PD-AAU-196

46948

PHILIPPINES

PRIMARY HEALTH CARE FINANCING PROJECT
(492-0371)

FIELD EPIDEMIOLOGY TRAINING PROGRAM (FETP)

COMPONENT

PROJECT PAPER SUPPLEMENT

USAID/MANILA

MINISTRY OF HEALTH

SEPTEMBER 1986

PROJECT PAPER SUPPLEMENT

FOR THE

FIELD EPIDEMIOLOGY TRAINING COMPONENT

OF THE

PRIMARY HEALTH CARE FINANCING PROJECT

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: C (A = Add, C = Change, D = Delete) — Amendment Number 2

DOCUMENT CODE 3

2. COUNTRY/ENTITY: Philippines

3. PROJECT NUMBER: 492 - 0371

4. BUREAU/OFFICE: Asia-Near East

5. PROJECT TITLE (maximum 40 characters): Primary Health Care Financing Project

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 12 DD 31 YY 91

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 86 B. Quarter 4 C. Final FY 88

8. COSTS ($000 OR EQUIVALENT $1 = ₱20)

A. FUNDING SOURCE	FIRST FY 86 B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	265	9,535	9,800	1,505	15,995	17,500
(Grant)	(150)	(1,850)	(2,000)	(1,505)	(14,961)	(16,466)
(Loan)	(115)	(7,685)	(7,800)	(0)	(1,034)	(1,034)
Other U.S. 1.						
Other U.S. 2.						
Host Country		100	100		14,500	14,500
Other Donor(s)						
TOTALS	265	9,635	9,900	1,505	30,495	32,000

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) PHX	532			14,966	1,034	1,500	-	17,500	-
(2)									
(3)									
(4)									
TOTALS				14,966	1,034	1,500		17,500	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 510 | 520 | 530 | 986

11. SECONDARY PURPOSE CODE: 532

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BRW	R/H	COOP	PART.			
B. Amount	8,000	5,000	500	5,000			

13. PROJECT PURPOSE (maximum 480 characters)

To increase access to and utilization of sustainable primary health care services managed and financed by communities and the GOP.

14. SCHEDULED EVALUATIONS
Interim MM 09 YY 85 | MM YY | Final MM 09 YY 91

15. SOURCE/ORIGIN OF GOODS AND SERVICES
[X] 000 [ ] 941 [X] Local [ ] Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

A Field Epidemiology Training component will be added to the project to strengthen the epidemiologic services of the GOP Ministry of Health, and develop its capabilities to train field epidemiologists.

17. APPROVED BY
Signature: John S. Blackton
Title: Acting Mission Director
Date Signed: MM 08 DD 30 YY 86

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM DD YY

AID 1330-4 (8-79)

Acronyms Used in the Project Paper Supplement

BCDC	-	Bureau of Communicable Disease Control
BNCDC	-	Bureau of Non-Communicable Disease Control
BRL	-	Bureau of Research and Laboratories
CDC	-	Centers for Disease Control
CDC/CE	-	Centers for Disease Control Consulting Epidemiologist
CDSS	-	Country Development Strategy Statement
EIS	-	Epidemic Intelligence Service
FETP	-	Field Epidemiology Training Program
GEIS	-	Global Epidemic Intelligence Service
GOP	-	Government of the Philippines
HEMDS	-	Health Education and Manpower Development Service
HIS	-	Health Intelligence Service
MOH	-	Ministry of Health
MOH/SE	-	Ministry of Health Senior Epidemiologist
NEDA	-	National Economic Development Authority
PHCFP	-	Primary Health Care Financing Project
PP	-	Project Paper
RITM	-	Research Institute for Tropical Medicine
UP-IPH	-	University of the Philippines Institute of Public Health
USAID	-	United States Agency for International Development
WHO	-	World Health Organization

PHC Financing Project Paper Supplement
FETP Component

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PROJECT AUTHORIZATION
AMENDMENT NO. 3

Name of Country: Philippines

Name of Project: Primary Health Care Financing

Number of Project: 492-0371

Number of Loan : 492-U-070
492-U-070A

1. Pursuant to Section 104(c) of the Foreign Assistance Act of 1961, as amended (the "FAA"), the Primary Health Care Financing Project (the "Project") for the Philippines (the "Cooperating Country") was authorized on July 27, 1983. The Project Authorization was amended on April 6, 1985 and on August 30, 1986. Pursuant to Section 104(c) of the FAA and in accordance with the authority delegated to me under Redelegation of Authority No. 133.1 dated May 24, 1985, the Project Authorization is hereby further amended as follows:

A. The level of planned grant obligations is increased from $14,965,787.18 to $16,465,787.18. The additional $1,500,000 in planned grant obligations shall be used to finance the Field Epidemiology Training Program ("FETP") Component, which shall consist of (a) developing the capabilities of the GOP Ministry of Health for field epidemiology training and the training of at least 18 field epidemiologists; (b) upgrading of at least three regional laboratories; and (c) the establishment of an epidemiologic research library within the Ministry of Health. The planned life of project for the FETP Component shall be five years and four months from the date funds are obligated for the FETP Component.

B. The Amendment to the Project Agreement providing for the FETP Component, which may be negotiated and executed by the officer(s) to whom such authority is delegated in accordance with A.I.D. regulations and delegations of authority, shall contain, in substance, the following essential terms and conditions, together with such other terms, conditions and covenants as A.I.D. may deem appropriate:

(i) Prior to the disbursement of any funds made available for the FETP Component, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the Cooperating Country shall furnish to A.I.D., except as A.I.D. may otherwise agree in writing, in form and substance satisfactory to A.I.D., a letter or letters expressing the intent of the Cooperating Country, subject to the availability of funds, by 1988 to assign all graduates of the FETP course to the position of epidemiologist in the Ministry of Health at least at the entry level of Medical Specialist I (or its equivalent from time to time thereafter) and to maintain such individuals therafter in such positions at that level or higher.

