



# A.I.D. HEALTH HERALD

Fall 1990

S&T/H Office

## EDITOR'S NOTE

This is the first issue of a periodic newsletter planned to continue the dialogue begun at the first meeting of the S&T/Health Cooperating Agencies. We hope to keep the Herald a simple, informal means of communication, by which we can keep you up-to-date on our thinking, major events, and A.I.D.'s evolving agenda in health. Comments and contributions are welcome -- address them Attn: The Herald, S&T/Office of Health.

## HEADS-UP

### THE BUDGET AND INTERNATIONAL HEALTH

By Ann Van Dusen

At long last the Congressional deliberations on the FY 1991 budget are over and the President has signed the bill. As the dust settles, we call your attention to the following:

- Budgets for health assistance continue to increase. Congress has appropriated the following for FY 1991:
  - \$135 million in health funds,
  - \$100 million in child survival funds,
  - \$ 52 million in AIDS funds, and
  - \$800 million in DFA funds, of which 10 percent is to be devoted to health activities in Africa (and another 10 percent for population activities).

At more than \$360 million in FY 1991, health represents A.I.D.'s second largest sectoral program, following agriculture.

- There is continued bipartisan Congressional support for Child Survival. In FY 1990, A.I.D. was given a target of \$200 million for child survival activities. For FY 1991, the target has been raised to \$250 million.
- Congress has given strong encouragement to country- and community-level AIDS control programs, reflected both in an increase of \$10

see BUDGET, p. 2

## SPECIAL EVENTS

### THE SIGNIFICANCE OF THE WORLD SUMMIT FOR CHILDREN

By Nancy Pielemeier

The World Summit for Children -- the occasion for one of the largest gathering of world leaders ever -- held in New York at September's end, presented an opportunity for U.S. and A.I.D. leadership in setting the agenda on issues affecting children. (The Summit was attended by 130 countries including 71 heads of state and 86 ministerial-level representatives.) A.I.D.'s lead role in providing staff assistance to President Bush in the Summit Planning Committee is evident in the final version of the **World Declaration on the Survival, Protection and Development of Children and the Plan of Action**. These documents were subjected to intense negotiation by national representatives; wording on apartheid and foreign occupation, international debt, AIDS, and family

see SUMMIT, p. 3

## FEATURES

Heads-up  
Meetings  
Special Events

[These are the kinds of regular features we envision - ideas??]



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**BUDGET, continued from p. 1**

million over the Administration's AIDS request and in an increase in the relative share going to A.I.D.'s program activities.

- For the first time in years, Congress has expressed strong interest in tropical disease control as well. This was reflected not only in an earmark for river blindness, but also in a commendation for A.I.D.'s efforts to improve management of the malaria vaccine program. This included encouragement to continue the program, and a strong encouragement to work with the Gorgas Memorial Institute in Panama in tropical disease research.
- There appears to be growing Congressional concern for "children in special circumstances," reflected in \$5 million earmarks for orphans and for civil war victims, as well as special programs for children in Cambodia and Romania.
- The FY 1991 appropriations also expanded support for family planning, vitamin A, breastfeeding, immunization and vaccine development programs.

In short, there is a clear message from Congress that health assistance remains an important element of U.S. foreign assistance, and that Congress expects A.I.D. to take advantage of the momentum generated by the World Summit for Children to provide leadership for international health activities. (See article on page 1.)

Meeting these expectations will not be easy, considering:

- the apparent reduction in mission requests for funds for child survival activities in FY 1991 and FY 1992;
- the limited number of new bilateral projects currently projected for FY 1991;
- the inability of many missions to take on management responsibilities for a number of new (earmarked) program areas, including river blindness, orphans, and prosthetics;
- the increased pressure on S&T/H to provide backstopping for field programs, both directly and through program-funded staffing mechanisms and our cooperating agencies;

- the increased demand from the field for technical assistance and an S&T response capability in such new areas as environmental health, chronic diseases, adult health, sector assessments, and policy analysis for non-project assistance;
- the increasing difficulty of implementing buy-in mechanisms; and,
- the continued decline in the number of direct-hire positions for health, population, and nutrition officers.

As many of you know, a great deal of attention is now focused on management issues in Washington. Reports on workforce planning and potential redundancies between regional and central bureaus are expected in December 1990. We will report in the next issue on the results of these efforts.

In the Office of Health, we are looking for ways to increase our ability to provide additional support directly to field missions. Our goal is to increase bilateral programming for health, and we will probably direct our efforts at a list of priority countries where the needs and opportunities are greatest.

These efforts will certainly involve follow up on some of the commitments made at the cooperating agencies meeting. (See article on page 3.)

These tasks may also involve using S&T funds to provide additional technical assistance to missions, core funding for technical advisors (TAACS and Child Survival Fellows), sector assessments and analytic back-up for non-project assistance, and continued central management of Agency-wide responsibilities, such as the orphans and war victims fund, and the support for WHO's Global Programme on AIDS.

We welcome your comments on the issues raised here, and on how we should respond together to these challenges.

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**LOOK FOR INFORMATION ON BUY-INS AND EVALUATIONS IN FUTURE ISSUES**

**MEETINGS  
DEVELOPMENTS SINCE THE COOPERATING  
AGENCIES MEETING**

By Dale Gibb

Six months after the Cooperating Agencies (CA) Meeting, we are pleased to give you an interim report on further efforts made on some of the themes discussed. While we would like to report greater progress, the initial steps outlined here represent our commitment to action. If you have a particular interest in a subject mentioned, please let us know.

1. Increasing the Role of the Private Sector in Health

The Health Services Division has been asked to take the lead in developing a private sector strategy. We will be looking for innovative ways of encouraging a more active and appropriate role for the private sector in health. John Tomaro will be helping to lead this effort.

A task force on the regulatory environment affecting health service delivery is being chaired by John Austin. The group, comprised of both A.I.D. and CA staff, has begun to identify the policies, laws, and regulations affecting health care, both as a basis for more meaningful policy dialogue and to support the design and evaluation of Non-Project Assistance programs.

2. Improving Communications in Information Dissemination

Michael Mueller, a Health and Child Survival Fellow, has taken the lead in developing a database with key information regarding cooperating agencies, principal contacts, and computer capacity as a step toward improving dissemination of information produced or used by the CAs. In addition, we are making a renewed effort to assure that technical documents developed by our current cooperating agencies, whether under grants, contracts, or agreements, be submitted to the Agency's "memory," the Center for Development Information and Evaluation (CDIE). To that end, we will soon provide guidelines of what should be submitted.

A third initiative in the information dissemination area is this newsletter. We hope it will come out regularly and contain information of interest and use to you, its readership. Let us know what kinds of information would be most helpful and interesting.

3. Transforming the Donor-recipient Relationship

Much has been said about donor collaboration, and most of it to the effect that much more needs to be done! We have spent a fair amount of time exploring practical approaches to improving donor collaboration ranging from the possibility of staff exchanges and internships, to joint program evaluations and sector assessments, to contracting mechanisms that allow us to "buy-in" to each other's efforts. We will be laying out the possibilities in these areas in a systematic fashion in later newsletters. Our aim is to encourage linkages and exchanges that go beyond strict resource transfers.

In the same "sharing" vein, we are organizing meetings on themes that interest various parts of the extended health family including:

- experiences in urban health delivery,
- environmental health, and
- emerging health issues (e.g. adult health).

4. Non-Project Assistance (NPA)

In line with our session at the CA meeting, we plan to explore further how NPA can be used in the health sector and the role of CAs in pre-project analysis, project monitoring, and evaluation. These explorations could lead to development of an NPA Handbook in health, of use to CAs and to HPN officers in the field.

5. Buy-ins; Add-ons

As these become an increasing part of our portfolio, we recognize the need to simplify and codify the process -- and to shorten processing time. A task force on this subject, headed by Holly Fluty, has been formed. You will be hearing more about its plans in the next newsletter.

**HOW DO YOU LIKE OUR LOGO AND TITLE?? ANY GREAT IDEAS?? LET US KNOW -- WE ARE THINKING ABOUT A CONTEST TO ATTRACT ENTRIES... KEEP IT CLEAN!!**

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SUMMIT, continued from p. 1

planning was hotly debated during the summer negotiation period. These efforts resulted in a refreshingly open discussion in the Summit documents of the key issues affecting the health and well-being of the world's children. The Declaration

commits signatories to work for child survival, protection, and development through adoption of a Plan of Action. The Plan sets overall goals to be met by the year 2000 and provides a guide for governments, NGOs, and international organizations to formulate their own specific plans of action by the end of 1991.

President Bush's statement to the Summit included a reference of key importance to A.I.D:

...I've asked Dr. Sullivan and Dr. Ronald Roskens, the Administrator of the Agency for International Development, to go to Africa to see what else America and the world can do to advance child survival across that continent and across the world.

Plans for the trip are well underway and staff in several African countries are busy with preparations for the visit.

An interesting aside: Having read in the New York Times that his comments were limited to five minutes, President Bush edited his own speech just prior to delivering it at the Summit!! This, however, resulted in cutting out several references to A.I.D. initiatives, including the Measles Initiative announced by Dr. Roskens at a press conference on September 13. [More details on this initiative and implications for field participation will follow in subsequent newsletters.]

Another initiative, undertaken jointly by A.I.D. and HHS, is a study of the barriers to improving children's vaccines. This study will be carried out by the Institute of Medicine of the National Academy of Sciences and will look at the legislative, legal, financial, and patent issues, as well as the basic science issues inhibiting the improvement in children's

vaccines. Later issues of the newsletter will have more on this initiative as the study progresses.

