid, has rolled out its new development strategy, titled “Changing Lives, Delivering Results.” It makes a strong commitment to results measurement and maximizing value for money; the strategy is supported by UKaid Bilateral Aid Review and Multilateral Aid Review. The Multilateral Aid Review was created to assess the value for money UKaid receives from its funding of 43 multilateral organizations. Value for money for UKaid was analyzed on the basis of extensive factors including: the organization’s transparency, its cost and value consciousness and ambition for results, its sound management and accountability systems, its ability to work well in partnerships and the effectiveness of its financial resource management systems. Nine organizations were deemed to offer very good value for money — including the Global Fund to Fight AIDS, Tuberculosis and Malaria, United Nations Children’s Fund and Global AIDS Vaccine Initiative. The Bilateral Aid Review named 16 countries where UKaid plans to phase out its bilateral aid, reducing the number of directly supported countries to 27.

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**THE DUTCH CUTS**

The Dutch Ministry of Foreign Affairs believes that a stronger geographical and thematic focus can increase the effectiveness of its development cooperation. The Dutch government is therefore concentrating its development funding on four sectors: security and legal order, water, food security, and sexual and reproductive health and rights. The government also announced that it will reduce the number of bilateral aid partners from 33 to 15 countries. The remaining countries were divided into three categories: low-income countries, fragile states and countries with a special commitment to the Dutch priority sectors. At the time of press, the new Dutch policy was pending approval by parliament.
Water for the World

Water has a profound impact on the most important issues of our time. You can’t discuss climate change, public health, education, food security, women’s issues or economic development without addressing water. It can bring stability and prosperity, or it can lead to crisis.

Sharing this finite resource between countries and providing equity in access will require greater leadership from the U.S. Already 40 percent of the world’s population lives in areas of water scarcity. With the Earth’s population growing by 83 million people every year, the demand and consequences of inaction will only increase.

On World Water Day, March 22, we celebrated the progress our country has made since the days when we barely spent $70 million throughout the world on clean water and sanitation. That progress is due in large part to the Senator Paul Simon Water for the Poor Act, signed into law in 2005 by President Bush. The Water for the Poor Act made, for the first time in our history, access to clean drinking water, sanitation and hygiene a priority of U.S. foreign policy.

The Water for the Poor Act has helped increase access to drinking water to 30 million people, provided access to improved sanitation facilities to over 15 million and disinfected more than 9 billion gallons of water. There are now high-level positions within the U.S. State Department and Agency for International Development (USAID) to coordinate policy and resources.

Yet we still have a long way to go in creating a comprehensive and comprehensible strategy. Today, nearly 900 million people lack access to an improved source of drinking water. Every year, 1.8 million children under the age of five die from a lack of access to sanitation and proper hygiene. This is more than from AIDS, TB and malaria combined.

If strong support from the U.S. continues, the world may reach the Millennium Development Goal for water by 2015. But we are on track to miss the sanitation target by 700 million people, and may actually see the number increase to 2.7 billion.

It is within our capacity to ensure that everyone has access to clean water and sanitation.

I will also reintroduce the Water for the World Act this year to ensure that the progress we have made within the State Department and USAID cannot be reversed, and that our resources are spent in the regions of greatest need.

The hallmark legislation passed in 2005 was a shining example of how water can help bring people together, even across party lines. I hope that as we reflect on this World Water Day, it can help bridge that divide once more. Our children’s future depends on it.
Professor Jan Pronk

A European Perspective: Interview with Jan Pronk

PROFESSOR JAN PRONK has earned the reputation of being one of the most influential people in development cooperation in the Netherlands through his roles as a politician and prominent United Nations official. He served as the Minister of Development Cooperation, Deputy Secretary General of the United Nations Conference for Trade and Development, and Special Representative for the U.N. Mission to Sudan for Darfur. With honorary degrees from the San Marcos University in Peru and the Institute of Social Studies (ISS) in The Hague, he currently teaches at the ISS as Professor in Theory and Practice of International Development. Prof. Pronk talks with Nils Gade, former Chief Executive of PSI-Europe.

NILS GADE: From PSI’s perspective as an organization working in public health, relevant indicators such as HIV prevalence and child mortality are going in the right direction. Yet, development aid is viewed by many people as a failure. Overall, do you think, with the Netherlands in mind, that development aid is better than its reputation?