2. The Project Authorization, as previously amended, remains in full force and effect except as hereby further amended.

John S. Blackson
Acting Mission Director

Date: 30 Aug 86

Clearances:

ORAD:JBrady
OCD:KEBrown
OPHN:WHJohnson
OFFPVC:BGeorge
PRO:DD'Antonio
CO:BLEckersley
OLA:BMMiller
OD:WTOliver

Project Paper Supplement
Primary Health Care Financing Project/FETP Component

I. Summary and Recommendations

A. Costs

Total costs are as follows:

	FETP Add-On	PHC Financing	Total
AID			
Grant	$ 1,500,000	$14,966,000	$16,466,000
Loan	-	1,034,000	1,034,000
GOP			
Counterpart Support	600,000	13,900,000	14,500,000
Total Project Costs	$ 2,100,000	$29,900,000	$32,000,000

B. Purpose

The Government of the Philippines has requested USAID assistance to establish a Field Epidemiology Training Program (FETP) patterned after the Epidemic Intelligence Service (EIS) program of the United States Centers for Disease Control (CDC). The purpose of this project is to strengthen the epidemiologic services of the Ministry of Health, thereby improving its capacities to investigate disease outbreaks, report and analyze disease surveillance data, develop methodologies for disease prevention and contol, and utilize epidemiologic information for planning, managing and evaluating health services programs. The achievement of this purpose is expected to contribute significantly to the fulfillment of the Agency's child survival mandate and the attainment of a CDSS goal to reduce infant and early childhood mortality.

C. Description

To achieve the purpose of strengthening the MOH epidemiologic services, the following activities will be undertaken:

1. The Health Information Service (HIS) of the Ministry of Health will be developed as a center for field epidemiology training, which will enable the country to perpetuate the program even after AID assistance has terminated.

2. An initial cadre of at least 18 trained field epidemiologists will be developed during the life of the project and will be provided with the status, prestige and financial incentives conducive to rendering effective epidemiologic services.

3. At least three strategically located regional laboratories will be upgraded in order to provide the needed laboratory support to trainees who will be undertaking actual outbreak investigations during the course of the training program. The project will provide the equipment and supplies to enable these laboratories to perform complete bacteriological examinations.

4. An epidemiologic research library will be established within the Health Information Service to provide field epidemiologists with ready access to medical and epidemiological literature when investigating epidemics and writing reports. The library will hold texts on important infectious and non-infectious diseases, significant disease surveillance reports, epidemiology journals and other materials useful to field epidemiologists. The services of the library will be made available not only to trainees but also to other epidemiologic investigators in the field.

D. Summary of the Project Analyses

The analyses in the project paper supplement conclude that the project is technically, socially, economically and financially feasible. The implementation plan is sufficiently developed to begin project implementation.

E. Waivers

A source/origin waiver for two vehicles to be used in the program will be requested.

F. Statutory Requirements

All statutory requirements have been met.

G. Recommendation

That the project paper supplement be approved and that an additional $1.5 million AID assistance be authorized under grant funding so that implementation can begin in FY 1986.

II. Problem Analysis

Within the Ministry of Health (MOH) the application of epidemiologic principles is essential not only for the study, analysis and control of

acute and chronic infectious diseases, including non-infectious environmental and occupational diseases, but also for the formulation of effective health management policy. Epidemiology in the narrow sense is the study of disease in a population as opposed to clinical medicine which is the study of disease in the individual patient. In a broader sense, however, the practice of epidemiology implies a logical approach to problem solution which begins with ascertainment of factual data (disease surveillance); analysis of these data without bias (statistical evaluation); development of appropriate intervention techniques based on data analysis (corrective intervention); and analysis of implementation efforts (program assessment). In this broad sense, the application of epidemiologic principles has value at all levels of health improvement programs.

The introduction of epidemiologic practices into health programs usually begins with the use of epidemiology in infectious disease control where the impact of epidemiologic principles may be most readily quantified in terms of reduced morbidity and mortality. As applied to control and prevention of disease, an effective epidemiology program requires: (1) the establishment of comprehensive and accurate national disease surveillance of those diseases which have the greatest impact on the public health and for which practical intervention techniques exist; (2) the investigation of disease outbreaks to determine their etiology, the population at risk, and the potential magnitude of the problem; (3) the development of appropriate intervention techniques based on analysis of acquired data, and (4) assessment of the effectiveness of the applied intervention.

The Philippines, like many other developing countries, has a serious shortage of professional epidemiologists in the government health services. Epidemiologic support services are practically non-existent. As a result, the country has not been able to maintain an accurate set of epidemiological data on which to base a rational resource allocation plan. Intervention programs tend to be not cost effective, because they are not targetted and focused on population groups and geographic areas that are contributing to high mortality and morbidity rates. The behavioral patterns of many common diseases have not been completely understood because of the marginal disease surveillance and epidemiologic investigations that have been undertaken, thus giving rise to the formulation of poorly planned and ineffective control programs.

The development of comprehensive epidemiologic services and appropriately trained specialist-epidemiologists is critical to the successful implementation of a country's health policy. An established and well functioning epidemiologic support system provides information to program planners on the behavioral patterns of important diseases that cause high mortality and morbidity, as they affect population cohorts and geographic areas. This information provides a rational basis for the planning, designing and evaluating of effective disease

control and prevention programs. Developing and maintaining reliable disease surveillance and effective disease control programs require properly trained manpower on one hand and a reliable information system on the other. The World Health Organization has been providing assistance to the MOH to help simplify and improve the health information system. The Japanese Government is planning to assist with the hardware requirements for automating much of the health information system. The critical missing element is the availability of epidemiologically trained manpower both to develop and maintain the quality and usefulness of disease surveillance data and to respond to the information generated with corrective interventions.

Because of the shortage of trained epidemiologists, for instance, response to epidemics has been slow and inadequate. It is claimed that since 1974 there has not been a single complete investigation of an acute disease outbreak. Ineffective control of outbreaks has led to the proliferation of areas of endemicity.

The major reason for the shortage of trained field epidemiologists is the absence of a program for their recruitment, training and employment. Although epidemiology is included as a core subject in the Master of Public Health program and most of the public health physicians and nurses holding supervisory positions in the public health system have gone through this program, the teaching has been mostly didactic and field work has been very limited. This has also been the limitation of the numerous short courses in epidemiology that have been conducted locally. Graduate programs in epidemiology, either masters or doctorate, have the same shortcoming. The teaching is theoretical, and even when a dissertation is required, the field work is often confined to a single area of study. Graduates, therefore, are not being prepared adequately to handle the surveillance activities, disease investigations, and program planning and evaluation that must be carried out by the epidemiologist in the field.

The second major reason for the shortage of field-trained epidemiologists is the limited career potential, lower social prestige, and lower financial potential for epidemiologists compared with that available to clinical colleagues. The epidemiology position in the current MOH personnel classification and compensation system is a low technical position and is often occupied by persons with inadequate formal training in epidemiology. Because of the lack of epidemiological skills, the responsibility of this position, especially at the regional and provincial levels, has been reduced to compiling and consolidating disease data reported by rural health units and hospitals. These data become archival statistics but are of no value in effecting improved disease control and prevention.