HPN and Education officers as well as cooperating agencies' staff will find much of the Declaration's language useful in working on human resource issues. Of particular note is language on child spacing, which was agreed to by all signatories, including the Holy See. The Declaration states in paragraph 20(4):

We will work to strengthen the role and status of women. We will promote responsible planning of family size, child spacing, breastfeeding and safe motherhood.

The Plan of Action further specifies in paragraph 17:

All couples should have access to information on the importance of responsible planning of family size and the many advantages of child spacing to avoid pregnancies that are too early, too late, too many, or too frequent. Prenatal care, clean delivery, access to referral facilities in complicated cases, tetanus toxoid vaccination, and prevention of anaemia and other nutritional deficiencies during pregnancy are other important interventions to ensure safe motherhood and a healthy start in life for the newborn. There is an added benefit of promoting maternal and child health programs and family planning together in that, acting synergistically, these activities help accelerate the reduction of both mortality and fertility rates and contribute more to lowering rates of population growth than either type of activity alone.

**Copies of Summit documents are available in English, French, Spanish, and Arabic from S&T/Health or from UNICEF.**

# A.I.D. HEALTH HERALD

Issue No. 2

Spring 1991

S&T/Health Office

## HEADS-UP

By Ann Van Dusen

### Child Survival Funding

A major interest over the past several months has been levels of Child Survival and Health funding. Because of the continuation of functional accounts which overlap with the Agency AC/SI project coding system, we continue to rely on the Health Projects Data Base and ISTI to sort out the final accounting of our Child Survival obligations. As of April 10, the totals indicate that FY 90 Child Survival obligations totaled \$185 million. At this point, FY 91 levels appear to be \$202 million, although levels usually increase over the year. Nonetheless, it will be a stretch to reach \$225 million, the Congressional target in FY 91, especially in the wake of the Gulf War-related evacuations from Afghanistan, Bangladesh, India, Jordan, Morocco, Pakistan and Tanzania. We will be working closely with the Regional Bureaus to see how we can advance obligations for both FY 91 and 92.

### Country Focus Strategy

One step in that direction is the Country Focus Strategy we have now put into effect to help us better backstop field activities and to increase the coordination of our resources. A backstop, or Lead Officer, has been designated for each country. He or she is expected to take the lead in coordinating activities in a country within S&T, with Regional Bureaus and desks. We launched the strategy with a series of meetings on African countries to develop input for a draft joint Population and Health Action Plan. That draft action plan will be used as the basis for dialogue with Missions on use of the DFA in particular countries, and especially any planned use of centrally-funded or arranged assistance. The plan will facilitate access for the field

to S&T health and population resources and should strengthen the focus of our support to country programs. We will hold similar meetings on Asia, the Near East, and Latin American countries over the next few months.

The Country Lead Officer is a point of coordination and not a gatekeeper. In that light, we hope that CAs and Mission staff will make an effort to provide the Lead Officers with information to help them do an effective job of improving our internal coordination and our help to the field. The current list of Lead Officers, as well as the Regional Coordinators, is attached to this issue.

### Health in the Urban Setting

Finally, in a follow-up to the CAs meeting of last May, on March 25, 1991, we held a day-long "Workshop on Health in the Urban Setting," attended by some 50 A.I.D. staff and S&T/Health Cooperating Agency representatives. Ken Oliviola, of U.S.C., led the discussions which were designed to explore emerging issues in urban health and develop a common understanding of the issues and our experience to date. The group then brainstormed possibilities and the relationship of urban health issues to the Agency Initiative, "Family and Development." We hope to report more on the workshop and its results in a future issue.

## **FEATURES**

Heads Up

An African Odyssey

Status Report on Agency Reorganization

Workforce Planning Study

Evaluation News

Buy-ins

## AN AFRICAN ODYSSEY

By Nancy Pielemeier

Following up on President Bush's promise at the September 1990 World Summit for Children, Health and Human Services (HHS) Secretary Louis Sullivan and A.I.D. Administrator Ronald Roskens led a delegation to Africa January 4-18, 1991, to "...see what else America and the world can do to advance child survival across that continent and across the world..." One of the major purposes of the mission was also to assess the impact of the AIDS epidemic on children and their families. The countries visited included Cote d'Ivoire, Nigeria, Uganda, Malawi, Zimbabwe, South Africa, and very briefly, Senegal. A planned stop in Mali was canceled at the last minute due to the Gulf War.

Gary Merritt, Chief of AFR/TR/HPN, and Nancy Pielemeier, Deputy Director, S&T/H, were the A.I.D. technical representatives on the delegation, which included 22 members from HHS and A.I.D., as well as a USIS reporter and a VOA correspondent. It was interesting and rewarding to be on the "other end" of such a delegation, and we were impressed by the expertness and facility of the A.I.D. Missions and embassies in receiving such a large delegation. We also were pleased and somewhat surprised at how substantive the visits were, given the brevity and rapid succession of the stops.

Most notable to the technical eye was the critical importance of technical staff in the Missions. Where we have direct hire and other technical staff which is closely correlated with bilateral activities, HPN activities were coherent and coordinated. There was good communication and open dialogue with the host country, and the policy framework was established for effective assistance in the health sector. Where there are no HPN officers or bilateral programs, the absence of this coordination is obvious.

Many tangible and intangible benefits have derived from this presidential-level mission. It was a good opportunity to introduce high-level A.I.D. and HHS officials to an impressive array of health and population sector activities and to the realities of the field. The two agencies also developed a better appreciation for the other's strengths and objectives in international health and development. Secondly, the Africa trip was good diplomacy. Both Dr. Roskens and Dr. Sullivan are

outstanding public speakers, and they conveyed a sense of the Administration's concerns for Africa. Mrs. Roskens and Mrs. Sullivan are also excellent diplomats. They met with heads of state and ministers of government and their spouses, spoke extemporaneously, toured innumerable health facilities, and generally contributed to the effort as members of the delegation. Finally, there are many implications for programs coming out of the trip which are being followed up by the individual missions, the Africa Bureau, and S&T.

The observations and recommendations of the delegation have been compiled in a report to the President (a copy is attached to this issue of the Herald). While to some extent individual delegation members were reinforced in their pre-existing beliefs, delegation members were generally agreed on the overall conclusions of the report. These included both disease- and intervention-specific and system-wide observations.

The delegation noted:

The results of child survival investments, particularly the reduction in measles and diarrhea cases and deaths, are impressive and highly visible. It is of utmost importance that these programs are sustained as efforts continue to promote integration of these activities and to strengthen primary health care systems.

- There is an urgent need to intervene to interrupt the AIDS epidemic, and HIV transmission can be reduced by intensifying assistance programs for AIDS prevention.
- Chloroquine-resistant malaria is an increasingly urgent problem both for child survival and for general health and productivity, requiring additional research and program efforts.
- There is a continued need for assistance for family planning in Africa to promote child survival, as well as to accelerate development and economic growth.
- Economic growth and human capital investment are critical to achieve development objectives in Africa.
- Health sector collaboration provides an excellent opportunity to engage in policy dialogue on health sector policy issues, as well as on broader

economic and social issues.

- The roles of data and information systems, technical assistance, and institutional linkages with U.S. institutions are crucial to improved effectiveness of health programs.

Special thanks are due to the Missions, and especially the HPN officers involved in scheduling and rescheduling trips and events, keeping the trains running on time, providing the delegation access to a wide variety of people and activities, and even providing beds during the last-minute, rescheduled stop in Dakar.

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## A STATUS REPORT ON AGENCY REORGANIZATION

Work on the restructuring of the Agency, announced by the Administrator on January 29, 1991, is proceeding rapidly. Three taskforces, on **Management**, **Operations**, and **Policy**, have been working intensively on what is known as the Transition Planning Process for the reorganization. According to Dr. Roskens, the reorganization should be viewed “not as a one-time event, but rather as a process to improve the efficiency and effectiveness of Agency management.” The planning phase will culminate in a proposed new organizational structure and new management objectives, all to be put into effect later this spring.

Three objectives set forth for the reorganization include:

- improvement in accountability,
- a unified “Agency viewpoint,” and
- clarification of organizational responsibilities.

In Congressional testimony on February 7, 1991, the Administrator stressed that, in the reorganization, the Agency was seeking solutions to such problems as slow responsiveness, 26 separate lines of reporting to the Administrator, and duplicative functions within the Agency. Responding to specific questions, the Administrator said that the reorganization is not designed to withdraw authorities from the Field, nor does he have any intention of eliminating the Office of Population.

Agency staff members have been urged to be involved with the restructuring exercise and to participate in the process through a series of meetings and/or by contacting any of the committee chairs or John Blackton, A/AID.

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## WORKFORCE PLANNING STUDY

### Progress and Implication

Last fall, the Administrator called for the establishment of an effective Workforce Planning System, designed to link the Agency’s program, planning, and personnel systems. The need for linkage between these systems has increasingly been recognized, as much of the traditional foreign policy rationale for foreign assistance has changed, and new foreign policy concerns have emerged, both at a time when the budget crisis has grown.

In response to the Administrator’s request, and under the leadership of the Office of Personnel, a group of senior A.I.D. officers was appointed as a Working Group to define such a system and its components. Some of the highlights of the first phase of the Group’s work were released in January. The Second Phase of the study is now underway, with completion planned for mid-1991.

In undertaking its work, the Group faced several constraints. For example, as surprising as it seems that A.I.D. has no long-range workforce planning, the Group was more surprised to find that no other U.S. government agency has a system that could serve as a model. Furthermore, it found neither a widely accepted definition of the A.I.D. workforce nor an agreed upon description of its components, nor an “official and clearly articulated vision of A.I.D.’s future direction, role, and objectives in the 1990s.”