JAN PRONK: Oh, definitely. In the last decade, the economic growth of African and Latin American countries has been higher than many people would have expected. However, it is inaccurate to say that such growth is a direct result of development assistance. What is more important than macroeconomic figures are social indicators concerning welfare of people. This welfare depends on economic opportunities, such as those provided by international trade, and on political factors such as domestic policies, good governance and distribution within countries. Development and poverty are no longer national or geographical issues. It is a class problem. For example, in India – with a population of 1.2 billion people – 500 to 600 million people are still stagnating below the poverty line. For me, the most important question is not to which extent the macro figures as a whole are improving, but to which extent those figures are improving for the one-third of the world population which is below the poverty line.

JPs The donor community is moving toward funding more local organizations. Do you think that international nongovernmental organizations (INGOs) will become redundant under this new paradigm of development?

JAP: INGOs can fulfill a variety of roles. Firstly, facilitating local groups and an international environment – a better globalization – in which home-grown options have a better chance. Countries cannot import democracy, economic development or human rights. You cannot import peace either. It has to be achieved at home. Secondly, an INGO must be an agent of communication, ensuring that local views are made known in other countries. Thirdly, INGOs must put political pressure on local powers to bring forward change in the interest of people. And finally, they need to gather and tell stories about the impact of international development on people. Such reports to policymakers, as well as to the international civil society, function as a counterweight, so that people have better insight into the meaning of standard data and official reports.

NG: Development aid probably has become more politicized. Why do you think it has become more difficult in the Netherlands to mobilize support to use tax payers’ money for development?

JP: There is a lot of discussion about development and development assistance in the world. Until recently, in the Netherlands there always was strong popular support for it. However, rational analysis would demonstrate that development aid is only of secondary importance explaining economic growth and development. Modesty – or honesty – requires that one should be careful claiming successes. However, this means – at the same time – that you may lose popular support for aid. I see development assistance as a device within the new international legal order established after World War II. You need to deal with international problems: peace and conflict, poverty, environment, instability and violations of human rights. And you have to do that together in an international system with common policies, international finance, a world economy and an international civil society. Presently, we see an emerging global middle class living an increasingly comfortable life. Many people don’t care much for the poor, for the voiceless, because they are afraid that they would have to give up part of their newly won wealth. They have to be educated that caring for less privileged people would be in their own interest. It is a political struggle and it’s not easy.

NG: Particularly in health, but also in other sectors, interventions funded by development aid are expected to recover their costs and be “sustainable.” Do you agree with that notion of sustainability?

JP: That is a very short-sighted vision of sustainability. Economic and social sustainability are far more important than financial sustainability. Cost recovery within a year or two or three years does not make sense. You have to invest in health, in order to make people live longer and contribute to society over time – over a lifetime.

NG: In your current position as a professor at ISS, what is the most important lesson you teach your students regarding investing in development?

JP: My most important message is, “Continue studying; continue learning. Never stop. Continue asking questions, stay critical and do not accept the first answer to the question which you have posed. Listen to the people in the underclass and in the other countries themselves. You are an outsider. You are sometimes a passenger, a passer-by, a visitor. The only people who count are those who are in the midst of the process themselves.”
Most often these services are provided by branded networks of local health workers who are trained, supported, monitored and subsidized by PSI as part of a social franchise.

Put simply, a social franchise is a network of private health providers whose services are standardized and quality-controlled. Clients may pay for subsidized services out-of-pocket, or with vouchers, insurance or other payment systems. Social franchises have emerged as an important way to strengthen health systems by building local capacity in the private sector and scaling up access to health care.

In many developing countries, the private sector is the first line of defense for people seeking basic health products and services. Yet often, private sector health care is under-regulated, the quality of service is low and the cost high.

In Myanmar, about 80 percent of health care visits take place in the private sector. According to a study by PSI, there were 5,578 general practitioners in Myanmar in 2009, with 2,400 new medical graduates joining the private sector every year. While the Myanmar Medical Council issues licenses to all medical graduates, there is no regulatory system to assess or monitor the quality of care being provided. And people must pay out of pocket for health care in the private sector – in a country where the average income is less than US $2 per day.

In 2001, PSI/Myanmar launched Sun Quality Health (SQh), a network of private clinics run by highly qualified providers who offer care for reproductive health, tuberculosis (TB), pneumonia, diarrheal diseases, malaria and sexually transmitted infections, including HIV.