Other Experiences With Field Epidemiology Training Programs

In 1951, the U.S. Centers for Disease Control developed a preceptorship

type of training program in epidemiology, called the Epidemic Intelligence Service (EIS). This program was conceived after recognizing that conventional academic and classroom oriented epidemiologic training programs were not producing the type of field epidemiologists needed to deal effectively with the diseases causing the majority of the mortality and morbidity in the United States. The main feature of the program was closely supervising the trainees as they worked on real problems in the community. The training approach resembled in concept the residency training programs common to all medical specialties. Since its inception, close to 1500 trainees have participated in the program. Of the 1500 epidemiologists trained, 85% were physicians, 6% were veterinarians, and the remaining 9% were a mixture of statisticians, microbiologists, dentists, nurses, etc. They were all assigned to training positions at the national or state level where they rendered useful services at the same time that they were trained. The retention rate of these trainees in epidemiology programs at the national or state level was initially about 85% with most of the 15% going either to academia or clinical medicine. In recent years, as the epidemiologic needs of the health programs have been fulfilled, the retention rate has fallen to less than 50%. It is claimed that the investigations that these supervised trainees have done on infectious and non-infectious, acute and chronic disease problems represent some of the best epidemiological work performed in the United States. The EIS officers, it is further noted, have become the critical cadre in the country's disease surveillance and investigative networks where they analyze and report data, investigate outbreaks of disease, develop methodology for disease control and prevention programs, and utilize these data for planning, managing and evaluating health services and programs.

Realizing the potential value of the EIS concept to health programs in both industrialized and developing countries, the World Health Organization and CDC initiated the Global EIS program in 1980. The purpose of the Global EIS or Field Epidemiology Training Program (FETP) is to assist interested countries in establishing a training program which will supply each country with the quantity and quality of field trained epidemiologists to meet the needs of its Ministry of Health.

Programs now exist in Thailand (6 years), Indonesia (3 years), Mexico (2-1/2 years), Taiwan (2 years), and Saudi Arabia (1-1/2 years). It is hoped that after five to eight years each participating country will have developed a cadre of trained epidemiologists and will have established a self-sufficient epidemiology training program. At that time there will no longer be a requirement for an outside epidemiological consultant. The Thailand program has reached that stage of maturation. and the U.S. consultant is being replaced in July 1986 by a selected Thai epidemiologist.

Those countries which have initiated the Field Epidemiology Training Programs have vastly improved their epidemiologic support services. This has resulted in much improved disease surveillance, outbreak investigation, and intervention implementation. In those countries which have initiated FETP programs, the retention rate among graduates working in epidemiology is about 85%. However, it is too early to measure this program's impact on mortality or years of productivity gained.

Applicability of the EIS Concept to the Philippines

While wishing to develop a cadre of trained field epidemiologists in order to strengthen its epidemiologic services, the MOH believes that the training program that it ought to adopt is one that (a) provides sufficient field exposure to the trainees; (b) permits trainees to function as epidemiologists at the same time that they are going through the course; (c) addresses the diseases of utmost importance to the country; and (d) enables the country to develop its capabilities to train and build up its cadre of field epidemiologists.

Among the different epidemiology training options available, only the EIS type of course fulfills the above criteria. For example, the MOH can opt to send Filipino trainees to CDC in Atlanta or to a neighboring country for field epidemiology training instead of trying to establish the program in Manila. The cost of maintaining trainees in the U.S. and the disadvantages of working on US disease problems, which are different from those found in most developing countries, argue against the CDC alternative. The neighboring country programs, while more relevant and less costly, are problematic because only a few Philippine trainees can be accepted at a time and there are language difficulties even in the countries where part of the curriculum is in English. In addition, the Philippines and the MOH would not benefit from having the trainees actually doing disease surveillance and epidemic investigations during the course of their two year training.

Another option would be to adopt a more traditional academic approach to producing more epidemiologists through the University of the Philippines Institute of Public Health (IPH). There is currently a masters degree program in epidemiology and plans for establishing the PhD program. The significant disadvantage of this approach is that the epidemiologists would come out of the system well-trained in epidemiological theory but lack the intensive, protracted and highly practical field experience which is built into the field training program. The mandatory academic course requirements for degree programs would interfere with getting adequate field exposure. This alternative also denies the MOH the benefits of having the students out actually responding to epidemics and collecting useful information on real disease problems.

Based on the above considerations, the GOP has requested AID assistance for the initiation of a Field Epidemiology Training Program (FETP) patterned after CDC's EIS model

III. Project Description

A. Project Goal

The goal of the PHC Financing Project is to reduce high fertility and infant and young child mortality. The FETP component is an essential supportive activity to accelerate the attainment of this goal, by making available accurate epidemiological data on which to base cost-effective and well targetted control programs appropriately directed at geographic areas, population groups and diseases that contribute significantly to high mortality and morbidity. The sector strategy, which is part of the Mission's CDSS, identifies the lack of reliable epidemiological data and the incapability of the MOH to target programs accordingly, as a major impediment to improving tne cost-effectiveness of their efforts to reduce mortality. Any success in increasing the rates of child survival, given limited resources, will depend on improving the MOH's ability to understand the epidemiology of diseases affecting children and their ability to seek out population groups at high risk of illness and death. This activity is supportive of AID's emphasis on child survival by contributing to building a solid foundation for programs like ORT and immunizations.

B. Purpose

The purpose of this project component is to improve and strengthen the epidemiologic services of the Ministry of Health. This means improving the capacities of the MOH to investigate disease outbreaks, report and analyze disease surveillance data, develop methodologies for disease control and prevention interventions and utilize epidemiologic information for planning, managing and evaluating health services programs.

The proposed strategy to be followed in order to achieve the project purpose consists of: (a) developing a cadre of trained field epidemiologists and providing them with the status, prestige and financial incentives conducive to rendering effective epidemiologic services; (b) developing a self-sustaining capacity within the MOH to continue training an adequate number of field epidemiologists with the necessary job incentives to remain with the program.

C. Project Outputs

The project purpose will be achieved by generating the following outputs:

1. Development of GOP Capabilities for Field Epidemiology Training and Development of an Initial Cadre of Field Epidemiologists.