Against that backdrop, the Group defined the parameters underlying a Workforce Planning System for the Agency, including:

- the need for stated objectives for a three- to five-year period,
- data collection on and analysis of the current workforce,

- projection of needs, and
- translation of needs into workforce management objectives and strategies, and policies for recruiting, training, and other personnel and management systems.

As a beginning, the Group defined the workforce as those having an employer-employee relationship with the Agency. This led to a workforce of 9,300 persons, a definition excluding some 10,000 others who work for contractors, PASAs, etc. Some 93% of that workforce is tenured; its median age is between 46 and 50. These characteristics automatically decrease flexibility in dealing with the workforce, as does its grade format. Rather than forming a pyramid, the workforce has a cross-shaped structure, with some 57% of its employees occupying FS grades 1-3, and GS grades 13-15, the bar on the cross. Furthermore, our backstop system, including some 26 Divisions, has ensured that we recruit to clone ourselves, recruiting technical specialists to meet what the Group termed “past needs” as much as emerging ones which usually involve cross-cutting themes.

Although there may be a lack of consensus on where A.I.D. is going, given constraints on funding and ceilings, the Group agreed that the Agency will have to rely even more on contractors and on a non-direct hire and extended workforce. That, in turn, led to the conclusion that the Agency will require a direct-hire workforce composed largely of generalists and “broad-gauged technical managers and a small cadre of technical and other specialists.”

The Group emphasized the generalists’ need for management, analytical, negotiating, and interpersonal skills, with less priority given to technical skills per se. Recommending that the direct-hire workforce not decline further, the Group urged that “more use be made of non-career, time-limited appointments for the acquisition of many skills.” In that area, the Group recommended that the roles of direct hire, non-direct hire, and foreign national professionals be better defined, with consideration given to allocating more authority to non-direct hires. On the other hand, the concern of many of those interviewed that in-house technical competence be maintained as an essential part of accountability was recognized.

Cross training was discussed as an essential need in moving “technical generalists” into management roles. Similarly, continuing technical updates are needed for the technical cadre as a means of retaining “cutting edge” expertise for the Agency.

With regard to the overall personnel structure, the Group urged collapsing the personnel backstop categories to provide a more flexible cadre. It also urged the reinstatement on a continuing basis of an international development intern program, with an uninterrupted inflow of recruits.

### Some Views on the Study to Date

What input have we had to the study? Ann Van Dusen and Duff Gulespie were interviewed by members of the Group, and the Group’s leader, Peter Askin, met with a joint session of the Health, Population, and Nutrition Sector Councils to discuss the study. Certain recommendations and qualifications of the study reflected those discussions, e.g., the Agency’s need to:

- retain technical competence and a group of technical specialists and to ensure that they are given an opportunity to upgrade their technical skills on a regular basis, and
- provide HPN officers and other “broad-gauged technical managers” with training in management and analytical techniques.

What has been missing, however, and is sought in the second phase study now underway, is participation in the Group by someone with a technical, rather than a program or project development, backstop orientation.

In sum, in terms of current program operations, we support both the idea of better defining the roles of different kinds of personnel and, given funding and ceiling constraints, of securing wider authorities for certain kinds of non-direct hire personnel in specific circumstances as one means of meeting the Agency’s need for technical expertise. We have, however, emphasized the need to provide specific Agency training to the extended workforce, and to assure official recognition of the supervisory role played by direct hire employees in dealing with the “extended workforce.”

## EVALUATION NEWS

### A.I.D. - HHS Agreements

Findings from a recent management review of interagency agreements with three major Public Health Service institutions documented the level of A.I.D.'s commitment with the PHS. Agency-wide, 33 agreements with CDC, OIH, and NIH received obligations in FY 90 totalling \$17.7 million. Obligations over the past five years averaged approximately \$15 million each year. The review, which was conducted by the A.I.D. Affairs Officer in Geneva, Paula Feeney, during her Washington TDY in the first quarter of FY 91, identified a number of other A.I.D. funding sources which have agreements with DHHS, including S&T/POP, OFDA, and the Africa Bureau's CCCD project.

The unique capabilities of OIH and CDC have been tapped for such activities as malaria vaccine research, AIDS surveillance, control of diarrheal disease, as well as augmenting the health staff through the TAACS program. While some Missions have bought in to S&T/H PASAs, others, such as India, Nicaragua, Egypt, Indonesia and the Philippines have entered into their own agreements with the Public Health Service.

Key recommendations included systematic dissemination of information generated by the PASAs and RSSAs, regularized consultations with CDC and OIH, standardized technical and financial reporting, and coordination of international efforts with Missions and Regional Bureaus.

### WASH III

The mid-term evaluation of the WASH III project was also conducted during the first quarter of FY 91. High marks were given to this showcase project, now in the third year of a five-year contract. Accomplishments of the WASH III project are many, including timely and qualified technical assistance to Regional Bureaus and Missions and providing outstanding leadership to the global water supply and the sanitation community. The project has been responsive to the growing demographic shift from rural to urban. WASH III products such as the institutional assessment guidelines, team planning, project start-up, etc., are proving useful throughout the

Agency. The evaluation was conducted by the IQC firm of MCD International.

### Other Plans

The final evaluations will soon be completed for REACH I and HEALTHCOM I. The mid-term evaluations for ISTI, PRITECH II, and TAACS are in the process of being finalized. Other evaluations scheduled for FY 91 include VBC (mid-term) and the Appropriate Health Resources and Technologies Action Group Ltd. (AHRTAG), the organization that produces the "Dialogue on Diarrhea" quarterly newsletter (mid-term).

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## BUY-INS

By Genease Pettigrew

Since the first buy-ins to the PRITECH I and WASH II contracts, totalling \$2.9 million in FY 85, buy-ins and add-ons to cooperative agreements have become an integral part of the S&T/Health portfolio. Buy-ins and add-ons remain an important mechanism that allows Missions and Bureaus access to research and technical assistance provided through a variety of health projects. Our growing portfolio has tremendously increased our capacity for buy-ins and add-ons. Mission obligations to S&T/H projects exceeded \$20 million in FY 90. This exponential growth occurred in spite of the growing complexity of using these mechanisms, e.g., different procurement processes for nonbilateral funds and bilateral funds, buy-ins to contracts, add-ons to assistance instruments, etc. Task forces and working groups have been established to deal with these problems and the inherent delays in processing actions. The latest group (the new Buy-in and IQC Steering Group), which includes Regional Bureaus, Central Bureaus, PPC, GC, FM and OP, is looking at issues related to processing speed, ease of accounting, implementation/monitoring problems, and institutionalizing the buy-in/add-on process in the agency handbooks.

Also, in an effort to expedite delivery orders under new companion "Q" contracts for buy-ins, the Office of Procurement (MS/OP) has decentralized responsibility

to regional backstop contracting offices; i.e. regional PIO/Ts will be handled by regional contracting offices in OP. However, delivery orders under the older "Z" contracts will still be issued by the central contracting branch in OP. MS/OP hopes to reduce the time for processing buy-ins and add-ons, especially bilaterally funded PIO/Ts. Because potentially six branches in the Office of Procurement will be accepting S&T/H buy-ins, it is vitally important that Missions submit buy-ins directly to S&T/H for logging and tracking (Attention: Janet Ice). S&T/H is in continuing dialogue with MS/OP concerning these new buy-in procedures and will closely monitor the process and timing of such actions. Tip for Missions: be sure the scope and budget

are well thought out and complete. To assist in preparing buy-in PIO/Ts, sample scopes and budgets will be provided in a separate mailing to Missions, as well as graphic illustrations of the buy-in process.

Watch this space for continuing information on buy-ins and other contract administration issues.

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**CUT-OFF DATE TO GUARANTEE  
FY 91 OBLIGATION OF  
ADMINISTRATIVELY RESERVED  
BUY-INS IS JUNE 28, 1991.**

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**Agency for International Development  
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Washington, D.C. 20523-1817**

# A.I.D. HEALTH HERALD

Issue No. 3

Fall 1991

S&T/Health Office

## HEADS UP

by Ann Van Dusen

A year ago, the Office of Health was deeply involved in putting together the U.S. participation in the World Summit on Children held in September, 1990, and attended by 71 Chiefs of State. We have now been asked to take the lead in preparing the report to UNICEF on U.S. development assistance efforts in support of the Summit goals. Your cables on actions of your countries have been very helpful to that end. Do fax or cable us with any other specifics that come up that can appropriately be termed U.S. development assistance in support of the Summit. Beyond reporting on progress and actions in each of the Summit goal areas, we will report on some global initiatives (e.g., the Administrator's trip to Africa, food aid, the Family and Development Initiative, and the PRISM exercise to identify indicators to measure progress).

### ***Workforce Planning and Reorganization***

Phase II of the Workforce Planning Exercise is underway, headed by John Hummon. Lee Hougen, formerly HPN chief in the Dominican Republic, is assigned to the workforce planning team and addressed the August 8th Health Sector Council meeting. As slow as it may seem, the process is progressing, with the team now working with the Health Sector to try to define a range, limited though it may be, of possible career patterns in the Agency for technical staff. Thus, instead of viewing a management post in the Senior Foreign Service or Senior Executive Service as the ultimate career goal for a technical professional, the team is exploring the need for and possibilities of a more flexible career structure that includes further advancement within sectoral programs. A small taskforce from the Sector will participate with the workforce planning group survey to develop that issue.

