STRATEGIC GOAL ON INVESTING IN PEOPLE

PUBLIC BENEFIT

Disease and lack of education destroy lives, ravage societies, destabilize regions, and deprive future generations of prosperity and participation in democracy. The U.S. Government's strategic approaches for the Investing in People strategic goal help recipient nations achieve sustainable improvements in the well-being and productivity of their citizens and build sustainable capacity to provide services that meet the people's needs. These initiatives also improve the lives of individuals by: 1) increasing their ability to contribute to economic development and participate in democratic decision-making; and 2) mitigating the root causes of poverty and conflict. The three priority program areas within this goal are Health, Education, and Social Services and Protection for Especially Vulnerable Populations.

Activities in the health area improve child, maternal, and reproductive health; prevent and treat infectious diseases; and increase access to better drinking water and sanitation services. Critical interventions combat HIV/AIDS, tuberculosis, malaria, avian influenza, neglected tropical diseases, polio, pneumonia, and diarrhea. Mothers and children are two special target groups for most of these interventions. U.S. Government investments strengthen local capacity to detect and respond to disease outbreaks; improve delivery of health services, essential drugs, and commodities; and support advances in health technology.

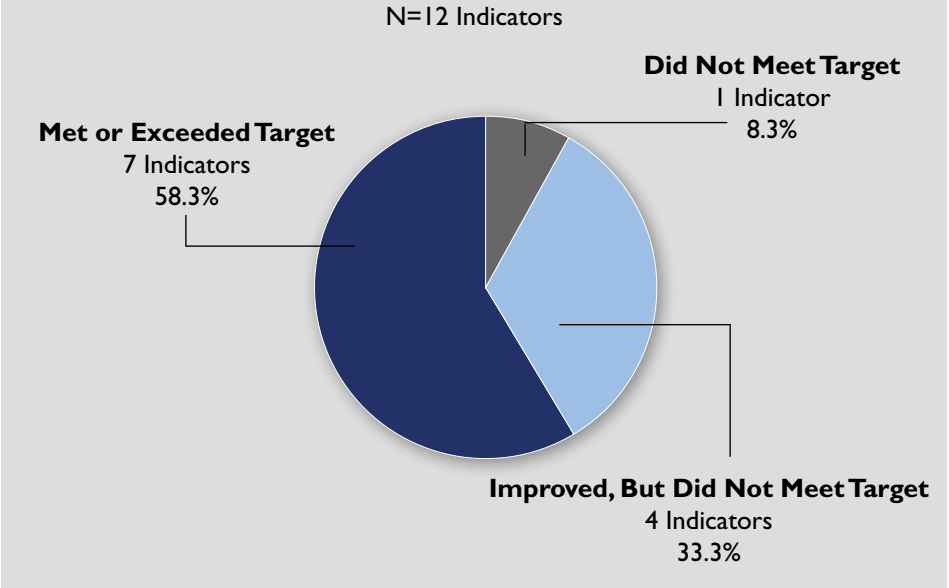
Education activities promote the creation and maintenance of effective, equitable, high-quality educational services and systems from primary education and literacy programs to strengthening the institutional capacities of public and private institutions of higher education. Investments in basic education generally yield high returns, particularly in the developing world, through improvements in labor productivity and participation in democratic processes, as well as improved health. All programs dedicate special attention to reducing barriers to education for girls and women.

Activities in the area of social services and protection for especially vulnerable populations help recipients manage risks and gain access to opportunities that support their full and productive participation in society. Social services assist those whose needs are not addressed by humanitarian assistance or other programs. USAID work in this area mitigates the long-term impact of economic and social crises, conflict, and torture. Programs strengthen the capacity of local governmental and non-governmental service providers to address the most critical needs of extremely vulnerable populations, such as victims of armed conflict, highly vulnerable children, and victims of torture.

STRATEGIC GOAL PERFORMANCE

In FY 2008, USAID-managed resources for the Investing in People strategic goal totaled approximately $6.3 billion, 45.6% of the Agency budget for the year. Of the 12 indicators illustrating USAID program performance for this goal, seven met or exceeded performance targets; four improved performance over the prior year but did not meet targets; and one did not meet its target.

2008 PERFORMANCE RESULTS



USAID-MANAGED RESOURCES FOR INVESTING IN PEOPLE
By Fiscal Year, Program Area, and Representative Performance Measure

	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
TOTAL ($ thousands)	12,712,484[1,2]	13,965,426[1]
INVESTING IN PEOPLE	5,002,922	6,370,419
Health	4,130,757	5,158,868
HIV/AIDS	2,541,281	3,168,287
Number of People Receiving HIV/AIDS Treatment in the 15 Focus Countries		
Number of People Receiving HIV/AIDS Care and Support Services in the 15 Focus Countries		
Tuberculosis	94,864	162,154
Number of Countries Achieving a Tuberculosis Treatment Success Rate (TBS) of 85% or Greater		
Number of Countries Achieving a Tuberculosis Case Detection Rate (TBD) of 70% or Greater		
Malaria	248,000	349,645
Number of People Protected Against Malaria with a Prevention Measure (ITN and/or IRS) in PMI Countries		
Avian Influenza	161,500	115,000
Other Public Health Threats	90,273	96,093
Maternal and Child Health	427,927	565,890
Percentage of Children with DPT3 Coverage		
Percentage of Live Births Attended by Skilled Birth Attendants		
Family Planning and Reproductive Health	450,566	467,267
Modern Contraceptive Prevalence Rate		
Percentage of Births Spaced Three or More Years Apart		
Water Supply and Sanitation	116,346	234,532
Number of People in Target Areas with Access to Improved Drinking Water Supply as a Result of U.S. Government Assistance		
Education	733,654	921,034
Basic Education	581,073	751,330
Higher Education	152,581	169,704
Number of Learners Enrolled in U.S. Government-Supported Primary Schools or Equivalent Non-School-Based Settings, Disaggregated by Sex		
Social Services and Protection for Especially Vulnerable Populations	138,511	290,517
Policies, Regulations, and Systems	2,074	4,988
Social Services	122,421	114,489
Social Assistance	14,016	171,040
Number of People Benefiting from U.S. Government Social Services and Assistance		