A primary proposed output is the development of the Health Information Service (HIS) as a center for field epidemiology training, which will enable the country to perpetuate the program even after AID assistance has terminated. The FETP will be managed by HIS with guidance from a resident CDC consultant epidemiologist (CDC/CE). A core FETP training staff will be organized by HIS and will actively participate in course design and training epidemiologists in order to acquire the necessary skills to organize and conduct an applied epidemiology training program. A MOH senior epidemiologist (MOH/SE)will be identified at the early stage of the program, and will co-manage the implementation of the program with the CDC/CE. This person will replace the CDC/CE when the program matures after four years.

Six new trainees will be accepted into the program each year and receive intensive supervision under the preceptor-type of training program. At the end of the five year project life, 30 trainees will have entered the two-year program and up to 18 trained field epidemiologists will have graduated into assignments. This rate of training will continue beyond the project life and until all regional and central level positions for epidemiologists are filled. The 18 FETP graduates will serve as the initial cadre of MOH epidemiologists who will regularly undertake epidemic investigations, and report and analyze disease surveillance information. The initial batch of trainees will be recruited from among young physicians or others who are interested in pursuing a government career in preventive medicine and public health.

From among the approximately 18 trained epidemiologists, five will be selected and developed to eventually become part of the FETP faculty.

The FETP proposes a two-year course patterned after CDC's EIS program. It will begin with an introductory four-week didactic portion on basics of epidemiology, bio-statistics, and the epidemiology of selected infectious and non-infectious diseases. The purpose of the preparatory course is to provide the trainees with the theoretical knowledge and practical statistical skills essential to begin the 23-month supervised field training.

After completion of the 1-month didactic course, all trainees will begin three rotations: General Epidemiology - four months; Clinical Epidemiology - three months, and Applied

Epidemiology - four months. In the General Epidemiology rotation, trainees will work on specific disease projects within the HIS assigned them by the Consultant Epidemiologist. In the Clinical Epidemiology rotation, they will be assigned projects that require them to obtain clinical data from appropriate local hospitals. In the Applied Epidemiology rotation, they will be assigned projects in other divisions of the MOH outside of the HIS, but still located within the San Lazaro Compound.

Throughout the first year's (11 months) rotations, trainees will participate in weekly seminars in the HIS/FETP offices, and will participate in outbreak investigations as determined by the consulting epidemiologist. Participation in outbreak investigations will normally take precedence over other activities.

In the first month of the second year, trainees will assist the consultant epidemiologist in teaching first year trainees. For the remaining 11 months of the second year, each trainee will develop a single long-term project, with the assistance of the consulting epidemiologist. These projects will focus on priority topics of importance to the MOH. In implementing the projects, each trainee will work with the staff of the appropriate division within the MOH. Even in the second year, however, trainees are expected to participate in weekly seminars and outbreak investigations.

At some period in the 2 year training program, each trainee will develop a national surveillance program for at least one disease and will have participated in at least four outbreak investigations, for two of which the trainee shall have been the primary individual responsible.

During the progression of the 2 year training period, the trainees will have maintained close ties and remain under supervision of the consulting epidemiologist but will have become progressively more self-sufficient so that at 24 months they can function as independent field trained epidemiologists.

At the rate of 2 epidemiologic outbreak investigations, one national disease surveillance program, 2 special epidemiologic projects, and 1 long term epidemiologic training program per 2 year trainee, a total of 144 such reports will be completed during the 5 year life of the project. In addition to serving the direct needs of the MOH, these will be published as appropriate in selected scientific journals.

An annual International Field Epidemiology Training Conference has been established (the first such conference will be held in

Taiwan on Sept. 15-19, 1986). Funds will be provided to send second year trainees and consulting epidemiologists to this conference and visit successful FET programs in order to share knowledge and experience with other countries thereby benefitting all participating countries.

The proposed project component will fund the technical assistance to be provided by CDC, which will supervise the implementation of FETP for at least four years. CDC will assign a resident consultant epidemiologist with extensive experience in FET programs who will be primarily responsible for teaching the course. In addition to fielding a consultant epidemiologist, CDC will provide institutional assistance in managing and teaching in the FETP and the provision of other forms of program support as may be necessary. Funding support will also be provided for trainees' living allowances, training supplies and materials, local trainer's fees, travel and transportation, salaries and operational costs of the program administrative staff, and participant travel.

2. Upgrading of laboratories

Laboratory support is essential to the investigation of disease outbreaks. In order to provide such support to the trainees who will be undertaking actual epidemic investigations during the course of their training, three regional laboratories will be upgraded. The proposed component will provide one laboratory each in Luzon, Visayas and Mindanao with the necessary equipment and supplies to perform complete bacteriological examinations. Virology exams will be done centrally in Manila, at either the RITM, Institute of Public Health or the Bureau of Research and Laboratories. The regional health laboratories are adequately staffed, hence adding personnel is not deemed necessary.

Funds under this project component will be provided to purchase bacteriological lab equipment, culture media, reagents and other consumables needed during the investigation of epidemics.

3. Establishment of an Epidemiologic Research Library

Field epidemiologists need access to medical and epidemiology literature when investigating epidemics and writing reports. This support service will be established at HIS, and will service the needs of the field epidemiology trainees and other epidemiologic investigators. The library will hold texts on important infectious and non-infectious diseases, significant disease surveillance reports, epidemiology journals and other materials useful to field epidemiologists.

The literature holdings of the Epidemiologic Research Library will be disseminated widely, and the library will service requests of any investigator in the field for copies of available journal articles, surveillance reports, epidemiologic information on infectious and non-infectious diseases, and the like.

Funding will be provided for the acquisition of books, subscription to journals, photocopying equipment, salary of a librarian, and library supplies and materials.

D. Inputs

1.	Technical Assistance	810,000
2.	Local Support Costs for CDC Consultant	140,000
3.	Training Support Costs (training allowances, local trainers' fees, transportation and travel, office improvements at HIS, training supplies and materials)	125,000
4.	Program Support Staff (salaries of administrative staff, office improvements at HIS, office equipment and supplies, conferences transportion & travel, vehicles)	235,000
5.	Purchase of laboratory equipment and supplies	70,000
6.	Purchase of books and journals and maintenance of a service library	40,000
7.	Participant Travel	40,000
8.	Evaluations	40,000
	AID TOTAL	1,500,000
	GOP TOTAL	600,000
	GRAND TOTAL	$2,100,000

IV. Relationship to Other Projects and Activities in the Sector

The relationship of the PHC Financing Project to other activities in the sector has been described in the main project paper. The FETP fits in as an additional component whose focus is to strengthen the

capabilities of the MOH to gather and analyze epidemiologic information that is essential for the design and evaluation of the effectiveness of public health programs. The development of this support service is so fundamental that it relates to practically every health promotion and disease control activity in the sector. The successful pursuit of AID's child survival mandate, for example, hinges on the sound understanding of the epidemiology of diseases affecting infants and young children.

