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ROBERT M. CLAY

Interviewed by: John Pielemeier

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TABLE OF CONTENTS

Background

Growing up in three U.S. cultures	
Travel and Study in Germany	
University of Texas, BS (Molecular Biology)	1972-1976
University of Heidelberg	1977-1978
Job at University of Virginia: Muscular Dystrophy Lab	
UCLA Masters in Public Health	1981-1982
Research in Bangalore, India	
Move to Washington, D.C. – job with APHA	
Part time work on ICORT (Intl Conference on Oral Rehydration Therapy)	
Joined USAID	1984
Employee at USAID/Washington	1984-1998
Advisor of Diarrheal Disease/ORT	
Chief of Health Services Division	
Dep Director of Office of Health	
UNAIDS established	
Selective Primary Health Care	
Maternal Health and Safe Motherhood Conference	1987
Health Systems Strengthening programs begin	1990
Malaria Control Programs increases	
USAID/Zambia Population, Health, and Nutrition Office Director	1998-2003
Ground Zero for HIV/AIDS	
ZamCare	

Corridors of Hope
Multi-Sectoral Approach to HIV/AIDS
Zambia Integrated Health Program (ZIHP)

USAID/India Dir. Of Population, Health and Nutrition Office HIV/AIDS programs in Tamal Nadu and Maharashtra SIFPSA (family planning) project in Uttar Pradesh Health Insurance Policy Framework Tuberculosis program Polio Eradication 1 st Urban Health Resources Center	2003-2008
Return to USAID/Washington as Director of Office of HIV/AIDS “What is the End-Game here?” USAID Principal Deputy for PEPFAR Conflict and Cooperation with CDC Establishment of Global Fund for AIDS, TB and Malaria Views on the future of USAID HIV/AIDS programs	2008
Deputy Assistant Administrator for Bureau for Global Health Health Financing and Governance project Senior Technical Group established GAVI (Global Alliance for Vaccines and Immunization) established SMGL (Saving Mothers, Giving Life) program established Shepherded drafting and publication of “50 Years of Global Health: Saving Lives and Building Futures”	2011
Retirement from USAID Received Administrator’s Distinguished Career Service Award Received PEPFAR’s Lifetime Achievement Award	2014
Began work at Save the Children as Vice President of Global Health	2015
Advice for youth interested in working in Global Health	

LIST OF KEY WORDS

Order of the Arrow (Boy Scout)
Nuclear Transplantation Research
Community Health Volunteer (CHV) scheme in India
Dr. Susi Kessler, APHA
Anne Tinker, USAID Office of Health
Intl Conference on Oral Rehydration Therapy (ICORT) 1983
Dr. Cliff Pease

Molly Hageboeck
Alma Ata Conference on Primary Health Care, 1978
Health for All by the Year 2000
Primary Health Care
Jim Grant, UNICEF Executive Director.
GOBI Strategy (Growth Monitoring, Oral Rehydration, Breast Feeding and Immunization).
USAID Administrator, Peter McPherson
Oral Rehydration Solution (ORS)
Charlie Flickner, Congressional staffer
2nd ICORT Conference, 1985
World Summit for Children, 1990
Jeff Harris, 1st head of USAID HIV/AIDS office
PEPFAR (President's Emergency Program for AIDS Relief)
SWAp (Sector-Wide Approach)
Dr. Katele Kalumba, Zambia Minister of Health
Dr. Tom Frieden, former Director, Centers for Disease Control and Prevention
Dr. George Curlin, USAID Office of Health
"The Fortune at the Bottom of the Pyramid"
Ambassador Holbrooke, US Ambassador to the UN
Dr. Kent Hill, AA, Bureau for Global Health
Lois Quan, Global Health Initiative Coordinator

INTERVIEW

Q: This is John Pielemeier on April 12, 2018, beginning an oral history interview with Robert Clay, a long-time and renowned USAID (United States Agency for International Development) global health leader. Robert, I'm going to ask you to start by talking a little bit about where you grew up and what might have led you to work in international development?

CLAY: I grew up in multiple places. I was born in Charleston, West Virginia but at age four, my family moved to Winchester, Kentucky, and then when I was 13, we moved to the Rio Grande Valley in South Texas. So, three very distinct and different cultures. My father was a Presbyterian minister so I think that was one of the reasons that I was interested in the whole area of service and helping others, especially from different cultures. My mother worked in child protection and adoption. She brought home many stories from her work of children in broken families as well as the joy of successful adoptions.

Our family history in the U.S. goes back a long time. My dad's family came to the U.S. in the 1760s. One of his relatives, I guess my great, great, great, great grandfather, way, way, back, was a delegate from Georgia to the Continental Congress in the 1770s. That line of the Clays also had a number of ministers in the family history. Then on my

mother's side, they came to the U.S. in the 1680s. They were Quakers and settled in Pennsylvania. In fact, my middle name Mather is from the Quaker family that settled outside of Philadelphia.

So both sides of the family represent quite strong religious/spiritual connections which influenced all of us children.

Q: Was Henry Clay a relative as well?

CLAY: He was from another branch of Clays that came from England first to Virginia and then settled in Kentucky. Our branch settled in Savannah Georgia then moved up to Virginia. Maybe we are related but that would be before they came to the U.S. One day I'm going to explore that in England since everyone asks that question.

Q: All right.

CLAY: When we lived in Kentucky, I had an ideal life as a typical American boy growing up. We had many kids on our block. We were always playing kick-the-can or capture-the-flag. We had snow sleds in the wintertime. But in the midst of all this middle-American upbringing, my family sponsored an African to join our family for a year. He was going to Kentucky State University and was from the Belgian Congo or Zaire (now the Democratic Republic of the Congo). His name was Alador Kabunda. He came home to our family on the weekends and stayed with us, particularly during the holidays. I was in the fifth grade. Alador's English was okay, but his native language was French so he needed practice. Alador and I would sit in the basement on weekends and talk a lot. For him my English was simple and easy to understand and what I was studying in school—grammar and writing—were things that he was trying to tackle. For that year, I got to know Alador, and I'm sure it was part of my fascination with the rest of the world outside of the little ideal area that I was living in.

In both West Virginia and Kentucky, my dad was ministering to people from Appalachia. It was a poor area. So again, you see that this idea of helping those that may not be as well off as you was very ingrained in our family. Then we moved to the Rio Grande Valley in South Texas. Our house was seven miles from the Mexican border. At my school, about 80 percent were Latino. That was quite a cultural immersion for me. On the one side, it was a fantastic environment to explore because we had Mexico close by, the beach—South Padre Island, and beautiful citrus groves. It was just exotic. But on the other side, I was in the seventh grade when we moved and I had lots of friends in Kentucky. I had enjoyed being out in the forested areas playing; we had a treehouse. In Texas, it was very different because all my friends were gone. It was just a different environment. Very hot in the summer and cactus everywhere. So I became very, very lonely. I can remember as a child just crying on the bed with my mom. But the way that I coped with that was to try to fit into this new culture. I became interested in horses. I joined the Future Farmers of America and I raised a pig to show in the county fair.

Over time I realized that wasn't who I was. I was play-acting. I was just trying to fit in. I tried to establish more of my own identity. I tried football for a while, but I didn't like the sport that much so I got into tennis and I eventually became the lead tennis player in high school. The other thing I did, and this was also relevant to overseas work, I got real engaged in the Boy Scouts. I became an Eagle Scout when I was 14. I was a staff member at the Boy Scout camp for three years and taught swimming, rowing, canoeing, and lifeguarding. I don't know if you know the Boy Scouts very well, but for older scouts there is a special group called the Order of the Arrow (OA) which is an Indian society based on the Leni Lenape tribe. Through the OA, I got quite interested in American Indian culture.

Our family traveled to New Mexico and Arizona to visit the Indian reservations. I made an Indian costume. So it was another cultural encounter, or experience that I had while I was there in Texas. Eventually I became the top rank in the OA (Vigil Member) and the Area Chief and was in charge of the Order of the Arrow in Texas. I was on the verge of becoming the national chief when I was there but I'll tell you later what happened. It was these very intense encounters or experiences with other cultures that I'm sure helped broaden my horizons from what I was normally doing in Texas.

Q: How big was your high school at that time?

CLAY: We had around 600 that attended.

Q: That's fairly big, and did you learn Spanish at that time?

CLAY: I would not say I did but I certainly learned a bit of Spanish, which I then lost. The other thing that I really focused on was science. I developed a science fair project that focused on sulphate and nitrate pollution in the Rio Grande Valley and it won the overall award for the Rio Grande Valley. I went on to the International Science Fair which was held in New Orleans that year to exhibit my project and was a finalist.

My high school senior year was so full and very compact. When you're a senior you feel like you're on top of the world, and clearly I felt that way. And then another step came in my international journey. I went to Germany as an exchange student. (This is why I didn't become the national OA chief.)

Q: After you graduated?

CLAY: Yes. I graduated in '72 and then I spent 14 months in northern Germany. I didn't know any German before I went. I lived with a German family and went to their Gymnasium (school for those going to the university). This taught me the importance of communication. I felt a real urge to communicate because I wasn't able to say things and join in conversations. So it really motivated me to learn the language.

Q: You were there for a year?

CLAY: Yes. I was there for a year and two months. They have 13 grades in their Gymnasium so I was in the 13th grade for most of the topics. For German language, I joined the 5th grade to learn basic German grammar. Kind of like Alador when we were talking earlier. That was a great experience.

When I walked into the room, the teacher hadn't arrived yet and they thought I was the teacher. So all of the 5th graders stood up and assumed I was going to conduct the class. Well, I just walked to the back row and sat down in a small little chair and they all looked at me like why is the teacher sitting in our seat? Then finally, the teacher came and explained that I was an American exchange student and I was going to join them in their class for German language. Then, the kids really warmed up to me for two reasons—one I could help them with their English studies. That was great because we could talk to one another. I could help them and they could help me. The second thing was I could play with them on their soccer team. I was a big advantage to their class because I was bigger and stronger.

Q: [Laughter] Oh my. You were real ringer huh.

CLAY: Yeah. It was quite a year.

I consider it kind of like a sabbatical year because I wasn't under the pressure to produce specific grades. I went to class but afterwards my best language experience was to be with friends and socialize where I would be using the language and learning about the culture.

Through the city government, I was able to go to Russia for Easter break in 1972. That was quite a trip. I also went with my German family to Davos, Switzerland for a month on their vacation break. So I was able to see a bit of the world in addition to Germany during this year.

Q: Had you applied to colleges when you went on this trip?

CLAY: Not before I went but while I was overseas, I applied.

Q: And what were you looking for at that point.

CLAY: I was interested in the sciences and I eventually studied molecular biology so that is where my interest was at that time. I ended up going to the University of Texas in Austin and while I was there, I lived in the German House. We all were required to speak German while we were living there. It was a way I continue my language experience while I was at the university.

Q: So you remained in that major for the full four years.

CLAY: Yes. I got a Bachelor of Science and the last year that I was there, I saw a notice that the German Department was offering fellowships to Germany. So just on a whim, I

decided to apply. I was interviewed and what they told me later—because I could speak so well and they had never had a science student apply for the scholarship before, I was selected. So, I studied at the University of Heidelberg for a year.

Q: And did you have a profession in mind? Did you have direction where you thought this would take you?

CLAY: I was going to be a scientist, you know a bench scientist, exploring the mysteries of life. In Germany, I continued on the molecular biology theme. I took courses in molecular biology as well as a course in the history of science that was my most difficult class because it had many words that I didn't understand. The sciences were easier because they used many similar English words and you could understand the basic science. But when you got into history then it became much more like literature with many more vocabulary. So that was harder. But I enjoyed it very much. We took some field trips to some museums with our professor. That was great. I also took one class on international development that I really liked.

Q: As you finished in Germany were you thinking about what was—. What year was it when you were there? Was it the year after your undergrad program?

CLAY: Yes. I was in Heidelberg in 1977 and '78.

The other thing about the German education is that they provide long breaks every quarter. You have long Christmas, Easter, summer, and fall breaks. The idea is that you would be doing class work or projects or you would be doing your independent studies or research. Most first year students use these breaks to do a lot of exploration and travel as learning trips. For Christmas I went with many university friends to Spain and had a great time there. Then for Easter, I drove down with a friend to Greece, his home country. That year I was able to explore quite a bit of the European environment. It was a very different experience of being at the university in Heidelberg than it was in my previous exchange program. Because the exchange program was in northern Germany, I was the only American in the whole community, so I was very unique.

When I was in Heidelberg, I was amongst many Americans. There are lots of Americans that come through Heidelberg, especially in the summer. It was also very different because I lived in an international dorm. So, in the dorm my roommate was Dutch, we had a student from Indonesia, there were two women from Syria, and a Palestinian student. We all lived on this one little, small floor. There were maybe ten of us all together and we had a common cooking area and a common recreation area. Every night we would cook, eat and watch the news together. So you really get to know your fellow students very well. To me, a lot of what Heidelberg was about was less about Germany and more about getting to know my fellow international students. Many of them were the ones that I travelled with to other places.

When I came back from this experience to the U.S., I was confused. I had this desire to be a scientist but then I had this terrific experience of seeing the world—seeing what was

out beyond the laboratory. I didn't know how to marry those two. So, the first thing I decided was that I should just see what it was like to be a scientist. I got a job at UVA (University of Virginia) in a muscular dystrophy lab.

It was fascinating research. I was doing what they called nuclear transplantation research. I was taking embryonic quails—the bird—and dissecting out the breast tissue, growing the cells and then injecting the quail nucleus into frog eggs. It was cross-species fertilization, trying to determine if the proteins that the cells were producing that were causing muscles to degenerate in muscular dystrophy were coming from the nucleus or the cytoplasm; it was cutting-edge research. No one had really done that before. What I enjoyed about this work was the exploration and adventure part of it, but also the precision that it required because you had to make these very fine needles and you had to puncture the frog oocyte just right and then inject the breast nucleus. It was a fine art. I realized that I enjoyed that a lot. It was a year and a half that I was in the lab and the people there were fantastic. Very smart, bright, it was a lot of fun. But I looked at some of the older postdocs who were there in the laboratory, and I realized that, to be really successful, you have to be extremely good to get the grants because it is very competitive. If you weren't, you were going to become just a graduate student for the rest of your life. And I saw people who just seemed to be perpetual students. I like school but it seemed to me like I needed something more for the long term. I wouldn't be satisfied if all I was going to be doing is focusing on the lab for the rest of my profession. There was so much more outside the lab that was interesting.

It was during that period that I started exploring how I could marry the science with the international. I came across this whole field of international health that was focused globally but they also wanted people with science backgrounds. I explored many different options during this period and decided to go back to school in international health (now called global health).

I still had my travel bug and I had never been to California. So I decided it would be interesting to do that. I had been living on the east coast for a while and I wanted to try something new. UCLA (University of California, Los Angeles) had a good international department in the public health school and I was able to get a scholarship so I enrolled at UCLA for my Masters in Public Health.

Q: So this was a Master's in Public Health? What kind of program was it?

CLAY: This was in the school of public health and I enrolled in a program in International Health where they teach courses for working oversea in developing countries, working in international environments, and the principles of public health.

We had classes in epidemiology, biostatistics, health systems, nutrition, maternal child health, etc. It wasn't really as challenging I guess as what I had been through before but I enjoyed the content. In fact, during my schooling I continued to work part-time in a lab because I wasn't sure that this was the right move yet. I got a position at the Brain Research Institute at the UCLA School of Medicine where I was working on muscular

dystrophy. I worked under a Japanese professor and I bring this up because one of the nice things about my time at UCLA was that I got to know many things about the Japanese culture. A postdoc in the lab and his family were living in Hollywood at the time and they had problems with theft. According to their tradition, they put their shoes outside their door before they entered their apartment. Some boys who lived down the hall took glue and actually glued their shoes to the floor. You know they just had it. They said, "We can't stay here anymore."

He was just going to send his family back to Japan. At that time, I was renting a room in a house in the Pacific Palisades, which had a great view looking over the Pacific Ocean. There was some extra space so I talked to my landlady and she agreed to have them come and live with us.

We lived together for almost nine months. That was a terrific experience because I got to learn a lot about the Japanese culture. Also very important is that after a month of eating at the school cafeteria and seeing the kinds of food they were having at dinner I asked if I could pay and join them for dinner and eat some of their good Japanese food. They agreed and we ate as a family every evening. We took trips together and then afterwards I went to visit them in Japan for six weeks.

Over this year that I was at UCLA, I actually noticed an advertisement in the school paper for fellowships to do research in India. I had always been fascinated with India ever since I saw a brochure from the Johns Hopkins University where they were talking about international health and had this picture of a bullock cart and an old man on a dusty road. Somehow, that picture just spoke to me. India was a place that fascinated me.

