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MANAGEMENT ASSESSMENT  
THE OFFICE OF HEALTH  
BUREAU FOR SCIENCE AND TECHNOLOGY

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EXECUTIVE SUMMARY

The Health Office of the A.I.D. Science & Technology Bureau manages a large and technically complex research and field support program. Its responsibilities and workload increased dramatically in 1985 when the Congress appropriated \$85 million additional funds for Child Survival. Today, the combination of health, child survival and AIDS appropriations make health the second largest Agency program. The Office plays a major role in the planning, implementation and monitoring of that initiative, in concert with the Child Survival Task Force, regional bureaus and field missions. In early 1985 the Office had 16 full-time equivalent (FTE) staff positions and a \$24.8 million budget (OYB). In 1988 it has 20 FTE staff positions and a \$63.1 million OYB. To cope with the additional workload the Office employs 18 additional (outside of ceiling) full and part-time staff.

The research projects (11) and field service projects (21) are directed toward high priority health problems confronting LDCs, focussed for the most part on "child survival" interventions. Taken together, immunizations and diarrheal diseases receive the great majority of the Office's time and money. Research is applied rather than basic, with the exception of malaria vaccine development, and field support projects are oriented toward improving service delivery and impacts.

Office performance is considered to be good despite its heavy workload. Research projects appear to be achieving their objectives, although impacts of such projects are difficult to assess. Field support project "clients", regional bureaus and missions for the most part, express almost universal satisfaction with the quality of services received. Quantitatively, the project contractors have undertaken an impressive number of assignments in almost all A.I.D. countries. They have made a major contribution to expanding and strengthening child survival programs around the world. The Office is well regarded by its international agencies, and A.I.D.

The expanded role noted above has caused some strains within the Office and with regional bureaus and missions. The most significant ones are summarized below.

- The Office does not have enough full-time regular A.I.D. employees to manage the program at its current level. Some project officers (Cognizant Technical Officers) are unable to devote adequate time to monitoring their projects and contractors. The Office should not undertake new projects until adequate staff is available.
- The program consumes a large proportion of A.I.D.'s total health/child survival budget (24% in FY89) (exclusive of special AIDs funds). Indeed, as A.I.D.'s Child Survival effort results in expanded mission bilateral projects, there may well be a competition between ST/H and the missions for funds.
- Field support technical assistance has become highly concentrated in the ST/H contractors as a result of quality performance, efficiencies of centralized resources, and convenience of contract "buy-ins". But, regional bureaus are not full partners in the planning, development and implementation of those "field support" projects intended to meet their needs.
- The Child Survival Task Force has done an excellent job coordinating the Initiative, but has generated confusion about organizational responsibilities among regional bureau and ST/H staff. This has apparently contributed to the mediocre performance of the Health Sector Council.
- It should be noted that a number of the projects in the Office portfolio, which have been regarded by regional bureaus as of lowest priority, have come into existence in response to specific Congressional interests.

The Office objectives remain valid and performance is good, but Agency management must consider carefully the appropriate scale of effort the Office should strive for considering financial and human resource constraints facing A.I.D. as a whole.

## I. Introduction

In the Omnibus Continuing Resolution for fiscal year 1988, Congress instructed A.I.D. to prepare reports assessing the management and performance of several offices including that of the Office of Health in the Directorate for Health, Bureau for Science and Technology (ST/H). These reports were to assess, inter alia, the validity of the goals and objectives of the Office; how well those goals are being achieved; the

performance of the Office in providing services, as appropriate, to other bureau offices and/or to the Agency's overseas Missions; and, given competing demands being placed on overall Agency resources, whether appropriate personnel and funding resources are being made available for the Office. As further explained by the Senate Appropriations Committee, these reports were to consider whether these offices "...are achieving their stated objectives, whether these objectives can be achieved more efficiently through an alternative organizational structure, and whether, in fact, these objectives remain valid in light of funding and personnel limitations."

In terms of methodology, the team interviewed more than 45 people, reviewed the comments from more than 60 cables from field missions, and reviewed a substantial mass of documentation.

### Background

A.I.D. has maintained a central office of health for many years with the objective of supporting research and development on technologies of importance to the developing countries, and providing technical support to its missions and regional bureaus. The Office was part of the Technical Assistance Bureau and Development Support Bureau prior to 1981 when the current Science and Technology Bureau was created.

During the 1970s the Office focussed on health sector management and planning methodologies in order to assist A.I.D. countries build their health delivery system institutional infrastructures, identify priority health problems and allocate resources to address them. Bio medical research was limited, although the malaria vaccine research program which continues today was begun then.

The orientation began to change in the early 1980s to a more disease-specific, and targetted field service program, commensurate with the development of focussed health program strategies being prepared by the regional bureaus and PPC. By 1982/1983 A.I.D health officers had targetted infant mortality reduction as their primary objective, in line with prevailing primary health care goals of WHO and UNICEF and selected oral rehydration therapy, immunizations, nutrition and family planning as their preferred tools. Several ST/H field support projects were started during 1981-1983 to assist with that Agency-wide initiative (Primary Health Care Operations Research - 1981, MEDEX - 1983, Primary Health Care Technologies - 1983). A.I.D. adopted a Health Sector Policy in December 1982 which defined these policy directions and introduced a new Health Sector Strategy in May 1983 which provided guidelines

for the development of Bureau and country assistance programs. This process led to definition of the Child Survival initiative, in concert with WHO, UNICEF and others, and resulted, in FY 1985, in appropriation by Congress of \$85 million additional funds for this purpose. An Agency Child Survival Task Force was created to coordinate and monitor the Initiative, but the bulk of the operational workload at the central level fell on the S&T Bureau Health Office. Subsequently, the Agency also received significant funding earmarked for AIDS activities. With the advent of the Child Survival and AIDS funds, ST/H was dramatically changed. In 1984 the Office had 16 staff (FTE positions) and its operating year budget (OYB) was \$24.8 million. In 1988 it has 20 authorized (FTE) positions and 38 total staff, and \$63.1 million OYB.

### Office Objectives

Program direction for the Office is guided by a number of Agency statements of objectives, functions and responsibilities. The Team reviewed statements included in the FY 88 Congressional Presentation (CP) covering a) A.I.D.'s Health Objectives and b) Central Programs Functions, Handbook 17 Statement of Functions for ST/H, and ST/H Statement of Responsibilities. They are consistent in their focus on a) development and adaptation of new technologies through research, b) application of research results through technical assistance to the field, and c) provision of technical coordination for A.I.D.

Substantively, the FY 88 CP states the Agency's overall health objectives as follows:

- Reduce infant and early child mortality and morbidity;
- Ensure that gains are sustained;
- Reduce maternal mortality and morbidity;
- Develop new cost-effective technologies and improved systems for delivery of child survival services in primary health care programs; and
- support other health interventions in LDCs where they are required.

The statements are consistent in their emphasis on technology development and field support, and yet provide considerable latitude for interpretation concerning relative priority and specific subjects to be pursued. The Team assessed Office performance against its three functions of research, field support, and technical coordination.