1. Includes USAID Foreign Service Retirement and Disability Fund and 60% of the Global HIV/AIDS Initiative account; does not include Public Law 480 funds.

2. Does not include the Andean Counter-Drug Program funds, or $110 million of Economic Support Fund transfer from the Department of Defense.

The President's Emergency Plan for AIDS Relief program exceeded its 2008 target, supporting over two million people with life-saving antiretroviral therapy. The tuberculosis program did not meet its targets for increasing the treatment success and case detection rates due to high rates of HIV co-infection, drug resistance, and continuing internal conflicts disrupting health services in the DRC. The President's Malaria Initiative (PMI) protected about 25 million people against malaria, meeting the year's target. Population surveys found that skilled birth attendants assisted with 48.2% of births during FY 2008, slightly exceeding the target of 47.8%. Forty-nine percent of births were spaced more than three years apart, the healthiest interval for infants and mothers, exceeding the target of 48.6%. About 3.0 million people had access to improved drinking water supply, an improvement over FY 2007, but falling short of the FY 2008 target of 3.4 million. USAID-supported primary schools or equivalent non-school settings enrolled 28.3 million learners, an increase over the prior year result of about 27.1 million, but did not meet the FY 2008 target of 31.8 million. About 5.3 million people benefited from USAID-supported social services and assistance, exceeding the target of 2.7 million.

In FY 2008, USAID conducted 219 evaluations, assessments, and special studies in this strategic goal area. These reviews represent 48.5% of the Agency's evaluation work and cover 32.5% of the total foreign assistance budget. Of these 52%, were used to make programmatic decisions and 44% were used to identify best practices and analyze lessons learned.

Budget and performance information for this goal is highlighted below, with key performance measures described in detailed tables linked to the relevant program area. These measures illustrate USAID's progress toward meeting its Investing in People targets. USAID and other U.S. Government agencies, such as the Departments of State and of Health and Human Services, jointly achieved the HIV/AIDS results.

USAID-MANAGED RESOURCES	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
INVESTING IN PEOPLE ($ thousands)	5,002,922	6,370,419
Health	**4,130,757**	**5,158,868**
HIV/AIDS	**2,541,281**	**3,168,287**

PROGRAM AREA: HEALTH/ HIV/AIDS

The President's Emergency Plan for AIDS Relief program takes a comprehensive approach to HIV/AIDS prevention, treatment, and care in developing countries. This program works in close partnership with host country governments and national and international partners. The Emergency Plan program targets 15 "focus" countries, as well as other bilateral programs around the world. The 15 focus countries are: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

Performance indicators on HIV/AIDS treatment, prevention, and care and support of vulnerable populations track progress for the 15 focus countries only. These results are linked directly and indirectly to U.S. Government foreign assistance and the Department of Health and Human Services funds. The following table reflects U.S. Government funding for each indicator by fiscal year.

The indicator on the number of people receiving HIV/AIDS treatment in the 15 focus countries (p. 28, top) measures the reach of the President's Emergency Plan programs and allows the Global AIDS Coordinator to determine which countries are facing challenges in scaling up their programs and which countries may have practices that should be replicated elsewhere. The Emergency Plan-supported treatment has helped to save and extend millions of lives, as well as avoid the orphaning of hundreds of thousands of children whose parents are infected with HIV/AIDS. Because of the rapid scale-up of the programs in partnership with the host nations, the U.S. Government exceeded its 2008 target supporting over two million people with life-saving anti retroviral therapy. This achievement represents a 48% increase over the past year's results.

Effective prevention programs are essential to ending the HIV/AIDS pandemic. The indicator on the estimated number of HIV infections prevented in the 15 focus countries measures the impact of prevention and other programs that mitigate HIV transmission, such as prevention of mother-to-child transmission and behavior change programs. The U.S. Census Bureau has developed a model to estimate the number of HIV/AIDS infections prevented, using extrapolated data from antenatal care clinic (ANC) surveys compiled by the United Nations Joint Program on HIV/AIDS (UNAIDS) and other demographic data. Given the data requirements for calculation, results will be available approximately one to two years after the reported year. Therefore, a comparison for the FY 2007 target

FUNDING FOR 15 EMERGENCY PLAN FOCUS COUNTRIES IN TREATMENT, PREVENTION AND CARE AND SUPPORT ($ thousands)	FY 2007 (incl. Supplemental)	FY 2008* Actual
Treatment	$1,338,832	$1,884,495
Prevention	$601,050	$902,414
Care	$908,697	$1,203,019
* Includes Department of Health and Human Services funding		

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Number of People Receiving HIV/AIDS Treatment in the 15 Focus Countries

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[1]
401,233	822,00	1.3M	1.7M	2.0M	Met or Exceeded Target	2.0M

Data Verification and Validation

Data Source: Semi-Annual and Annual Progress Reports as captured in U.S. Government Country Operational Plan Report Systems. The 15 focus countries are Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia. HIV/AIDS results are achieved jointly by USAID and other U.S. Government agencies, such as the Departments of State and of Health and Human Services.