We will try to provide more specific information in the next few months.

As a member of the "streamlining task force" under the Agency reorganization, I was asked to collaborate with an APRE colleague on an effort to outline a "contract" between the Central Bureaus (namely S&T, FVA, and PRE) and Missions. We will be discussing this more at the LAC HPN Conference, and we would be interested in your views on this multi-aspect subject. It is very much related to an exercise which has become an annual event at A.I.D.—namely, the Regional Bureaus' priority ranking of S&T projects. Bottom line: It is important to find ways to improve communications and planning between field programs and Washington offices.

### ***Staffing***

Finally, we continue to work on the overall staffing problem in the health sector. The Office of Population has developed a "Big" strategy, designed to focus resources on the countries with the largest populations. Our challenge is a different one, given our continuing emphasis on child survival, and the variety of new and important health threats, including AIDS, malaria, tuberculosis and cholera. We are reexamining the child

## **FEATURES**

### **HEADS UP**

### **THE FUNDING PICTURE**

### **SPECIAL FUNDS FOR CHILDREN**

### **MALARIA**

### **NEW PL 480 TITLE III**



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survival emphasis countries, the proposed AIDS emphasis countries and other targets of our major programs to arrive at some staffing guidelines which we hope to use in combination with those of the Office of Population to improve coverage of the sector. In the next *Herald*, we will discuss some of the mechanisms that we are using to supplement direct-hire resources to that end as well. In the meantime, look for a cable on the '92 Technical Advisors in AIDS and Child Survival (TAACS) Program.

### Office of Health Staff

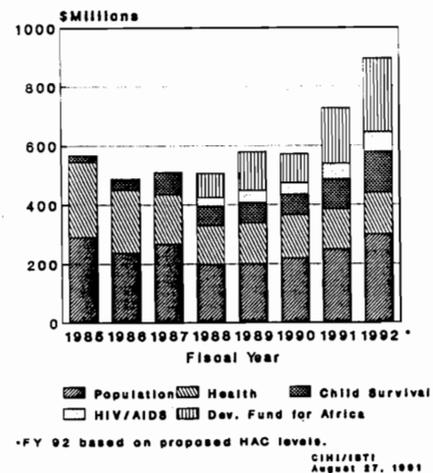
With regrets on both sides, Nancy Pielemeier, Deputy in this Office since January 1990, left in August to accompany her husband on his assignment as A.I.D. Affairs Officer in Brazil. We miss her already, but look forward to being able to work with her on various tasks in Latin America and elsewhere. Meanwhile steps are underway to have Tom Park, HPN Chief in LAC, join us as her replacement in October. We are also hopeful that Barbara Turner will be joining the Office as Chief of the Regional Coordination and Support Division. To keep you up on staff and backstop assignments, we will send out an updated Directory early in FY 92 to include country backstopping assignments. In this issue we have tried to catch you up on two aspects of our programs about which you may be less aware—Displaced Children and War Victims, and Malaria.

## THE FUNDING PICTURE

Final obligations for FY 90 for A.I.D.'s total Health, Child Survival, and AIDS programs totaled \$383.2 million, or \$149.1 million, \$185.6 million, and \$48.5 million respectively. These figures include funding for bilateral, regional, and central programs. Despite the slight decrease in funding during the last fiscal year, current estimated figures for FY 91 and FY 92 are significantly higher. Preliminary figures from the Annual Budget Submission (ABS) show an increase in the entire portfolio of approximately 20-25%.

The proposed levels of the House Appropriations Committee (HAC) continue the trends of the last eight years in which appropriations exceed the Agency's request levels for these programs.

USAID FUNDING FOR HEALTH, CHILD SURVIVAL AIDS AND POPULATION BY APPROPRIATION



Proposed HAC levels currently show increases in the Child Survival Fund and AIDS account of approximately 40% and 25% respectively for FY 91, and again for FY 92. The population account estimates have increased as well, by 14% from 1990 to 1991 and 20% from 1991 to 1992. After a planned 40% increase in the Development Fund for Africa (DFA) between 1990 and 1991, the HAC proposed an additional 25% increase for FY 92. Approximately 15% of this budget is targeted for health, child survival, and HIV/AIDS activities, and another 10% for population activities.

The graph shows actual funding for FY 85-90 by appropriation, and funding for FY 91-92 based on the proposed HAC levels from July 1991. Also included is population account funding as well as funds from the DFA attributed to family planning activities.

## SPECIAL FUNDS FOR DISPLACED CHILDREN AND VICTIMS OF WAR

by Allen Randlov

In FY 91, the Administrator asked S&T/H to coordinate the use of two Congressional earmarks, the Fund for Displaced Children and the War Victims Fund. S&T/H helped with the War Victims Fund in FY 89 and 90. PPC/PB and OFDA coordinated the Displaced Children's Fund in FY 88-90. This article is about the Displaced Children's Fund. The next issue of the *Herald* will carry an article about the War Victims Fund.

## UPCOMING CONFERENCES

Please contact us if you need specific information on these meetings.

<u>Date</u>	<u>Event</u>	<u>Location</u>	<u>Contact</u>
<b>SEPTEMBER</b>			
15-20	LAC/HPN Regional Conference	Coral Gables, FL	Lloyd Feinberg
24-26	International Symposium on Wastewater Reclamation & Reuse	Gerona, Spain	John Austin
25-26	Children's Vaccine Initiative Management Committee	Geneva	Pam Johnson
<b>OCTOBER</b>			
7-8	UNICEF - Summit on Children: Follow up - Sustainability	New York	Ann Van Dusen
6-9	Malaria Vaccine Scientific Consultant Group Meeting	Washington, DC	Bob Wrin
10-12	Micronutrient Conference	Montreal, Canada	Mary Ann Anderson
14-18	WHO-EPI Global Advisory Group	Antalya, Turkey Pam Johnson	Robert Clay
<b>NOVEMBER</b>			
4-5	AIDS Prevention Conference	Rosslyn, VA	Jeff Harris
4-8	Middle East Water Summit: Global Water Summit Initiative	Istanbul, Turkey	John Austin
7-8	Integration of STD Control - MOTHERCARE and S&T/H/AIDS	Rosslyn, VA	Mary Ann Anderson
10-15	APHA Convention	Atlanta, GA	Robert Clay
20-22	NAS-Policy and Planning Implications of the Epidemiological Transition for Developing Countries	Washington, DC	Petra Reyes
<b>DECEMBER</b>			
9-12	VI International Conference on AIDS in Africa	Dakar, Senegal	Jeff Harris
11-13	International Conference on Acute Respiratory Illnesses	Washington, DC	Jerry Gibson
<b>JANUARY</b>			
26-31	International Conference on Water and the Environment (WHO)	Dublin, Ireland	John Austin

The Displaced Children's Fund was established to provide specific assistance, outside of a Mission's regular budget, for orphans and children displaced by natural or man-made disasters. Beginning in 1988, OFDA has provided \$1,968,000 in grants to NGOs in Ethiopia, Mozambique, Uganda, Sudan, and Angola. PPC's portion of the earmark, \$4,389,000, has gone to Uganda, Madagascar, Indonesia, Nicaragua, and Mozambique. The legislation for the Fund contains a "notwithstanding" clause that allows funds to be used in countries where A.I.D. usually cannot work (i.e., Angola), with NGOs that are not registered, etc.

In FY 91, the program included \$5 million for S&T to coordinate and \$500,000 from OFDA's budget. OFDA developed a set of guidelines that meshed with their programs and provided funds to NGOs in Ethiopia, Angola, and Liberia. S&T/H developed a different set of guidelines based on Mission responses to a worldwide cable and a review of program documents from A.I.D., UNICEF, etc. and relevant literature. These guidelines take a longer term, somewhat more developmental approach.

In FY 91, we ended up with grants to NGOs in Bolivia, Peru, Colombia, Guatemala, Nepal, Thailand, Sri Lanka, Indonesia, Mozambique, Madagascar, Ethiopia, and Uganda. Projects in Bolivia, Guatemala, Sri Lanka, Indonesia, Ethiopia, and Uganda focus on orphans. Thailand, Peru, Colombia, Guatemala, and Madagascar concentrate on street kids. Nepal has developed an educational endowment through a local NGO using A.I.D.'s Debt for Development authority to set up an interest-bearing account that will provide scholarships for around 100 orphans per year. Mozambique has a reunification program for children that have been separated from their families.

Several of the grants (Thailand, Bolivia, Uganda, Ethiopia, and Guatemala) are umbrella grants to larger NGOs which will provide small sub-grants to local NGOs. The old saying "small is beautiful" seems to be the way to get to these children who need support of the type that governments and large groups have a hard time providing. We hope to develop more mechanisms to get funds to groups that are too small for traditional A.I.D. grants in the future. As the director of one of the groups focused on street kids said, "If the NGO is big enough for the A.I.D. Mission Director to have heard of, it probably doesn't need A.I.D. funding."

Almost all funds have been transferred to Missions for obligation. Nearly as many mechanisms for setting up grants as there were grants have been used. Some are with local NGOs, some with U.S. NGOs, and one with a European NGO. Several grants are part of a larger Mission PVO co-financing project (Nepal, Sri Lanka). Bolivia's project is implemented through a PASA with the Peace Corps.

The earmark for FY 92 looks as if it will be \$8 million, with a sub-earmark of \$1.5 million for street kids. A.I.D. has proposed that \$3 million from the Development Fund for Africa count against the earmark.