## II. PERFORMANCE

### A. Research & Technology Development

1. The research portfolio consists of 11 projects whose life-of-project funding exceeds \$200 million. Table 1 below provides a complete list of the projects with their starting and termination dates, principal contractors, funding and ST/H project officer. The projects concentrated on a few high priority subjects, mostly concerned with "child survival." Several projects include many components, sub-projects, or grantees, which complicate their management.

A rough analysis of the portfolio reveals that six projects are devoted directly to problems confronting diarrheal disease and immunization interventions of child survival programs in the field. They are projects 5928, 5940, 5947, 5952, 5951.01 (Sub-project), and 5920. Three of them are devoted to diarrheal disease control (5928, 5940 and 5952), two deal with immunizations (5947 and 5951.01) and one is concerned with child survival service delivery systems across the board (5920).

Three other research projects support child survival objectives, but less directly than the six projects cited above. They are 0453 (Malaria Immunity and Vaccine Research), 5967 (Malaria Field Trials) and 5935 (Diatech). And two projects appear to be unrelated to the Agency's child survival strategy - 1126 (Tropical Disease Research) and 5957 (Americares).

2. The Team found that the research portfolio corresponds closely to the Office's (and Agency's) objectives. It is tightly focussed, for the most part, on high priority field problems and is mostly applied research which promises usable results in relatively short time periods. Exceptions to the first criterion are the TDR annual grant to WHO, and Americares. The first is the Agency-wide policy of supporting WHO, while Americares was in response to a special interest. The malaria vaccine research program represents very long-term basic research which contrasts greatly with the rest of the portfolio.

3. Should A.I.D. be involved in basic research such as the malaria vaccine research program? We encountered strong views among persons interviewed and from reports, as to whether the Office should continue to support the malaria vaccine research program. In fact, the malaria vaccine activity introduces the question as to whether AID should ever again attempt to undertake long term basic research of this nature. Most members of the Team would opt for not undertaking long term basic research again. One member believed that A.I.D. should

engage in supporting basic research on major LDC related problems, but should find ways to reduce the direct management burden of such involvement. Malaria vaccine research is basic scientific research as distinct from applied research, and poses a special opportunity as well as a significant concern. As a serious LDC health problem it is a legitimate AID and CS priority. With no U.S. domestic interest in malaria, it is not appropriate for NIH attention. DOD interest is restricted to temporary protection of healthy adult males. Consequently malaria vaccine research is almost an international research orphan. AID has invested or projected \$89 million in vaccine research as well as \$5 million in field trials over the past twenty years. Until recently (according to informed sources) AID appeared to be on the verge of a breakthrough, but current success is now estimated at from anywhere from two years to indefinite. Concern has been expressed whether AID should persist in this area of basic research which takes approximately \$10.0 million annually from the ST/H budget. Supporting termination would be (1) AID's lack of USDH scientific personnel capable of managing basic research in malaria vaccine, (2) indefinite time frame, (3) indefinite funding required. Supporting continuation would be the (1) huge investment in terms of time, money and expertise already provided, (2) possible nearness of success, (3) scourge that malaria is in terms not only of human health and suffering, but in terms of hampered economic development and (4) lack of predominant interest in the problem by other health research agencies. The team does not have the expertise to make a firm recommendation, but concludes that malaria vaccine research needs periodic (annual?) intensive progress review which maximizes cooperative interaction with all USG and donor entities involved in malaria vaccine research.

4. The research program is the product of extensive interaction with U.S. and international experts in the fields in which AID is involved, as well as of internal AID policy and programmatic strategies. ST/H has sought and obtained guidance for its research agenda from technical advisory groups which it has sponsored or in which it participates, including the following:

- NIH, Expanded Biomedical Research Opportunities in Developing countries. An External advisory Panel recommended approaches AID should take with respect to ARI, diarrheal diseases parasitic diseases, and viral diseases. 12/82

- NAS (BOSTID), Establishing Priorities for New Vaccine Development. 1982

- AID, Malaria Strategy Workshop. External experts encouraged AID to continue investing in vaccine research. 1983

- WHO, Advisory Committee on Medical Research (ACMR). Recommended health research strategy for supporting Health for All by the Year 2000. 1985

- NIH (Institute of Medicine), New Vaccine Development Priorities. 1986

- BOSTID, U.S. Capacity to Address Tropical Problems. 1986

- Global Task Force on Child Survival. 1985

- WHO, Advisory Groups on Diarrheal Disease Control Program and EPI Program. Ongoing

In addition to periodic guidance from the external advisory groups cited above, the Office receives feedback from AID's Research Advisory Committee (RAC) composed of about 20 outside experts representing universities and private industry. Its Panel on AID's Health Research Strategy met in October 1986 and again in September 1987 to review the overall research program. The conclusion of the second review was that "...AID's health research program appears to be a vigorous and productive one, whose principal resources are directed toward important issues."

In fact the Panel identified only one project which it felt was of marginal value - Pediatric Chronic Diarrheal Disease (5940)- not because of the subject itself but because it was devoted to basic research at a single U.S. institution with little experience with developing country problems. This project was included in the Office's research program as a result of Congressional interest.

The Team concurs with the RAC's overall assessment and found that the research program is closely linked to the ST/H "field support" projects and Mission health programs as well. Indeed, we found that AID's field operations (Missions), technical support (Regional Bureau and ST/H), and research (ST/H) programs are focussed on the same set of priority health problems characterized, for the most part, as child survival, with increasing concentration on diarrheal and immunizable diseases which impact primarily on infant and young child mortality.

5. The research portfolio consumes approximately 55% of the total Office budget, excluding AIDS funds. The RAC urged that more funds be devoted to the ST/H research program, if available. However, the Team feels that, given ST/H's other important task of mission support, the current proportion of ST/H funds devoted to research should not be increased.

One way to minimize this potential conflict is for ST/H to design research projects which can collaborate with planned or ongoing research programs supported by Mission projects, thereby reducing the need for central funds to set up parallel research projects. One team member cannot determine whether or not the current proportion of funds devoted to research in ST/H should be decreased. This distribution should be a function of the nature of the problem, the role of A.I.D. can play in the larger arena of health science, and the extent to which A.I.D.'s involvement focuses attention on a research agenda particularly important to the LDCs. A.I.D.'s approach to research should be integrated and involve both mission and central capabilities. Where USAIDs are able to convince recipients of bilateral assistance to participate financially in these research efforts, the overall effort is strengthened. There will be occasions, however, where S&T may have to bear the largest share of overall research funding. This does not alleviate the need for research coordination which must be improved to ensure maximum return for the dollar. In addition mission operational projects can provide vehicles for ST/H to add research components. We understand that the PRICOR project does this now. The Office should make a careful survey of Mission-funded research and operational activities to identify suitable candidates.

6. The eleven ST/H research projects are managed by one GS career AID officer, one US Public Health Service officer on loan from CDC, and two Interdepartmental Participating Agency (IPA) experts on loan from Johns Hopkins University and State of Maryland. The Office Director, RAC and this Team agree that the research program management and staffing is a major problem confronting the Office.