Data Quality: The data are verified through triangulation with annual reports by the United Nations Joint Program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) that identify numbers of people receiving treatment. Country reports by UN agencies such as UNICEF and the UN Development Programme indicate the status of such human and social indicators as life expectancy and infant and under-5 mortality rates.

Notes:
1. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Number of People Receiving HIV/AIDS Care and Support Services in the 15 Focus Countries

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[1]
2.9M	4.4M	6.6M	8.2M	9.7M	Met or Exceeded Target	10.0M

Data Verification and Validation

Data Source: Semi-Annual and Annual Progress Reports are captured in U.S. Government Country Operational Plan Report Systems. The 15 focus countries are Botswana, Côte d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia. HIV/AIDS results are achieved jointly by USAID and other U.S. Government agencies, such as the Departments of State and of Health and Human Services.

Data Quality: The data are verified through triangulation with population-based surveys of care and support for orphans and vulnerable children; program monitoring of provider capacity and training; targeted program evaluations; and management information systems that integrate data from patient care management, facility, and program management systems.

Notes:
1. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.

of 2.8 million infections prevented will not be available until FY 2009. To ensure reliability of the data, country longitudinal ANC prevalence rates will be triangulated with population surveys of HIV testing results, UNAIDS country bi-annual reporting prevalence rates, and United Nations country reports indicating status of human and social development indicators.

The indicator above on the number of people receiving HIV/AIDS care and support services in the 15 focus countries measures the reach of the Emergency Plan programs, allowing the U.S. Government to determine which countries are facing challenges in scaling up their programs and which countries may have practices that should be replicated elsewhere. The Emergency Plan

VOICES FROM THE FIELD

A STORY OF HOPE

Bridget Chisenga, who is HIV positive, is an AIDS Relief Adherence Officer with Catholic Relief Services (CRS) in Zambia. She describes her personal story and how the President's Emergency Plan for AIDS Relief impacted her life: "Last December on World AIDS Day, I gave President Bush a hug. I wanted to thank him and the American people, who are making an incredible difference in the lives of millions living with HIV, including me. Years ago … I lost my husband to AIDS and expected to meet the same fate …. Fortunately, I was able to start taking antiretroviral medications, thanks to an AIDS Relief program in Zambia funded by the U.S. President's Emergency Plan for AIDS Relief. This program is literally saving my life. And with this new lease on life … I am taking care of my siblings, as well as a house full of orphans. My improved health also lets me continue my work as an AIDS Relief Adherence Officer in Zambia with CRS. … I want Americans to realize just how significantly their generous contribution is improving people's lives across the globe. You are enabling miracles to happen each day." (Adapted from a story provided by Catholic Relief Services.)

programs that provide care and support to people living with or affected by HIV/AIDS, including orphans and vulnerable children, have helped save and extend millions of lives. The U.S. Government exceeded its FY 2008 target supporting key care and support services for nearly 9.7 million people, including nearly four million orphans and vulnerable children. These results represent a 46% increase over last year's results and were achieved through rapid scale-up of programs in partnership with host nations.

PROGRAM AREA: HEALTH/ TUBERCULOSIS (TB)

Twenty-two developing countries account for 80% of the world's TB cases; the disease kills more than 1.2 million people each year in those countries. Furthermore, TB is a serious and common co-infection for HIV-infected individuals. The focus of USAID's TB program is to combat multi-drug-resistant TB (MDR-TB) and extremely-drug-resistant TB (XDR-TB). Resources are used to conduct drug resistance surveys, introduce and help scale up infection control practices, and build desperately needed national laboratory capacity. The results achieved are measured at the national level by strategically leveraging USAID resources with funds from other donors, in particular the Global Fund to Fight AIDS, TB, and Malaria (GF). Members of the Stop TB Partnership, including the World Health Organization (WHO) and USAID, are promoting accelerated implementation of the Stop TB Strategy, which includes expanding the directly-observed-treatment short-course (DOTS) strategy in health facilities and communities; helping reinforce health systems; addressing MDR/TB and TB/HIV and other challenges; engaging all care providers, public and private; empowering people with TB and the communities that care for them; and promoting research. The two performance indicators for TB programs (p. 30) measure treatment success rate (TBS) and case detection rate (TBD). In FY 2008 USAID did not meet the targets for either indicator.

Tracking the number of countries that meet their TBS is a key indicator of how effectively the U.S. Government is fighting this disease. TBS is the proportion of patients who complete their entire course of treatment; the target for each country is at least 85%. TBS has improved steadily in high-burden countries in Africa, Asia, and the Middle East, and several countries receiving USAID support are close to reaching the threshold for this indicator (for example, Zambia is at 84%). The slow progress in countries like Brazil is linked to high rates of HIV infection, drug resistance, and inadequate health services.

TBD is measured by dividing annual new smear-positive notifications by estimated annual new smear-positive cases (incidence). TBD efforts directly contribute to advances in the control of TB by notifying those whose tests are positive for TB and getting them involved in the DOTS strategy. This indicator reflects the number of countries receiving USAID assistance with a TBD of 70% or greater. As anticipated, two more countries, Indonesia and Kenya, reached or exceeded the target in FY 2008. However, the DRC dropped below 70% because continuing internal conflicts disrupt health services. Thus, four countries reached the threshold in 2008 against a goal of five. In general, increases in TBD rates in DOTS areas have made an important contribution to the overall improvement in case detection since 2001.