Lloyd Feinberg, (703) 875-4644 is the principal contact in S&T/H for the Displaced Children's Fund. Allen Randlov (703) 875-4684 and Ashton Douglass (703) 351-7911, are alternative contacts. We will try and re-invigorate an AID/W coordinating committee for FY 92. In 1991, Sherry Grossman for AFR, Kris Loken for ENE, Mellen Tanamley for LAC, Martia Glass for APRE and Tammy Halrast-Sanchez in OFDA helped with setting priorities, country selection, and review of proposals.

We are beginning to develop programming guidelines for 1992 and need your input! We want comments and critiques on what was accomplished in FY 91 and how to proceed in the coming year. If you have an interest in the Fund and want to look at background papers, the FY 91 action plan, grant documents from specific countries or on particular types of projects—let us know! If you need help to investigate the situation in your particular country, a S&T/H contract with the Atlantic Resources Corporation can provide consultants. In FY 91, teams of consultants and direct-hires (paid for and contracted from Washington) have worked on displaced children's projects in Ethiopia, Guatemala, and Uganda. Missions in Bolivia and Colombia used funds allotted from AID/W to hire local consultants for situational analyses and design of projects.

We already have several requests for FY 92 funds (Ethiopia, Mozambique, Guatemala, and Mexico). Are there more? A worldwide cable will be forthcoming requesting your assessments of need and expressions of interest. If you need to do a quick check on the local situation, try the local UNICEF office. Their Program for Children in Especially Difficult Circumstances is collecting country-specific data.

## MALARIA

by Dennis Carroll

In response to the increasing public health problem posed by malaria worldwide, A.I.D. and other international agencies are reevaluating the current options for controlling malaria. As part of this reevaluation, A.I.D. has commissioned two studies to evaluate the current status of control efforts and to make recommendations to relevant U.S. government agencies in order to focus their efforts in malaria research, prevention, and control.

In October 1991, the Institute of Medicine of the National Academy of Sciences will release its findings in "Malaria Obstacles and Opportunities," which is expected to address the need for a balanced agenda for both research and control. There is a need to develop the new tools, to test and apply those tools appropriately and economically, and to utilize more contextually specific and rigorous approaches to U.S.-supported malaria control activities in countries where the disease is endemic.

Also in October, the American Association for the Advancement of Science will release its "Malaria Strategy for Africa." This study was commissioned by the Africa Bureau and is intended to assess and make recommendations on current options for the control of malaria in Africa.

In addition, A.I.D. is supporting the World Health Organization's (WHO) efforts to organize a ministerial level conference on malaria to be held in October, 1992, in the Netherlands. Health ministers of 94 malaria-endemic countries and representatives of other member states which share this interest are expected to attend. To arrive at technical and political consensus by the member states concerned, three interregional preparatory meetings are being organized by WHO with A.I.D. assistance and are to be held in 1991 and 1992.

The first of the regional technical meetings, for Africa, is scheduled to be held in Brazzaville, People's Republic of Congo between October 21-25, 1991. The second interregional meeting, for Asia, will take place in New Delhi, India in February 1992, and the third meeting, for South America, will be held in Brazil in June, 1992. These meetings, in addition to providing a forum for evaluating the two A.I.D. studies, will help to

evolve a global strategy for the prevention and control of malaria. African Missions are encouraged to be responsive to government requests for funding of African participants to Brazzaville.

In the field, A.I.D.'s support for comprehensive malaria control programs includes efforts in vector control and chemoprophylaxis through bilateral programs in Pakistan, El Salvador, Belize, Honduras, and Ecuador. The Vector Biology and Control Project (VBC), a centrally funded resource, has devoted approximately 70% of its efforts, or one million dollars annually, to short-term technical assistance, training, and information to improve country malaria control efforts. VBC places strong emphasis on developing an integrated malaria strategy that incorporates a broad range of preventive and control techniques. These include:

- designing economically and culturally sustainable interventions;
- developing a comprehensive scheme within the agriculture and urban sectors, as well as in the general health community, for malaria prevention;
- strengthening institutional and human resource capabilities to prevent, treat, and control malaria.

Finally, for more than 20 years, A.I.D. has provided major support for the worldwide malaria vaccine development effort. Major strides towards achieving this goal have been made over the past several years. Multiple candidate vaccines are now under development and several have undergone testing in humans.

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## NEW PL 480 TITLE III — NOT BUSINESS AS USUAL

The new Title III Act permits multi-year grants of PL 480 foods in supporting nutrition, child survival, and health. The Offices of Health and Nutrition are each prepared to assist Missions in crafting activities. Technical assistance can be provided to evaluate the options available, collect data, prepare proposals, or monitor programs. For more information or copies of the directories of the Offices (which contain a complete description of the central projects from which TA can be obtained) please contact Steve Landry, S&T/H or Frances Davidson, S&T/N.

A.I.D. Agency for International Development  
Bureau for Research & Development  
Office of Health Newsletter

# HEALTH HERALD

Issue No. 4

Winter 1991

## Hear Ye, Hear Ye . . .

**The Good News!** With the arrival of Tom Park on December 2 as the new Deputy of the Office of Health, and Barbara Turner's arrival December 10 as Chief of the Regional Support and Coordination Division (RSCU!), we are almost fully staffed with permanent, as opposed to acting, officers.

**The Bad News!** Field staff continues to suffer; eleven FSOs are "assignable" in the next round but there are 14 current vacancies, each requiring seasoned HPN skills. It is possible that Recruitment will recruit 10-12 new IDIs for the HPN sector, so at least the long range outlook is improving. Nonetheless, we face continuing shortages. In the meantime we will try to remedy these, at least in part, through mechanisms such as the TAACS program, Health and Child Survival Fellows, and the Michigan Population Fellows programs. Although we are still working out the details with PPC on FY 92 funding for TAACS, we do anticipate a continuation of the program. Let us know if you have a current or future need for such non-direct hire long-term assistance in your program.

As a result of an R&D Division Chief's Retreat, we have restructured the **Country Backstopping** exercise to provide increased support to priority countries. Backstop officers will be backed up by others in their division, assuring continuity. In the next issue we will provide more information on the system; in the meantime, the Regional Coordinators (Lloyd Feinberg for LAC and Eastern Europe, Allen Randlov for Asia and the Near East, and Dale Gibb for Africa) will try to make sure that project documents get to the right officers and provide any support you need.

A.I.D. Staff will be following up on the large number of requests for help brought back from the **Africa Scheduling Conferences** in Nairobi and Abidjan last month. Staff are also looking at cables coming in from other regions outlining technical support requirements in FY 92. Our goal is to give as much support as we possibly can, within all the obvious constraints.

Speaking of constraints, we are also in the midst of the **budget reclama** process here in Washington. During the first go around on the FY 92 budget, over \$50 million of health, child survival and AIDS funds were held back for allocation later in the year. We fear that this will make an already slow year (because of the sequential CRs, continuing resolutions) even slower.

**In the next issue**, we will provide an overview of the Health Office Portfolio to give you a better sense of its scope. In the meantime, we are looking forward to the International Consultation on the Control of Acute Respiratory Infections (ICCARI) meeting in December, and to seeing many A.I.D. colleagues and counterparts. Finally, we send warm wishes for the holidays and a happy and healthy New Year. ☺

— Ann Van Dusen

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## Data for Decision Making Project Takes Off

Ever wonder how those decisions about spending the health budget get made? Or how the priorities are established among competing health problems? Or how much should be allocated for which problem? Or what program should be given up in order to address a new disease like HIV/AIDS? Or what treatment policy should be adopted for an existing health problem? When A.I.D. assessed the use of available information from its health projects, it found that lesser developed country decision makers were not incorporating existing information into the process of making policy and technical decisions, setting priorities or developing strategies. A.I.D. found that in spite of a sizeable investment in information gathering, there was almost no investment in helping leaders of the developing countries use the information appropriately. A new Research and Development Bureau health project has been launched to help senior executives, program managers and senior technicians use data for improved decision making.

In October, the R&D/H Applied Research Division announced the selection of the Harvard School of Public Health (HSPH) consortium and the Epidemiology Program Office of the Centers for Disease Control (CDC) to implement the project. The Data for Decision Making Project was thus launched to help the leaders of lesser developed countries make information-based decisions in the health sector.

The project strategy calls for a top down-bottom up approach to improve the decision making process in LDC. The top down (policy) approach, implemented by the Harvard Consortium works with senior executive and ministerial level decision makers to establish policies that are based on the best health information provided from various sources such as epidemiologic surveillance, surveys, research and demographic projections. The health information will be analyzed in the context of national, economic, cultural, and political circumstances. The use of "tools" will help them in making analysis of public health data and in preparation of the information for presentation. These tools include computer models of the outcome of various policy opinions, projec-

tions of morbidity and mortality for health problems, cost effectiveness and economic impact studies. The implementors will use others tools to work with the decision makers to help them develop policies, present them to the health and other ministries, legislative bodies and the public in order to inform and/or to advocate their position.

The technical, or bottom up, approach of the project, implemented by the CDC serves to make the health information accurate, reliable and available. By working to improve the existing health information systems and other data sources, CDC will make the information gained from health data worth considering in the decision making process. They will also work with senior technicians and program managers to improve systems, carry out analysis and present information for a variety of decisions. They will train host country nationals to utilize epidemiologic micro-computer tools for analysis and presentation.