Problems include excessive workload for the Cognizant Technical Officers (CTO) as the project officers are called, who all have additional duties as well, unfamiliarity with AID procedures, system and field programs (PHS and IPA), lack of clerical assistance, and frequent turnover of CTOs. Despite agreement on the nature and severity of the problem, the Office, RAC and Team each offers different solutions. As part of a general reorganization plan, the Bureau proposes to create a separate Research Office which would have the effect of giving greater stature to that function and obtain additional CTO positions (AID and/or PHS) for technical experts. In contrast, the RAC recommends that ST/H delegate much of the research project management responsibility to U.S. universities. The Team agrees with neither position and proposes instead that the Office assign AID career health officers (FS and GS) as project officers to manage the research projects, as it now does for the field support projects, and retain non-career technical experts to serve as resident staff advisors for the principal

subject areas (diarrheal disease, immunizations and malaria). The latter would assist with all Office projects in their respective fields. This issue is discussed more fully in Section III.

B. FIELD SUPPORT

1. Performance

a. The field support project portfolio is tightly focussed on the Agency's child survival priorities. The projects which provide services directly to the field are organized "categorically" or "vertically". Each of the following projects is devoted to one functional problem or intervention: WASH - water & sanitation, HEALTHCOM - communications, PRITECH - ORT, SUPPORT - ORS, , VBC - vector borne diseases, and AIDSTECH - AIDS. One project, REACH, addresses two subjects, immunization and health care financing. Each is implemented by a prime contractor and various sub-contractors. (See Table 1).

The rest of the field support projects provide a variety of services, or people to missions, ST/H or other entities (e.g. Peace Corps) to help them pursue AID's child survival and AIDS initiatives, for the most part. Projects which do not fit that description are Asia-Pacific Public Health Management, Development of International Linkages in Medical Education with African and Caribbean Countries (Morehouse College), Milwaukee International Health Training Center, and MEDEX. Those four were all initiated by the Office in response to strong Congressional support and all are scheduled to terminate in 1988 or 1989.

b. Field support project performance has been very good. Regional bureau and mission representatives give high marks to the technical performance of the consultants provided through the ST/H field support projects. What criticism there has been has centered almost exclusively on issues of planning and arranging the services, and is directed at both the ST/H office as well as the contractor. But, that criticism is remarkably infrequent and mild considering the large number of assignments performed, often under difficult circumstances. No comprehensive record exists covering all of the projects, but from a cursory review of reports, analysis of field cabled comments and the Team interviews, it is apparent that the field support projects have played a major role in planning, designing and supporting implementation of a large number of mission health projects. In fact, they have been associated in some way with almost all of the current mission projects.

c. Field support projects are diverse in their objectives and types of services provided. Some are pro-active whereas others are reactive, by design. Some provide long-term and short-term services, whereas others provide only one or the other. Some include a "research" or technology development component and others do not. Although they all collect technical information related to their subjects, only some are expected to actively disseminate it. Table 2 below illustrates this diversity in matrix form.

As a rule, the "proactive" projects are those which were initiated to promote priority child survival interventions, encourage missions to include them in bilateral projects, and provide long-term technical services in some countries to accomplish that end, if necessary. PRITECH, REACH and HEALTHCOM fit that description. Reactive projects provide short-term services for important but lower priority interventions which are prominent in many missions' health portfolios. WASH and VBC fit that description.

Although complaints from missions and regional bureaus are relatively few, they relate almost exclusively to the more pro-active projects. Problems seem to arise over selection of "emphasis countries" for long-term work, inability to respond because of excess demand and lack of funds, difficulty in identifying consultants in certain fields (health care financing), and short turn-around time given by missions.

d. Agency initiatives in AIDS appear to be proceeding coherently and expeditiously.

AIDS as health problem confronting A.I.D. burst into life in FY 86 with an initial funding of \$2 million. Subsequently in FY 87 A.I.D. committed \$17 million to the AIDS programs. In FY 88 Congress earmarked \$30 million to continue AIDS prevention and control programs. ST/H's response was to create the AIDS Technical Support Project (936-5972) which has two principal components AIDSTECH and AIDSCOM. Both components are designed to complement WHO activities and to assist LDC governments to set up AIDS detection, control and prevention programs. Field support is emphasized over research.

AIDS activities are coordinated through the AIDS Working Group which meets weekly and involves both S&T offices and regional bureaus. Management of AIDSTECH resides in S&T Health, while AIDSCOM management has been conferred on S&T Education.

A.I.D.'s creation of an S&T project and the establishment of the Working Group have probably been the quickest possible response to provide field support for this new health crisis.

However, use of the working group coordinating concept needs to be monitored to assure it is discontinued as soon as AIDS activities have become incorporated into normal implementation procedures.

e. The Office does not offer a field support project/contractor for health services planning and management generally, although that was the main emphasis of its program prior to 1980. Persons interviewed in ST/H and the regional bureaus feel generally that most planning and management requirements are met through the existing projects in the context of strengthening health systems to accomplish concrete intervention-specific objectives. In addition, PRICOR is analyzing these issues through its operations research work and the Office makes available services of three Indefinite Quantity Contractors (IQC) for health planning and delivery systems consultant services. Furthermore, missions frequently provide overall planning and management technical assistance through their bilateral project contractors. The Team concludes that those needs are being met satisfactorily through present mechanisms.

f. AID health sector technical services have become highly concentrated in the ST/H project contractors. The Team noted that most of this work is now performed by consultants from the five principal ST/H contractors and inquired about its consequences. We found that performance has probably improved as firms have specialized in certain fields and response capability is good. Furthermore, the contractors have used numerous experts from many suppliers through extensive sub-contract networks to do the work, thereby spreading the work around and expanding the networks of experienced consultant technicians. The growing use of contract "buy-in" arrangements has greatly facilitated mission use of the central projects and has contributed to this apparent concentration. (See Section B.2.b below) Missions appear to be using IQCs relatively infrequently, probably because the buy-in mechanism is so attractive. The Team concludes that the apparent concentration is the consequence of successful performance and has actually strengthened the sector.

g. Mission demand for field support services has been strong. Field demand for the direct service projects has exceeded initial expectations and has prompted early start-up of follow-on projects in the cases of PRITECH and WASH II. REACH and HEALTHCOM also expect to reach their funding limits ahead of schedule. In general, ST/H funds have covered 50% to 70% of the services during FY 1987 and FY 1988 and mission and regional bureau "buy-ins" paid for the rest, a clear indicator of field demand. For the field support portfolio as a whole buy-ins paid for 16%, 15% and 29% of the services provided in

FY85, FY86 and FY87 respectively. Bureau management places great importance on buy-ins as an indicator of the value missions and regional bureaus place on ST/H services. The Team agrees that it is valid as a rough indicator, but cautions that while buy-ins serve the missions' interest in obtaining quality expertise, they also respond to missions' needs for convenience and the avoidance of delays which would be occasioned by new competition for services.