I knew that Peace Corps wasn't working in India anymore but this could be an opportunity to go to India. It was through UC Berkeley. So I applied in November 1980 and fortunately was accepted. There were nine of us in the program from many different areas and across the U.S. It was supported by a grant from the Department of Education. So for the second year of my master's program, I actually went to India and lived there for a year through this UC Berkeley Program.

Q: Where were you in India?

CLAY: The program was based initially in Delhi. We had a month of university coursework, learning about all aspects of India. Then we had six weeks in Mussoorie (a hill town in the Himalayas) for language training, where I learned basic Hindi. Then they assigned you, based on your research proposal, to various institutions. I was looking at community health and was working with two institutes, the Indian Institute of Science and the Indian Institute of Management.

I was based in Bangalore in South India in the state of Karnataka. That is where I carried out my research work. The Government of India in 1978 decided to launch the Community Health Volunteer (CHV) scheme throughout India. But as you probably know, health is a state issue in India. States had to vote to join this national scheme. Well,

the southern states felt like the Community Health Volunteer was too low level. They wanted someone more experienced, more trained, more like a nurse in their framework. So they didn't initially join the national program. What they realized though after several years was that they weren't taking advantage of national level resources that came with the program. They were losing money.

There was a pilot in 1981 to see if this CHV scheme would work in Karnataka. They did the pilot in the Mysore district and that is what I was to evaluate. I was looking at performance and results and then making recommendations back to the state; whether they should go ahead with this program.

Q: What were the differences in the pilot's low level training for the community health worker versus what the state had been doing previously?

CLAY: The state really didn't have any lower-level workers that were based in the villages. They were expecting people to go to the health facilities that had nurses and doctors. So they lacked that aspect of the health system at the time. It was a great opportunity because when I arrived in Bangalore, the first thing I did was to spend a month touring different projects that had been doing community health programs in the past so I could see what was the range of experiences and expertise.

I went to Maharashtra and stayed a week with Dr. Aroles at the Jamkhed Project. They are two physicians from the Johns Hopkins University who had come back to the area where they had been raised and started this integrated rural development program using community workers. I was able to spend this time with them, observing what they were doing. In total, I visited eight different NGOs. I went to Tamil Nadu to see their program and also, Gandhigram. With that background, I went out and designed the research for my study.

We received a stipend for our stay in India. I was able to reduce my costs so I could save part of my stipend and hired two Indian assistants who would be the interviewers and translators because obviously, I didn't have the South Indian language skills. Plus, the villagers would not be as open having a white American male come in and ask them questions.

We went to 30 different villages in various different places and I was able to get the government to provide the vehicle and the gas to be able to do this. It was fascinating because during the day, I would observe things and then at night over dinner I would ask my Indian colleagues, "Why did this community health volunteer not join us in the conversation or why did he go through the back door?" And they would explain, "Well he was a different caste. You know you can't do that." All these real subtle things about India. I could observe it and then I would have two people who could explain it to me. So I really felt so fortunate because I got to learn about village life and what went on firsthand through that whole experience. And we all became such good friends.

Q: For these interviews, would you be there in the village for a day or how long would you be there?

CLAY: Yes. We would do a separate village every day. We would first go to the Panchayat Chairman to get their approval and usually that would require us to have tea and snacks/meal with him. Once he figured out that we were okay then we would make a map of the village. We would randomly select different households and would go to the five or six different families and interview the members. Then we would interview the community health worker. We would make sure that we would include scheduled castes and tribes in our sample areas.

Q: What was sort of the backdrop here for your work and what was going on health wise in India what were the major health problems that states were supposed to be dealing with?

CLAY: Well, at the time India was not like it is today. It was more backward. There were very high rates of child mortality, infant mortality and poverty. In the late 1970s, Indira Gandhi had her emergency program where there was forced sterilization. When we came initially to the villages, most of the villagers would run to their houses because they thought we were coming to sterilize them. That was the first thing we had to convince them—that no, we were not there for forced family planning. We were there to help them improve their health.

India at that time had tremendous population pressures. I don't think many people thought that India would ever be able to progress because of the enormity of the challenge in front of them. So it is amazing to see what has happened in the country over time. Back then, India was a very closed society. They didn't have free trade. They were trying to develop their own industry but many of their products were of very poor quality. When they opened up their economy in the 1990s, it really did change things tremendously.

Life in the villages was difficult. I experienced this personally one evening when at night I thought I had cholera. Since we didn't have any electricity at the time, I couldn't tell for sure. Fortunately, it was just a very bad case of diarrhea.

Q: So, the village health worker program, you made a recommendation to start in the state? What was your recommendation?

CLAY: I did because in my view it provided access to the villagers that they didn't have. I did recommend that they needed to do a better job in terms of selecting the community health volunteer because many times they were under pressure to identify someone, and often the Panchayat Chairman chose his own relatives—maybe an unemployed boy that needed some help. So with all the training and all the support that went into the program, it usually didn't pan out in the long run because these individuals volunteered for a while and then they got tired and went to the city. So it didn't sustain itself and they really needed to do a better job in finding the right people.

This was ideally a married woman who had children and was respected within her community. Spending much more time on the selection criteria was very important. There were other recommendations. Some of the community health volunteers, in order to make ends meet, were doing more curative work for pay but they didn't have the training. They were supposed to be doing prevention but the communities were demanding curative activities so there needed to be some rebalancing there. Some of the supplies they didn't have and there were stock outs. It was a typical program that you often see oversea. They were having many similar problems so I provided recommendations on those areas.

Q: Were these workers paid or were they volunteers?

CLAY: They were all volunteers and over time that became an issue in some of the areas because they felt like they were not being fairly compensated for their time. They had other jobs—they were farmers or they were doing odd jobs around the village. So they felt like they should be paid.

Q: That sounds like an excellent place for a research study and as you completed that what was your next step?

CLAY: Well just to add a couple things before we move on. In my career, I have drawn on that experience, that year in India. I'm sure it's very much like what Peace Corps volunteers do as well. I always tell people going into the field of global health that you need to have an experience where you actually internalize what it's like working at the community level because if you don't have that internalized you likely will be making some really poor decisions later on in your career. Being able to think about how the community will react and what the villagers will do is a very important base to build on.

In addition, there were nine graduate students in the Berkeley program. I was the only one working in public health but we had people in other disciplines. My roommate when we were at the college in Delhi was an architect student from Columbia and he was studying Indian architecture. At the end of our trip, we had a week in Kashmir on a houseboat where we reviewed what our experience had been. It was fascinating to see all the different aspects of India from all these various disciplines.

For example, we had a lawyer who was helping the Dalai Lama with some property in Calcutta that was caught up in the Indian court. It was this experience of working through the Indian legal system that was his learning experience. It was a total development kind of perspective. We had a civil engineer who was looking at how they construct buildings. So I think it also gave me a very broad development perspective that I didn't have going over to India.

Q: As you were completing this did you write a report and did you have to present it?

CLAY: Yes. I wrote a long thesis on the program that was submitted to Berkeley. I actually had a couple of articles that later on were published. So I tried to disseminate the work that I did.

Q: Did you have to make a presentation to the state ministry, secretary of health?

CLAY: I did. Yes, to the Minister of Health in Karnataka. I briefed him on what I found. It turned out that he had relatives from some of the areas that I had worked in. So he was quite interested in my perspective of village life and what was going on in those areas.

Q: How old were you at this point?

CLAY: This was May, 1981 so I was 26. Old enough to think I knew the world but young enough not to really know much.

Q: So at the end of this research you went back. Did you have a second year at UCLA?

CLAY: I came back to UCLA but didn't have to take any more courses since I had finished all my credits for my degree as the work that I did at Berkeley counted for my second year. I just stayed on for another three months at UCLA writing up my research. During that time, I also became a cook for a Japanese family for free room and board. He was a surgeon and she was a professor so they needed someone to cook for them and to help their son in school. I did that on the side and finished my research reports. I also decided that after India I was really to commit to doing international work—answering this long pondered question for me.

I figured that if I was going to be serious about this new career, I needed to be in either Washington, New York, or Geneva and have some work experience. My parents had moved from Texas back to Virginia where they were originally from. So I decided to come back to the east coast in December 1982. But before I left California, I applied and was accepted into the doctorate program at UCLA for the fall of 1983. I wanted to keep that option open. I came to Washington and started looking for jobs—trying to get something relevant to my experience and my interest. I remember having index cards with all these different groups and going around, sending resumes. You know the old way you used to do this. It doesn't seem very efficient but it's the way we did it.

I landed a job at the American Public Health Association after a month. Dr. Susi Kessler, who was head of the International Section of APHA, had a grant from UNICEF where they were doing research studies—issues papers are what we called them.

I was brought on board to help them do research on primary health care in developing countries which was exactly what I had been looking at in India. I thought this was a great opportunity to get to know the literature and to get my foot in the door. It was part time. Through that whole assignment, I kept seeing USAID. Everything was funded by USAID, and I thought I needed to get to know what this organization was about. When I

was not working, I went over to USAID. I had an appointment to see this person Anne Tinker. I was supposed to see Al Henn but he was traveling.

Anne was there and she talked to me about USAID. I told her a little bit about my background and experience. I'm sure she was trying to figure out what to do with this guy. She sent me up to the front office to talk to the deputy director of the Health Office whose name was Dr. Cliff Pease. I don't know if you remember Cliff.

Q: Vaguely yes.

CLAY: It turns out that at that very time USAID had this huge conference that was going on. They didn't expect it to get so elevated but it did. It was called the International Conference on Oral Rehydration Therapy, ICORT [1983]. USAID was hosting this conference in about a month's time and they were scrambling to try to get things done. Peter McPherson, the USAID Administrator, had seized on this as an opportunity to position USAID in the whole child survival movement. Cliff needed somebody to help him.

So I said, "I will be happy to help." I said, "I can come over in the afternoons and help you out if that works for you". He said, "That's great!" I figured I could do this for a month and get to know the organization better. So, I came over and Cliff said the first day, "We have a need right now for you to go over to the State Department. This woman Molly Hageboeck is working in PPC (Office of Policy, Planning and Coordination) on the conference. She needs help and you need to go over and provide some assistance to her.

So I went over to the State Department.

Q: AID was not located in the State Department building at that time.

CLAY: Part of USAID was located there, the regional bureaus, the administrator, the policy office but the technical offices were located in Rosslyn. I originally went to Rosslyn to talk to the Science and Technology Bureau, where I first started. But, Molly was working in the State Department, in Foggy Bottom.

For the next couple of weeks I was just doing odd jobs, anything that needed to be done. I got exposure probably that I would have never gotten if I had stayed in the technical office. I was being thrown into all kinds of meetings and taking notes and writing things up and I was engaged in high-level meetings at the same time. USAID had a whole bunch of VIPs that were coming and I was asked to even help arrange the limousines to greet them at the airport.

It was quite an amazing assortment of things but it provided me with a pretty quick overview of what was happening at USAID at the time and to meet many people and learn about the organization.

Q: Now were you staying in PPC with Molly or were you with the Office of Health for that month or so?

CLAY: I was working with Molly through this period but then with Cliff Pease later, I think the week before the conference started, he said, "I need you back over here." So, I was kind of going back and forth between the two. Then, at the conference itself, of course, everybody was all hands on deck. And I was supposed to take care of those VIPs!

I remember the Minister of Finance from Bangladesh was there and he wanted to go shopping so I had to arrange for a car to take him out on the town. And then Dr. Lincoln Chen, who is a very distinguished researcher and leader in global health, had requested that I helped him out. At that time, he was from the Ford Foundation. I also got to know Dr. Jon Rhode from MSH [Management Sciences for Health] during the conference. He played a key role in the child survival revolution of the 1980s.

Q: Management Sciences for Health.

CLAY: Yes. Anyway, a whole bunch of very dignified leaders in the field were there and I was interacting with them because they needed logistics and I was kind of the logistics guy. I had to get them their rooms; I had to get them food, copy papers. So I was rubbing noses with some of the leaders in the field and that was quite fascinating and made the month's work worthwhile.

Anyway, the conference was quite successful and there was a need afterwards for follow up. So Cliff asked me, "I know you are volunteering here but we would like to have you stay on and we can actually now pay you a little bit. So would you be interested?" I said, "Well I still like what I am doing at APHA but I can come over when I am available. So they wrote out a purchase order. You probably did that for some of your consultants you hired. I had to deliver a report on follow-up to ICORT once a month and based on that report I would get paid.

I did that for about half a year. Then Dr. Nyle Brady, who was head of the Science and Technology Bureau, wanted to bring on board staff that had technical background to beef up the Science and Technology Bureau. He used 50 AD (Administration Determined) positions that he got from Administrator McPherson to do that.

Q: Which are administratively determined political positions.

CLAY: Yes exactly. Scott Radloff, who became the head of the population office, came in with that group of people and so did I. I was hired in April of 1984 and I started to work with USAID full time. I had been asked several times earlier if I wanted to come on as a direct hire. I told them no because my original plan was to get to know USAID for a little bit. I was young and free so I thought I would go up to New York and work for UNICEF and try to get to know that organization. Then I thought, if I could swing it, I would go to Geneva and work for WHO [World Health Organization]. I would try to get the lay of the land before I got too committed. I also still had plans to return to school to

get my doctorate. But because of the focus on child survival and the attention it was getting at USAID, I couldn't see another opportunity like this becoming easily available elsewhere. I decided to stay with USAID, thinking that over time USAID could possibly then send me back to get a PhD and help pay for my education. Of course, President Reagan decided to cut all of those programs so that never happened. But I felt like I was always learning something new at USAID. No matter what position I had, there was always some new challenge that I was dealing with. It was hard, particularly when you've just come out of so many years of schooling to compare the on-the-ground experience including the travel and exposure to sitting in a classroom doing graduate work. I never went back. I probably now regret not doing that. But I must say that I got a terrific education by staying with USAID and the many careers I've had in it.

Q: When you came on board as an AD was that expected to end after the end of that administration or did they transfer you over to another kind of a position? How did that work.

CLAY: Normally the political leaders decide on ADs so when the administration leaves most of those people move on. But because these were "technical ADs" they operated slightly differently. Many of these positions were transferred from an AD to a GS. I was then made a GS direct hire employee.

Q: So you were at a pretty mid-level kind of position or rank?

CLAY: I came as a GS 14.

Q: Now, Nyle Brady was still there? Were you working with him at all directly or were you working just in the Office of Health?

CLAY: Mostly in the Office of Health. Dr. Brady was overseeing all of the different technical areas but I worked with Ann Van Dusen, George Curlin, and Ken Bart and of course Anne Tinker. I became Anne's deputy in the Health Services Division.

Q: So you were in Washington then, for quite a long time.

CLAY: I was there for 14 years on the GS side and I probably would have switched over to the Foreign Service sooner but I had some family obligations during that period. I got married and my wife, Carol, had a career as well so we had to balance that. Also we had a grandmother who needed care. Once my wife warmed up to the idea of going overseas and when our grandmother passed on, we decided it would make a lot of sense to get back overseas where our main interest lie.

I then switched from GS to the Foreign Service.

Q: An interesting question comes up in my mind. How do you warm somebody up who's going into a Foreign Service life as a spouse?

CLAY: Well her professional work was not as exciting and challenging as it was when we first got married. So I think it was time for a change on her side. Carol is very much of a traveler. She has a background in anthropology and so I think she was very keen to do this as long as she didn't have her family obligations.

That side of the equation overseas was not easy for her. Carol was a documentary film director so in each of our post, she had to establish herself and find work. That was hard. But Carol is determined and very talented so she did find work and produced some terrific award-winning videos about development issues.

Q: Yes it is. The trailing spouse role continues to be difficult.

While you were working in Washington were you still doing your child survival work primarily or working with other issues too?

CLAY: I was asked to be the head of the Diarrheal Disease/ORT work in the Health Services Division when I first came. Later, Anne Tinker left and so I took over her position as Chief of the Health Services Division.

Q: She went to the World Bank didn't she?

CLAY: She did and had a great career there and at Save the Children. The new role in the Health Services Division gave me a broader portfolio looking at immunizations, diarrheal disease, nutrition, maternal and child health, communication, quality of care, and health system research.

When President Clinton was elected, we had a change in the front office and I moved up to be Deputy Director of the Office of Health from 1992 to 1998.

Q: And who was your boss?

CLAY: I had three supervisors during that period. One was Bob Wrin. Bob was the first director that I worked for. Then they made the Director a Foreign Service position so David Oot came in and then Joy Riggs-Perla. Both were long-time Foreign Service Officers. That was very instructive to me because I was both of their deputies and yet I didn't see a way in which I could become a director unless I went to the Foreign Service. As Anne Tinker told me, "USAID is a foreign service institution so if you really want to be a leader you need to be in the Foreign Service." I really value these years as I learned so much from David and Joy.