The Data for Decision Making Project will complement the efforts of the host countries and several multi-lateral and bi-lateral development organizations working to improve the collection and use of information by the health sector. These efforts include the International Clinical Epidemiology Network sponsored by the Rockefeller Foundation, the Multi-Donor Essential National Health Research Project and the World Health Organization Health Trends Assessment Project. ☺

—James Shepperd



## Environmental Health Notes

Environmental conditions have long been known to affect human health. Approximately one year ago, the USAID Office of Health sent a cable to all field Missions requesting information and priority ranking of environmental health problems. These were grouped in the following categories: air pollution; solid waste management; wastewater management; toxic, hazardous and radiological wastes; water supply and sanitation; vector-borne disease control; housing and shelter; food hygiene; and occupational and health and injury control. The response cables and

the information obtained during an environmental health workshop provided the basis for the environmental health strategy. This strategy was completed in August of 1991 and a copy was sent to all field Missions.

The Environmental Health Strategy is in the process of becoming the Environmental Health Program. Next year A.I.D. staff will be able to provide technical assistance to Missions related to a broader range of environmental health concerns.

In brief, environmental health is defined as encompassing those diseases and health problems that result from environmental conditions or are exacerbated by environmental degradation. The purpose of this program is to assess environmental risks and manage and prevent environmental health problems.

The environmental health program will include the defined categories: ① water supply and sanitation; ② wastewater management; ③ solid waste management; ④ hazardous materials management; ⑤ air pollution control; ⑥ occupational health; ⑦ injury prevention and control; ⑧ vector borne disease control; and ⑨ food hygiene. This expands upon the services currently provided through the WASH III and VBC projects.

The environmental health program paper is currently being developed, based on the information from cable responses regarding the environmental health strategy. Mission buy-in capacity will be an important part of this program. ☺

— Helga Rippen



## A.I.D. Launches Global Breastfeeding Initiative for the 90's

From the seeds of a breastfeeding strategy, the Innocenti Declaration in 1990 and numerous, small-scale breastfeeding activities supported by A.I.D. over the past decade, a major initiative in breastfeeding was recently launched with the award of a \$30 million, five-year cooperative agreement (CA). One impetus for this initiative has been Congressional recognition of the lack of attention paid, under the

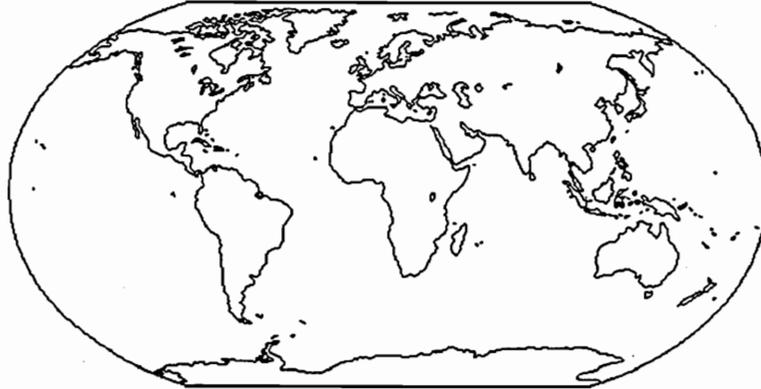
Agency's Child Survival Program, to breastfeeding programming; another has been increasing demand for comprehensive field support.

The recently awarded CA has gone to Wellstart, a group that has been providing "lactation management training" to multidisciplinary teams from teaching hospitals in developing countries, with A.I.D. grant funds from the Office of Nutrition since 1983. With the additional assistance, Wellstart will broaden its breastfeeding focus and expertise to provide field support in the following areas: assessment and strategy formulation; policy dialogue; training of health providers at all levels inside and outside the formal health care system; communication and social marketing; curriculum development/revision; outreach to women (*e.g.*, mother support groups, improving women's nutritional status, and strategies for working women); information dissemination; applied research; and monitoring and evaluation.

Up to ten countries will be selected for long-term comprehensive national breastfeeding program support. Short-term technical assistance will be provided to as many countries as possible. In addition, seven to ten applied research studies will be undertaken to advance the state-of-the-art in breastfeeding promotion. The aim of the CA is to test, expand, refine and monitor practical and successful approaches to promoting and supporting optimal breastfeeding practices. A standardized database across countries will measure impact on breastfeeding practices due to A.I.D.'s support, using more appropriate indicators, data collection and analysis tools than have been applied to date. A.I.D. has been working closely with WHO and UNICEF to define the indicators to be used. These monitoring and evaluation efforts will be coordinated with major surveys collecting similar information, *e.g.*, the A.I.D.-supported Demographic and Health Surveys. Studies of cost-effectiveness and economic benefits of breastfeeding will be carried out as well since little information currently exists in this area. Resources will also be available to support activities of a worldwide policy nature. Missions interested in participating in any of the components of the breastfeeding CA should contact **Dr. Mary Ann Anderson**; R&D/H/HSD. ☺

— Mary Ann Anderson

## • MEETINGS AND CONFERENCES •



### ***December 1991***

- 5-6 Demographic Health Survey Scientific Advisory Committee Meeting • Columbia, Maryland  
(Contact: Pam Johnson)
- 9-12 Sixth International Conference on AIDS in Africa • Dakar, Senegal  
(Contact: Jeff Harris)
- 11 AIDS Management Meeting • Arlington, Virginia  
(Contact: Jeff Harris)
- 11-13 International Consultation on Control of Acute Respiratory Infections (ICCARI) • Washington, D.C.  
(Contact: Ann Van Dusen or Robert Clay or Jerry Gibson)
- 16-18 Childhood Vaccine Initiative Consultative Group Meeting • Geneva, Switzerland  
(Contact: Pam Johnson)
- 16-20 Vaccine Initiative International Conference on AIDS in Africa • Dakar, Senegal  
(Contact: Erin Soto or Celeste Carr)

### ***January 1992***

- 26-31 International Conference on Water and the Environment (WHO) • Dublin, Ireland  
(Contact: John Austin)

### ***February 1992***

*No meetings reported prior to press time.*

## USAID Hosts International AIDS Prevention Conference

During the past five years, the United States Agency for International Development (USAID) has been a leader in the fight against AIDS, supporting over 650 HIV/AIDS prevention and control activities in 74 less developed countries. On November 4-5, the Agency convened an international meeting to review the lessons learned from implementing AIDS prevention and control programs. The second annual AIDS Prevention Conference was held in Arlington, Virginia and was attended by approximately 400 persons united by the scientific and societal challenges of the AIDS pandemic. The participants included experts who implement and manage USAID programs in Africa, Asia, Latin America and the Caribbean and representatives of international donor agencies, private voluntary organizations, non-government organizations, academia, private sector companies, Congressional staff and several US Government agencies including the Centers for Disease Control, National Institutes of Health, Peace Corps and the Department of Health and Human Services.

The 1991 AIDS Prevention conference was organized around the three key interventions that are the backbone of USAID's programs to prevent the sexual transmission of HIV:

- ① condom use and distribution,
- ② reduction of an individual's number of sexual partners, and
- ③ diagnosis and treatment of sexually-transmitted diseases.

Of these three areas, the biggest advances have been in our understanding of condom use and distribution. Through creative commercial marketing programs, we have been able to make condoms available at an affordable price thereby increasing condom demand and use, especially by those who are at high risk of HIV infection. Research findings presented also underscored the importance of a community-based approach to AIDS prevention efforts, especially in encouraging people to reduce their number of sexual partners.

The tone of the conference was set by Mrs. Janet Museveni, First Lady of Uganda. Through an emotionally-delivered speech, Mrs. Museveni demon-

strated that Uganda has had enlightened and courageous leadership in facing the AIDS epidemic. Although other countries in the world have minimized the extent of their AIDS problem out of fear of losing tourist or donor income, Uganda has forthrightly acknowledged its problem. In response to the AIDS epidemic, Uganda's AIDS Control Program of the Ministry of Health, in cooperation with religious and community groups, has been active in education campaigns, in providing care for those infected, in working to ensure the safety of the blood supply, and in conducting critical epidemiological surveys and research.

In summary, the conference was an extraordinary opportunity to share information, ideas and experience what will serve as the basis for the first phase of the Agency's recently-announced, intensified program for AIDS prevention and control. The conference was also an invaluable opportunity to renew and expand the personal contacts and networks that make up the partnership necessary to conquer the AIDS pandemic. ☺

— Ioanna Trilivas



## Private Sector Family Health Clinics Project

The Private Sector Family Health Clinics Project will be designed to provide underserved populations in peri-urban areas of rapidly growing urban centers of four to six developing countries with access to essential health services, preventive and curative, by privately owned and operated facilities.

This five year-project will be launched on October 1, 1992. A cable describing the project and asking for expressions of interest will be sent to USAID Missions in late December 1991.

Questions or requests for information should be requested from :

**John B. Tomaro, Ph.D., M.P.H.**  
R&D/H/HSD • USAID  
Washington, D.C. 20523-1817  
Telephone: (703) 875-4663  
Fax: (703) 875-5490

# Special Funds for Displaced Children and Victims of War

## Part II

As mentioned in the last issue of the *Herald*, R&D/Health has helped program the War Victims Fund on an informal basis since 1989. In 1991 we were asked to officially take responsibility for coordinating two Congressional earmarks, the Displaced Children's Fund and the War Victims Fund. In that article, Allen Randlov wrote about the Displaced Children's earmark.

The War Victims Fund represents strong Congressional concern, led by Senator Patrick Leahy (D-VT), for the well-being of civilian victims of civil strife. It quickly became evident that, as with displaced children, a universal definition of this target group was not possible. Local circumstances can influence the definition greatly. For example, in Uganda and Mozambique we found that there were thousands of children who had contracted polio as a result of missed immunizations, which in turn was affected by years of civil strife. They are as much victims of civil strife as those who stepped on land mines. Even ex-combatants who receive no government support after initial medical treatment can be considered under the fund.