USAID-MANAGED RESOURCES	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
INVESTING IN PEOPLE ($ thousands)	5,002,922	6,370,419
Health	**4,130,757**	**5,158,868**
Tuberculosis (TB)	**94,864**	**162,154**

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Number of Countries Achieving a Tuberculosis Treatment Success Rate (TBS) of 85% or Greater

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[1]
4	6	7	8	7	Did Not Meet Target	9

Data Verification and Validation

Data Source: World Health Organization (WHO) Reports, Global Tuberculosis Control, Geneva. Countries covered are Afghanistan, Bangladesh, Brazil, Cambodia, DRC, Ethiopia, India, Indonesia, Kenya, Mozambique, Nigeria, Pakistan, Philippines, Russia, South Africa, Tanzania, Uganda, and Zambia. Data from Ukraine are expected to become available for the first time in FY 2009. Targets are set three years in advance and due to the duration of TB treatment results are reported from data that are three years old. This indicator tracks 19 tier 1 countries for which progress can be monitored consistently over time; Ukraine does not have validated data for this indicator. Zambia did not begin to report to WHO until 2004.

Data Quality: The USAID Analysis, Information Management and Communication (AIM) Project examines all third-party data for this indicator and triangulates them with a variety of sources to verify their quality, validity, and reliability.

Notes:
1. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Number of Countries Achieving a Tuberculosis Case Detection Rate (TBD) of 70% or Greater

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[1]
1	3	3	5	4	Improved, but Did Not Meet Target	7

Data Verification and Validation

Data Source: World Health Organization (WHO) Reports, Global Tuberculosis Control, Geneva. Countries covered are Afghanistan, Bangladesh, Brazil, Cambodia, DRC, Ethiopia, India, Indonesia, Kenya, Mozambique, Nigeria, Pakistan, Philippines, Russia, South Africa, Tanzania, Uganda, and Zambia. Data from Ukraine are expected to become available for the first time in FY 2009. Targets are set three years in advance and results are reported from data that is two years old. This indicator tracks 19 tier 1 countries for which progress can be monitored consistently over time. Ukraine does not have validated data for this indicator. Zambia did not begin to report to WHO until 2004.

Data Quality: USAID's Analysis, Information Management and Communication (AIM) Project examines all third-party data for this indicator, and triangulates them with various sources to verify their quality, validity, and reliability.

Notes:
1. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.

PROGRAM AREA: HEALTH/ MALARIA

In June 2005, President Bush launched the President's Malaria Initiative (PMI), pledging to increase U.S. Government funding by more than $1.2 billion over five years to reduce deaths from malaria by 50% in 15 African countries. The increased funding enables the U.S. Government to accelerate expansion of the PMI program to achieve the President's target. The two critical emphases of PMI are insecticide-treated mosquito nets (ITN) and indoor residual spraying (IRS), which when used properly are highly effective in controlling malaria.

After only three years there is evidence in at least five PMI focus countries that the program is having an impact on malaria transmission. For example, in Zanzibar the percentage of children who tested positive for malaria dropped from 22% in 2005 to less than 1% after distribution of long-lasting ITNs and IRS. In Malawi, where coverage with ITNs has been increasing rapidly for several years, a 2007 household survey in six districts showed a 43% decline in severe anemia (a major effect of malaria) among children aged six to 30 months compared with 2005. In Zambia, malaria parasite prevalence decreased by 54%, from 22% to 10%, between 2006 and 2008 in children under age five. Severe anemia in the same age group decreased by 68%, from 13% to 4%, demonstrating a major improvement in children's health because of the scaled-up malaria prevention and treatment interventions. Finally, in Rwanda a 2008 national survey showed malaria parasite prevalence falling below 3% from its historic level of at least 9%.

The indicator below measures the number of people protected against malaria with a prevention measure (ITN, IRS, or both) supported by PMI funds. It also indicates whether U.S. assistance is succeeding in extending the prevention measures that are necessary to reduce the number of malaria deaths in 15 African countries by 50%.

USAID-MANAGED RESOURCES	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
INVESTING IN PEOPLE ($ thousands)	5,002,922	6,370,419
Health	**4,130,757**	**5,158,868**
Malaria	**248,000**	**349,645**

PROGRAM AREA: HEALTH/ MATERNAL AND CHILD HEALTH

Maternal and child health (MCH) activities increase the availability and use of proven life-saving interventions that address the major killers of mothers and children and improve their health and nutrition status. Examples of MCH activities include: effective maternity care and management of obstetric complications; prevention services including newborn care, routine immunization, polio eradication, safe water and hygiene, and micronutrients; improved maternal, infant and young child feeding; and treatment of life-threatening childhood illnesses.

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Number of People Protected Against Malaria with a Prevention Measure (ITN and/or IRS) in President's Malaria Initiative (PMI) Countries

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[2]
N/A[1]	3.7M	22.3M	25.0M	25.0M	Met or Exceeded Target	30.0M

Data Verification and Validation

Data Source: USAID program information. The 15 PMI focus countries are Angola, Benin, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Rwanda, Senegal, Tanzania, Uganda, and Zambia. The 2006 results are based only on efforts in Angola, Tanzania, and Uganda. The FY 2007 results reflect activities completed in 7 countries and rapid start-up activities initiated in 8 new countries.