The FETP component is the only activity in the sector that will systematically recruit, train, and deploy field epidemiologists who will carry out the necessary investigations and generate the information to meet MOH health planning and programming needs. The World Health Organization is currently assisting the MOH to improve its health information system through the provision of computers and fellowships. The MOH is also planning to seek Japanese Government assistance for much of the hardware requirements for automating the entire health information system.

V. Implementation Plan

A. Administrative Arrangements and Analysis

The FETP activity will be part of the service delivery support component of the PHC Financing Project, and will be placed directly under the Office of the Deputy Minister for Public Health. Its offices will be located within the building of the Health Intelligence Service (HIS) in the Ministry of Health compound at San Lazaro.

The experiences of Thailand and Taiwan FETP have shown that the expediency with which trainees can go forth to investigate outbreaks and pursue epidemiologic studies is greatly determined by the level at which the training program is located within the health bureaucracy, and the proximity of the trainees to the office which receives reports of epidemics. With offices located at HIS, trainees can know immediately when outbreaks occur and can therefore respond rapidly. The program will be placed at the Deputy Minister level or higher so the trainees can cross over into different bureaus with minimum difficulty.

Since FETP is a new activity of the Ministry of Health, a program staff dedicated to managing the implementation of FETP will be required. To insure required capability, adequate commitment, teamwork and performance it is essential that the program management staff have the freedom to recruit and supervise the program support staff, especially during the early years of the program when a great deal of extra effort will be required. For this reason, the program staff must be funded by the Project until the FETP is institutionalized at the MOH. At the completion of the

Project, all program staff paid by the Project will be absorbed by the MOH as GOP employees dedicated to continuing the FETP. All program staff will be located at HIS under the administrative umbrella of the Deputy Minister.

The program management staff will consist of: an in-country consultant epidemiologist from the U.S. Centers for Disease Control, who together with a MOH Senior Epidemiologist will be responsible for managing the FETP program. The program management staff will recruit and employ: (1) an administrative assistant who will assist the management staff in performance of administrative duties; (2) a librarian who will manage the Epidemiologic Research Library and computer facilities, respond to requests from field epidemiologists, trainees and management for literature search and abstracts, catalogue all outbreak investigation reports, assist the management staff in developing a newsletter and a system for rapid retreival of resource material; (3) two secretaries with word processing and data entry skills, one to provide for the secretarial needs of the trainees and enter all significant reports on outbreaks into the library computer memory, and the other to provide for the secretarial needs of the management staff (i.e. the trainors), organize the availability of visiting faculty, and manage production of the newsletter; (4) a driver to provide transportation support for official duties of the management staff (e.g. project administration, liaison with USAID, NAMRU, RITM, UP/IPH, transport of visiting lecturers, hand carrying important communications) and the trainees (e.g., for field investigations on Luzon, field trips for training, instruction at various contributing resource institutions). A second driver will be provided by the MOH.

Based on the experience of FETP programs in other countries, the availability, quality and direct control of adequate program support staff is essential to the success of FETP and necessary to the cost-effective utilization of the more expensive management staff, especially the CDC consulting epidemiologist. Without adequate program support staff, the scarce time of the management staff - which should be dedicated to program organization, intensive training, supervision of student research, outbreak investigations and evaluation - is wasted on routine but necessary support activities. A relatively minor support staff input (less than 2% of project costs) is necessary to insure the cost-effective utilization of technical assistance inputs (two-thirds of project costs). The recurrent cost implications are relatively insignificant to the MOH. The cost of maintaining the support staff beyond the life of this project will represent only a .0000435 (four thousandths of one percent) increase in the MOH operating expense budget which increased by 10% 1984 to 1985 and by 42% 1985 to 1986.

The Deputy Minister for Public Health will serve as the ex-officio Director of FETP and will be responsible for the general direction of the program. The consultant epidemiologist from CDC (CDC/CE) and the senior epidemiologist from the Ministry of Health (MOH/SE) will be named co-managers of the Field Epidemiology Training Program. They will jointly be responsible for arranging and conducting the training of epidemiologists in the 2 year FET Program and for interacting with other programs of the MOH and ensuring that the FETP serves the needs of the MOH most effectively.

In addition to their teaching and program management functions, the two senior epidemiologists will arrange for outside instructors to assist in the training as necessary. They will also ensure that the FETP training addresses the needs of the MOH and that graduates of the FETP are placed in jobs most appropriate to serve the needs of the MOH.

An Advisory Committee will be organized which will make policy recommendations to the Director of the FETP. The Committee will advise on matters of recruitment, placement, and priority areas of concern regarding the upgrading of epidemiological capabilities within the Ministry of Health. The Committee will be chaired by the Deputy Minister for Public Health and its membership will be composed of the two FETP program co-managers, the directors of the Health Intelligence Service (HIS), the Bureau of Communicable Disease Control (BCDC), the Bureau of Non-Communicable Disease Control (BNCDC), the Bureau of Research and Laboratories (BRL), the Research Institute for Tropical Medicine (RITM), the Health Education and Manpower Development Service (HEMDS), the Dean of the Institute of Public Health, and one Regional Health Director.

The BRL and RITM will provide the laboratory support for outbreak investigations. The Institute of Public Health of the University of the Philippines will be tapped for lecturers and resource persons during the course of the training period.

There is adequate assurance that the proposed implementation arrangement is feasible because of the simplicity and straightforwardness of program design. The availability of an already trained Filipino epidemiologist who will work with the CDC consultant at the very outset is an advantage that the Philippine program enjoys over other similar programs. The program enjoys strong support from the Minister of Health and the Deputy Minister of Public Health. Already, moves have been made towards the upgrading of the position of epidemiologist within the Ministry so that the program can attract trainees of high caliber.

B. Detailed Implementation Schedule

The signing of the Project Agreement Amendment will signal the formal start of implementation of the FETP component. Assuming that implementation activities will start on 1 September 1986, the FETP component will have a total implementation time of 64 months (through December 1991).

Immediately after the signing of the Project Agreement Amendment, the MOH will issue a Ministry Order establishing the FETP under the Office of the Deputy Minister for Public Health. At this time, the appointment of the MOH senior epidemiologist (MOH/SE) who will co-manage the FETP with the CDC consulting epidemiologist, will be formalized. The MOH/SE will set in motion the activities leading to the hiring and organizing of program staff, the recruiting and selecting of the first batch of trainees and the improvement of offices where the program will be housed.