PSI/Myanmar provides training, patient education material, access to high-quality products, and supervision and monitoring. In return, the providers commit to specified service standards and a price structure that gives them a small profit but makes their services affordable to people from low-income communities. PSI/Myanmar also works with the Myanmar Medical Association to offer continuing medical education. Most of the physicians in the network are members.

In 2008, PSI/Myanmar launched a second franchise, Sun Primary Health, to increase access to health care in rural areas – where about 70 percent of the country’s population lives. This network includes midwives, lower-level medical staff and farmers. They are trained and supported to provide education, services and products for reproductive health, diarrheal diseases, pneumonia and malaria, and they refer clients to SQh clinics for TB and other acute illnesses that they are not equipped to treat.

By February 2011, PSI had 1,229 SQh providers in 169 of Myanmar’s 325 townships and 1,029 Sun Primary Health providers in 45 townships. In 2010, PSI provided more than 1.2 million reproductive health consultations, tested 205,439 people for malaria and provided malaria treatment for 44,739 people, and contributed to registering and treating about 11 percent of the country’s TB cases.

PSI and its local affiliates now support 19 owner-operated franchise networks and another 12 networks owned by PSI or national governments in sub-Saharan Africa, Asia and Latin America. These networks provide more than 33.5 million people with essential services in key health areas. They also have enabled countries to scale up new interventions quickly, as in Swaziland and Zambia where the networks conducted more than 50,000 circumcisions in just one year.

Building on existing expertise, one provider at a time, PSI is supporting social franchises to scale up access to health services among the poor and underserved around the world.

PSI Author: Julie Archer, Associate Researcher, Research & Metrics, Washington, D.C.
In January, I traveled to Benin to meet with the Board Chairs of our affiliate organizations in West Africa. This was an occasion to hear local perspectives from Benin, Togo, Cameroon, Côte d’Ivoire, Burkina Faso and the Central African Republic, and to knit together, at the board level, the global network that is PSI.

PSI and our affiliates see the value of this mutually beneficial relationship. Our affiliates benefit from the capacity-building support of the international network that would otherwise be inaccessible: knowledge exchange and support with business development; advocacy; external affairs; financial, business and technical services; and establishing local governance. In turn, having programs with deeper and deeper local roots – platforms, as we call them – allows us to better meet the needs of the people in each country where we work and to achieve lasting local health impact.

As we tried to articulate in “Global to Local,” the global health community, and everyone active in development issues overall, wrestle with this idea of sustainable development and how to coax development solutions from recipient countries themselves. We know a locally-led approach has a better chance of success over time.

Like many doing work on the ground, PSI feared that our bottom-line health impact achievements would be undermined by opening ourselves and our platforms up to greater local governance.

However, the reality of our experience in many countries – gleaned through decades of work – has demonstrated to us that embracing more local governance can enhance, not undermine, health impact.

PSI now has a proactive institutional development vision that encompasses our approach to sustainability and what some call “localization” – a vision that takes into account our own history and experience in managing affiliates, the evolving views of donors and host governments, and the need to keep our work focused primarily on health impact.

Our vision is that 10 years from now PSI will be a network of strong, locally governed organizations that maximize health impact specifically because they maintain a close, organic and recognized association with PSI.

The timing and pace of implementing this vision must be locally driven. As you have read in “The Evolution of an Affiliate,” we followed PSI/Uganda as it transitioned into its local affiliate PACE in order to maximize bottom line health impact in Uganda. Not all will follow this path.

While some PSI affiliates are completely locally governed and locally managed, like PACE, the Society for Family Health in Nigeria, or Greenstar Social Marketing in Pakistan, others are far away from this status and may never reach it. In some countries, such as Southern Sudan, a fully locally operated organization might not be able to maximize health impact. Most fall in between these extremes along a spectrum. They are not yet fully locally governed and operated but are increasingly self-reliant and locally grounded, and draw strength from being part of a global network. PSI is not seeking to put itself out of business. Our clients and consumers will deserve and require our support for many years to come. What we do seek is to evolve, be dynamic, and find the sweet spot between “local” and “sustained health impact at scale.”
Fatra iray isaky ny 3 volana dia milamina ny saiko

Anontanio ny dokotera raha mila fanazavana momba ny tsindrona FFP iProFemina