Data Quality: Performance data, verified using data quality assessments (DQAs), must meet standards of validity, integrity, precision, reliability, and timeliness. Each operating unit must document the methodology for conducting DQAs. (For details, refer to USAID's Automated Directive System [ADS] Chapter 203.3.5; http://www.usaid.gov/policy/ads/200/203.pdf, p. 20–23).

Notes:
1. PMI was launched in June 2005, so complete year results were not available until 2006.
2. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.

USAID-MANAGED RESOURCES	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
INVESTING IN PEOPLE ($ thousands)	5,002,922	6,370,419
Health	**4,130,757**	**5,158,868**
Maternal and Child Health	**427,927**	**565,890**

USAID's MCH strategy is to achieve average reductions of both under-five and maternal mortality by 25% in at least 25 high mortality burden countries and average reductions of child malnutrition by 15% in at least 10 of these countries. This second goal can be achieved through the delivery of high impact interventions to prevent or treat the major causes of maternal and child mortality and malnutrition. The focus of the strategy is on accelerating programs to increase coverage of the key interventions: antenatal care and skilled birth attendants; newborn care; breastfeeding and appropriate child feeding; immunization; vitamin A and zinc supplementation; and prevention and treatment of diarrhea and pneumonia.

The indicator below on DPT3 coverage rate refers to the percentage of children in developing countries ages 12-23 months who received three doses of diphtheria/pertussis (whooping cough)/tetanus vaccine at any time before the Demographic and Health Survey (DHS). DTP3 coverage and frequency of attendance of skilled birth attendants are two of the flagship measures of performance of maternal and child health programs because they demonstrate a working health system, utilization of health services, and positive care-seeking behavior. All of these factors contribute to a reduction in morbidity and mortality. Coverage of child immunization through regular programs, rather than special campaigns, is an internationally accepted health indicator because it improves overall immunization status, as well as being a good indication of a working health system and utilization of services. Progress in this area contributed to an increase in global coverage for DTP3 from 73% to 81% between 2000 and 2007, translating into protection for 33.0 million additional children. Through the USAID-supported Global Alliance for Vaccine Initiative, nearly 3.4 million premature deaths were averted from 2000 to 2008. This was an increase of 600,000 deaths when compared to the previous estimate.

Most non-abortion-related maternal deaths happen during labor and delivery or within the first few days of the child's life. Because potentially fatal complications can occur among women who do not fall into any of the traditional high-risk groups, they are difficult to predict and prevent. In many countries births occur at home. Increasing the frequency of attendance of skilled birth attendants is more likely to result in prompt recognition of complications, initiation of treatment, and lives saved. The use of skilled birth attendants has increased considerably, more than doubling in Nepal, Indonesia, Bangladesh, and Egypt.

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Percentage of Children with DPT3 Coverage

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[1]
60.4%	61.1%	60.5%	61.5%	61.7%	Met or Exceeded Target	62.0%

Data Verification and Validation

Data Source: Demographic Health Surveys; Census Bureau (for population weights) for Armenia, Bangladesh, Benin, Bolivia, Cambodia, Dominican Republic, Egypt, Eritrea, Ethiopia, Ghana, Guatemala, Guinea, Haiti, India, Indonesia, Jordan, Kazakhstan, Kenya, Madagascar, Malawi, Mali, Mozambique, Nepal, Nicaragua, Nigeria, Peru, Philippines, Rwanda, Senegal, Tanzania, Uganda, Yemen, Zambia, and Zimbabwe. Targets for DPT3 coverage through 2006 were based on the rate of change observed during the 1990s and assumed a 1% annual increase as of 2004. The 0.5% annual increase for FY 2007 and beyond reflects slower growth for the indicator since 2000.

Data Quality: The USAID Analysis, Information Management and Communication (AIM) Project examines all third-party data for this indicator and triangulates them with a variety of sources to verify their quality, validity, and reliability.

Notes:
1. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.

STRATEGIC GOAL: INVESTING IN PEOPLE						
Program Area: Health						
Performance Indicator: Percentage of Live Births Attended by Skilled Birth Attendants						
FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[1]
46.8%	47.8%	47.7%	47.8%	48.2%	Met or Exceeded Target	48.3%
Data Verification and Validation						
Data Source: Demographic and Health Surveys data and CDC/Reproductive Health Surveys for Armenia, Bangladesh, Benin, Bolivia, Cambodia, Dominican Republic, Egypt, Eritrea, Ethiopia, Ghana, Guatemala, Guinea, Haiti, India, Indonesia, Jordan, Kazakhstan, Kenya, Madagascar, Malawi, Mali, Mozambique, Nepal, Nicaragua, Nigeria, Peru, Philippines, Rwanda, Senegal, Tanzania, Uganda, Yemen, and Zambia. Targets for skilled birth attendants were set by using the estimate for 2004 and adding a 0.5% increment increase every year.						
Data Quality: The USAID Analysis, Information Management, and Communication (AIM) Project examines all third-party data for this indicator and triangulates them with a variety of sources to verify their quality, validity, and reliability.						
Notes: 1. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.						