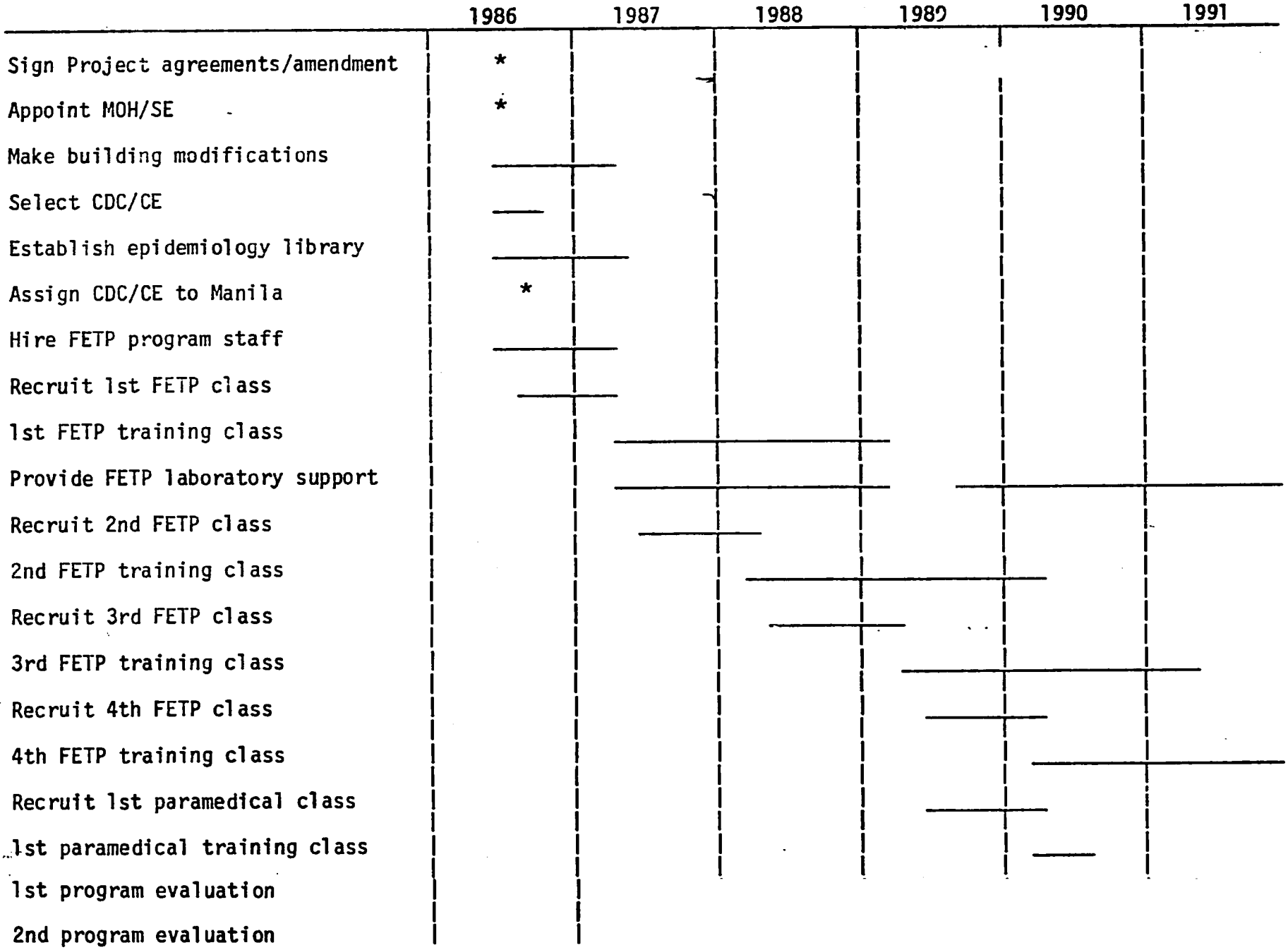
The CDC consulting epidemiologist (CDC/CE), will be selected from those who have applied to CDC for the post in the Philippines. Final selection will be a joint decision by the Global EIS staff of CDC and the MOH. Once the CDC consultant has been selected, preparations for the consultant's transfer to the Philippines will take place and he/she will be expected to arrive in the Philippines by 1 December 1986. The co-managers of the program will then spend the next three months organizing the course, selecting trainees, and preparing for the training program which is scheduled to begin on 1 March 1987.

Recruitment of prospective FETP trainees will be done through personal contacts by the CDC/CE and MOH/SE and through Ministry circulars to the different regions and provinces. Applicants will be screened by an Admissions Committee which will look into each applicant's scholastic record, service record, and his willingness to pursue a career in epidemiology within the Ministry of Health. The Admissions Committee will be chaired by the Deputy Minister for Public Health, and will have the following as members: MOH/SE, CDC/CE, directors of HIS, RITM, BCDC, and BRL.

The above activities will be accomplished within six months (1 September 1986 to 28 February 1987). The training of the first FETP class will begin on 1 March 1987 and continue for two years.

Continual guidance for the program to ensure that it effectively serves the needs of the MOH will be provided by the Advisory Committee. Recruitment of the second class of trainees will commence in July 1987 in order to have the next class ready by March 1988. The above timing and process of recruitment and selection of trainees will be followed for the succeeding courses.

FETP SCHEDULE



From the early classes of graduates, prospective faculty members for the program will be identified who can be developed to become potential FETP teachers in the future. As the program progresses, steps towards the institutionalization of the program within the Ministry of Health will be worked out. After approximately four years, when this program has become self-reliant and the HIS has developed the capability to train the epidemiologists needed by the MOH, the CDC/CE support will be withdrawn. After five years, FETP will function as a totally MOH supported and directed program.

C. Financial Plan and Analysis

The FETP component will require a total funding of $2.1 million over the five year life of the project. AID will finance $1.5 million (71%) while the GOP will contribute $600,000 (29%) of the total budget.

1. AID Project Budget

The $1.5 million AID funding support for FETP will all be in grant, and will be in addition to the $14.966 million that has already been authorized for PHCF. The $1.5 million add-on grant will be obligated incrementally starting in FY 1986.