So that was part of the attraction to switch from GS to FS—to be able to get into some of the higher leadership positions at USAID. But also to get closer to the field actions where change was happening.

Q: This is John Pielemeier on April 18 talking to Robert Clay for our second interview. We are talking about some major USAID involvement in worldwide health initiatives that

was taking place while Robert was in Washington in the Office of Health. Robert why don't we start with the child survival revolution that USAID and your office were very much involved with.

CLAY: Thanks John. Just to set the context for the 1980s. We just had the Alma Ata Conference on Primary Healthcare in 1978 that established the global goal of “Health for All by the Year 2000.” That was the slogan that everyone was promoting and trying to get community health workers to do in villages around the world. This was based on models of China’s barefoot doctors, Community Health Volunteers in India, as well as even some experiences in the Soviet Union in the 1800s with what they call the Feldsher system. There was a lot of consensus that we needed to improve access at the community level through lay individuals; sometimes they were paid but mostly they were volunteers. This was the program that I studied while I was in India.

So Primary Health Care (PHC) was a major focus in global health at the time. But in the early 1980s, there was a global recession and so it looked like a whole lot of the resources were going to be pulled from international development and from global health specifically. Jim Grant, who was the Executive Director of UNICEF at the time, tried to figure out how we could promote what we are doing more effectively with our funders. How could we make sure that we have a positive story to tell? From discussions that he had with key advisers including Dr. Jon Rohde, who was a principal adviser to USAID (who I met at ICORT), and others, the GOBI Strategy was developed. They picked four initial interventions—that was growth monitoring, oral rehydration therapy, breast feeding, and immunization.

The GOBI Strategy was widely promoted by UNICEF. Jim Grant was famous because he would go up the Hill to testify in front of Congress. He would pull out from his coat a syringe, an ORS packet, or a growth chart and he would begin talking about these to anyone who was interested but specifically to those who had resources that could provide money.

He would also talk about the number of children that could be saved. He often said that if one hundred thirty-four 747s crashed, the world would be outraged. They would create a major movement and investigate why this happened. That's what's happening right now with children. We're having this number of children dying every year; 40,000. But these interventions (GOBI) can save these children.

He really brought it down to a simple message—this intervention can save this number of lives. If you give us these funds, we will save these children for you. And it was a great strategy in terms of gaining Congressional support as well as increasing funding for child survival.

Within this context. Administrator McPherson was quite interested in some work that was being done by USAID in developing countries specifically around oral rehydration therapy (ORT).

ORT was developed and tested at the International Center for Diarrheal Disease Research in Bangladesh (ICDDR, B). Many of the people in the field of diarrheal diseases got their field experience during the refugee crisis following the Bangladesh civil war when ORT was widely used. They used ORT to stem cholera as well as diarrheal diseases dehydration at the time. ORT is a simple solution of sugar and salt that addresses the dehydration. There were two programs that the Administrator had noticed: one was in Honduras and the other was in The Gambia. He sent one of his top advisers out to look at these two sites and to report back to him if this is something that is having an effect and something we should continue supporting. The word back from these trips was that yes, this was a winner. It is something that the Administrator can really promote. It will save lives. It is a miracle when you see a child that was dehydrated get ORT and then come back to life. It really is an incredible intervention and USAID should invest in this.

At that same time there was a conference that was being put together. A scientific conference of luminaries around the world and they were calling it the International Conference on Oral Rehydration Therapy. (ICORT) I mentioned this earlier. Administrator McPherson said, well why don't we take this conference and invite leaders of the world and make this a big public event so that we can push this whole approach of ORT for diarrheal diseases.

The ORT Conference put USAID on the map for one of the GOBI interventions, oral rehydration therapy. UNICEF, Jim Grant and Peter McPherson were often competing on the global stage for attention and resources. But over time they worked out their territories with USAID pushing and promoting ORT and UNICEF taking the lead on immunization. These two interventions got more focus than the other two interventions (breastfeeding and growth monitoring) and they became known as the “twin engines.” They were clearly the two interventions that would receive most of the support through the mid-1980s.

Q: Robert, have you ever taken ORT yourself?

CLAY: Yes, I have. It is actually good for runny diarrhea if you feel like you're getting dehydrated. It doesn't solve diarrhea: it's basically addressing dehydration. I have never had severe dehydration where I needed to have ORT as a life-saving intervention or saline because of dehydration.

Q: Well my wife, Nancy Pielemeier, is a devotee of this and she always carries around a couple of ORT sachets in her purse and at one point we were travelling in Egypt with a group. A small group and we were getting together at the breakfast table before going out for a day of touring around and I really felt terrible and she said, “Here take this.” We basically got the amount of water we put the ORT solution in, I drank it and she said go back to the room and lie down. In an hour let us know how you feel. In an hour I was in great shape and we spent a whole day touring around all because ORT really works.

CLAY: Yes, there are a lot of interesting factors around Oral Rehydration Therapy. What we've learned over time is that it's really the fluids early on when you have diarrhea

that's important. So drink plenty of fluids. But once you start losing lots of your electrolytes (your salts), you get weak and tired, and then you need to replace them.

That's the miracle of ORT. It has the right mix of sugar and salt to replace those lost in your body. So you don't feel weak and you don't become worse. There was a lot of debate in the '80s about the right concentration of sugar and salt. There were many home remedies that were around and we were trying to educate women to actually measure it out with a spoon into a cup. You can do it but it's very imprecise, so it was determined that you really needed to go more the packet route. They would be premixed and you would just have a much clearer message as opposed to trying to understand the whole method of mixing it from scratch.

Q: Were you encouraging that the mix be put in to a Coca-Cola bottle or a milk bottle or something that was fairly common?

CLAY: Whatever container is common in that community or in that country. Sometimes, it might be a liter jug that they had that is widely marketed. Sometimes, it would be a different container so we would adapt the message to whatever was appropriate for that setting.

Then on the packet itself, we did a lot of work. The early packets were written out so you had to be literate to understand the directions. We worked to put on pictorial instructions such that an illiterate person could look at those and follow how you would actually make ORT. These messages were then tested in different areas. We had very specific graphics for different regions and a lot of work went into that as well. Finally, a lot of work went into the communication and marketing aspects, looking at the behavioral messages and communication channels.

The biggest program that USAID funded was the work in Egypt where we supported the Egyptian government. Dr. Bert Hirschhorn, a noted medical doctor in the area of diarrheal diseases, was the Chief of Party for the USAID/John Snow Inc. project there. The project was well funded by the Middle East Bureau. It was the forerunner in terms of establishing that using ORT on diarrheal diseases with effective behavioral and communication messages could actually lead to measured reductions in infant mortality on a large scale. The results from this project were used in many different countries to justify why we should continue to support ORT.

At the same time, USAID was not just standing by on the other "engine" which was immunization. We implemented work on that front too. USAID had countries around the world where we were supporting immunization programs, particularly in Latin America. However, UNICEF took the lead on the global stage. That culminated in the universal immunization target for 1990. UNICEF also negotiated days of peace in conflict zones where they would get both sides to stand down so they can go in and immunize the children.

There was a strong drive to get all countries up to 80 percent immunization coverage. Looking back, it was great to mobilize and focus attention on immunization but in some countries, particularly the poorest countries, in order to reach that target we had to set up parallel systems so they were able to succeed. A couple of years later, if you looked at the immunization numbers, they had dropped significantly in poorer countries. In these countries, we weren't able to sustain the levels over the long run since parallel systems had been built.

On the other hand, middle income countries that reach these targets were able to keep fairly high rates of immunization so they were able to build on the systems and able to incorporate their programs. In the poorer countries where they had the weak infrastructure that wasn't possible. I think that was a major lesson about sustainability and often one that people have referred to in global health over time. The importance of having ambitious targets but you must not have parallel systems to reach those targets; otherwise they often are not sustainable in the long run.

Q: I think you did an excellent job of basically measuring the performance of the child survival program and being able to show the public and the Congress of that success.

CLAY: So Ann Van Dusen, Nancy Pielemeier, Pamela Johnson and others were all very much engaged in putting together our annual child survival reports that went to the Hill that indicated to Congress how the funds were being used and what impact we were getting. We had of course the Demographic and Health Surveys that started in 1984, building on the World Fertility Surveys. We measured many indicators and were able to show over time the impact our programs were having. The whole data-driven approach was something that sustained the resources. Because when you think about it—Congresspersons had to make choices about how to use limited funds. Here are programs that talk about saving children. They have data to substantiate the claims. Many people on the Hill told those of us in the program that our Representative or Senator can go back to their constituents and say this is how I am using your resources. Because of this, there was strong bipartisan support in the work of child survival.

Q: I recall, Tony Hall or wasn't there a special committee on child survival too on the Hill?

CLAY: Yes. On the Hill there were quite a number of champions for child survival. Tony Hall was one of them. They continued to provide funding even if the Administration didn't fully request the needed resources.

Actually, a funny thing happened when I went up to the Hill after several years of the program. Charlie Flickner was a senior Hill staffer who was very involved in health. I remember him telling me that basically the child survival account and program was "his program." He clearly owned this. It was his baby. I said to myself, well I've never seen you in any of the meetings where we were doing the work. But he was critical in getting the funds and had real ownership of the program. The more people that owned this the better for the program.

USAID continued its leadership globally by having a second ICORT Conference in 1985. I had the responsibility of being in charge of the conference and it was a lot larger than the first conference because we had more time to plan and implement our ideas. We brought in many more people to talk about the programs and it was a big success. We had US Senator Ted Kennedy come and lots of other high officials join. ICORT continued to send the signal that ORT was an important program and USAID was a major leader. It was also an important venue for people to share their experiences. For example, the Egypt project I talked about earlier had a central stage to talk about what they were doing. The PRITECH and the HealthCom Projects were all able to share lessons and get other countries interested. There was actually a third conference ICORT III that was held a couple of years later. In all, in the '80s there were these three international events that involved the global community and it really propelled the field forward quite significantly.

Jim Grant once mentioned that “one of the ways that you keep policymakers engaged and continue to support your program is to host these kinds of events where they can come in and give speeches and they can see progress.” I think the success of the ICORTs really led UNICEF to organize the World Summit on Children in 1990 which brought together more global leaders in the world to focus on the plight of children than any other conference before. And actually a little aside, but your wife Nancy and I went. And there is a famous, at least, in my mind, picture of Nancy and I shaking hands to the backdrop of a picture of Ronald Reagan and Mikhail Gorbachev shaking hands at the U.N. So yes, both Nancy and I were there.

We witnessed this pretty amazing gathering of world leaders in affirmation of child survival in 1990. And of course that led eventually to the whole push in 2000 to the Millennium Development Goals (MDGs). So there was a whole series of events, global events that propelled and kept children very much on the top burner and on the stage of world leaders.

Q: That's a great story. Let's move ahead to one other major program that I know you were involved with. In the mid to late '80s it became clear that HIV was becoming a major worldwide epidemic and AID started slowly, I think gradually, to try to figure out how to deal with that. Please tell us about your role and your office's role in starting up the work on HIV/AIDS.

CLAY: So I was in the Health Services Division and Jeff Harris led the newly formed HIV/AIDS Division.

Q: What year would that be?

CLAY: I'd have to check, but I would say the mid-1980s.

Q: Alright.

CLAY: Our support for HIV/AIDS started around 1985 with a grant to WHO to support the Global Program on AIDS. We had a couple of staff that USAID seconded to that program. One was Dr. Tony Meyer from the Office of Education. He went to head up their communication program. Jeff was the HIV/AIDS lead in the office. I wasn't in that division but obviously as senior staff I would hear a lot of what was happening. At the time, we really didn't have a means to treat HIV/AIDS. It was focused on prevention.

It's interesting to look back because much of the early prevention messages were intended to scare people. I remember a famous poster with skull and crossbones on how to avoid HIV/AIDS – the message was if you didn't watch out you were going to die. So, very draconian kind of messages that people were designing. But you know over time we started to learn that this was actually stigmatizing people with AIDS. So the messages changed.

USAID continued to support WHO but then started to realize that we needed to have a bilateral presence as well. We created two main projects AIDSTECH—FHI (Family Health International) was the implementer and AIDSCOM—AED (Academy for Educational Development) was the implementer for that. Those two projects worked together to provide assistance to countries that were dealing with high prevalence of HIV/AIDS.

In 1990, I became the Chief for the Health Services division so my observation of HIV/AIDS during that period was from the perspective of a colleague.

Then in 1992 when President Bill Clinton was elected, I moved up to be the Deputy Director in the Office of Health and Nutrition and Bob Wrin, who had been the office deputy for a short time, became the Office Director. He had previously been overseeing some of the communicable and infectious disease work. I helped to oversee all the different divisions and one of them was the HIV/AIDS division. So from '92 to '98, I was engaged with some of the work that both Dr. Helene Gayle and Dr. Jacob Gayle oversaw when they were heading up the HIV/AIDS team. That was the time in the mid '90s when UNAIDS was developed. Helene was a major player in helping to create the new United Nation's AIDS program. Dr. Peter Piot was the first director of UNAIDS. Our programs were evolving and USAID started to develop more bilateral HIV/AIDS programs that provided technical assistance and research as well as some of the diagnostic work for HIV/AIDS.

Q: As I recall Robert, USAID was the largest single donor involved with HIV/AIDS for that beginning period. Am I correct on that?

CLAY: Yes that's true and I think one of the factors is that we had a big epidemic here in the U.S. and of course that propelled many advocates to lobby with the U.S. government and also Congress to make sure that we were providing assistance to these programs around the world.

Q: As I recall part of the work that Jeff Harris and others were doing had to do with sort of what would be the package of interventions that would be recommended globally or at least for AID programs. There was research done as I recall in Africa and I was in Brazil at the time or was moving to Brazil as mission director and we had a huge HIV/AIDS epidemic there, the largest in the hemisphere. After I arrived there, we designed a large program supporting the issue in Brazil but dealing basically with the use of condoms, sexually communicable diseases, and IEC (Information education and communication) into a three-package program that we were told we should push forward.

CLAY: Yes, and so that was really the preventive package that was developed and promoted in many countries. There were some successes. For example, there was the Uganda program that was called Zero Grazing that was trying to change the behavior of older men having sex with younger women in those communities. This program made very important contributions to our understanding of what was happening around personal behavior. It helped us understand the sexual patterns of individuals, how many sex acts they were having, where they were going, and the role of commercial sex workers.

Then we started to identify countries according to their type of AIDS epidemic. There were countries having a generalized epidemic: largely in southern Africa and East Africa where the hotspots were. We also had other countries with concentrated epidemics where the virus may just be in some high-risk groups.

There was fear about what happened as AIDS continued to infect more and more people. During this time, we started to document the effects that HIV/AIDS was having on the overall country's society. I can talk a little bit more specifically about this when we discuss Zambia because Zambia was actually the epicenter from the mortality of HIV/AIDS at the time.

Q: What was the Congress doing at this point? Was there support for dealing with at risk populations on the Hill? Or was that a difficult issue to deal with?

CLAY: You know at this time I had less engagement on this issue with Congress but indirectly I know that there were strong supporters. They helped write legislation and helped ensure that we had funding for the program. How widespread that was I can't really say.

Q: Were there any other major programs that you would like to talk about for your period when you were in Washington.

CLAY: Well I think there are some trends that I think are important.

You know I mentioned GOBI and the twin engines. They were labelled as selective primary health care. Instead of including all of the broad primary health care as described in the Alma-Ata Declaration, selective primary health care focused on select interventions that are proven cost-effective and can be scaled up.

During this period, there was a big debate. There was a lot of disagreement between UNICEF that was supporting this targeted approach and WHO that was still wedded to the broader primary healthcare perspective. I saw this play out quite a bit. Halfdan Mahler (WHO) and Jim Grant (UNICEF) were involved with the ICORT II Conference and some of the tensions that developed there involved these two different views. They worked it out, but they had clearly different approaches. What happened over time is that people realized that both had some benefits. Primary health care is essential, the Alma-Ata declaration and vision were sound but it was premature to say it could be achieved by the year 2000 because clearly the systems weren't in place to be able to support that.

The other issue to bring up is maternal health. In 1987, there was the global Safe Motherhood Conference. This was a very important event because so much focus had been on the child, but the mother, the pregnant woman, had been in many ways neglected. There were in-depth discussions at this meeting about how can we increase our focus on maternal mortality. Dr. Alan Rosenberg from Columbia University famously asked, "Where is the M in MCH?" noting that maternal health was being neglected. Following that conference, USAID then developed the global Mothercare Project that was focused on reducing maternal mortality and it did some very important work. Dr. Marge Koblinsky was the director for the Mothercare Project. She continues even today to be a leader in this field. USAID was able to create a lot of complementary momentum around maternal health in addition to the child. I think that's very important.