The fund has supported activities in: Afghanistan, Angola, El Salvador, Ethiopia, Lebanon, Laos, Mozambique, Cambodia, Sri Lanka, Uganda and most recently, Viet-Nam.

These are not "mainstream" A.I.D.-assisted countries but are rather countries where broad, short and medium term humanitarian assistance is needed. The fund has "notwithstanding" language in its legislation that permits projects in situations and countries where A.I.D. is not usually active. What distinguishes this fund from the emergency assistance provided by the Office of Foreign Disaster Assistance is the long-term developmental approach.

Four ideas shaped the early stages of the fund: First, to primarily focus on prosthetic services; second, to work in countries where A.I.D. missions could help plan and implement activities; third, to focus on relatively few countries in order to leave behind meaningful impact in terms of trained manpower and physical infrastructure; and fourth, to

work as much as possible with organizations that were already operating in the target country.

Based on the first year's experience, we realized that a primary focus in the simple production and provision of prosthetic devices (primarily legs) was not adequate. Children, a major group of beneficiaries, require larger devices as they grow, and suffer more harm than good if this is not done. Also, the average life span of a leg is only three years. Often reconstructive surgery is required, without which the use of a prosthesis is impossible.

Another factor discovered was that the number of children suffering from polio and in need of orthopedic surgery and braces far outnumber those with war wounds. To summarize, medical and vocational rehabilitation are also essential parts of a comprehensive program. All three components; medical, physical, and vocational rehabilitation, must be sustained if they are to have a significant impact.

As a result of these lessons, the Senate broadened the legislation and has included bill language extending the fund to cover "medical, and related assistance, including prostheses and vocational rehabilitation for civilian victims of war."

The fund, (as is the case of the Displaced Children's Fund) was established to provide additional assistance to a mission's regular budget. Since 1989, \$5 million has been provided annually. We are just beginning the programming cycle for 1992. Evaluations of ongoing projects in Uganda, Mozambique, Sri Lanka and Laos are planned early in 1992 and will help decide about expanding these efforts. A visit to Ethiopia is scheduled to investigate the possibilities of adding vocational and medical services to a program that currently focuses on prosthetics. This will also provide an opportunity to see if we can support Ethiopia's efforts at Community Based Rehabilitation (the rehabilitation practitioner's version of what an A.I.D. parlance is community involvement in primary health care).

There is still flexibility on how the FY 92 funds will be used. If you think there are possibilities in your country, call **Allen Randlov** in R&D/Health at (703) 875-4684, Fax (703) 875-4950, E-Mail or cable. ☺

—Lloyd Feinberg & Allen Randlov

A.I.D. • Bureau for Research & Development • Office of Health Newsletter

# HEALTH HERALD

## Hear Ye, Hear Ye . . .

**The Good News!** I think we may have to change this format because coming up with good news these days is a real challenge. Our move to the 12th floor took place and the view is great. So much for the good news.

**The Bad News!** I can really cook here. Starting from last issue's Good News on new staff, Barbara Turner has since been taken away from us to work on the Agency's program for the Commonwealth of Independent States. Field staff continues to suffer from lack of personnel (I can see this one being a permanent entry—perhaps broadening to include AID/W staff as well). What else? The foreign aid bill remains deadlocked. The President's Commission on the Management of A.I.D. Programs has issued its draft report. One recommendation is that A.I.D., in order to give it a little more clout, be merged with the Los Angeles County Water Authority. The use of non-direct hire personnel is under special scrutiny. Our contracts office will lose three staff just when we have to obligate funds for all your juicy contracts. Jeff Harris will leave us in April to return to CDC—this is really bad news, tempered only by the assignment of Helene Gayle, also of CDC, to replace him.

It is hard to follow all these issues from afar. What do you think about a worldwide HPN Officers conference in Summer 1993?

—Tom Park

## World Summit

A little more than a year ago, President Bush met with heads of state and governments of 71 countries at the World Summit for Children. In its Plan of Action, the Summit called for each country to develop a National Plan of Action, to further the goals of the Summit. Since UNICEF is serving as the Summit's secretariat, they will be provided the Plans (or reports on the Plans) early this year. To help develop the individual nation's plans, UNICEF was asked to work with Third World countries, and in many cases has also in collaboration with US-AID. In Washington, the task of developing the report fell to a large inter-agency task force chaired by the State Department's Office of International Organizations. The Task Force has endeavored to put together a comprehensive report of on-going and planned activities focusing on the Summit's Plan of Action. The U.S. report will contain information on development assistance or A.I.D. related activities underway that benefit children in developing countries and will also contain a section highlighting work of domestic agencies on programs of direct benefit to U.S. children.

Although focusing specifically on U.S. government activities at the federal level in support of children, the report also emphasizes the work of the private sector, communities and NGOs. A dissemination strategy for the report, to be released in April, is being developed by the task force in collaboration with the White House. Watch for details of the report to be discussed in upcoming issues of the *Herald*.

—Dale Gibb

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# A.I.D. Plans Program in Commonwealth

I'll bet you never thought there would be an A.I.D. health program in Alma Ata! However, with the increased interest in assistance to the New Independent States (nee the USSR, aka CIS), we thought you would be interested to learn about the health situation in this dynamic and important region.

And, a region it is. The NIS is composed of 12 independent republics as diverse as the Ukraine-now Europe's third largest country- and Kazakhstan.

As the program develops and we get information that we think will interest you, we will pass it along.

The Office of Health recently hosted two well known Russian demographers at the State Department, where they presented their findings on "The Main Problems of Medico-Demographic Development in the USSR." Drs. Irina Virganskaya and Vitaly Dimitriev are both physicians, working in an emerging field called "Medico-Demographics." They presented data that showed:

- ❖ Substantial variation between the morbidity pattern in the European parts of the NIS, where cancers and circulatory diseases are more common, and the Central Asian republics, where infectious and parasitic diseases are predominant;
- ❖ Significant differences in fertility and ideal family size among republics; and
- ❖ Higher mortality rates in childhood than other developed countries, and large variation between republics (e.g., the Baltics have an IMR of 11-12 per 1000 births, Central Asia has a IMR closer to 45 per 1000 births).

There is growing information and concern about the outbreaks of vaccine-preventable disease in the CIS. Immunization coverage had reached 85 percent in the USSR, but fell to 67 percent in 1990, and apparently continues to drop. In 1990 and 1991

vaccine production was interrupted at several large Soviet facilities for significant lengths of time, resulting in gaps in supplies. Reports of infectious disease outbreaks in CIS cities are becoming more common. Moscow reported 560 cases of diphtheria this year-an increase of more than 600 percent from 1989, over 330 cases of poliomyelitis were reported in 1990, and as a result of poor coverage, there could be over four million additional cases of measles this year alone.

Secretary Baker outlined a program for assistance to the NIS at a January meeting of international donors. Early U.S. Government initiatives include: shipment of Department of Defense excess medical supplies; an emergency medical program to alleviate critical shortages of essential medicines and child immunization; hospital partnerships; and U.S. trade promotion in the medical sector. The first medical supply delivery teams are beginning to return from Tashkent, Samarkand, and one is leaving this week for Alma Ata. So for the first time, Alma Ata is becoming a real destination, not just a mythical place somewhere in the USSR!

— Pamela Johnson

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## Measles Initiative

The Agency has decided to make a special effort to assist several key African governments in their efforts to reduce the impact of immunizable diseases on their children. This is a direct follow-up to the World Summit for Children and the subsequent trip by Administrator Roskens and HHS Secretary Dr. Sullivan to Africa. In this effort, measles was accorded special emphasis because, in most immunization programs, it is the vaccine with lowest coverage.

In an effort to reduce the management burden for missions as well as to benefit from a variety of skills, the Measles Initiative (MI) will combine the technical assistance of three R&D/H projects; REACH, Quality Assurance and HealthCom. One contractor

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### *Measles continued . . .*

will take the administrative lead in each of the countries but will have access to technical skills from the other projects.

After receiving the funds from the Administrator's Special Reserve, representatives from the three projects met with leading immunization experts and donor representatives for a two day planning meeting in October 1991. During the sessions, the participants received background on current measles activities and developed initial strategic plans and methods for implementation of the Initiative.

Following communication with African missions, two technical teams visited four African countries in January 1992 for an initial selection and planning of program activities in country. Kenya, Burkina Faso, and Niger were selected to receive support under the Measles Initiative. Nigeria was also visited and, though not selected as a MI country under the current funding, it will be the focus of urban health assistance through the REACH project which will include measles control activities.

In each country visited, the team found that measles was a serious problem and that there was widespread support for increased efforts to control the disease. Targeted geographic areas were identified and drafts of Memoranda of Understanding and work scopes for long term advisors were developed. The Measles Initiative plans to carry out baseline surveys in the target area and conduct longer assessment in the coming months. This will lead directly into a long-term plan for implementation of activities.

We have been very pleased with the progress to date. The missions and host governments have been extremely supportive, and we are learning much from having the three projects involved. We are hoping that these activities will be able to develop new and innovative strategies to help control measles which will be of help to immunization programs worldwide as well as to the three specific MI countries.

— Robert Clay

## Staffing in the Health Sector

With this issue of the Herald we are providing the most up-to-date list possible of all direct hire, TAACS and Fellows staffing in the Health Sector, and in both AID/W and the field. The list, which does not include contractors or FSNs, is limited to those in the field who would count against a Mission ceiling, and those R&D/H has a reasonable chance of tracking; hence the omission of FSNs, contractors and even Mission-funded PSCs. Perhaps, with solid input from you, we will even be able to add some of these. As a first step, we would appreciate feedback and corrections to the list, bearing in mind that it presents our current knowledge rather than suppositions or rumors.