PROGRAM AREA: HEALTH/ FAMILY PLANNING AND REPRODUCTIVE HEALTH

The U.S. Government's family planning and reproductive health (FP/RH) program is designed to expand access to high-quality, voluntary family planning services and information and reproductive health care. This program is intended to reduce unintended pregnancy and promote healthy reproductive behaviors. USAID assesses program progress by using a variety of indicators, including modern contraceptive use and optimal birth spacing. Use of modern contraception increases and birth spacing improves when: a) people know about the health and other benefits of family planning and where they can obtain voluntary family planning services; b) voluntary planning services are easily accessible and of high-quality; c) a wide range of temporary, long-acting, and permanent methods are available and affordable; and d) family planning use is an accepted normative behavior.

U.S. Government support for service delivery, training, performance improvement, contraceptive availability and logistics, health communication, biomedical and social science research, policy analysis and planning, and monitoring and evaluation helps create these conditions. Family planning is an effective and cost-effective response to the serious public health issues of maternal and child mortality. Studies show that family planning, through birth spacing, has immediate benefits for the lives and health of mothers and their infants. Ensuring basic access to family planning could reduce maternal deaths by a third and child deaths by nearly 10%.

USAID-MANAGED RESOURCES	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
INVESTING IN PEOPLE ($ thousands)	5,002,922	6,370,419
Health	**4,130,757**	**5,158,868**
Family Planning and Reproductive Health	**450,566**	**467,267**

Between 2000 and 2008, USAID family planning assistance contributed to a steady increase in the average modern contraceptive prevalence rate from 32% to over 39%. This has resulted in an increase in total satisfied demand for family planning from 44% to 52%. Importantly, this has contributed to a decrease in the total fertility rate, in targeted countries, from an average of 4.6 children per woman to 4.1. A strong family planning program can be expected to increase the modern contraceptive prevalence rate (MCPR) at the country level by one to two percentage points annually. The MCPR indicator (p. 34, top) measures the percentage of in-union women of reproductive age (15–49) using, or whose partner is using, a modern method of contraception at the time of the survey. Increased contraceptive use leads to decreases in both births and abortion rates.

The second family planning indicator (p. 34, bottom) percent of births spaced three or more years apart, is a relatively new indicator. Longer birth intervals are associated with a significant reduction in risk of mortality for both mothers and infants. By measuring the trend of birth intervals spaced more than three years apart in areas receiving foreign assistance, USAID can assess the impact of its programs on reproductive behavior that lead to a posi-

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Modern Contraceptive Prevalence Rate

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[1]
36.9%	37.9%	38.6%	39.9%	39.2%	Improved, but Did Not Meet Target	40.9%

Data Verification and Validation

Data Source: Demographic and Health Surveys data and CDC/Reproductive Health Surveys for: Armenia, Bangladesh, Benin, Bolivia, Cambodia, Dominican Republic, Egypt, El Salvador, Ethiopia, Ghana, Guatemala, Guinea, Haiti, Honduras, India, Indonesia, Jamaica, Jordan, Kazakhstan, Kenya, Madagascar, Malawi, Mali, Mozambique, Nepal, Nicaragua, Nigeria, Paraguay, Peru, Philippines, Romania, Senegal, Tanzania, Uganda, Uzbekistan, Yemen, Zambia, and Zimbabwe. For India, data are from Uttar Pradesh, where USAID's Family Planning/Reproductive Health program is focused, rather than from India as a whole. Targets for MCPR were set using an expected progress of one percentage point annually as of 2004.

Data Quality: The USAID Analysis, Information Management and Communication (AIM) Project examines all third-party data for this indicator and triangulates them with a variety of sources to verify their quality, validity, and reliability.

Notes:
1. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Percentage of Births Spaced 3 or More Years Apart

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[1]
46.8%	47.6%	48.8%	48.6%	49.0%	Met or Exceeded Target	49.3%

Data Verification and Validation

Data Source: Demographic and Health Surveys data and CDC/Reproductive Health Surveys for Armenia, Bangladesh, Benin, Bolivia, Cambodia, Dominican Republic, Egypt, El Salvador, Ethiopia, Ghana, Guatemala, Guinea, Haiti, India, Indonesia, Jordan, Kazakhstan, Kenya, Madagascar, Malawi, Mali, Mozambique, Nepal, Nicaragua, Nigeria, Peru, Philippines, Senegal, Tanzania, Uganda, Yemen, Zambia, and Zimbabwe. For India, data are from Uttar Pradesh, where USAID's Family Planning/Reproductive Health program is focused, rather than from India as a whole. Targets for birth spacing were set using expected annual progress of 0.7 percentage points as of 2004.

Data Quality: The USAID Analysis, Information Management and Communication (AIM) Project examines all third-party data for this indicator and triangulates them with a variety of sources to verify their quality, validity, and reliability.

Notes:
1. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.

tive health impact for mothers and children. For many years, the U.S. Government promoted birth intervals of at least two years as the healthiest for mother and child. More recent data suggest that spacing births at least three years apart significantly lowers maternal and infant mortality risk compared to shorter intervals. The program guidance and the indicator reflect this new consensus.

PROGRAM AREA: HEALTH/ WATER SUPPLY AND SANITATION

Access to a clean, reliable, and economically sustainable drinking water supply and use of effective improved sanitation are key components of a country's ability to attain health, security, and prosperity for its population. Access is achieved through diverse approaches, including both direct support for small and large-scale infrastructure development and indirect support for institutional development, community-based systems, demand creation, facilitation of private supply of products and services, and financing to ensure long-term sustainability and expansion of access.