The volume and purpose of field travel by ST/H staff is another useful indicator of field demand for ST/H field support services. Of an Office total of 691 TDY days in FY 87, 297 days (43%) represented direct support to mission projects, and missions paid 52% of the TDY costs of that portion. That positive indicator of mission support for ST/H staff travel is corroborated by complaints expressed by eight missions by cable to the Management Assessment Team that ST/H field support division staff do not visit them enough. They attribute the problem to a perceived shortage of Operating Expense travel budget.

Based on these two indicators (buy-ins and travel), the Team concludes that mission demand for ST/H field support services from both contractors and staff is strong. Missions are willing to use their own OYB and OE budget funds to get it.

## 2. ST/H Relationships with Regional Bureaus

### a. Good working relationships exist, despite occasional conflicts.

The Office takes great pride in its "field support" project portfolio, and cites as evidence that it is rightly focussed and well managed the heavy demand for services and high "buy-in" levels attained. The Team agrees that the projects are providing a very valuable service to Missions and regional bureaus and that ST/H has done an excellent job in developing and managing the projects. Regional bureaus and Missions find the projects to be very convenient and effective sources of technical services. Therefore, although ST/H is utilizing a surprisingly high percentage of total A.I.D. health and child survival funds, (24% in FY89) there have been no complaints from missions or regional bureaus. (However, as ST/H's proactive efforts bear fruit and missions increase their bilateral health/child survival projects, competition for funding may emerge. In such event, we would expect ST/H's share to decline to a more typical percentage.) Despite this excellent performance, regional bureaus express some dissatisfaction with the way in which ST/H plans and carries out the "field support" function. They cite instances where

they perceive that ST/H actually pursues its own "agenda" in the name of offering field support and services. The Team identified a number of such instances and looked into the reasons for conflict.

In reality, "field support" misrepresents the nature of some of the projects and does not accurately reflect the basic policy of the SAA and previous Administrator. Their common objective for ST/H, as stated frequently in writing and verbally, has been to guide and direct regional bureaus and missions into certain specific programmatic and technical areas, most notably two of the "engines" of Child Survival - oral rehydration and immunizations. Consequently, ST/H "field support" projects providing those services were clearly designed to promote those Agency priorities in the field, and not just to respond to mission requests for support to their programs.

Although the field and Administrator's objectives have not really been at variance, numerous occasions for interpretation and adaptation arise in order to meet needs of many national programs around the world. In effect, the technical services contractors have been used, in part, to implement or reinforce the application of Agency policies where the normal Agency actors have not been adequately responsive. The most dramatic example of this is the Agency's attempt to introduce Oral Rehydration Therapy programs in Africa. In response to the Africa Bureau's inability to assign health officers to their missions and initiate mission health projects which could incorporate ORT interventions, the PRITECH project was designed to initiate long-term ORT programs in Africa, operationally independent of missions if necessary.

The fact is that while policy is made centrally, policy implementation is decentralized. Where these are not consistent, an ST/H project which is implementing central A.I.D. policy may well generate regional bureau dissatisfaction.

b. Concentration of technical support suppliers in ST/H has given its contractors substantial influence over A.I.D. health policies and field programs.

As a result of ST/H's successful performance in anticipating and /or responding rapidly to field demand for technical services (or to Agency directive to promote services) the vast majority of short-term technical assistance, and a growing proportion of long-term services as well, is provided from ST/H contractors - PRITECH, REACH, HEALTHCOM, WASH, VBC. IQCs, which represent alternative sources of expertise, are much less widely used now because it is more convenient to use the ST/H suppliers. Figures for FY 85 showed 43 work orders for \$1.8 million, FY 86 showed 38 work orders for \$2.1 million, while FY

87 dropped substantially to 17 work orders for \$0.7 million. Furthermore, regional bureaus are discouraged from establishing their own contract suppliers because ST/H can meet most of their needs more efficiently, given the increasingly liberal "buy-in" provisions.

The concentration described above may be necessary and appropriate to accomplish Agency (and Congressional) policy objectives. But, it changes the relative power and roles of the Bureaus, and has also given substantial influence over A.I.D.-wide health program policies to the ST/H contractors themselves. The team heard of instances where those contractors interpreted technical guidelines to Mission staffs and host country counterparts who were not in a position to judge the validity of the interpretations. The contractors appear to be handling their responsibilities well, being sensitive about overstepping their mandates. In fact, several requested that their ST/H CTO's spend more time with them in order to ensure close coordination. However, ST/H should make sure that their contractors implement Agency directives and guard against any inadvertent abuse of their growing influence.

### C. Technical Coordination

#### 1. Health Sector Council and Agency Directorate

##### a. Background

Prior to 1981 health officers of the Development Support Bureau and regional bureaus met periodically on an informal basis to discuss technical and programmatic subjects of mutual interest. In 1981 this coordination function was formalized by the Administrator through the formation of a Health Sector Council, chaired by the new Agency Director for Health and Population. The Agency Directorate and Sector Council were to provide a mechanism for the accomplishment of the Agency-wide role in health which the Administrator wished the Bureau to play. The Sector Council was to provide the Agency Director a regular means for exercising his Agency-wide role, in collaboration with the senior technical specialists of the regional bureaus, PPC and external contacts.

A number of A.I.D. officers believe that the Agency Directors have been playing a much larger internal Bureau role than was initially contemplated for them, while the Sector Councils have dealt mostly with S&T Bureau business; that most of the issues considered in the Sector Councils have presented the opportunity for the regional bureau technical representatives to comment on Science and Technology Bureau programs, but have not served as an opportunity for consideration of issues presented by regional bureaus.

In September 1987 the ST/H office sought regional bureau feedback on its performance in meeting its Agency-wide and field support responsibilities. Several persons interviewed said that the Office did not take the Sector Council mechanism seriously enough and maximize its potential for achieving cross-fertilization and coordination of Agency health programs. They pointed out that the Child Survival and AIDS Task Forces were doing a better job. They added that the Agency Director (also Health Office Director) was not using the Sector Council mechanism to carry out his Agency-wide role.

b. Team Findings

Based on interviews and review of minutes of Council meetings, the Team found that the Council mechanism has been used during the past year, at least, to obtain regional bureau feedback and concurrence on Office projects and activities, review substantive topics of general interest, and to discuss Agency-wide policy issues concerning primarily the Child Survival initiative. Regional bureau representatives feel that the Council meetings have served to improve coordination and communication between them and ST/H, but has not been as effective as it could be. They complained that meetings have not been held regularly each month, but scheduled to meet the needs and convenience of ST/H. While the meetings were irregular, seven meetings were held during 1987.

The Team was advised that the function of the Health Sector Council was complicated, and somewhat compromised, by the work of the Child Survival Task Force which met periodically during the past several years to coordinate the Child Survival Initiative. Those meetings, chaired by the Deputy Assistant Administrator of the Science & Technology Bureau, covered much of the ground that the Sector Council would normally have discussed in the absence of the Task Force and, in the view of the Office Director, reduced the need for frequent Council meetings.