Then in the '90s what was happening along with HIV/AIDS was an increasing focus on the systems approach. People saw that we reached the immunization targets in the 1990s but we weren't able to sustain all of them. So this issue of how do we build systems so that we can sustain our work was gaining attention. Something we talked about earlier.

It was then that the USAID/Reach project was developed that had focused on both—immunization (its main focus) but also on health financing. It was a bureaucratic way of getting some health financing activities initiated by coupling it with a focus on immunization. This component was later pulled out to make a separate project called the Health Financing and Sustainability (HFS) project. Bob Emory, who recently retired from USAID, was instrumental in managing this project. HFS helped set the stage for USAID's engagement in many ways with sustainability topics that continues even today.

The other thing that happened in the 1990s is a growing support for malaria control. A key focus was on bed nets as an intervention as well as insecticide residual spraying and better case management. USAID had been supporting malaria vaccine development for decades to try to get a vaccine that worked but so far we haven't found the right combination – though a lot of research knowledge and several key findings have happened.

Q: A lot going on. Meanwhile the budget for the Office of Health was rising rapidly.

CLAY: Yes, it continued to increase because, as we talked earlier, we had data and could show progress over time as documented in the reports to Congress.

Congress continued to be pleased with the work USAID was doing. Even when the administration would cut our budget, Congress would always replace it. This continued even during a period when the rest of USAID was facing major cuts, particularly on the agricultural side. The health budget continued to grow with Congressional support. I'll just make a little comment here. I think we saw that same relationship between evidence of success and progress and congressional support for PEPFAR. PEPFAR took that notion of data and monitoring to a much greater level. It invested very serious resources and in fact committed a lot of time and energy and that was a real important ingredient to the financial success of PEPFAR.

Q: Which is still continuing. Well that's very useful background information Robert. You mentioned earlier that you were thinking about perhaps going overseas at some point. What led you finally to do that?

CLAY: Well, I think I mentioned earlier, our family situation changed. Our elderly grandmother passed away so that freed us up to think about going overseas which is something I obviously wanted to do for some time. My wife had her own consulting business and was at a point where she felt she could put it on hold or possibly continue some of the work overseas. So we were fortunate to be able to go to Zambia as our first overseas assignment as a Foreign Service Officer. Zambia was an incredible experience because it was at the peak of the mortality of HIV/AIDS when we came. The disease really spread quite rapidly in the '90s but as you know, it takes seven to ten years for the virus to develop into full-blown AIDS. So when we arrived it was at the peak of morality in the society.

Q. Right before we get into that. Let me just ask you, how did you come into the Foreign Service was it a part of a group? Was it a class or was it just an individual action? How did that happen?

CLAY: I indicated to the office that I was interested in going overseas. I had a few Mission Directors come and said they would love to have me work in their country. But at the time, what needed to happen was that all the Foreign Service Officers had to bid and then, if there were any vacancies left, it will opened up for civil services employees to convert over for a temporary foreign service assignment.

So Zambia was a country where they didn't have any eligible bidders at that time. I put my name in the hat and was selected and then I had to go through the whole Foreign Service interview, exam and entry process.

Q: FSO?

CLAY: A non-tenured Foreign Service Officer (Foreign Service Limited). My tour was for up to five years but only for Zambia.

If I wanted to stay overseas then I would have to again bid, go again through the same procedure, when a position was open to non-tenured Foreign Service Officers. However, after a designated period, I was able to convert to a full tenured Foreign Service Officer and could bid with other FSOs.

Q: Were you excited about going to Zambia?

CLAY: I was. I knew Paul Hartenberger who was the health officer before me. I was pleased that Zambia had a full portfolio of projects. I had known it through my work here in Washington and so I was delighted that I was able to go to Zambia.

What year was that?

CLAY: I arrived in August 1998.

I remember leaving Washington. It was a very hot summer here. When we arrived in Harare, we had to put blankets and coats on because it was in the middle of their winter. I remember writing back to my family. “You can’t believe we arrived in Africa and are really freezing.”

We moved our two cats with us. That was one of our biggest logistical challenges. We were met in Harare by the Mission. The Mission transported us from Harare to Lusaka by car because the flights into Lusaka would not allow pets in the cabin. We could only get into Harare and then we had to go by land back up to Lusaka.

Q: Oh my. Who was the mission director in Zambia at that point?

CLAY: Walter North was the mission director. He was there for two years and then he moved to India after Zambia.

Q: Just to jump ahead, how many years did you stay in Zambia?

CLAY: I stayed five years.

Q: A full five years!

CLAY: Yes, and I would say my fifth year was my best year. I would often counsel Foreign Service Officers to stay longer if they could—because in many ways, my last year I had the confidence of the government. I knew the country. I think my voice was much stronger and listened to more within the government and the donor settings. Also, I was part of the portfolio redesign so, I learned a lot from the review of the past 5 years of our work. Sometimes, I think Foreign Service Officers leave too soon and they don't actually learn the lessons of their time in country.

Q: So tell us a little more about what you found when you arrived in Zambia.

CLAY: Well, Zambia was a quiet place compared to big cities like Washington where we were coming from.

It had a very active health program and USAID was a real leader in health. What was quite interesting for me was their Sector-wide program because I had been involved in some of the health financing and sustainability work earlier in Washington. The SWAp was very active with the UK and with support from Sweden, Norway and other donors.

Q: And SWAp is a—.

CLAY: Sector-Wide Approach. We were giving money to the government after they meet certain milestones/benchmarks.

Q: It was essentially program assistance, sector assistance.

CLAY: Right. Shortly after I arrived, the end of September, 1998, we got word that Charlie Flickner, an important senior Hill staffer, was very upset that any child survival account money was going for any of these SWAps because he felt it was a waste of money, there was limited accountability and it wasn't bringing back results.

So from the start of the next fiscal year (which was October, 1998), USAID was not allowed to use child survival resources for any new sector-wide approaches. But Zambia was the one country where we were grandfathered in. We were able to continue but other countries could not start. It made Zambia very unique since we were able to take this very interesting approach to development along with other parts of our portfolio which included family planning, activities on health, and so forth, and integrate them together. Then, of course we had the beginnings of a major HIV/AIDS Program at the time too.

Q: Do you recall the amount of the SWAp contribution that USAID was providing?

CLAY: You know I have to go back to get the exact figure. It was a couple million dollars, I think, broken out over quarters. The government needed to do some policy reforms before we disbursed the funds. For example, there were some benchmarks with health information systems that needed to be achieved (computers purchased, staff trained, software developed) and once those benchmarks were verified then we would disperse the funds to the Ministry of Finance. It gave us a seat at the table for policy discussions in Zambia that were held in these sector-wide approach meetings. We weren't sitting on the sidelines any more. This was very important because it allowed us to influence government policy and programs that were happening at the time.

Zambia is an interesting country because under President Kaunda they had set up quite an extensive social support system of free health for all, free education, and lots of promises of general social support. They initially funded this through their copper mines. But they ran into financial difficulties. They then started taking out loans. They had several World

Bank, IMF loans that helped keep them alive during the '80s. Basically, it all came crashing down in 1990 and they had a major meltdown that resulted in a change of government. At this point in time, in the 1990s, when things were really falling apart, a professor at the University of Zambia, Dr. Katele Kalumba proposed to the government a package of health reforms that included a decentralized approach with greater flexibility for innovation and incentives. It was picked up by the winning party as a key part of their new platform. He was subsequently named the Deputy Minister of Health (later the Minister of Health) and while I was in Washington, I always heard how Zambia was really at the forefront of health reforms in Africa and doing quite innovative things. So, again a very interesting country to come to.

Before I arrived, there was however a lot of concern by Zambian Parliamentarians on the implementation of the reforms. When they visited their districts, they didn't see the changes they were expecting and would complain that there were no bed sheets, no drugs, and the clinics were filthy and dirty. So they didn't see the impacts of the health reforms that were so visible at the capital but hadn't shown any big effects in their districts. There was big push back and Katele was eventually moved from Ministry of Health and his deputy, Professor Luo, became Minister of Health right when I arrived. Her mantra was "Where's the beef." She was really trying to address this concern that health reforms have to show results to actually have an impact. That was a real lesson for all of us there—that if you pursue health reforms, at the same time you have to have visible demonstration of impact or else you're going to lose your constituents and support.

Q: Early on.

CLAY: Early on. Yes. So maybe they are low hanging fruit but you have to show some important progress, or else it takes too long for all these big changes to happen to keep your political support there. That's what happened in Zambia. They lost their political support and much of the reforms—I wouldn't say they failed—but they didn't realize their full potential.

Q: Did you travel around the country quite a bit?

CLAY: Yes, I travelled all over. In fact, some of my trips were with the Minister. She is famous for visiting facilities at eleven o'clock at night, even two in the morning, requiring that all staff be there so that she could do her "inspection". She was very active in terms of visiting facilities and ensuring that things were right at the location. So yes, I traveled with her. I traveled with the U.S. Ambassador, who was quite interested in HIV/AIDS. We had very interesting visits up to the north. As our projects are based all over Zambia, I traveled in other places as well.

Q: So can you recall the names of the minister and the ambassador?

CLAY: Well, the Minister was Professor Nkandu Luo and the Ambassador was Martin Brennan. He came from Uganda. Uganda was another country where they had done quite

a bit of work on HIV/AIDS. So Ambassador Brennan brought a passion that was very helpful to us.

There is a whole lot I could talk about HIV/AIDS if we want to go into that area.

Q: Zambia was sort of ground zero for what was going on in southern Africa and the depths of the epidemic and effects on populations, not only rural populations but urban populations as I recall. Talk a little bit about how you decided where USAID should focus its resources.

CLAY: Since it was a generalized epidemic, we had national programs (communication/condom distribution) as well as specific programs for high-risk groups (sex workers, truckers, etc.) As I mentioned earlier, we really didn't have a treatment option. Most of our resources were focused on prevention. If someone needed to be treated, they would have to fly to South Africa and the treatments that they had (AZT and others) were very expensive—they could be up to twenty thousand dollars or so. It was very unaffordable.

I should tell you the story of my secretary at USAID when I arrived. Over several months, I started noticing that she was losing weight and it was very clear that she was HIV positive. But because of the stigma and discrimination, no one would ever talk about it, and she would never talk about it either. The whole staff just watched her as she was losing her life.

She eventually passed away.

I remember today, going to the funeral and being asked to speak and thinking to myself at the time what a great opportunity to talk about HIV/AIDS and prevention and what we should all be focusing on. But I was told strictly by the family do not mention that she died of AIDS.

Her son, who was still alive, would be the focus of widespread discrimination against him and the family if that was widely known. So that experience, I think motivated our entire office to do whatever we could do so that wouldn't happen again. It motivated us both with our programs, to redouble our efforts as well as care and education for our staff. We started one of the first HIV care programs for USAID and embassy staff. There were many different layers to this work.

We provided education to our Zambian staff about HIV/AIDS. We had seminars. We also created a fund so that when TDYer came they could help. This started after a Congressional delegation came to Zambia and ask what they could do. I said, "Well actually what would be helpful is if you could donate some resources and we could use this to help people who are coping with family members that are affected with AIDS." So they donated some of their funds and we decided to set up an official fund for families and people who were living with HIV/AIDS, through our financial office. We created a

flyer and put it into TDYer's welcomed kits, suggesting that they could contribute some of their extra per diem. We also set up a volunteer program where people could donate their time to work with an HIV/AIDS group. They could take a paid day off once a month and help a pre-approved organization. That way our staff across the board could actually be involved and not feel hopeless. It was called ZamCare. Some of our staff helped with orphans and vulnerable children in an orphan program or if they were computer specialist, helped with an information system in one of the NGOs working on HIV/AIDS. We try to set this up so we could match their skills with the needs of these groups.

We had also a specific program for our drivers because I noticed that when we were out on TDY, the drivers would often mingle with the communities. This seemed like a missed opportunity that we could utilize. So we trained them to educate communities about HIV/AIDS. Some of them are really quite good at it, bringing the community around and they would just talk to them in their own language about HIV/AIDS. They would answer questions and they would demystify and correct some of their misperceptions. These drivers became actually quite good AIDS ambassadors.

Q: What a unique program.

CLAY: We spread the word about it. Other countries picked up on some of this. It really was driven by the fact that our own staff was affected by HIV/AIDS and we needed to do something to protect them.

In terms of our external HIV/AIDS portfolio, one of the key groups that we focused on was the faith-based communities and these were instrumental in terms of changing behavior. In Zambia, every Sunday you would have about 80 percent of the population there in churches. So engaging pastors was important to get them engaged in HIV/AIDS education programs. We also worked with Imams for the Muslim population, Hindus, and Sikhs. In fact, the Ambassador hosted several inter-faith HIV/AIDS meetings at his residence.

The other group that had tremendous influence on village behavior was the traditional leaders. We focused especially on the tradition of "cleansing" because in some Zambian tribes the practice is that when a woman's husband dies then the brother of that husband needs to "cleanse" her, meaning have sex with her the next day. Oftentimes, that brother would be infected with HIV, particularly if the husband died of AIDS. So the woman would become infected. We spent a lot of time working with traditional and paramount chiefs to get them to come up with an alternative. I was really impressed with the northern part of Zambia where the chiefs came up with this innovative solution. They said that if you sit the widow on your lap for half an hour that would satisfy, she would be cleansed. So that created a whole alternative social norm and avoided this very risky behavior that had been practiced.

Working through the traditional leaders and the churches and other faiths were two main areas where we focused the behavior change activities. Then of course, we had social

marketing of condoms that Society for Family Health (SFH) did and we expanded that quite rapidly to all the different groups.

We had also an innovative program working with truckers. There were four USAID health officers that worked together on this (Zambia, Malawi, Zimbabwe, and South Africa). We came up with this idea ourselves. In a meeting in Zimbabwe, we looked at our HIV/AIDS programs and realized that we were all dealing with similar issues. We agreed that we should try to tackle this jointly so we could learn and be more effective. One activity was in communication, trying to have common communication material so if people picked up South African radio or television in their country, they would hear the same kind of messages that would reinforce those in Zambia, Zimbabwe, and Malawi.

The most important program we developed was what we call the “Corridor of Hope” — where truckers from Mozambique would be driving from the port of Maputo, Mozambique to the DRC, stopping in South Africa, Zimbabwe, and Zambia. All along that way there were concentration hotspots of sex work, especially at border crossings. We created this program working with the high-risk populations of sex workers that were operating in these hotspots along the corridor. We provided condoms, both male and female, as well as educational tools and also support to them in terms of their educational opportunities. Many of these workers were seasonal sex workers who, in the dry season, had no money and they needed to go and make some through sex work. We needed to help protect them from the HIV virus or else they would go back to their villages and infect others.

Q: Quite a varied program. Did you have issues with men who had sex with men or other at risk groups? Or was it more traditional male female sexuality that you were dealing with.

CLAY: So Zambia was a generalized epidemic so we had both traditional male/female sexuality and high-risk groups. When I arrived, the estimates were that 20 percent were positive. This is at a time in 1998 when South Africa was in single digits. Other countries that later became hot beds, such as Swaziland, were in their early stages. Zambia and Uganda were much further along.

That's why I said that Zambia was at the peak of the mortality because their populations had been infected in the '90s possibly because of the fall of the economy. There was a lot of disruption that happened in the culture that caused some of the transmission of HIV. So we were seeing the result at the end of the decade.

The visible signs of it were just incredible. We lived on a road in Lusaka that was called Lake Road. Funeral processions drove passed our house on the way to the cemetery on Leopard's Hill. Every day you would see processions of people going to bury their dead. It got so bad that we had to make a policy in the Mission that you could only go to a funeral if you were related because people were actually out of the office so often because they were attending so many burials.

It was devastating to the society and because of that we started the Multi-sectoral approach to HIV/AIDS in Zambia. We realized that it wasn't just a health issue—it was a development issue affecting all of our sectors. To address this, I created a group in the Mission of all the offices so we would have a stronger multi-sectoral approach. After one year, we rotated leadership to another office director to ensure ownership.

We went from a health lead to education and then democracy and governance—all focusing on HIV/AIDS coordination. The other offices had real needs in their own sectors because they couldn't achieve their results without controlling the AIDS epidemic. In the agricultural sector, the farmers were dying and they weren't able to get the yields in their fields. Judges were dying. We had economists and leading business men that were dying. So everyone in our entire Mission had an internal need to work on HIV/AIDS and that was a great driving factor in terms of this multi-sector approach. We started joint activities with each sector in one location in Livingston. The learnings from this and other platforms really allowed Zambia to take advantage of these global initiatives that were coming out in 2000. We were developing a way to work across sectors and a way in which we could absorb resources. For the first couple of years of PEPFAR, Zambia boxed way above its weight in terms of the resources it was getting and even today it continues to get one of the largest shares of PEPFAR resources and has shown remarkable results over this period.

Q: Anything else about your tour in Zambia you'd like to mention at this point?