In the meantime, to provide Missions who are less aware of the alternatives to direct-hire staffing and to give them a better idea of what is available, we are featuring the TAACS program in this issue. In future issues we will cover the Health and Child Survival Fellows program, the AAAS Fellows program and the Michigan Population Fellows program.

Please send any changes in the Direct Hire/TAACS/Fellows list to R&D/H, Dale Gibb or to ISTI, Tara Lewing, to allow us to try to keep the list current. We hope to provide it to the field with each upcoming issue of the Herald.

— Dale Gibb



### R&D/H has Moved

In January 1992, the Office of Health moved from dispersed locations on the sixth and seventh floors to occupy the entire 12th floor. When corresponding with R&D/H staff, please use our new address:

**USAID/R&D/H**

**Room 1200, SA-18**

**Washington, D.C. 20523-1817**

The main telephone number for each division remains unchanged.

# A.I.D.'s Cholera Strategy

Late in January 1991, several Peruvians appeared at hospital emergency rooms with voluminous water diarrhea and, in many cases, vomiting and muscle cramping. *Vibrio cholerae* biotype El Tor was identified in stool specimens. Within weeks, cholera had spread inland from coastal areas and moved beyond Peru to neighboring countries, primarily Ecuador and Colombia. Through the end of December, 1991, Peru had more than 300,000 cases and 2,800 deaths, while Ecuador and Colombia had 44,000 and 11,000 respectively.

Cholera is the most infamous of the diarrheal diseases, a category whose less-fabled but more prevalent causes include *Rotavirus*, *Salmonella*, and *E. Coli*. During the current [Cholera] Pandemic, El Tor cholera has spread from Asia, where it first appeared in Indonesia in 1961, to Africa before arriving in the coastal waters of Peru in 1991. While cholera is certainly the most notorious of the diarrheal diseases, more children die annually from the "ordinary" diarrheas than from epidemics of cholera.

The appearance of cholera in the Western Hemisphere has given renewed attention to the importance of preventing and treating diarrhea and to re-emphasizing the crucial role that oral rehydration therapy (ORT) plays in preventing dehydration and death from diarrhea. A.I.D. has more than 10 years experience in facilitating the development and implementation of national control of diarrhea disease (CDD) programs which have contributed to reductions of mortality rates usually attendant to dehydrating diarrheas. In Peru, for example, where CDD activities have been underway since the early '80s, the case-fatality rate among cholera cases has been about one percent. Traditionally, case-fatality rates for cholera have been significantly higher, 20 percent or more.

The success of national CDD programs in reducing diarrhea-related mortality is in part attributable to the work of A.I.D.-financed projects. WASH (Water and Sanitation for Health), PRITECH (Primary Health Technologies), HealthCom (Health Communication), ADDR (Applied Diarrheal Disease Research) and

Central Procurement of ORS have worked collaboratively with one another as well as with national and international public health officials to improve the planning and response capability of health officials in Latin America and the Caribbean (LAC). The main objectives of A.I.D.'s LAC cholera strategy have been:

- ❖ To familiarize national health officials with the WHO cholera control and treatment procedures;
- ❖ Strengthening the national and local systems for the selection, procurement, distribution, storage, and use of necessary supplies for the treatment of cholera, especially oral rehydration salts (ORS);
- ❖ Planning and facilitating cholera case management training for all levels of health professionals;
- ❖ Improving health communications to affect cholera-related health behavior such as home-management for diarrhea, collection, storage, and use of water, food preparation, and personal and household hygiene; and
- ❖ Improving disease surveillance and epidemiologic capacity at the national and local levels.

The good news to come out of the recent Latin American cholera crisis is that it has re-focused attention on the causes and treatment of diarrheal disease, still one of the major causes of childhood death worldwide.

—John B. Tomaro & Susan K. Kolodin



*NCIH continued . . .*

National Council for International Health (NCIH), is a 21 year old non-profit information and advocacy organization dedicated to improving world health.

For more information, please contact the NCIH Conference at (202) 833-5903, or write: NCIH Conference Department, 1701 K Street NW, Suite 600, Washington, D.C. 20006.

# NCIH International Health Conference

"Improving the Health of Underserved Populations-A Global Partnership," is the theme for the 19th Annual NCIH International Health Conference, June 14-17, 1992.

The conference will explore successful strategies for meeting the health needs of underserved populations. The themes to be discussed are:

- I. ***Sharing Experiences for Improving the Health of Underserved Populations*** covering AIDS/STDs, child survival, family planning, community-based approaches, rural health, women's health, urban health;
- II. ***Lessons Learned: Principles for Action*** including community involvement, disease oriented approaches, health care financing, health systems, human resource development; and
- III. ***Targeting Opportunities for Future International Collaboration*** highlighting inter-country partnerships and successful partnership strategies.

The conference is part of a three-year project by NCIH to determine how Third World health strategies can be applied to solving health issues in the U.S. Using this strategy, NCIH conducted five highly successful regional conferences across the country in Texas, Alabama, North Carolina, and in the city of Boston. Currently, local participants are working to implement specific ideas developed at their conferences. This initiative has received major funding from the Carnegie Corporation of New York.

The NCIH Annual Conference brings over 1,400 public health and medical professionals from across the U.S. and abroad to the nation's capital to hear over 200 presenters, 50 invited speakers, and to network with colleagues and over 60 exhibitors. The

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# Technical Advisors in AIDS and Child Survival

Some twenty-five missions have already or will shortly benefit from the presence of a Technical Advisor in AIDS and Child Survival or TAACS, often redundantly referred to as a TAACS Advisor. In addition, assuming planned funding comes through, a TAACS will be assigned to each of the Regional Bureaus in addition to working in R&D Health, Population, and the Africa Bureau.

TAACS were first recruited under the authority of a special provision in the Foreign Assistance Act of 1987 providing A.I.D. authorization to seek personnel from the U.S. Public Health Service to design, implement and evaluate child survival programs. The authority was expanded the next year to include U.S. universities and institutions of higher learning as sources of assistance, through the use of the Inter-Agency Personnel Authority (IPA), and in 1991, was broadened further to permit recruitment under personal service contracts with private and voluntary organizations. In each case, personnel recruited under the authority become essentially employees of A.I.D. for purposes of rights and privileges. Until now, all persons funded as TAACS have, with the authorization of individual Mission Directors or Office Directors, been provided with direct hire authority as well, in terms of being able to supervise and be supervised by direct hire, sign vouchers, and represent the government. As it now appears, this year certain TAACS will be funded with OE funds and others with program funds, it is probable that the direct hire authorities will generally be restricted to those funded with OE monies, although this issue is still under discussion. At press time, it seems that TAACS in AID/W as well as those serving along in a Mission (none are at the moment) will be OE funded, with program funding still permitted for overseas advisors. Since the funding for the program, again this year, comes from AID/W, the continuing confusion on the issue should matter less to the Missions that it appears; furthermore, any

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**TAACS continued . . .**

compromise affects, for the moment, those advisors funded with '92 funds.

At the moment, R&D/H, through CEDPA, a TAACS contractor, is carrying out a two week orientation for five TAACS as well as assorted other R&D Fellows (AAAS, Health and Child Survival, and Michigan) which seems to be well received. Although the evaluation carried out of the TAACS program last year indicated Missions and AID/W had found the program very helpful in carrying out an increasing workload in health and AIDS, most pointed out a need for improved orientation of the TAACS, to allow them to become more quickly functional in HPN offices. The orientation is essentially a mini-project design and implementation course that will familiarize attendees with A.I.D. processes, in both Washington and the field.

Africa has thus far made the greatest use of TAACS, with advisors serving today in Burkina Faso, Mali, Niger, Uganda, Nigeria, Rwanda and CAR. Advisors will shortly be posted to Ghana, Kenya, Cameroon, Malawi, and are to be funded in '92 for Ivory Coast, Togo, and both REDSOs. Most of the Africa TAACS have been obtained via CDC through the R&D/H PASA with the Office of International Health. Academia (Johns Hopkins, Hahnemann, and Maryland) are currently providing TAACS under IPA arrangements. In addition, shortly we expect a contract to be concluded with a private voluntary organization to provide additional TAACS for Washington and the field. TAACS are

serving in Boliva, Indonesia, Honduras, Ecuador, Jamaica, Morocco, Yemen, and will be shortly going to Nicaragua.

Most TAACS serve a total of four years, with funding provided in two-year increments. Given the number of mechanisms by which TAACS are obtained and the questions raised in the last two years regarding the kind of funding to be used for the program, it has been difficult to predict the amount of time needed to recruit and field advisors. At this point, notification of the need for a TAACS, recruitment and clearances may take 14-16 months. In some cases, it has been possible to provide the selected TAACS to a Mission on a short-term basis to expedite work prior to final clearance.

Total funding authority for the TAACS has been limited to \$8 million in the last three years, an increase from the initial \$5 million. Although the future parameters of the program, in terms of kind of funding, are still a question, Missions should advise if a TAACS appears to be needed, as a means of helping R&D/H estimate the need for ceiling. We in turn, will advise as soon as possible as to whether '93 funding is to be obtained from USAIDs' program budgets or provided from Washington. The former appeals, at this point, to the resolution. In the meantime, have faith in the '92 TAACS proposals which have already been submitted, including extensions. As soon as we get third quarter funding, the actions should be processed. We will notify each Mission shortly of the specific status of requests.

— Dale Gibb

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