Regional Bureau representatives also complained that ST/H sometimes brings subjects to Council meetings on which they seek regional bureau concurrence, without having given the regional bureau people adequate time to study related material and reflect on it. The regional bureau people suspect that ST/H tries to extract concurrence to ST/H's proposals and impose its will unfairly, in the name of urgency and AID priorities. Although ST/H claims that they do not intend to act in a directive manner, and that they want to work collaboratively with regional bureaus, the experience as perceived by some regional bureau representatives is otherwise. On the other hand, the Office Director requested, at the April 23, 1987 meeting, that regional bureau

representatives propose agenda topics for discussion at subsequent meetings. Based on the Team review of Council meeting minutes, it must be concluded that the regional bureau representatives have not done so.

The original conception of an Agency Director was one which suggested a great deal of Agency representation and coordination at international and domestic scientific fora and a nominal amount of internal Bureau and Office management. The Office Director was expected to attend to the internal workings of the Office. In the case of the Agency Directorate and Office of Health, which are identical and headed by the same person, the separate roles of Agency Director and Office Director have become indistinguishable.

c. Conclusions

The Team concludes that the Council has played a valuable role in increasing coordination and communication between the health sector technicians in ST/H and regional bureaus, and provided a formal mechanism for obtaining feedback on ST/H projects. But it is not meeting the Administrator's original expectations that it would provide the mechanism for the Health Agency Director to exercise his "Agency-wide" leadership role. We note that the Agency Directorate is not functioning as originally contemplated and feel that that role is probably not realistic given AID's decentralized management structure. But, the Council is serving a very useful communication function. We also observed an effort on ST/H's part to use the Council as a means to collaborate with the regional bureaus in meeting their common objectives, but with less than full success, as noted above. Regional bureau representatives have not taken initiative to make the Council meetings more useful to them by bringing topics to it for discussion or proposing changes in its structure or role.

The Council probably cannot be expected to be much more than it is at present because it is actually just one element in a spectrum of AID decision-making mechanisms - formal and informal. On the one hand considerable business is transacted daily between ST/H and regional bureaus on many subjects, including project-specific implementation, Agency-wide policy issues, personnel and ST/H new project development. Some of this represents preliminary work on subjects which are eventually dealt with formally at Council meetings. But, on the programmatic and resource allocation side, decisions are usually reserved as the prerogative of each bureau's top management, with involvement of their respective Program Offices.

## 2. Child Survival Task Force and AIDS Working Group

The task forces, while serving a very useful purpose, intrude on ST/H's relations with the regional bureaus. The Child Survival Task Force was set up in 1985 with the advent of the Child Survival Initiative to coordinate its implementation within AID and interact closely with the Congress and international agencies. One of the S&T Bureau Deputy Assistant Administrators was appointed Chairman. Regional bureau and S&T Bureau persons interviewed agree that the Task Force was instrumental in making the C.S. Initiative work as well as it has. However, they also agree that it causes confusion about leadership of the program, which appears to many to be split between the DAA/ST and Agency Director (Office Director) for Health. Furthermore the respective functions of Task Force meetings and Health Sector Council meetings with respect to child survival subjects is unclear. Some observers feel strongly that the Task Force intervenes too much in the operations of the Health Office. Its original mandate was to "...coordinate and monitor implementation of the health and nutrition projects funded by our additional Health and Nutrition funds." It subsequently broadened its mandate to take on a leadership role in successfully creating an Agency-wide emphasis on child survival.

The Chairman advised the Administrator on February 19, 1988 that the Task Force's development work was largely complete and that its principal concerns during 1988 will be implementation and continuing Congressional interests. He advised the Team that the Task Force had accomplished its principal objectives. In view of that, and the evidence of management and communication problems currently associated with it, which impinge upon ST/H's relations with the regional bureaus, the Team concludes that the Task Force should be disbanded now. The mechanisms required to sustain the Initiative are in place and the Health Office, in collaboration with the regional bureaus and PPC, is capable of coordinating its implementation. Surely the Task Force's remaining task of handling "continuing Congressional interests" can be handled by ST/H in cooperation with PPC and LEG.

The new AIDS Working Group is also doing a commendable job under great pressure. In light of the experience of the Child Survival Task Force, the Team concludes that a target date should be established for termination of the AIDS Working Group. Only if mechanisms are not in place and programs are not operating routinely at that time, should it be extended.

### 3. Child Survival Information System

The Health Office is providing a valuable coordination function for the Agency through its Health Information System Project. The system is operated by a contractor as part of the CSAP-Support Project (936-5951). The contract was initiated in early 1984 to develop a data bank of information about USAID Child Survival and other health projects, compile relevant statistics on USAID countries and assist the ST/H Office with various analytic tasks. An evaluation conducted during December 1987 found that the data have been used for tracking progress of USAID-funded health and child survival projects and for planning and monitoring A.I.D.'s health programs worldwide. Furthermore, the system (HIS) has provided all the data for the annual Child Survival Reports to Congress. It is being used by the regional bureaus for their own program monitoring and planning purposes, and increasingly by outside agencies, including the United Nations Water and Sanitation System.

### 4. Technical and Policy Coordination with External Organizations

Office staff participate actively in technical and policy fora with external groups. On the technical side, the Office Director and a large number of cognizant technical officers (project managers) attend meetings with international and U.S. groups to discuss issues related to their projects, including coordination of similar efforts conducted by others. Approximately half of the Office travel in 1987 was for that purpose, in contrast to project implementation purposes per se. The Office maintains close contact with the World Health Organization, National Institutes for Health and Centers for Disease Control units of the U.S. Health and Human Services Department, and universities with which it collaborates on a number of activities.

On policy and programmatic issues the Office participates heavily, directly and indirectly, in communications with Congress about A.I.D.'s health and child survival program. We were told that Office staff prepare numerous documents used in communication with Congress, and sometimes participate directly in such communications. This function appears to place a heavy burden on the staff, taking time away from their project and office management responsibilities. The Team noted that the PPC Bureau had handled a large share of this responsibility in previous years, before its staff was reduced.

### III. Management Issues

#### A. Staffing

##### 1. Number of Office's authorized positions is inadequate.

S&T Health is staffed with a bewildering variety of kinds of employees. There are no fewer than 14 categories of employees including full and part-time personnel. (See table 2) Some of these employees can function as full cognizant technical officers (CTO's), others can't. Some are long term, others may be gone on a moment's notice. The Team counts 38 employees, excluding two experts working on a "when available" basis (WAE). This figure can be rendered obsolete at any time.

In terms of perspective, a comparative set of figures is instructive. In FY 1985, ST/H had 16 FTE (full-time employee) ceilings. There were, then as now, assorted other personnel. ST/H's share of the S&T Bureau's FTE ceilings was 7.4%. The FY 85 funds assigned to ST/H for management (prior to the Child Survival build-up) constituted 9.8% of all S&T funds. From this perspective the ST/H office had reasonable numbers of staff to match resources assigned. By FY 1988 (current) the FTE allocation to ST/H had increased 25% to 20 ceilings (though all are not currently filled) constituting 10.6% of all S&T ceilings. The funding resources conferred on ST/H to manage have increased by 335% and now constitute 24.9% of all S&T funds. While these comparisons are necessarily gross, discounting the reality that some funds are merely "passed through" to WHO, there is little doubt that the ST/H office is being made responsible for more funds without commensurate increase in staff. Hence, the proliferation of ad hoc solutions, some quite innovative, to bring in additional people not subject to ceilings.