CLAY: I'll mention a few things. There was some very interesting work on micronutrients where we partnered with a private company, Zambian Sugar, the largest producer of sugar in Zambia, to fortify sugar with vitamin A. This was something that happened over several years. It was one of these win/win situations where they were able to have a market for their product. We were also able to fortify the food. So the vitamin A levels really improved.

We developed an integrated health program in Zambia called the Zambian Integrated Health Program that has four components to it. One was a service delivery called ZIPSERVE, the other was a policy component called ZIPSYS, and we had ZIPCOM which was the communications behavior change group. We also had the social marketing program. All four of those were designed so that they would be packages of one broader program. In some ways instead of hiring one prime and having subs, what we had was four full primes and so we were able to have the full weight of each of those groups but on the flip side it mean that we needed to manage them. The management rested with us to make sure that the four groups worked together. What we did stipulate was that the four all had to co-locate in one building. They had to produce a combined work plan. We had joint management meetings of all four groups once a week so all four would come together and discuss what needed to happen in the program. At the time, it was a groundbreaking approach.

Subsequent to that, other projects that have followed this model or have done similar things but at the time it was quite innovative. I give credit to Paul Hartenberger, who was my predecessor for putting in the initial design.

What we found is that we were able to get the groups working quite well together but there was a backlash. That is, the government saw this huge wealth of resources all together—they were very visible. This program was quite powerful in a sense. It used just one building and had lots of staff. In a way it became a target for the government because they saw the actual strength of USAID versus the other partners operating in Zambia. The other bilaterals largely invested in the SWAp, so they didn't have large external TA programs. We often had to defend our TA projects to the Government, explaining why we just didn't give our money directly to the government. But ZIHP was very instrumental in terms of providing that technical insight, the capacity, to the Zambian government at a time when they were building up their programs.

Zambia had established a Central Board of Health that was the operational arm of the Ministry of Health. It was designed to have both flexibility and higher salaries, being more on contractual basis. This was one part of the innovation in Zambia. ZIHP provided essential technical assistance to the Central Board of Health and helped build its capacity.

Q: You must have had a very positive thinking procurement officer at USAID to allow you to do that to.

CLAY: Well we did. Our procurement officer was actually based in Botswana. It was the regional procurement office. So maybe being offsite we were able to get away with a lot of things that we couldn't do if we were in the same country.

Q: Well that is totally unique. Do you know if the model is still being followed with USAID in Zambia?

CLAY: What happened after ZIHP is that the emphasis shifted to HIV/AIDS. When PEPFAR arrived, it really expanded HIV/AIDS work. It was so large, the amount of money that came in was so great, that it created a separate program and so some of the integration that we were trying to achieve through ZIHP was undercut by the more vertical focused program.

It was interesting, I went back to Zambia about ten years later and I couldn't believe what the mission staff asked me, "What ideas do you have about how we can integrate our program?"

They had been living with the separation of HIV/AIDS and other health for so long that they had forgotten that before PEPFAR there was actually a very robust integrated program that had been developed. So I told them, "You have to look at yourself because you actually have that evidence in your history." But they had forgotten it, so I reminded them. I think there is much more of an attempt to try to bring those two together. However, one has so much money over the other that it was hard to do.

Q: Right. Let me ask you in terms of the SWAp program, is that still continuing?

CLAY: You know I don't know for sure.

I would imagine in Zambia that they still have the full funding that other donors are promoting. Zambia had a problem with the Global Fund for AIDS, TB, and Malaria. There was some corruption and I know that issue really became a barrier for countries providing money to the government. So funds dried up for a couple of years. I think they now are flowing but I am out of date on that.

One thing just to add. I mentioned that we built up the capacity of the Central Board of Health because they were the implementing arm of the government. That was the focus of the donors. Later after I left, the Minister of Health felt like the CBOH had gotten too powerful and he wanted to have more of that mandate within the Ministry of Health. So he abolished the Central Board of Health. So that was a real blow to the effort that all the external groups had put into Zambia to develop this institution.

In fact, there wasn't much capacity development in the Ministry of Health because they were focused on coordination and policy. When they became the implementing arm that is when the problem started to develop, since the corruption was at the Ministry of Health. I think if they still had the Central Board of Health with their systems and their training and so forth that probably wouldn't have come up. In the end, we actually strengthened the wrong institution. If we had known that the Ministry of Health would eventually be the implementer, our target should have been the MOH but we could not have known that at the time.

Q: Well it's a common issue whether you work through the ministries or work around them.

All right just one last question on that. In terms of the SWAp itself as an effective mechanism for managing a large number of donor resources from a large number of donors and utilizing funds, moving funds to the field, how successful do you think the SWAp programs, at least the one in Zambia, how successful do you feel it has been?

CLAY: I would say mixed and I say that because—and I look at others SWAps the same way—they are very focused on doing broad policy work with the assumption that the government will be able to implement. What I think the SWAps typically have done is that they underestimate the amount of technical assistance that is needed to make it work efficiently. In some ways, USAID was able, through our programs, to fill this gap and provide technical assistance to the government that was in addition to the SWAp. SWAps need to internally have sufficient TA to build the capacity and experience base in the governments or they need to rely on external TA. That needs to be provided for in the plans. Typically, the SWAps underestimate the amount of TA resources required.

In Zambia, I think we were progressive in that the SWAp membership and the actual meetings weren't limited to those that were just contributing. So it wasn't just a funding meeting. We tried to include other donors so that they could get to know what the systems were and to get comfortable. It took a couple of years but then they could slowly join and become part of the process. In some countries, I've seen that isn't the case. I think that misses a real important opportunity to expand the number of donors.

The SWAp did allow us to get into the kitchen of the government and kind of see what's happening. I think in that regard it was successful that we were able to see why some of these problems are developing, offer solutions and work with the government on these issues. Certainly, I think the government felt that they had a good mechanism to better coordinate the work of the donors.

In Zambia, we had fifteen different bilateral donors as part of the SWAp; it was a huge number of people working in country. I can compare that to India where I think we only had five or six bilaterals. The Indian government said we will only work with you if you give us so much money so that actually eliminated a lot of the smaller donors. But in Zambia it was open to anybody. So it needed to have a way to coordinate.

I think over time Zambia is getting much better in terms of looking at performance and being able to target where a donor could provide support. It does create a common view; certainly from the government perspective it gives them a coordinated program which I think is the only way we are going to have sustainable programs in the future.

Q: Tell us a little bit about your move to India, what year you moved there and what your position was.

CLAY: So I moved to India in 2003 and I was head of the Population, Health, and Nutrition office. We were 80 million dollars out of maybe 110 million in the Mission, so about eighty percent. A very large part of the program.

We worked at the national, state, and local level. We worked across all the areas in health. So it was quite a comprehensive program. Clearly, a big difference going from Zambia to India. In Zambia, 50 to 60 percent of the budget in the health sector was from external resources and in India it was around 12 percent. So the government was the dominant player in India—they were in charge. The other real clear difference was that they had a vision of where they wanted to go. So it was refreshing to be in meetings knowing that this is a country that has a vision and was trying to achieve it.

Q: I'm surprised that the program was that big. You said federal, state, and local level.

For a long period of time I know USAID had worked with NGOs like CARE and CRS with maternal child health programs. Where those still going on?

CLAY: The CARE program was still going on but I think more and more of our work was through what they called Societies. We did that particularly through the HIV/AIDS

work in Tamil Nadu and Maharashtra where we had programs called APEC and AVERT that were societies. They were led by the government but didn't have to follow all of the government rules so they provided a more effective mechanism in those two states.

The other huge program that we had in India was in family planning that was the SIFPSA Project (State Innovations in Family Planning Services Project Agency) in Uttar Pradesh (UP). This is actually something that started in the 1990s. It was a performance-based program like the SWAp in Zambia where the government had certain benchmarks. They had to meet these benchmarks and then we would disperse our funds against those milestones. But it was only with USAID as the donor. The program had continual reviews, audits and documentations about whether they met or didn't achieve these targets. We were able then to disperse the funds against that. It was kind of a new program at that time and it had mixed reviews.

The government leadership was central to ownership. However, there were high turnover in terms of the staff. Because they were IAS (Indian Administrative Service) officers, they would be coming and going and so you could not get somebody who was a real champion. They would be great for the program and then they would be transferred and you would have to start all over again. That lack of continuity at the leadership level was a big issue.

They did achieve a number of important benchmarks across many areas of family planning in a very difficult state. In fact, that was the one thing that I noticed right away. Because USAID chose to work in UP, which is one of the most difficult states in India, and we had stuck by it for ten years, it gave us credibility within the ministry. People really appreciated the fact that we took on the hard job and we were still working away. I benefitted a lot from that goodwill the ministry had towards us.

Q: Interesting. You were running the Health Office, who was your mission director.

CLAY: So Walter North was my first mission director. Then, George Deiken who comes from a Russian, Central Asian FS background, was the second.

Q: In the long run you were there for five years. Were most of these programs underway or did you start new programs?

CLAY: It was mixed. The HIV/AIDS programs were there but they hadn't really expanded. At least the ones in Maharashtra we expanded into some other new areas. The Family Planning Program was already there. We increased our work in Health Systems. The area of public private partnership became quite rich. Largely because of the challenge by the permanent secretary Mr. Hota who was there for almost four of my five years. So I had a long running relationship with Mr. Hota which was great. I invited him to come over to the Embassy. This was actually one of the few times an Indian government official actually drove up in his white Ambassador car and came into the Embassy. We met him in the Ambassador's conference room and talked about the program. It was in that meeting that he challenged us.

He said, “You guys know how to work with the private sector so why don’t you help me.” He was coming from the mining sector because IAS offices rotated from different sectors. They are groomed to be good managers. He was not a health specialist but his background and training showed him that the private sector had an important role to play.

He said in the Ministry of Health, he felt that the doctors’ voices were excessively strong and that there needed to be people there who understood how to engage the private sector and how to negotiate with them. He was quite interested in our work on health insurance. He felt that the government actually was not getting a good deal in their negotiations on health insurance and he wanted people that could actually help. He asked us as a donor if we could we help more on the public private partnership side. So that became a key part of our portfolio.

Q: That is interesting.

That Health Insurance Program is something that I know USAID has been involved with in several countries including in West Africa. Were they developing a health insurance program network—was the U.S. model the model you were using or were you using a European model or what kind of model for health insurance were you focusing on?

CLAY: What we were doing at the beginning was trying to get the building blocks for health insurance. For example, how much do you get reimbursed for various illnesses. So we worked a lot with our economic growth colleagues on this, just trying to establish the DRGs, diagnostic resource group, for different health conditions.

Just establishing a broader health insurance policy framework was essential so that when companies would be interested there would be some guidelines for work so it would not be just a free for all. That was a lot of what we were doing.

Some states had actually started negotiating and the first experience had been so abysmal that these insurance companies had basically signed these contracts and in the first year they didn't pay anything out. They weren't really well negotiated. We were trying to train the government officials on what you look for and how do you negotiate fair deals.

Q: Did you enjoy India on a personal basis?

CLAY: You know India divides people into either people that love it or those that dislike it. There are not people in between. Since I had lived in India before, and it is where I started my development work, I have an affinity towards India. So yes I enjoyed being there. It was very different because in the previous time with UC Berkley I was in the south so being up in Delhi in the north, people are different and food is different. It was a different perspective. It was fun exploring and getting to know a new part of India.

Q: It's a continent and an amazing country.

Who was prime minister during the period you were there?

CLAY: Let's see, they had the elections while we were there and the Congress Party won. Dr. Manmohan Singh was the former finance minister. Sonia Gandhi led the Congress Party and she decided not to become prime minister. She asked Manmohan Singh to become PM and he was very well respected. He engineered the whole opening up of India to the rest of the world in the 1990s and he helped create the miracle of India. He was well-respected and very low key, but a very strong prime minister.

Q: So they were open to private investment, they were more open to donor involvement?

CLAY: Yes, I mean it was night and day from the '80s to when I was there the second time. Before, everything was done only through the government sector and they had changed that around. So, very dynamic, in fact it was very optimistic while we were there. India was really on the path to becoming a superpower in their minds.

We kept telling them that if they were going to become a superpower that they needed to get their infrastructure finished and they also needed to learn how to contract out because they kept asking me at USAID to bring in all these people. I said, "Well eventually you are going to have to learn how to do this yourself." Get your policies and systems so that you don't have to rely on the donor to do this, so that you can do it on your own.

Q: Interesting. The HIV issue, most of us don't think of India as one of the most affected countries. Am I wrong about that?

CLAY: Well in terms of the numbers, anything that is in India is huge. So, actually India, when I got there had the second highest number of HIV/AIDS infected people after South Africa. It was a concentrated epidemic. It started in the south. In Tamil Nadu, in Chennai, that was where the first case was detected. In India, the high-risk groups had much higher prevalence than the general population.

Migration is also a factor since there is not the speed bump of country barriers that you have in Africa. You have migration that goes from the south to the west to the east and to the north. You have all the migrant workers that are traveling all over. You also have migration to the cities. In UP, you see a lot of people go to Mumbai or Calcutta to seek jobs and they go for two to three years then they go back to their village.

So the real concern that we had was that these migrants would be coming particularly from UP—which the conditions there are ripe for any kind of an epidemic—that they would go to these cities, they would have high-risk behaviors, would get infected, and would come back and start infecting their own communities. We spent a lot of time looking very carefully at the basic level indicators in places like East UP, where a lot of people went to Calcutta.

We did start to see some of these districts change to high prevalence. Even though when you look at UP in general it would be very low prevalence but you would have these

hotbeds of where people had been migrating. So we focused our programs on those districts and migration.

The most rampant epidemic was in the injecting drug users. This really started in the northeast. We know that needles are very potent carriers of the virus so that was another key area of transmission.

Q: There were no religious barriers to working in HIV/AIDS in India? One thinks of some of the barriers initially in Latin America. Certainly with the Catholic Church, with issues like use of condoms for example. Where there are any religious barriers in India?

CLAY: Not in the same way. I think there are some misunderstandings about what causes disease and a lot of misconception about how you acquire infections including HIV/AIDS. There's a lot of misinformation that's there.

I think what really saved India is its strong extended family network because the family is a central societal unit. I think that has given it a more conservative nature in the society. The AIDS epidemic was restricted to the high-risk behavior that was not prevalent throughout India and I think that really helped the country. The other aspect is that the government took very seriously their HIV/AIDS control programs. There was a fairly robust response, particularly in the high prevalence districts, both in prevention and treatment. I think that was very important. They had seen what had happened in Africa and they didn't want that to be repeated in India.

Q: And tuberculosis? Was that also a growing issue in India at the time?

CLAY: Yes, India is the number one country with the most TB cases. The DOTS Program was first developed in Chennai.

India has had a major role in terms of leading the response to TB. Actually, Dr. Tom Frieden, the former director of CDC, was in India, seconded to the TB program through USAID for three years before I got there. The TB program rapidly scaled up. They had the international conference of TB in India while I was there.

The program was hailed as a success because of the rapid pace of scale up in terms of reach, coverage, and access. But the quality of the programming wasn't up to par. So a lot more work needed to be done on that.

There was innovative use of the private sector. I remember going to private shops and seeing TB signs around. People who sell shoes were able to be trained to help diagnose and identify TB patients.

Q: That's amazing. I have another level to ask you about.

In an earlier period. I know there were a number of high level international exchanges between Indian scientists, researchers, and health specialists with Americans of the same

genre. I think George Curlin and other people in AID have been involved in some of those high level commissions. Vice President Gore may have had one of those commissions as well. Was that still going on when you were there?

CLAY: Yes, that was. I attended both the Indian and the U.S. side of those commissions when they met. They were fairly high level. The two governments would pledge their support for new initiatives. When I was there, I would say that the relationship between the U.S. and India was probably at its peak.

Definitely, the best I've seen. President George Bush came out to India while I was there. I remember spending quite a bit of time in the field, in Hyderabad, helping prepare for his and Laura Bush's visit when they came. There was an issue around nuclear energy that became part of that dialogue.

Having lived through the '80s where the U.S. was often opposed and our policies were very much out of sync with each other, things had changed dramatically. They were much more friendly towards the U.S. now.

Q: Well, we've talked about working on several levels. Did you have any difficulty attracting staff to work with you in India?

CLAY: No, we had many people who wanted to work for USAID. For the average awards manager position, we would get 30, 40, 50 applicants. I had no problem with finding people to work with us.

People would stay too. Even today, I was back in India three weeks ago and some of the staff that worked with me are still there at USAID. Not all of them, but there are still some key ones that are there ten years later. That is great news.

Q: Right, many of these are Foreign Service nationals?

CLAY: Yes, all of them are. The Americans I knew while I was in country have all since left.

Q: In terms of a personal level, with you and your family, any problems with pollution in Delhi that has been growing over those years?