USAID-MANAGED RESOURCES	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
INVESTING IN PEOPLE ($ thousands)	5,002,922	6,370,419
Health	**4,130,757**	**5,158,868**
Water Supply and Sanitation	**116,346**	**234,532**

The indicator (p. 36, top) measures the number of new people who gained access to an improved water source, such as a household connection, public standpipe, borehole, protected well or spring, or rainwater collection, during the reporting period. The FY 2008 results improved over the prior year, but did not meet the target. This stems primarily from a delay in the start-up of the program in India, and the suspension of all regularly planned water and sanitation activities because partners focused on emergency responses to Cyclone Sidr in Bangladesh.

It is important to note that the significant increases in funding for water supply and sanitation activities from FY 2007 to FY 2008 should be reflected in expanded program outputs in next year's performance report, since FY 2008 funds were made available for programming very late in the fiscal year. This will allow the scale-up of innovative models such as USAID/Indonesia's work to connect poor households to a piped water supply through community-managed systems connected to a metered utility-provided supply. Program expansion is already reflected in the current report; an additional 15 countries reported FY 2008 results for this indicator, providing access to improved drinking water supply to another 1.57 million people in USAID target areas.

Credit: Maureen Taft-Morales, USAID

A Ugandan child under an insecticide-treated bed net provided as part of USIAD efforts to halve malarial deaths.

STRATEGIC GOAL: INVESTING IN PEOPLE						
Program Area: Health						
Performance Indicator: Number of People in Target Areas with Access to Improved Drinking Water Supply as a Result of U.S. Government Assistance						
FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[2]
N/A[1]		2.1M	3.4M	3.0M	Improved, but Did Not Meet Target	5.5M
Data Verification and Validation						
Data Source: FY 2008 Performance Reports from Armenia, Bangladesh, Bolivia, Burkina Faso, Ecuador, Ethiopia, Ghana, India, Indonesia, Madagascar, Mali, Pakistan, Philippines, Somalia, South Africa, Africa Regional, Asia and Near East Regional, and Europe & Eurasia Regional Bureau, as captured in the U.S. Government Foreign Assistance Coordination and Tracking System (FACTS).						
Data Quality: Performance data, verified using data quality assessments (DQAs), must meet standards of validity, integrity, precision, reliability, and timeliness. Each operating unit must document the methodology used for conducting the DQAs. (For details, refer to USAID's Automated Directive System [ADS] Chapter 203.3.5, http://www.usaid.gov/policy/ads/200/203.pdf, p. 20–23).						
Notes: 1. FY 2007 was the first reporting cycle under the new Foreign Assistance Framework. A full cycle of performance data for indicators under the framework, including past year results, is therefore available in 2008. 2. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.						

PROGRAM AREA: EDUCATION/ BASIC EDUCATION

The U.S. Government supports equitable access to quality basic education by improving early childhood, primary, and secondary education delivered in both formal and informal settings. The basic education program includes literacy, numeracy, and other basic skills programs for both youth and adults.

At the outcome level, this increased support is expected to raise the net enrollment rate (NER) of primary level students in USAID-assisted countries. The NER is affected by not only U.S. Government interventions, but also the host governments, the broader donor community, and the individual country's context (for example the declines in the percent of Kenyan youth attending school since the outbreak of civil strife in the country). The U.S. Government is particularly interested in actual learning, not just in enrollment. Currently, there are no global indicators for learning outcomes, however, progress is being made in the development of learning outcome indicators, and other broader, more meaningful aggregate indicators of education performance.

As shown in the basic education indicator (p. 37), one of the many outputs leading to an increase in NER is the number of learners enrolled in USAID supported primary schools or equivalent non-school-based settings. This indicator tracks individuals formally enrolled in U.S. Government-supported primary schools and other equivalent non-school based settings, such as individuals receiving basic education via radio and/or TV programs. Increases in the number of learners contribute directly to the United Nations Millennium Development Goal of 100% primary school net enrollment rate by the year 2015.

The FY 2008 results improved over the previous year but did not meet the target because a few countries such as Indonesia and Uganda shifted focus to a limited number of schools to ensure the long-term sustainability of the programs. However, India demonstrated notable success because implementing partners worked with state governments and private entities to scale up successful education interventions. Furthermore, 22 countries that were not part of the original FY 2008 target countries submitted FY 2008 results for this indicator, increasing the number of learners enrolled in USAID-assisted schools by another 12 million.

USAID-MANAGED RESOURCES	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
INVESTING IN PEOPLE ($ thousands)	5,002,922	6,370,419
Education	**733,654**	**921,034**
Basic Education	**581,073**	**751,330**

STRATEGIC GOAL: INVESTING IN PEOPLE						
Program Area: Health						
Performance Indicator: Number of Learners Enrolled in USG-supported Primary Schools or Equivalent Non-School-based Settings, Disaggregated by Sex						
FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[2]
N/A[1]		27.1M (Girls 48%)	31.8M (Girls 48%)	28.3M (Girls 47%)	Improved, but Did Not Meet Target	24.6M (Girls 49%)
Data Verification and Validation						
Data Source: 2008 Performance Reports from Burma, Burundi, Egypt, El Salvador, Ghana, Guatemala, Haiti, India, Indonesia, Kenya, Macedonia, Mali, Pakistan, Peru, Philippines, South Africa, Sudan, Tanzania, Uganda, and Africa Regional, as captured in the U.S. Government Foreign Assistance Coordination and Tracking System (FACTS).						
Data Quality: Performance data, verified using data quality assessments (DQAs), must meet standards of validity, integrity, precision, reliability, and timeliness. Each operating unit must document the methodology used for conducting the DQAs. (For details, refer to USAID's Automated Directive System [ADS] Chapter 203.3.5, http://www.usaid.gov/policy/ads/200/203.pdf, p. 20–23).						
Notes: 1. FY 2007 was the first reporting cycle under the new Foreign Assistance Framework. A full cycle of performance data for indicators under the framework, including past year results, is therefore available in 2008. 2. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.						