##### 2. CTO workload is heavy.

To address the workload, ST/H assigns a Cognizant Technical Officer (CTO) for each project (and, on occasion, subproject, see table 3). To cover the 29 existing projects in FY 1987, S&T identified 18 CTO's who each managed from 1 to 3 projects. While, on the face of it, this project workload may not appear excessive, effective performance depends heavily on such variables as: the nature of the project, the quality of the contractor, the number of subprojects, the number of buy-ins, the CTO's own A.I.D. implementation experience, the amount of travel funding available, etc. Furthermore, many CTO's have significant work requirements in interacting with US and international scientific bodies, participating in regional bureau activities, and, as the Agency's last repository of information on health, responding to ad hoc requests from Congress and the public.

Of specific interest in terms of CTOs is the unusually heavy research portfolios carried by the research staff, 3/4's of whom have only limited A.I.D. implementation experience. This heavy workload reduces the ability of these technical specialists to interact technically with operations research or field support type activities, whether in S&T or in the field.

3. CTO's do not travel to the field enough.

As noted in Sec. II.B.1 above, ST/H staff travel is a chronic complaint. Field missions repeatedly urged ST/H officers to visit and to provide technical advice to projects in the mission's own portfolio. The team was advised that (a) travel funds were inadequate and (b) staff time available for travel was limited. In terms of funding resources, it may be necessary for S&T management to re-examine priorities relating travel funding to project management responsibilities. Also of note, in FY 1987, ST/H officers traveling in support of mission activities had 299 days of TDY spread among 11 officers. This works out to one 3 week trip per year per active officer, a fairly nominal figure. Much greater mission support could be provided by either increasing the number of officers providing field support and/or increasing the numbers of TDY days in the field per officer, or both.

4. CTO's and Office management face potential accountability problems.

In terms of accountability, each CTO is expected (required?) to be knowledgeable about project progress and expenses. Travel to project sites is certainly essential to assure that minimal financial responsibility is maintained. While A.I.D. vulnerability assessments are not necessarily impeccable indicators of potential fiscal mismanagement, it should be noted that in the last vulnerability assessment (July 1985) ST/H was rated as a moderate risk (2nd highest category) at a time when it had yet to assume significant increases in funding from Child Survival and AIDs earmarks. The team was informed that a vulnerability assessment (now called an internal control risk assessment) was currently being undertaken since June 1987 but had not yet been completed.

5. Non-career technical experts should not serve as project officers (cognizant technical officers).

ST/H has followed a policy of recruiting highly qualified and experienced technical specialists to serve as CTOs for the projects in its research portfolio. This is seen as a means of strengthening the Bureau's, and AID's technical capabilities and helping to make it a leader in certain technical fields. Because AID has very few such biomedical technical specialists

among its career ranks ST/H has brought in many people from outside for short term assignments - usually two years. It has been very successful in attracting qualified persons from the U.S. Public Health Service, universities (IPAs, AAAS Fellows, CS Fellows) and state government (IPA). At the present time ST/H employs 11 such persons who are formally, or informally, in charge of 12 projects, representing 82% of the research portfolio and 41% of the total portfolio.

Based on its interviews with AID staff and ST/H contractors, the Team identified a number of problems associated with the Office's heavy reliance on the non-career technicians for project management responsibilities.

a. They do not know the "AID system" and it takes a year or more to really do so. By the time they are really part of the system and working effectively within it they depart.

b. More time must be devoted to management/ administrative aspects of the projects than to the truly technical aspects for which they were hired. This is compounded by the fact that the Office provides technical staff with very little administrative/clerical support.

c. The practice may contribute to the poor communication and technical interface between the research projects' staff and field service projects' staff, who are career AID health generalists for the most part. The research portfolio does not appear to be feeding into the "field service" portfolio from within the Office. Research findings are more likely to enrich field service projects through networks external to the Office.

Conclusion: The Team concludes that all ST/H projects should be managed by AID career officers, with appropriate inclusion of FS officers. We feel that many FS Health Officers with field experience would do the job admirably, and would appreciate opportunities to work closely with some of the most exciting applied health research work being done in the world. But, they could not do the whole job alone. A small number of highly qualified experts, such as have been used to date, should be assigned by ST/H to serve as technical advisors to all of the Office projects in their respective fields. For example, a diarrheal disease expert should "backstop" the ICDDR-B, ADDR, and WHO research projects and the PRITECH, SUPPORT projects, and advise on ad hoc matters that arise periodically. That arrangement would maximize their technical contributions to the entire portfolio, and strengthen the field and "AID system" synchronization of the research portfolio. This arrangement would probably require additional FTE positions for the Office, but reduce its dependence on temporary, above ceiling employees to run its complex program.

## B. Office Structure

### 1. Office structure does not facilitate effective program coordination.

The present office organization structure places excessive burden on the Health Services Division to a) design and manage the highest priority field support projects (PRITECH, REACH, HEALTHCOM, PATH and PRICOR), b) maintain liaison with all mission programs, and c) perform ad hoc duties for the Office, such as organize ICORT III. By contrast, the Vector and Water Borne Disease Division is responsible for two projects (WASH and VBC) which are completely field support in nature, and yet they are not managed as part of the Health Services Division. The other major project in the Vector and Water Borne Disease Division (Malaria Vaccine Research) is very complex and should be part of a research management unit.

The Epidemiological Research Group, popularly referred to as the Research Division, manages several projects closely related to the principal child survival interventions pursued by the Health Services Division, but with very little communication between them. Finally, the Child Survival Coordination unit, which has played a useful role helping the Office handle the many special requirements of the Child Survival Initiative, now overlaps some of the functions of the Health Services Division and is also managing some projects as well. It should be integrated into the regular Office structure when the Child Survival Task Force is disbanded, as recommended above.

### 2. The Office should be reorganized, joining all field service projects and field liaison functions together and placing all biomedical research activities together.

The Office of ST/H has been considering a reorganization for as long as 18 months. The Bureau plan for the reorganization of the Directorate of Health involves the creation of two Offices within the Directorate of Health, one for Research and one for Field Support. Within each Office would be two or three Divisions (as appropriate). (The Divisions would not, as of the present, have sufficient staffing to justify their receiving that name classification.) Each Office would have a Director at the SES level. While the Directorate has been allocated four (4) additional FTE ceiling, two of these ceilings would be utilized by creating the Office Director positions. The remaining two FTE ceilings are expected to be used for an additional CTO and an additional secretary.

Bureau management should make sure that reorganization will alleviate current problems of overloaded project officers (CTOs) and poor internal coordination between units.

Unfortunately, the plan currently proposed by the Bureau would, in the Team's opinion, exacerbate rather than alleviate, those problems. Although that plan correctly places research in one unit and services in another, it separates them organizationally even more than now by elevating each to Office status. We feel that could inhibit interdepartmental communications even more and probably hurt prospects for recruiting AID career health officers to manage research projects as recommended above.