CLAY: So, again, I think we were in one of the better windows. They had just put liquid compressed natural gas for all their busses and auto rickshaws, so that had dropped the smog in the big cities. Compared to the years before, it was actually much cleaner in Delhi. Since then the number of vehicles have escalated so it has gotten worse since we left.

We didn't have too many problems. Of course you have to be careful with the food you eat because it is very easy to get infected because there are just so many people living together, especially in the cities.

Q: And one more question, just a general question, in terms of working with the embassy. Often the embassy might have a science attaché whose areas of interest cross a bit with what AID does. Did you have much interaction with the embassy and how did you find it?

CLAY: We actually did. I think our roles were well defined so we didn't feel like we were stepping on each other. While I was there, we set up a health cluster to bring everyone together.

There were maybe ten government agencies or so that had something to do with health so we would bring everyone together about once a month to talk about what we were doing. We rotated the chair so I chaired it for the first year and the health attaché chaired it the second year.

Yes, I think things worked fine. We also had CDC there as part of the PEPFAR program. We tried to work out a good way to divide the work between the two of us. USAID was the larger component of the program in India. CDC came in with their specialty skills.

Q: Well we covered quite a bit of ground. Anything else would you like to mention?

CLAY: Yes. There are two things I would like to mention.

First, there is a book, *The Fortune at the Bottom of the Pyramid*, which was written all about—and largely in India—how to make products cheaply and market them to the masses and make a small return. But because there are so many people you are marketing to, you can make a good profit. That philosophy led us to working a lot with the private sector.

Unilever was one where they had a whole series of detail staff that would go out to villages and promote their products. We were able to get them to agree to promote some of our health interventions like ORS and a water container for safe drinking.

Using their tremendous reach that they had through their community marketing enabled us to increase our health results. That was exciting and the kind of interesting work that we were doing.

Then of course I have to mention the Polio Eradication effort. India had a lot of focus on the challenge of polio eradication. There was a lot of assistance that was provided to India. But it was really the Indians who carried this forward. What is interesting is that the Poliovirus had to be given much more frequently than in the U.S. environment because there are so many bacteria in the gut of Indians at the community level. We had to go out ten, twelve times a year to the same person to give them the Polio vaccine before they were immunized against the virus.

So there was constant campaigns every month to the point where the communities—you know it's amazing that they continued to accept the Polio vaccine. We did end up with

some resistance from the Muslim populations who through miscommunications or beliefs felt like this was an attempt of the Hindus to sterilize them somehow through the polio eradication. We had to sit down with the Imams and tell them what this program was all about. That it was really for the community. And have them issue declarations about how the polio eradication works.

So, again it was an amazing achievement that India carried out.

Q: Were you there when they finally—.

CLAY: I came back. When I left it was on the way down but they hadn't finished the final case. Once they had the final case then they have a period of certification. So they can't have any reoccurrence during this time. I was back in 2014 when they officially got certified as Polio free. It was a great day.

Q: That is amazing. That's great.

Well I know USAID played a role in that. The Rotary Foundation, I think has been involved over the years. Were there any other major players?

CLAY: Yes, the CORE project with various different NGOs focused a lot on the community level and getting villagers involved. It particularly focused on key spots in Uttar Pradesh where we had particular presence.

Q: Well it's an amazing country and you had a wonderful tour there. I think you said that the fifth year was your best. You want to elaborate on that?

CLAY: That is right. I had the trust of my counterparts in the government and the knowledge of our program so I was more effectively at policy level to talk about what happened at the community level, the district, the state, and the national level. India has these initiatives, you can call them Presidents Initiatives. In their language it's called Missions. The first one was in the '90s when they were trying to get the IT sector booming so they had this national mission on information technology. They had this mission on rural health called the Rural Health Mission.

It was a nice opportunity to be able to participate in government discussion and dialogue about where they are with rural health. I felt like over time I was able to be better informed about what they were doing but also what the U.S. government had been finding through our programs. So I was able to be more effective in those forums, especially my last year.

Q: What else about India would you like to pass along? You have covered a great deal of territory here.

CLAY: One thing is Urban Health. We were instrumental in setting up the first Urban Health Resource Center. This was an area that hadn't been receiving much attention in

many countries but particularly in India. I think USAIDS technical assistance and advocacy helped eventually create the National Urban Health Mission which was folded in with the Rural Health Mission. It does still exist today, a focus on urban health. As we know from the demographic information, Urban Health is going to become more and more important over the years and so that was a contribution that USAID made.

Q: After about five years which would be 2008, you were ready to depart?

CLAY: Yes, so five years in India we felt that we needed to cleanse ourselves, so we actually took a month and we went to New Zealand. It is probably the cleanest place we could imagine in the world. We had a great time in the north and south islands breathing fresh air, drinking healthy juices and being with the sheep. That was our transition, trying to get back health and back into the first world. After New Zealand, we stopped off to get our things. So for the last evening in India we stayed in the amazing Imperial Hotel. My secretary worked out a deal where it was within per diem and we had a great room due to her persuasion. A great way to celebrate India and have a great stay and then we came back to the U.S.

Then I jumped right into the HIV/AIDS world. It wasn't as difficult as people had painted. I think largely because I've been thinking about billions of people in India. India is so huge, you just think expansively. So I went from billions of people to billions of dollars. PEPFAR was a big program but I was used to dealing with big things so it was okay.

Q: Let me ask one last question on India.

What future do you see for USAID for the health sector in India? Should there continue to be a program there?

CLAY: There should and I would say the future really is innovation. And being a hot bed of innovative ideas that can be used in other countries is a strong reason to stay in India.

The reason that Indian is so dynamic in this area is because of the population pressure and the economic pressures. There's a lot of focus on appropriate cost effective innovation. We may have a lot of innovation in the U.S. but we also have a lot more resources that we can apply to it. India has to do it on the cheap. So some of the innovations actually can be quite appropriate to the U.S. scene as we are looking to try to reduce our overall health expenditures. The way that they do it within a lesser resource environment can show the light to some of the things that we can be doing cheaper here and more efficient here.

I think for developing countries there is a big push of trying to get India to take some of its lessons and help the plight in Africa. I know BRAC, a NGO from Bangladesh, has been doing some work in Africa. India could provide some of that vision and technology to others. The other thing we keep telling Washington is that India has the resources but they don't have the capacity to be able to address all the marginalized areas that need

assistance. Our assistance to them allows them to use their money in a much more effective manner so they can get much more effective results. I think that's a compelling case because we are leveraging and empowering them to be able solve their own problems. Without our window to the world to show what others are doing by technical assistance I think there would be much less progress and they wouldn't be able to advance as quickly.

Q: Very interesting.

CLAY: And if you look at any problem that we are trying to achieve globally, any preventable child or maternal mortality problem, you can't do it unless you solve it in India and you can't do it in India unless you solve it in Uttar Pradesh. So you have to take India seriously if you are going to have a global impact.

Q: Well this is excellent. Robert, thank you again..

Q: Good morning.

This is John Pielemeier on May 9 with a third interview session with Robert Clay.

And Robert we are talking about after your tours in Zambia and India. You came back to Washington. Let's talk about that part of your career.

CLAY: Okay, Well the biggest dilemma I guess for people who have worked in India is what happens after India. In a country with 1.2 billion people and a scale that is enormous, it is hard to know what to do next. Especially, when you look at the bid list and you see countries that are the size of a district in India or maybe less than a state, it's hard to fathom where you go after the experience in India.

I had the option of retiring while in India or staying on, and I definitely wanted to stay in India. Through the course of my tour, I actually extended one more year so I was in India for five years as I have mentioned. My last year, I was approached by Kent Hill (AA for the Global Bureau) to see whether I wanted to come back and lead the USAID/PEPFAR program.

At first I thought he was joking because PEPFAR had such a bad internal reputation. And I had been engaged in PEPFAR's predecessor with the Life Initiative in Zambia and then with PEPFAR in India so I was aware of some of these challenges.

I knew the tensions with the management of organizations, the pressure to move money, and the focus on reporting. At the same time, after Zambia and India, I knew the importance of the HIV/AIDS work. I also thought that it would be useful to be back in

the U.S. after ten years overseas. At that time, USAID was enforcing the twelve year rule, so I would either have to come back now or in two years.

I made the plunge and took the position as the Director of the Office of HIV/AIDS in the Global Health Bureau. It was an office of 140 staff and a budget of \$3.3 billion (60% of PEPFAR at that time) It was a time of a lot of uncertainty. The PEPFAR program had been around for a while, but there were a lot of tensions between the different agencies, largely because USAID had traditionally been working in the space of HIV/AIDS and under PEPFAR it was a whole of government approach including CDC, but also DOD, Peace Corps, and HHS. USAID had the sense that everybody was trying to take away what they had been doing in the past. There was a real feeling of hunkering down, feeling of being attacked that was really prevalent within the office. So one of the things that I did when I first came back—after talking to all the staff, and doing my assessment—was to establish that we needed to have a two-track approach. One to pursue changes within the whole PEPFAR program and to see whether we could have a more equitable distribution and play more to our strength than we currently felt. There were some opportunities coming up including a change in the PEPFAR Ambassador. So that seemed like an opportune time where we might be able to address these broad concerns. That was one track—a higher track to try to change the model.

But I told the staff, we also have to have a track that said we're going to be best-in-class for the current model because we can't just be defensive. We can't just think that they're taking our football and therefore we're not going to play. We have to be very actively engaged and until we have any changes at the broader level, we needed to really be focusing on delivering what we had been asked to do with good quality and sound technical assistance. So that's how we started. I think it really helped the staff get to a much more positive position and attitude.

This was a very stressful environment with lots of issues. My time as the head of the USAID/PEPFAR program, which was three years, I would characterize as working in the grey zone.

The grey zone is where we didn't have clarity between the two dominant players—CDC and USAID. So every day there would be these issues that would come up about whose doing what. Why was CDC taking lead on this—or CDC would come and say why is USAID doing this.

There was just a lot of negotiation between the two agencies. Previously, CDC and USAID worked very well together because there were defined roles. CDC was the expert in surveillance, lab and epidemiology. In the past, oftentimes the missions would request CDC to come to their country to provide those services because they complemented what we did. But PEPFAR, because of the size of the money, give huge increases in resources to all agencies. So, CDC's role changed dramatically.

Over time CDC became a different organization within the PEPFAR program and in some ways they became a sister organization to USAID. In some countries like Zambia,

they just divided the country in half and CDC did half the program and USAID did the other half. It meant that CDC was developing expertise and prevention programs and doing all kinds of things that traditionally they hadn't done. And that became a real source of tension.

Dr. Debbie Birx was the head of the CDC/PEPFAR program in Atlanta and I was the head of the USAID/PEPFAR program in Washington. We both spent a lot of time negotiating and discussing issues between the two organizations. We also went on numerous joint field trips to be able to build the relationships necessary to manage this program.

I can go on if you want.

Q: That's great. It's really important. That has been a critical issue over the several years of the PEPFAR program.

CLAY: Right. I think the other thing that I felt from that time at PEPFAR is that when I came back from the field, I was really amazed that there was so much information that the field was providing to Washington through the PEPFAR management information system.

You know PEPFAR is famous for their reporting. It served them very well in terms of being able to respond to Congressional inquiries. We were able to turn around very quickly what was happening at PEPFAR whenever Congress asked for something. That was key to the continued bipartisan support on the Hill and was key to continued increase funding beginning in 2003 all the way to 2010, huge increases every year. I was amazed when I came back to see that a lot of that information the field provided was never being utilized or analyzed. There was a huge opportunity cost of the field collecting this information. They weren't going out to see these programs: they were basically filling out forms at headquarters. So that was a key area that I championed when I was back. Trying to get more reasonable information collection differentiating between what was necessary in Washington and what could stay in the field. During that period there was a whole revision of the HMIS system. I think it became a little more rational though PEPFAR has always been very heavily focused on information collection.

Q: Right. I think from the early days PEPFAR set up its own information collection system unlike in other parts of USAID. It had the reputation of being a family killing assignment for people who would work in missions because you worked on weekends. They also as you mentioned were unable to get to the field as much as they wanted. It was very staff intensive.

CLAY: Correct. In fact, there were some missions that would advertise their post was not a PEPFAR country and therefore you could come and not have to do PEPFAR. So that became a selling point for attracting Foreign Service Officers.

Thinking back, PEPFAR was a mixed bag. Yes, it was hugely intensive, there was widespread burnout. A lot of it I think could have been more streamlined and better managed and I think we actually would have achieved more. At the same time, largely because of those funds that we had, PEPFAR was able to do things that other programs weren't able to do. The caliber of the staff, the level the discussions and in some ways the interagency rivalries demanded the best. I think USAID's staff were always feeling like they were on the edge and having to really perform at a very high level in order to survive in the PEPFAR environment. So I think it was a strong incentive for USAID to do its best.

There are some practices I think that came out of PEPFAR that should be incorporated in other programs. Particularly the whole area of data and being able to explain what we're doing and being able to analyze the data.

But there are other areas that we need to not repeat and learn from. PEPFAR was designed as an emergency program, so it started because we had drugs that needed to get to people. Whatever means were feasible at the time, which often meant parallel systems, PEPFAR used them. So it was not designed as a development approach because the development would take time and there were people that were dying.

USAID's position at the table was that we should set up systems, sustainable process, and we should work to bring others along. I think a lot of the others PEPFAR agencies around the table were looking mostly at treatment expansion.

Over time, PEPFAR started to re-examine its approach. I would attribute this largely to the response to those in the Obama administration and the Hill when they saw how much money was mortgaged to the ARV (antiretroviral) treatment.

Once you put someone on ARVs, you can't just take them off. So you're basically obliged for the rest of their life to provide these services. Therefore, the mortgage of our resources is quite significant. The Hill kept asking, "What is the end game here? When are we actually going to be able to see some return, or not have this huge commitment because it really was undercutting so many other worthwhile global health programs with all this money going into the PEPFAR program."

Q: Robert, this reminds me of a similar issue in the previous years with USAIDS program with contraceptives for family planning where we provided, we were the only donor providing contraceptives in many countries. And many countries were not providing their own. There was a lot of pressure over the years to move out of that, spending so much money on buying contraceptives and finding other ways of those being provided either by other donors or rather the host country themselves. And that has been relatively successful. AID did make that transition.

CLAY: You are right. The difficulty with PEPFAR was that there was so much money so quickly that it displaced virtually all the other donors. Also many ministries of health made the rational decision that if there's so much coming into this sector, that they would

move their resources over to cover other shortfalls they have. We had countries where 80 to 90 percent of the program was funded by the U.S. government. And if you do that for four, five, six years it is very difficult to get that changed around. What PEPFAR was trying to do is to reengineer the program midway and try to bring in sustainability to the program. They put big resources behind it. There were lots of different meetings and strategies. McKinsey came in and did all kinds of studies for us. They did move a lot towards the approach, but PEPFAR is still a long ways from becoming a sustainable program in that regard. So yes, I think it could have been designed up front as opposed to trying to retrofit it later on.

On the other hand, I know that there would have been thousands of people continuing to die if the services didn't get out there. So it's a debate and it's a tension within the program.

PEPFAR had two main leadership bodies. The principles were the PEPFAR ambassador and the agencies political leadership. Then there were the deputy principles who led their programs in their agencies. I was the USAID deputy principal. During my tenure, deputy principles played a key role in terms of debating and discussing. I remember meeting every week for three, four, or five hours going through all the different programs, all the issues—excruciating meetings. And you know thinking back I wondered if we could have done that differently. But it did bring everybody together and forced us to really confront issues.

You got to see the potential when everyone worked together. You know the USG is a very powerful organization with all the wealth of the expertise across the board. It is really phenomenal when we all work together. I would say that was not rare, but it was not a frequent occurrence. Oftentimes, we were working across purposes. And I think that the whole of government is good in theory but in practice it has real downsides, particularly if roles and responsibilities aren't well defined as in PEPFAR.

The irony is, that because of the amount of money and the emotional issue of HIV/AIDS, and the visible progress that we had through the indicators, PEPFAR was and continues to be seen as one of the most successful programs in the U.S. government on the outside. It really is viewed as a way in which the government has really been able to tackle an area and make a huge difference.

And that's true. That is correct. But inside the organization, and this is a story you don't hear much outside of the organization—inside of the organization there are, as I mentioned earlier, a lot of hard feelings, there are people who basically would never work in another PEPFAR country because of the tensions that exist. There is also inefficiencies and duplication.

One of the biggest problem areas was the country budgets. What often happened the first year was that PEPFAR would announce a budget to the country and then let the country decide how they're going to divide it up.

Basically the parties in country, largely CDC and USAID, would spend weeks and weeks arguing and fighting over who does what. At times, it got very, very childish and in the first year people really went to defend their own turf. It was not a good beginning on collaboration.