The major activities of the FETP component and their estimated costs to AID are:

1.	Technical Assistance	$ 810,000
2.	Local Support Cost for CDC Consultant	140,000
3.	Training support cost (training allowances, local trainers' fees, office improvements, transportation and travel, training supplies and materials)	125,000
4.	Program Support Staff (salaries of administrative staff, office improvements at HIS, office equipment and supplies, conferences, transportation and travel, vehicles)	235,000
5.	Purchase of laboratory equipment and supplies	70,000
6.	Purchase of books and journals and Maintenance of a service library	40,000

7.	Participant Travel	40,000
8.	Evaluations	40,000
	TOTAL	$1,500,000

2. Government of the Philippines (GOP) Contributions

The GOP contribution to the FETP component of PHCF will amount to $600,000. The GOP counterpart, which will be both in cash and in kind, will cover the salaries of trainees and the staff of HIS, RITM and BRL participating in the program, provision of training and office spaces and utilities, and part of the staff travel and transportation costs and laboratory supplies required during the investigation of epidemics. The host country contribution will amount to 29% of the total budget needed for the FETP component, which satisfies the statutory requirement for counterpart share.

The provision of living allowances to trainees will be the major recurrent cost item when the MOH takes over the funding of FETP upon phase out of USAID assistance. The MOH intends to source this funding requirement from its Residency Training Program. Every year the Ministry appropriates funds to support around 80 hospital resident trainees who train in the various medical specialties such as pediatrics, obstetrics, surgery, anesthesiology, etc. The plan is to set aside five or six slots annually from the residency program to support field epidemiology trainees. The funding requirements to maintain the laboratories and the research library will not be substantial and can easily be accomodated in the MOH budget.

3. Financial Management of the Project

Of the $1.5 million USAID grant for this project component, around $810,000 will be used to fund the technical assistance to be provided by CDC which will supervise the implementation of FETP for four years. This will be handled through a Participating Agency Service Agreement (PASA) with CDC and will be managed through the Contracts Office in AID/W. Around $690,000 will be disbursed locally for the whole five-year life of the project.

Final decisions on the method of financing will be contingent upon ultimate decision regarding commitment mechanisms. However, at this time, the following methods of implementation and financing are proposed:

Method of Implementation	Method of Financing	Approximate Amount
TA - PASA	Direct Payment	$ 810,000
Local Cost Support for CDC Advisor - AID direct contract	Direct Payment	140,000
Office Renovation - HC contract	Direct Payment	50,000
Training Support Costs HC or AID direct contract	Direct Payment	125,000
Program Support Staff Operations - HC or AID direct contract	Direct Payment	90,000
Commodities - AID procurement through Procurement Agent contracts	Direct L/Com	40,000
Commodities - Host Country Procurement - Purchase Orders	Direct Payment	165,000
Participant Travel - Invitational travel or PIO/P	Direct Payment	40,000
Evaluation - Personal Service Contracts	Direct Payment	40,000
Total Project		$1,500,000

The direct payment method of financing is being resorted to because the host country does not have the financial resources to make payment and seek daily reimbursement; and the timely release of funds is crucial to the successful implementation of FETP. An alternative would be for the MOH to negotiate with the Office of Budget and Management to allow it to establish a trust fund to which USAID can directly release funds for the local cost requirements of the project. Such a mechanism would allow USAID to disburse funds on an advance - liquidation basis and funding could be made immediately and unequivocally available to support the different implementation activities without going through the GOP appropriation and budget disbursement system.

D. Commodity Procurement Plan

The commodities to be procured under this project include two locally made vehicles, office equipment and furniture, laboratory equipment and supplies, and library books, journals and other materials (See Annex G). Around $40,000 worth of laboratory equipment and supplies and library materials will be procured from the U.S. utilizing GSA or a procurement services agent mutually acceptable to AID and the host country.

A source and origin waiver will be sought for the two locally manufactured vehicles to be procured locally by USAID. The other commodities to be procured locally, valued at around $135,000, will be procured through the host country procurement - purchase order method, with USAID making direct payments to suppliers. All procurement actions by the host country will follow AID regulations contained in AID Handbook 11.

Part of the technical assistance to be provided by CDC is to supply the program with three IBM/XT computers. CDC will procure the computers following U.S. Government regulations and title them to the MOH. The MOH will retain the computers after USAID and CDC assistance phases out.

I. Project Specific Analyses

A. Technical Analysis

This analysis will focus on: (a) providing the technical rationale for strengthening the country's epidemiology services, and (b) establishing the technical feasibility of the approach being adopted to accomplish this project purpose.

Epidemiology, the study of disease in populations rather than in individuals, is the technical basis for the practice of preventive medicine. In the past two decades the role of preventive medicine - the control and prevention of disease in populations, has become increasingly important for economic reasons, as the cost of curative medicine - the treatment of disease in the individual - has become more expensive. It is likely that this trend will continue for many years.

Epidemiologists are needed in the MOH who can expand and update national disease surveillance programs leading to rapid recognition of disease problems, who can conduct disease outbreak investigations leading to control and prevention of disease, and who can conduct the applied epidemiologic research necessary to define and resolve other health problems.

A well trained, widely distributed, and utilized epidemiologic expertise in the MOH will lead to improved understanding of disease conditions that affect various population groups, which in turn will provide the rational basis for more cost-effective disease control and prevention measures.

In the Philippines, there is one school of public health (UP/IPH) which offers varying levels of training in epidemiology. However, all such training is didactic, and while the principles and theory of epidemiology are taught, there is no provision in the academic training program for providing the practical field experience needed to produce a fully trained epidemiologist prepared to go into the field and establish national disease surveillance, conduct outbreak investigations, and perform applied epidemiologic research.

The MOH is proposing to introduce a Field Epidemiology Training Program (FETP) to develop the necessary epidemiologic expertise to meet the needs of the MOH.

The FETP concept was developed by CDC in the U.S. and recognized by the World Health Organization as the best available means of introducing an epidemiology training program into a country which recognizes this need. The FET program is modelled after CDC's domestic epidemiology training program and basically consists of providing appropriate persons, usually physicians, with a two year applied epidemiology training experience.

The CDC approach has been proven to be technically feasible. As of January 1985, five countries had established FETP programs - Thailand, Indonesia, Taiwan, Mexico, and Saudi Arabia. The Thailand program has been in operation for 6-1/2 years and is now considered self-sufficient, so that all outside technical support will be withdrawn this year. An extensive evaluation recently conducted indicates that the program is able to operate on its own and can produce trained epidemiologists at an acceptable rate to meet the country's needs. The programs in other countries are all in various stages of progression toward this goal.