The addition of two high-level managers to serve as office directors represents another serious flaw in the Bureau's plan. Any new staff provided to this Office (Directorate) must serve as project officers (CTOs) to ease the current serious overload. Many persons interviewed by the Team (staff, contractors, international agency officers) expressed serious concern about the situation, and most field criticisms of the Office reflect the same problem. The Team feels that CTOs are already unable to stay as close to their respective projects and contractors as they should in order to discharge their project officer responsibilities properly. In fact, the Team urges that no new projects be started which would place additional management burden on CTOs and that the Office actually reduce substantially the number of management units or activities for which it is responsible.

The Team feels that creation of two health Offices might generate even greater claims for scarce funds and staff, which, given the high percentage of Agency health funds already controlled by ST/H, and the possible and desirable increase in mission bilateral programs competing for these funds, would be a most unfortunate outcome.

Since 1985 the Agency has placed a very heavy management and technical burden on the Health Office without providing a commensurate increase of appropriate staff. The Office staff themselves have contributed to the problem by continuing to propose additional projects, albeit useful field support resources (Maternal & Prenatal Care, Health Care Financing, Epidemiological services). As noted below, the Office is in a precarious situation in terms of carrying out its project management responsibilities. It is in danger of letting success get out of control. Consequently, Agency management must take a hard look at what it wants from the Office, its role vis-a-vis regional bureaus, and either increase its staff and operating expense budget or cut back its program to match the staff available.

C. PROJECT IDENTIFICATION, DESIGN & APPROVAL PROCESS

Ideas for new projects seem to emerge from a variety of sources, including informal staff brainstorming, perceived demand from the field, discussion with regional bureau and mission staff, political/management priorities, outside experts, etc. This appears to be a normal and healthy process which encourages creative thinking from a number of sources. But, the project design steps which follow initial identification of project ideas are equally important. A rigorous design process is required to keep the portfolio focussed on priorities and to produce projects which are relevant and implementable.

The S&T Bureau has a formal project design procedure which includes preparation of a Concept Paper, PID and Project Paper. Concept papers are reviewed by the Senior Assistant Administrator. If approved, a project team is to be formed, including a member of ST/PO (Program Office), members of ST/H, and sometimes representatives of other S&T offices, regional bureaus, General Counsel and Contracts Management. A PID is prepared for SAA approval, unless he had waived PID preparation at the Concept Paper stage. That is often done for follow-on projects but rarely for new projects. Regional bureau representatives are consulted early in the process and cables are sent to missions soliciting their views and expressions of potential demand for proposed project services, including estimated "buy-ins". Regional bureau inputs and concurrence are sought for the Concept Papers, PIDS and PPs.

In practice, PIDs and Project Papers have been prepared for all the recent "field support" projects, but for only some of the research projects. Of the current ST/H total project portfolio of 32 projects of which 6 were unsolicited proposals, PPs were prepared for 14. ST/PO involvement has been minimal and, although regional bureau people have been consulted throughout the process, they have not participated as full team members.

Issues:

a. ST/H does not prepare Project Papers for all projects. Because the Agency has found the project paper preparation and review process to be a useful way to assure that all pertinent issues are addressed, it seems appropriate for ST/H to follow that process for all of its projects. Content and emphases of project papers can be modified to meet the needs of particular types of projects.

b. The S&T Bureau reviews and approves project documents (Concept Papers, PIDs, PPs) seriatum rather than in a common meeting format. Regional bureaus have found that the meeting format for project review and approval purposes is useful because it generates discussion of alternatives and critical assessment of the proposals. Meetings permit representatives of interested offices and bureaus to participate in the decision-making process on an equal basis with the project proponents. The process also serves to inform interested offices about the projects. In view of regional bureau comments to the Team about lack of opportunity to participate in ST/H project design process, it would be prudent for ST/H to hold project review and approval meetings where all parties could express, and share, their views together. Sector Council meetings are not appropriate for this function because Council membership does not include all of the appropriate skills required for project review. Furthermore, Council meetings are intended for collegial discussions of technical subjects, and formal review of project proposals should raise additional programmatic and funding issues which transcend the Council members areas of concern and/or expertise.

c. ST/H does not include regional bureau representatives on project design teams. Although regional bureau representatives are consulted on some project designs, especially "field support" projects, they are not brought into the design process as formal participants. Now that many ST/H projects are essentially USAID service projects, and the distinction between "central" and "regional" projects is blurred, regional bureau staff should participate actively in the design of many ST/H projects. It is not enough for ST/H to consult with regional bureaus about the design of their (ST/H) projects. Instead, the projects should be regarded as joint projects and regional bureau staff should be full partners in their conceptualization, design, implementation and evaluation. Differences of emphasis and technical content should be resolved collaboratively through the design process. In fact, regional bureaus have consciously refrained from establishing regional technical support contracts through their own projects because ST/H already has a project contractor in place to meet their needs. ST/H has encouraged regional bureaus to rely on their service projects in lieu of starting their own. The WASH, VBC, PRITECH, REACH, HEALTHCOM projects are cases in point.

d. Project Development Officers (PDOs) do not participate in design of ST/H projects. In fact, the S&T Bureau does not have any PDOs. The Program Office is expected to play that role but it is understaffed and inexperienced in project design. ST/H has several CTOs with project design experience but they do not play an Office-wide role. Ideally, S&T could create a PD

capability to serve bureau-wide, but in any event, should create a mechanism which will take advantage of the rigorous project design and review system which is extant in the regional bureaus. The Office should ensure that all of its CTOs take the A.I.D. Project Design and Implementation course (if they have not already done so) to increase their understanding of the issues involved.

TABLE 1

RESEARCH	START	END	S & T HEALTH PORTFOLIO		MANAGER	LUNIFACTUM	ANNUAL DTR			
			LIFE OF PROJECT	ORIG. THRU			87	88	89	
Malaria	931-0453	75	89	89,000	75,112	Heiby (GS)	Various	9.9	8.5	8.5
TDR	931-1126	76	90	40,300	32,300	Shiff (IPA)	WHO	2.5	2.5	2.5
DDRP	936-5928	84	88	18,025	14,025	Lin (IPA)	ICDDR-B	3.4	2.5	2.0
FED. CHR. DDRT	936-5940	84	87	3,298	3,000	Lin (IPA)	Burkina	0.5	-	-
Vaccine	936-5947	84	88	7,430	6,000	Bender (GS)	MSD-DIH (Clinton)	0.8	1.0	0.5 (CS) 0.4
ADDR	936-5952	85	9/90	12,500	12,500	Lin (IPA)	HIID	1.2	1.7	1.5
Americares	936-5957	85	9/90	800	800	Shiff (IPA)	Americares Found.	-	-	-
Field Support										
HEALTHCUM	931-1018	78	93	12,500	12,500	Clay (GS)	AED	2.0 0.1	2.0	2.5 (CS)
PRICDR 1, II	936-5920	81	90	19,553	19,553	Heiby (GS)	CHS-URC	2.0	1.8	1.9
PRITECH	936-5927	83	88	44,700	40,000			4.0	2.1	2.0 (CS)
.1 PRITECH		83	88			Feinberg (GS)	MSH	0.1		
.2 CDC		84	88			Feinberg (GS)	CDC			
.3 REACH		85	90			Abramson (GS)	JSI			
.4 HLTHFIN		86	88			Randlov (FS)	WHO			
Hlth Resources										
Sources	936-5929	84	9/88			Ice (GS)	DIH	0.6	0.9	0.7
MEDEX Support	936-5932	83	8/88	4,600	4,600	Feinberg (GS)	Univ. of Hawaii	1.0	0.5	-
DIATECH	936-5935	85	9/90	11,000	10,000	Bender (IPA)	PATH	- 2.0	- 2.0	1.0 (CS) 1.5
DRT-HELP	936-5939	85	12/91	7,300	7,300	Clay (GS)	AHRT PRAGMA Peace Corps	- 1.0	- 0.8	0.9 (GS) -
WASH	936-5942	84	89	19,700	19,700	Austin (GS)	CDM	2.4	1.5	0.5
VBC	936-5948	85	8/90	19,880	19,880	Shiff (IPA)	Medical Services Co	1.6	1.5	1.8
Asia Pacific Public Health Management	936-5950	85	3/90	2,200	2,800	Heiby (GS)	Univ. of Hawaii	-	-	-