USAID had most of the HIV/AIDS activities before PEPFAR, so CDC was trying to increase their amount. This became very ugly in some places. The second year when this happened again people said, wait a minute, we're going to have to go through this again? Some continued to fight but others just divided it in half. You do this and we will do that and then we go on our separate ways. It really wasn't truly whole of government. It was just divided geographically or it could be technically divided. Or they just said let's just do what we did last year. Let's not revisit it. We're going to do a straight line. That happened in a number of countries where things just continued as normal. And I always felt that this was one of the real shortcomings of the whole approach. There wasn't a real in depth review of what had happened and then changes to the system. Strategic decision making was not happening around the budgets.

We saw that in Ethiopia where initial allocation of resources was for an epidemic that we thought was around 4 to 5 percent. So the amount of money was appropriate for that. But during the course of PEPFAR, after one or two years, there was a revision of the numbers based on current data that showed prevalence was much lower, largely concentrated in the urban areas and not in the rural. Because of this tension, the amount of money continued to be at the level of the previous assessment. There weren't any changes to the funds to match the epidemic and that created huge pipelines. When we got to 2011/2012, our review showed massive pipelines in some of these countries where the epidemic didn't match the amount of money that was being sent.

In some ways that pipeline helped those countries because that's what saved them when the funding became flat lined in 2010. We had exponential growth up to 2010 and then we had a flat line in funding. But after 2010 the expenditures continued because of the pipeline that existed. We continued to be able to ramp up the program but then eventually that pipeline ran out so eventually people had to start looking at reductions of their work or more cost effective programming.

Q: Interesting. Those are really key issues. As you worked with the Hill who were the major players that you were working with?

CLAY: Under PEPFAR? Let's see, Nancy Pelosi was very involved and I spent a day with her during a Codel to India. Sheila Jackson Lee, a Congresswoman from Houston, was also quite involved. She came to Zambia while I was there.

It's interesting when you go to the Hill and ask people what was the entry point for them with HIV/AIDS. It was often orphans and vulnerable children. So both in Zambia and India, we had staffdels and codels that would visit children's programs and that was the way that they were able to start understanding and get to know the effects of HIV/AIDS. That was also true with Ambassador Holbrooke. This goes back to my time in Zambia.

He came out to Zambia when he was the U.S. Ambassador to the U.N. He visited a project that we had in Zambia that was focused on orphans and vulnerable children.

We had probably 200 kids that were in this area playing and doing all kinds of things. Holbrooke turned to me and he asked how many of these kids are here because of HIV/AIDS. I said, we don't know for sure but probably seventy to eighty percent. Later on, in an interview that he did on the plane back from Africa, he said a light bulb went off and he began to understand the significance and the scope and enormity of the AIDS epidemic.

He visited a couple of other places but it was from that trip that he then worked to get the special session on HIV AIDS in the U.N. in January.

Q: January. What year was that?

CLAY: It was January 2000. Vice President Al Gore chaired the U.N. Security Council special session and that really was the start of the global response. In the late '90s and early 2000s, we in the field were crying out and asking where is the global response because we were seeing this disaster happening right in front of us. There was very little international outcry and we thought this should be on the front page of all the papers because of what we saw happening.

From the U.N. session, there was a big ramp up globally, and that eventually led to the Global Fund on AIDS, TB, and Malaria and it also had a huge impact on the support for PEPFAR. Everybody has their own version of events that transpired. I would venture to say it was that field exposure and understanding of the impact that Ambassador Holbrooke took away from his Africa trip that got him motivated and it was an effect that got others quite engaged in the whole issue. That reinforced what was happening around the world.

Q: You were with the Office of HIV AIDS in Washington for three years? Did you say?

CLAY: Yes I was there for three years.

Q: What years were those again?

CLAY: So I came back from India in 2008 in September.

I was there from September 2008, '09, '10, to August, '11. Then in August 2011 Susan Breems (the SDAA in Global Health) was going to be leaving for her overseas Mission Director assignment in Zambia. She asked me if I would like to take her position. And she made very convincing arguments. After three years of PEPFAR, I thought it would be worthwhile to expand my horizons a little bit. My background earlier was much more on the maternal and child health. I thought it would be interesting to get more engaged in the other sides of the Global Health program. I took over that position and I was there for three years as well.

Q: Just to go back to summarizing for your HIV AIDS; you mentioned a number of initiatives and efforts that you were engaged with. Was it easy or difficult to staff up the HIV AIDS office given its reputation?

CLAY: It was harder in the field. As we said before, PEPFAR had a reputation as a burnout assignment. But for those who were ambitious, they saw it as an opportunity for advancement because when you're sitting in a country where you're overseeing 300 million dollar programs it certainly looks good on your AEF. So I think in some ways we were able to get ambitious Foreign Service Officers who wanted to really advance in those positions.

In Washington, because of the resources that we had in HIV/AIDS we were able to attract people. Some of it happened before I came back but the Office of Population had some very good staff that joined HIV/AIDS in the areas of procurement and behavior work and communication on NGO projects.

In some ways, family planning was going through a lean time. HIV/AIDS was having a robust period so people saw opportunities to advance under HIV/AIDS that they didn't see necessarily under the family planning program. So we had a number of people that joined.

That was great because these were the staff that really understood the agency more broadly as well as they had much more of a sectoral approach and that was one of the strong suits for USAID in the HIV/AIDS programs.

We are a development agency unlike any of the other PEPFAR agencies so we looked at things from many different lenses. We should bring our economic growth work, our education, even our democracy and government work to the issues of HIV/AIDS.

Certainly in Zambia, when I was there, that was a hallmark of our program. A multi-sectoral approach.

Q: Who were your deputies or how many deputies did you have?

CLAY: In the HIV/AIDS office, my deputy was Paul Mahanna who was the previous deputy under Ken Yamashita who was head of the HIV/AIDS office before me. When I left, we actually created another position, a Foreign Service deputy. During my time I was the Foreign Service director and Paul was the civil service deputy.

Q: Was the front office in AID involved much with the program?

CLAY: They were, but it waned over time. I would say that was mostly because of the way that PEPFAR's governance was carried out. We had a very active USAID principal, Kent Hill. He was very instrumental in key decisions and in making sure that USAID's perspective was very strong on the table. Later on, the Principle Group seldom met.

When they did meet, it was more of a reporting meeting. I think because of their lack of engagement, the front office didn't have as much ownership over PEPFAR as the previous GH/AA did.

And during that time the deputy principles became really the key discussion group and often times the decision makers and recommenders of what should happen.

Q: You moved over to another position in the Office of Health. But if you look back now into what's going on with HIV/AIDS, I know that at your present position with SAVE, I'm sure you have some involvement with HIV. What can AID be proud of or what not be proud of in terms of its involvement with PEPFAR over the years.

CLAY: That is a good question. I would say that USAID can be very proud of what our field missions have done. Many of the country results, especially early on but also including later results were coming from programs that USAID was implementing. USAID had the respect from the governments and we had a very action-oriented approach to our programs. So we can be proud of our work, and we led in some key areas—in support for orphans and vulnerable children (OVC), prevention of mother to child transmission (PMTCT), and also the work that we did in research. USAID was very critical actually to the whole approach of medical male circumcision and establishing the research for circumcision. The trials that we supported advanced the knowledge significantly.

The Capriska trial in South Africa supported by USAID looked at tenofovir gel which is a women-controlled means to prevent the transmission of HIV/AIDS. Initially it showed positive results and so there was a lot of attention. Subsequent analysis and trials showed less effect due to lack of adherence. If women actually applied the gel, it was very effective but the application and use of it was not as high to have long-term effects. This was disappointing. But I think what was critical is that it really advanced the science—it was state-of-the art. I think that evidence generation is fundamental to the success of AIDS prevention. USAID can be proud of its role in this research.

Of course, the supply chain management program USAID supported, including the logistics of procurement of all kinds of equipment across the board made major contributions to the field.

Q: In terms of dealing with the epidemic, where do we stand today? In terms of the role of the U.S. government is that requirement to continue funding still as serious an issue as it was previously. Can the resources be reduced over time. Where do we stand on that?

CLAY: There is a lot of modeling that shows that if we continue to invest in our programs over the next two to three years we can come to a tipping point and then we can start to see a decline in resources in what's needed to address HIV/AIDS. But those resources aren't just from the donors. Remember, the bulk of the resources for HIV/AIDS are actually from the host countries. Overall, governments contribute over 50 percent of resources. Clearly more domestic resource mobilization needs to happen as countries

grow. In middle income countries, more needs to be invested. The issue becomes one of priorities because as you can treat AIDS and AIDS become less of a generalized epidemic, the epidemic becomes more concentrated. Then the pressure and maybe the visibility of HIV/ AIDS becomes smaller so there is less of a push to support it. It's a dilemma because the actual political will to be able to achieve the goals will decline as we start to have success. And concentrated epidemics are often from marginalized groups (injecting drug users, men who have sex with men, commercial sex workers) and governments are often reductant to work with these groups.

I think the huge breakthrough and a shift in strategy was when it was demonstrated that when you take ARVs it reduces your infectivity and there's a preventive effect with treatment. That is a critical discovery and a huge change. People started to get the idea that you could just test and treat. You could give ARVs to individuals and that would lower their viral load and therefore it would help stop the spread of the epidemic. So there's been a big push on the treatment side that has curative as well as preventative aspect.

There is a lot of hope that we can do this. If you really get to looking at a long-term cure you're talking about a vaccine. Again, USAID has been a leader in vaccine research as well as Walter Reed and others. The work we have been doing on the vaccine is something USAID can be very proud of. But it will take a lot more time to have a successful vaccine.

Q: Is the Gates Foundation also involved that?

CLAY: Yes, it is. I don't know what their current spending level is but yes.

Q: Did you work with Gates as well on their earlier programs?

CLAY: Yes, when I was in India I was on their Indian board for their HIV/AIDS program, Avahan. USAID actually provided lots of assistance to Gates when they came into India on how to set up their program.

They took a very different approach than we did.

They worked initially outside the government, using a McKinsey model. They partnered with many of the USAID implementing organizations that were there. Gates gave them grants and contracts and focused on specific key areas. Like all donors, they were able to show impressive results. In my view, it was not sustainable and some of it was very high cost so they needed to do much more through the system and make sure that you know that the government could be able to sustain this. The second five years they did try to do that. Some things the government said, "Nice work but we can't replicate it. This is way too expensive". But the Avahan project is well documented and widely known. It's widely published in peer review journals. There is lots of knowledge about what they were doing. It was a bit frustrating for us at USAID because we felt our work in HIV/AIDS in Tamil Nadu, the APAC project, and the AVERT project in Maharashtra

were equally good projects. But we just didn't have the resources or the time to publish and to get the right recognition. It's one thing that I have championed—the importance of getting your work known in the broader community. That is best done through peer review journals.

Q: Great. Well let's move ahead to your work in your new position in the Office of Health.

CLAY: Not the office, but the Bureau for Global Health. Yes. I became the Deputy Assistant Administrator (DAA), taking over from Susan Breems. It was a much broader program and perspective.

I supervised all the technical offices – population and reproductive health, maternal/child health and nutrition, and HIV/AIDS. Then during the course of my tenure there, I created the fourth office, the office of health systems. That was made possible partly because of the AA for Global Health, Dr. Ariel Pablos Mendez, who was a very strong champion for health systems. He wanted to increase the emphasis so working under his vision, I helped to create that office. So I was the supervisor of the four technical offices.

Q: Before you get too far on that, why did USAID need to have a health systems office aside from the fact that Ariel, the AA, was interested?

CLAY: Health Systems Strengthening (HSS) is really the future challenge in health. Actually, when I came back from the field, it is something that I found missing right away. Because in the field people understand health systems. That is what they do—they work through systems. The HSS leadership in many ways was really coming from our field offices. Back in Washington, we had a group located in one office, in the health infectious disease and nutrition office that worked on some of these issues but it wasn't cross cutting. It wasn't across all the different areas so we needed to have a focal point to advance the state-of-the art. We needed a vision of where we wanted to go but not to create a parallel system. We talked about having a small office of about 20 people but having a much broader network of individuals that would be our virtual team. So throughout each of the offices there would be champions of health systems as well as country offices that would be leaders.

We networked with our country field staff to have a much bigger body of people that support health systems. I think it has proven over time that health systems are coming up over and over again as we look at the challenges under the SDGs.

Q: Right. Unlike some of the other problems that AID funds, it wasn't earmarked by the Congress. Right?

CLAY: Right. So that was a big struggle because Congress didn't have money specifically set aside for health systems strengthening. The flagship of that office was the Health Financing and Governance Project.

But there was other work that we could pull in that we were doing—pharmaceuticals, quality assurance, health worker training, etc.—work that we had been doing over time that we could pull together and create a critical mass.

Congress really realized the importance of health systems strengthening during the Ebola epidemic because they could see that countries that have stronger systems like Uganda, Nigeria, were able to address Ebola before it became a huge outbreak. Whereas Liberia, Guinea, and Sierra Leone had weak systems. They were overwhelmed and weren't able to respond because of this lack of basic infrastructure and capacity. When I went up to the Hill during or after the Ebola epidemic, people would just immediately say, “yes we get health systems now, because we understand in the Ebola context what systems can do for you.” So it's a big learning event for those on the Hill. Before that when you met with someone they would say “don't talk to me about health systems. I can't sell that with my representative. They can't sell it to the people in their districts”.

What I would often say is, what health systems does is that it enables you to get those results. Not just this year but for the next ten years. So you can basically see this effect on child mortality that will continue to have that impact over time. They would understand that, but still Ebola really convinced the Hill that health systems were important.

Q: What other activities were you involved with as the DAA for the Bureau for Global Health.

CLAY: Well, I was the senior Foreign Service officer in the bureau.

I oversaw Foreign Service officers coming and going and was part of the FS selection decisions. But I am very proud that I worked with H.R. to develop a new track for Foreign Service officers.

Q: Oh really?

CLAY: Yes. Basically, the people who had advanced in their careers up to FS1 and wanted to get into the senior management group (SMG), they had to have, as the name implies, a management focus. You would become a manager, on track to become a future mission director, largely because of your management expertise. That was the rationale with the management side.

But we felt that if a person has technical expertise, they should also have a way to advance to a senior level from a technical track. So we developed a senior technical group (STG) which is a separate track from the senior management group (SMG). Their job was much more focused on technical leadership, publishing results, engaging in technical consultations at a very high level, global leadership, and those kinds of things. I think for the field it really gave a real boost to people because they always felt like at a certain point they had to just become a manager. They realized that in fact if they wanted

to continue to advance they could continue to hone their technical expertise and then advance it to the senior technical group.

Like SMG, we talked about how there could be training opportunities for the STG. There could be secondments—someone could take a six-month sabbatical or secondment to CDC or NIH to really hone in on some technical expertise before they move forward. What we had to do initially is take people already in the system that had good capacity and moved them into the technical track. The longer-term plan was that as people came up the ladder, if they were an FS2 then they could make a decision whether they wanted to go senior management group or go senior technical group. Depending on their choice then they could get appropriate secondments or appropriate training to be able to advance their career along that line

Q: Robert I know your time is very limited right now. Shall we stop here and reconvene?

This is John Pielemeier on May 14. Starting a fourth interview session with Robert Clay. And we're talking about Robert's work as the deputy assistant administrator in the Office of Global Health. We've just finished talking about the creation the Office of Health Systems and Robert why don't you take it from there to tell us about the other activities during this tenure.

CLAY: One thing that would probably lead from the health systems office discussion would be the role that I played with GAVI which is the Global Alliance for Vaccines and Immunization, [former name, now called Gavi, the Vaccine Alliance] Initiative; which is a multi-lateral organization that was set up in the early 2000s to improve immunizations worldwide. It is a public-private partnership and it has had remarkable success. I was on the Executive Board of GAVI and represented the U.S. government.

The reason I bring it up is because, over the course of our deliberations, it was very clear that GAVI had intent to work on health systems, but it hadn't really understood if their programs were having much of an impact. They had sent out some funds to countries so that they could focus on health systems within the immunization program but most of what they got back was supporting material procurement—vehicles, things that are possible with a flexible budget line but it was not really addressing any of the core health systems issues. Dr. Seth Berkley, who was the Executive Director of Gavi, asked that a group of us form a Health Systems task group. I was part of that. It was very exciting work to be sitting around with my colleagues from different organizations including the World Bank, Johns Hopkins, UNICEF, USAID, John Snow, and country representatives as part of this discussion about how we should get countries to thinking about sustainability within their programs and not just seeing it as a flexible budget line item.

We did a lot of assessment, we talked about some of the guidelines that we could put into the grants going forward, trying to really focus on this whole issue of sustainability. I think the work that GAVI did helped influence some of the work of the Global Fund as well. So, I feel really good about that. USAID has had a lot of experience and influence

in this area. Of course the Health Systems Office was producing lots of good evidence that I was able to share in the GAVI HSS Task Group.