PROGRAM AREA: SOCIAL SERVICES AND PROTECTION FOR ESPECIALLY VULNERABLE POPULATIONS

Social services and assistance programs play an important role in reducing poverty, offering targeted assistance to meet basic needs for vulnerable populations. Activities in this area address factors that place individuals at risk for poverty, exclusion, neglect, or victimization. When populations are helped to manage their risks and gain access to opportunities that support their full and productive participation in society, they rebound from temporary adversity, cope with chronic poverty, reduce vulnerability, and increase self-reliance. Activities include disability services and provision of wheelchairs, support for war victims, and services for displaced children and orphans.

In FY 2008, the War Victims Fund greatly expanded access to affordable prosthetic and other orthopedic and rehabilitation services. The Displaced Children and Orphans Fund (DCOF) supported a variety of programs designed to ensure that vulnerable families were able to remain intact and provide the necessary care and protection of their children. The DCOF also supported reunification of unaccompanied children with their own or alternative family care units and initiated new approaches to strengthen livelihoods through small and intermediate enterprise development and other market-based interventions. The Victims of Torture Fund strengthened the

VOICES FROM THE FIELD

RADIO WAVES IMPROVE ACCESS TO EDUCATION

To improve access to elementary-level education programs worldwide, USAID developed a distance-learning, interactive radio instruction (IRI) system that increased the number of learners enrolled in U.S. Government-supported primary schools or equivalent non-school-based settings. The cost-effective system reaches a large number of students in rural and hard-to-reach communities. The program, now in use in over 20 countries, combines radio broadcasts with active learning to improve educational quality and practices. In Zambia, students receiving math instruction via IRI achieved a higher score than 71% of the students who did not receive radio instruction. In Nigeria, IRI instruction on literacy achieved a 4% boost in learning gains in one year. IRI learners in Pakistan and India demonstrated gains in speaking and understanding English. Governments in Guinea, Mali, India, and Zambia are now continuing IRI broadcasting and programming on their own, building on the work of USAID-funded activities.

capacities of 16 torture treatment centers to treat and rehabilitate individuals, families, and community members suffering the physical and psychological effects of torture. In FY 2008 the Fund initiated assistance for torture survivors in Iraq. The Disability Fund supported 30 programs in 23 countries that increased the participation of people with disabilities in the programs. Finally, in 2008 the Wheelchair Fund supported provision of thousands of wheelchairs to those most in need and in collaboration with the WHO, issued the first-ever Guidelines on Provision of Manual Wheelchairs in Less Resourced Settings.

USAID-MANAGED RESOURCES	FY 2007 Actual	FY 2008 653(a) Final Base Plus Enacted Supplemental
INVESTING IN PEOPLE ($ thousands)	5,002,922	6,370,419
Social Services and Protection for Vulnerable Populations	**138,511**	**290,517**
Policies, Regulations, and Systems	**2,074**	**4,988**
Social Services	**122,421**	**114,489**
Social Assistance	**14,016**	**171,040**

The representative indicator below tracks improvement in the coverage of a nation's social assistance and social service programs for vulnerable people and is also a proxy indicator of a government's commitment to poverty reduction. USAID exceeded its FY 2008 target because an additional 2.5 million people benefited from its social services and assistance as countries like Armenia and West Bank/Gaza saw a sharp increase in their recipient population. Furthermore, an additional 14 countries that were not part of the original FY 2008 target countries submitted FY 2008 results for this indicator, increasing the number of people benefiting from USAID services by another 1.36 million.

STRATEGIC GOAL: INVESTING IN PEOPLE

Program Area: Health

Performance Indicator: Number of People Benefiting from U.S. Government Social Services and Assistance

FY 2005 Results	FY 2006 Results	FY 2007 Results	FY 2008 Target	FY 2008 Results	FY2008 Rating	FY 2009 Preliminary Target[2]
N/A[1]		1.8M	2.7M	5.3M	Met or Exceeded Target	3.0M

Data Verification and Validation

Data Source: 2008 Performance Reports from Armenia, Bangladesh, Belarus, Bolivia, Burkina Faso, Colombia, Democratic Republic of Congo, Ghana, Haiti, Honduras, Liberia, Madagascar, Malawi, Russia, Rwanda, West Bank and Gaza, and Africa Regional (USAID), as captured in the U.S. Government Foreign Assistance Coordination and Tracking System (FACTS).

Data Quality: Performance data, verified using data quality assessments (DQAs), must meet quality standards of validity, integrity, precision, reliability, and timeliness. Each operating unit must document the methodology used for conducting the DQAs. (For details, refer to USAID's Automated Directive System [ADS] Chapter 203.3.5, http://www.usaid.gov/policy/ads/200/203.pdf, p. 20–23).

Notes:
1. FY 2007 was the first reporting cycle under the new Foreign Assistance Framework. A full cycle of performance data for indicators under the framework, including past year results, is therefore available in 2008.
2. FY 2009 targets are set at a preliminary level and will be updated when the FY 2009 budget is appropriated.