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CSAP Support	936-5951	85	90	7,000	3,750	Johnson	(GS)	AMA ISTI NCIH Johns Hopkins	0.3 1.6 1.3 -	- 1.4 -	- 2.0 -	FM (CS)
Support	936-5953	85	12/91	2,973	1,673	Clay	(CS)	PATH	0.5	0.5	0.8	(CS)
Morehouse	936-5954	85	7/88	897	897	McJunkin	(CS)	Morehouse	-	-	-	
Milwaukee	936-5958	86	4/88	425	425	McJunkin	(CS)	Milwaukee	-	0.2	-	
DHS	936-3023	84	89	2,625	2,625	Johnson	(CS)	Westinghouse	- 0.5	0.1 0.4 15.0	0.1 0.4 15.0	(CS) AIDS
Sp. Pr. AIDS	936-5965	86	6/88	5,000	1,150	Harris	(PHS)	WHO	5.0	-	-	
Med.Fld. Trials	936-5967	87	9/92	5,000		Bender	(PHS)	Papua NG	2.0	2.0	2.0	
HEALTHTECH (LINK) II	936-5968	87	3/91	2,500		Johnson	(GS)	PATH	1.0 1.0	0.8 -	0.8 -	
FRITECH II	936-5969	87	92			Feinberg	(GS)	MSH w/AED, etc	2.9 -	3.0 -	3.5 -	(CS)
Tech. Adv. C.S. (PHS Details)	936-5970	87	93	2,000		Terry	(DHS)	DIH (PASA)	- -	0.5 -	0.5 -	(CS)
AIDS TECH Support	936-5972	87	9/95			Harris (AIDSTECH) Sprague (AIDSCOM)	(GS)	FHI AED	2.9	-	-	
IOCs	936-1466	87	90			Peltigrew	(GS)	Various				
WASH III	936-5973	88				Austin	(GS)	TBD	-	1.0	2.5	
HLTH. FIN.	936-5974	89							-	-	0.6	
Maternal	936-5966	88	93			Tinter	(GS)	TBD	- -	0.7 0.8	1.3 -	(CS)

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S&T(H) - STAFFING

TABLE 2

<u>CATEGORY</u>		<u>USDH</u>			<u>"D"</u>	<u>"SURPLUS"</u>		<u>OUTSIDE CEILING</u>				<u>TOTALS</u>
		<u>GS</u>	<u>FS</u>	<u>PHS</u>		<u>AD</u>	<u>COMPLEMENT</u>	<u>IPA</u>	<u>PHS</u>	<u>AAAS</u>	<u>CS</u>	
Professional	FT	10	2	3	2	1	2	2	1	3	1	27
	PT	4	-	-								4
Support Staff	FT	4	-	-								4
	PT	3	-	-								3
Total		<u>21</u>	<u>2</u>	<u>3</u>	<u>2</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>1</u>	<u>3</u>	<u>1</u>	<u>38</u>

TABLE 3

## S &amp; T Health Cognizant Technical Officers (CTO)

<u>FIELD SUPPORT</u>	<u>PROJECT</u>	<u>PROJECT NO.</u>	<u>TERMINATING</u>	<u>LIFE OF PROJECT (LOP \$'000)</u>
1.	<u>Lloyd Feinberg</u>			
	1. PRITECH I & II (ORT)			
	I	936-5927.1		\$44,700
	II	936-5969		
	2. MEDEX		'88	4,600
	3. PASA with CDC	936-5967.2	'88	
2.	<u>Allen Randlov</u>			
	1. REACH - project mgt 1/2 time			
	2. Maternal and Prenatal Health Project Dev - 1/2 time			
	3. Health Financing	936-5927.4		
3.	<u>Susan Abramson</u>			
	1. REACH	936-5927.3		
4.	<u>Robert Clay</u>			
	1. Healthcom	931-1018.1		12,500
	2. ORT-HELP	936-5939	84-91	7,300
	3. Support	936-5953		2,973
5.	<u>John Austin</u>			
	1. WASH II	936-5942		19,700

6.	<u>Clive Shiff</u>			
1.	VBC	936-5948		19,880
2.	Americares	936-5957		800
3.	TDR	931-1126		40,300
7.	<u>Tom Bender</u>			
1.	Vaccine	936-5947		7,430
2.	Malaria Field	936-5967		5,000
3.	DiaTech	936-5935		11,000
8.	<u>Lin</u>			
1.	DDRP	936-5928		18,025
2.	ADDR	936-5952		12,500
3.	PED. CHR. DDRT	936-5940		3,298
9.	<u>Jim Heiby</u>			
1.	Malaria Vaccine	931-0453		89,000
2.	PRICOR II	936-5920		19,553
3.	Asia Pacific PH Management	936-5950	85-90	2,200
10.	<u>Pam Johnson</u>			
1.	CSAP - support	936-5951		7,000
2.	NCIH	936-0271		
3.	Demo & Health Surveys	936-3023		2,625
11.	<u>Eugene McJunkin</u>			
1.	Int. Linkages in Med Ed	936-5954	7/88	897
2.	Milwaukee IHTC	936-5958	4/88	425

12.	<u>Janet Ice</u>		
	1. Health & Human Svcs (RSSA)	936-5929	N-A Annual 200
13.	<u>Jeffrey Harris</u>		
	1. AIDS	936-5965	5,000
	2. AIDS TECH	936-5972	
14.	<u>V. Barbiero</u>		
	1. Healthtech	936-5968	2,500
15.	<u>J. Terry</u>		
	1. TACS PASA with OIH	936-5970	2,000
16.	<u>D. Sprague</u>		
	1. AIDSCOM	936-5972	
17.	<u>G. Pettigrew</u>		
	1. IQCs	936-1406	
18.	<u>Ann Tinker</u>		
	1. Maternal/Prenatal Health & Nut.	936-5966	

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