Another thing to mention. In the 1990s, maternal health hadn't had the same kind of champion as there had been for AIDS, TB, and malaria and certainly for child survival earlier. We were always looking for someone who could be that political champion for this very important cause. In the year 2000, a lot of studies were showing the critical need as well as some of the key interventions that we could be using in safe motherhood. So when Secretary Clinton was appointed Secretary of State it seemed like we had a real alignment with her personal interest as well as the need of this community with having someone who could be a real champion.

During her tenure as Secretary, there was a group that formulated a program called Saving Mothers, Giving Life (SMGL). This was originally conceived in the State Department with some assistance from USAID and CDC. Lois Quam was the Global Health Initiative Coordinator and she took a real lead in terms of the political dimensions of the program. It had very ambitious goals. Within a year, the idea was to reduce maternal mortality by 50 percent in selected countries.

SMGL was a public-private partnership so there was engagement by a host of people including the governments of Norway and the U.S. (USAID and CDC), Merck for Mothers, Every Mother Counts, Project C.U.R.E, and the American College of Obstetricians and Gynecologists.

It was a very fast moving train. There were quite a number of field visits and eventually Zambia and Uganda were selected as the two countries to work in. In many ways, it was designed along the principles of PEPFAR and PMI (President's Malaria Initiative), to have high visibility and impact, but unfortunately we did not have the resources that those two initiatives had. There were commitments of up to \$200 million but these didn't materialize and there was always a struggle to get adequate resources to keep the program going. The first year had a lot of activity, a lot of work. Then as Secretary Clinton's tenure was ending and some of the political staff were going to be departing, there was a real need to figure out how to make this as a sustainable effort. For about six weeks I negotiated with the State Department, and particularly with Lois, to make the case that USAID should be the home for SMGL and that we had the best perspective to be able to lead this in the future. As you know, that wasn't the decision that was made for PEPFAR—it was based in the State Department.

There was jockeying back and forth between the different agencies of who would continue to do this. Fortunately, this negotiation was successful and the project moved over to USAID. I chaired the Leadership Council of SMGL for the first year. During this time, we made some important changes. We extended the time from just a year to five years to make it much more of a development program. We also involved the partners in a much more fundamental way. Many of them felt like they were simply riding the fast train driven by the State Department but they wanted to have their views more considered.

Columbia University carried out an external evaluation and characterized SMGL as having a big push with a long tail. Meaning that the first year was a big push that was really exhausting and many of our staff in the field was burned out from all the central activity. The long tail was the activities that we included to make it more sustainable.

We wanted to make SMGL a lot less centrally driven and more engaged with the countries and field staff. We included the countries into the Leadership Council and reduced the number of headquarters high-level visits so that the staff could actually get something done. The program has continued. In fact, right now I am involved in helping write up some of the lessons. We have twelve papers that will be published in 2019 and I am engaged in the editorial comment section with former colleagues.

I think this program has helped demonstrate some important principles of maternal health care and hopefully will be a model for others to be able to use in the future.

Finally, I would just add, while I was the DAA, we had a gap in terms of the Special Adviser for Orphans and Vulnerable Children that managed the USG interagency activities regarding OVC. There were seven different U.S. Government agencies involved. For nine months, I oversaw the program and then helped recruit the permanent special advisor for the program from Columbia University. It was again another intensive experience and a whole of government approach.

Q: Let me just interrupt briefly. On the maternal health, I recall Mary Ellen Stanton was one of the initial leaders within AID pushing for a focus on that area.

CLAY: Yes, Mary Ellen was very involved in the early stages of the SMGL and she continues to be involved.

Q: I didn't know she was still working.

CLAY: Oh yes, she is still working away.

Q: All right. Anything else about the work in your DAA position that you would like to talk about?

CLAY: Well, the most important thing you do in a job is to make sure you find a good person to take over when you leave. I was very fortunate that Jennifer Adams was in the PPL (Policy Program Learning) Bureau, and I successfully recruited her to take over my position. She subsequently was the Global Health Acting Assistant Administrator for quite some time and now she is the Mission Director to Mozambique. I was very proud to have been able to help in that transition and get some great talent in the GH Bureau.

Q: That's great. I know Jennifer well, she came in to work with me in Brazil on an excursion tour when she was in Washington. I guess we convinced her to move into the Foreign Service. She's had a fabulous career.

CLAY: She has and is still having one.

Q: All right. Now you talked about being replaced. Where were you going?

CLAY: I had to make a decision; I had been in Washington for six years. So, as a Foreign Service Officer I needed to get back out into the field. At the time, my father was 93 and needed care. He was in Virginia so I wanted to stay around the Washington area. I had been with USAID for 31 years so I thought it might be a chance to retool myself and do something else. My former colleague, David Oot, was talking to me about his plans for retirement at Save the Children.

So it worked out for me that as he retired I was able to come and take over his position and then added the HIV/AIDS-TB work that was being done here at Save the Children to the Department. I became the Vice President for Global Health at Save the Children and have been here for the last three and a half years.

Q: How old were you when you retired Robert?

CLAY: I was sixty.

Q: Sixty. All right. How many years in working with USAID?

CLAY: Thirty one. So I joined when I was 29.

Q: That is quite a long tenure. We will move ahead to talk about your work at Save, but as you look back on that career both in Washington and in the field are there some real highlights that you're quite proud of and then are there some things that you wish that perhaps might have gone differently?

CLAY: Well, a lot of the things I have been talking in this oral history would be my highlights. I would say in general, when I look back, I am most proud of the mentoring that I did with the host country nationals because they're the people who stay when you leave and they continue the important programs.

I was very pleased to see the progress that many of them had made. Even if they had moved on from USAID, the leadership positions that they have had in their own countries are so important. Some have actually gone to work international but many of them are still in the countries. I would say, as a Foreign Service Officer that is really your legacy- the staff, mentoring, and empowerment that you do with them.

In terms of things that didn't work out, I guess looking back at USAID it seems like so much of my time, and this is probably everyone's feeling, was spent in fighting forest fires, and there are so many political imperatives. You feel like you are being very short term focused and the longer-term development issues often were sidelined because of the

immediate crisis. Particularly, as one moves up the ladder, you tend to have most your days full of problem areas so you are just trying to put out fires and solve pressing issues.

Looking back, it would have been nice to have a year maybe at the War College or some other place where you could use some of your experience and think a little more long term. That was somewhat the idea behind the Senior Technical Group. We had built in more secondments and sabbaticals in that track and your progress would be rated on more long-term development goals as opposed to just management issues. I guess I would have liked to have spent more time in that track than on the management side.

Q: One thing that you're well known for is, I believe, you lead the effort to put together a history of USAID's work in international health document. Would you talk a bit about that?

CLAY: There was a period in USAID where there was a lot of doubt and confusion and an under appreciation of USAID historically. This was the case especially when I led the HIV/AIDS office where PEPFAR and CDC were constantly telling USAID that we didn't know what we were doing and that they were always better than we were. Staff that were newly joined had a very different opinion of USAID than others did that were there before.

Also, there was a very different reaction that I would get in the field when you tell people you are from USAID. People are very respectful and they admire the long history of USAID in many of these countries that have been there for 20, 30 years. But when I came back to Washington, it seemed like USAID could only make mistakes. We had the old way of doing things, we just were not flexible enough or new enough and everybody wanted to try some other way of getting things done. I didn't agree with this but it was a perception.

It just seemed like we needed to ground ourselves in our history and just make our staff aware of the legacy of what we were inheriting from others and the incredible work people did before us.

I started exploring a little bit about the history of USAID. Ariel encouraged me to do this and I really appreciated that because I was able to devote time to this effort. I remember the first meeting we had within the Global Health Bureau. We invited some of the old timers to come and I wasn't quite sure how supportive they would be. We had hired a consultant to help us pull together some of these ideas.

That meeting was very interesting. We could not stop people from talking because they were so eager to share their experiences. Kind of like this oral history project (laughter). Because you do not have many occasions that people actually are interested in what you do. It was very clear to me in that meeting that we were on to something and so we formed a steering committee and started a whole process of interviewing folks and getting documents together.

It was a work of love, trying to get this to a point where we could share and be proud of the document. We wanted to not be a static document so we put it on the website and then people could update it periodically and keep it current.

I was really pleased with the product. We also had numerous presentations that we gave both to the USAID staff as well as to the external audience. I was also asked to make some presentations at several universities. I think USAID has an incredible history that many people do not understand, particularly younger staff. So one goal was that every new employee, particularly Foreign Service employees would have this to study and to learn from so that they can, with a sense of pride, talk about who they work for and what they do.

Q: What was the title of the final product?

CLAY: It is 50 Years of Global Health, Saving Lives and Building Futures I have a copy on my desk.

Q: Roughly that would be about six or seven years ago?

CLAY: Yes it was done in 2014.

Q: And if people want to get it they can google that name.

CLAY: Yes, it is online.

Of all the technical areas that we talked to, the nutrition community was most interested to tell their story. Their feedback on the final product was that they didn't have enough space so they decided to do their own history of nutrition at USAID. This is being done along similar lines, but they are focusing on a much deeper dive into the nutrition area to add to the broader history.

Q: Very good. That is wonderful.

CLAY: You asked about things that I were proud of. I have to mention the Polio eradication work in India.

It is remarkable that India was able to eradicate Polio. So much work went into that effort. I was one of the doubters that India would be able to do that. But it became a sense of pride for Indians and the government put a huge amount of their own resources into the eradication effort. It was really a remarkable achievement.

The Indian Government has used the success as a form of inspiration for doing other things. So that would be up there on the list of things that I am proud of.

Q: Robert, when you retired did they give you a gold watch, or a pin, or a going away party? Or did they just say give us the key to your door. How did that work?

CLAY: Well, there were parties. Raj Shah, the USAID Administrator, came and they gave me all kinds of certificates. You know all that stuff.

Q: Not everybody knows what all that stuff is.

CLAY: Well, I received the Administrator's Distinguished Career Service Award. I also received the Lifetime Achievement Award from PEPFAR. I was totally surprised that I was given the award at the PEPFAR meeting in front of 3,000 people.

I was sitting in the audience and they were giving the background of the awardee. I was thinking, boy that person did a lot of what I did. I wonder who that was. (Laughter) Then finally, towards the end I realized, they are actually talking about me!

Q: That must have been amazing.

Well it was a great career. And let's continue on a bit; one more thing before we go, let's go ahead and talk about your move to Save and what you've been doing there over the last few years.

CLAY: Okay. I've been here for three and a half years.

It was a pretty smooth transition because David Oot stayed on for another month and he helped me understand this new organization that I was joining. It was also helpful that Joy Riggs Perla was here too. I could talk to them as we did at USAID to try to understand how things are different. I had essentially a "support group" here so that was great.

What attracted me to Save was the passion of the people. Also there is a really strong mission here at Save the Children that drives a lot of ambition, and the dedication of the staff which is really nice to see. The technical issues were very similar to the kind of discussions that we had at USAID. Except that, Save is more focused on country-level activities. At least, in my last positions at USAID, global issues were more the focus. But here a lot more is focused at the country level—so a bit of a difference.

We have some excellent staff here at Save the Children so it was nice to see that we can attract people of that technical caliber. Save had gone through a lot of reorganization. They created one common platform for all the different Save the Children members around the world. There are 28 different members and Save/US is the largest of those members. That took a little bit of time to get used to the diversity. It is a little bit like the UN in that regard. When we are talking about reproductive health, you're having to deal with people from Scandinavia as well as from Italy. So it's a whole spectrum of discussion. It is different from just having folks from one country run an organization.

One of our big focuses here is on the newborns where we have had 17 years of funding from the Gates Foundation. It is a real luxury to have that kind of long-term support

because it has given us a capacity to develop real breadth in this area, do randomized controlled trials, and lots of fieldwork. The USAID five year cycle period has some rationale, but there is a downside too. You get longer-term vision when you have longer-term support from the donor.

We also do quite a bit of nutrition. It is a big program—our largest bilateral programs. Of course, child health is a big area for us with ICCM (Integrated Child Case Management). We do work with pneumonia, diarrhea, and malaria.

Q: How many countries does Save work in? Do you have an estimate?

CLAY: Overall, Save the Children works in 120 countries.

We have a budget of about \$2.2 billion. So it's a large group, much larger than I had understood before I came here.

Q: Who do you report to now?

CLAY: I report to the head of the International Programs Division.

We have four main sector areas. Global Health, Hunger and Livelihood, Education/Child Protection and Humanitarian Assistance. Global Health is the largest. Dianna Myers is the Vice President for International Development. So she oversees all of those four areas.

Q: You are working in a much smaller bureaucracy. What differences do you see and do you find it easier to do your work?

CLAY: Somedays I am not sure it is smaller because of the nature of all the different members and offices. We are trying to streamline it but every place has its bureaucracy.

The biggest difference I find between USAID and the positions I had in Washington and now here at Save is that "my skin has gotten thinner". I had to have really thick skin at USAID because so many political issues would come at you and there were so many high level people and issues flying at you all the time.

Here at Save, I don't have that same kind of world. We have issues but they aren't the types that find their way up to the Hill or in the Washington Post or anything like that.

Q: I won't ask you how long you plan to continue working but it's obviously been an extraordinary career. When you run into young people, and I'm sure you do all the time, coming out of a master's in public health programs, or in other health or international health related programs and they ask about careers in international health and perhaps working with USAID are you one of the people who might be positive on that or do you think things are more difficult now and you do you steer them in another direction?

CLAY: Well. I encourage them to pursue a career in Global Health.

Whether it is with USAID or with other groups that would depend on their interest and what they want to do. Some of the younger staff are interested in just getting short-term experience like with a donor to get to know them better. I encourage them to work for USAID because that is an important skill to have and consider a Foreign Service opportunity because I feel like you probably get much more out of a career in the Foreign Service than you would out of just a short term stint in an organization.

I am actually teaching a class on sexual and reproductive health at George Washington University. I have thirteen students that I teach every week and many of them are quite interested in overseas work. I've been talking to them about careers as well. The one thing I advise all of my students (and others) is while you are young, try to get as much experience as you can, particularly get your overseas experience. Whether it be at a community, village, through Peace Corps or through an NGO, volunteer somewhere. As you get older, you have more constraints in your life. And it's not as easy to do that. That is the rock you are going to build your professional career upon.

So for myself, it was the year that I spent in the villages in India that I constantly go back to in thinking about that woman in that hut that I was sitting in - how would she be thinking about things. That grounding is so important. I remember people who would come to India who didn't have that field-level perspective, they just seem so much more confused and at a loss about how things work. So I urge them to get direct experience while they are young and mobile.

Global Health is an exciting area. It has changed a lot since when I started. We had more countries to choose from, we had countries that were more stable that were still moving forward that needed assistance. More and more of the countries that we are working in now are fragile countries. So you have a combination of development and humanitarian need—either manmade or natural disasters. It is harder, the assignments and the opportunities are much more difficult positions now than they used to be.

Q: If someone asks you what kind of skills do I need to work through the next 20 to 25 years in international health, aside from technical public health training, what are the skills would you recommend people focus on?

CLAY: I would say two things. One, in Washington, in headquarters, or in a developed country, you need to be efficient and good at multitasking. You need to be able to handle and be able to produce quickly and rapidly and stay ahead of the game. These are all very, very important skills to have. I think if you have been through our education system, those are skills that are honed very carefully over the course of your career.

On the other side, when you are working overseas, those same skills can be a detriment to you in the sense that you can come across as being arrogant. You can miss the biggest opportunities if you rush around. The skills that you need overseas are good interpersonal skills, you need to have a lot of patience, and you need to be able to work with people because trust and confidence are very important in overseas work. If you are too into

efficiency that when you arrive at a meeting and it does not start on time, you get upset, or at the end of the meeting, you get up and leave because you have another one that you booked right away, you are probably going to miss the most important part of that interaction. That is sometimes when the real information is shared. People get to know you and you build up that trust which is so critical. That is why; I think I said this earlier, my fifth year in both India and Zambia where the best because the host country officials had trust in me and had real confidence. They did not have that when I first arrived. Those traits are extremely important for overseas work.

When I see a young USAID staff or a consultant that would come from the U.S. you often see that those traits are not as sophisticated as even some of our FSN staff that we have overseas.

Q: Wonderful, wonderful. In concluding the interview, is there anything else you'd like to add?

CLAY: I guess in conclusion, I would just say how I think this project and oral history in general is so important for those of us who have been in the field and are continuing to work and for those who will be studying this. I think learning from our past and knowing how things have changed and why things are the way they are needs to get much greater attention than they currently do. This is because you just see over and over again people making similar mistakes or not building on what has been done in the past. I applaud this project and I hope it continues to get long-term funding.

Q: Well thank you Robert. This has been excellent.

End of interview