The MOH is proposing to establish a FETP which will be physically located at the Ministry of Health offices. It will enroll approximately six physician trainees each year for participation in the two year training course. Graduates of the program will be placed in positions where they can use their epidemiologic training most effectively to meet MOH needs. The necessary outside support for program start-up will be provided by USAID. It is anticipated that within 5 years the Philippine Field Epidemiology Training Program will be self-sufficient and able to meet the epidemiologic needs of the MOH without any outside technical assistance.

B. Social Soundness Analysis

No change from original Project Paper.

C. Economic Analysis

The project is expected to result in improved capacity of the Ministry of Health (MOH) to undertake disease surveillance and control, and utilize epidemiologic information for planning, managing and evaluating health services programs. In turn, this should lead to better designing and targeting of health intervention programs, resulting in improvements in health conditions and more efficient use of government resources.

The economic analysis of this project considers:

1. Relevance to the country's economic situation;
2. The appropriateness of grant financing;
3. The cost effectiveness of the selected approach; and
4. The likelihood of sufficient economic benefits.

A. Relevance to the Country's Economic Situation

Shortly after the Primary Health Care Financing Project Paper was prepared in July 1983, the Philippines plunged into a severe recession. This recession has reversed gains from the favorable performance of the economy in the seventies. Although average annual family income in current prices increased from ₱3,736 in 1971 to ₱30,748 in 1985, its real value declined by seven percent over the same period. Also over the same period, the proportion of medical care expenditures in total expenditures had increased slightly from 1.8 percent to 2.1 percent. With 70 percent of the population living in poverty, however, it is highly probable that the increased proportion of medical care expenses in total expenditures was mainly due to urgent needs, i.e., for curative purposes, and hence reflected a worsening health situation.

The GOP is increasingly constrained in providing basic services. The real budget for program implementation operating expenditures for health services outside Metro Manila decreased by 35 percent between 1983 and 1986. Even with measures to reduce expenditures and increase revenues, the government is facing a $1.2 billion budget deficit for 1986 alone. Foreign debt exceeds $25 billion with debt servicing exceeding 37 percent of export earnings. Enormous debt servicing and budget deficit problems are likely to continue to beset the government over the next several years. Hence, finding ways to improve health conditions without using substantial resources is urgent.

The FETP component directly addresses both the heightened needs of Filipino households for preventive health care and the equally pressing need of the GOP for cost effective health intervention programs. This will be accomplished through better targeting and focusing of intervention programs on specific vulnerable population groups and geographic areas. Improved understanding of common disease patterns will result in better planned and more cost effective disease control programs.

B. Appropriateness of Grant Financing

The GOP's financial position, and the FETP's innovative approach to institutional development and its expected diffused social benefits argue for grant financing of the component. The FETP constitutes an attempt to develop the institutional capability of the MOH to utilize applied epidemiology. Project goal realization will require highly innovative approaches to utilize epidemiology concepts in actual disease surveillance, control and intervention. The project is expected to result in substantial diffused social benefits for which cost recovery is not practical. Intervention programs, focused on the vulnerable population groups and geographic areas characterized by specific disease endemicity, will result in a generally reduced incidence of diseases, benefiting local communities and population groups, both in targeted and surrounding areas.

C. Cost Effectiveness of FETP Approach

The cost effectiveness of the selected approach of in-country training with technical assistance is apparent in a preceding section's discussion on the applicability of the EIS concept to the Philippines. The two potentially feasible options to the selected approach presented in the previous discussion both involve overseas training. Both alternatives would entail trainee maintenance costs abroad which would exceed maintenance costs of consultants in the Philippines under the selected approach. In addition, both alternatives would not afford MOH the benefits of actual disease surveillance and epidemic investigation during the two-year training period. The alternative of sending Filipino trainees to the U.S. is further disadvantaged by different disease problems there relative to those of most developing countries. On the other hand, while neighboring country programs are perceived to be less costly and more relevant to local needs than the U.S. alternative, the scheduling and language problems associated with this alternative render it inferior to the selected approach. On the basis of these considerations, the selected approach is clearly the most cost effective.

D. Likelihood of Sufficient Economic Benefits

The following analysis follows that of the economic analysis for the PHC service delivery support component of the PHCF Project Paper. A major and direct economic gain by Filipino households from the FETP component is the anticipated savings on medical treatment arising from lower incidence of illness and death within the targeted communities. Although the following discussion focuses on savings with regard to the reduction in average medical expenditures of families, such savings may also be interpreted to refer to the reduction in the public sector costs of providing hospital and/or curative services resulting from the preventive nature of disease intervention programs as a result of improved disease surveillance and control.

While it is not possible to calculate the FETP component's economic rate of return without fully knowing the final economic output, the social discount rate in the Philippines can be used as an alternative to determine the required economic impact to justify the investments for the FETP. The reasonableness of achieving that impact can then be examined in the light of existing and prospective scenarios. In order to do this, several simplifying assumptions are used: (1) the FETP funds are disbursed annually in real 1986 million dollar values in the following manner ($.322 million of the $2.1 million budget are accounted for by a seven percent annual cost escalation factor):

1986	1987	1988	1989	1990	1991
.130	.395	.312	.346	.287	.308

(2) economic returns over a 20-year period will flow evenly for each dollar invested; (3) no new returns are attributed to the project after its completion; and (4) average medical and health care expenditures of a Filipino family represent their outlays for the common illnesses that are to be mainly affected by both preventive and curative services. Although adjustments for shadow prices of foreign exchange and unskilled labor would be desirable, these were not undertaken. It is believed that such adjustments would not have a significant impact on the conclusions of this analysis.

Using the NEDA-estimated social discount rate of 15 percent, the FETP component must achieve an annual economic return valued at $.284 million at 1986 prices by 1992. This means that the beneficiaries, given the assumptions, will have to gain economic benefits equivalent to a value of at least $.284

million or ₱5.96 million (based on an expected average exchange rate of ₱21.00 = $1.00 in 1986) annually as a result of the FETP component. Otherwise, the FETP component funds should be invested in alternative activities.

The same methodology was used in the PP to derive the required benefits for the service delivery support component. The required level of economic benefits for this component was estimated at $2.35 million or ₱26.1 million in 1983 prices. This is now equivalent to ₱52.2 million in 1986 prices, assuming an eight percent Philippine inflation rate for 1986 or a 99.9 percent increase in prices between 1983 and 1986. Total economic returns from both components should therefore be ₱58.2 million per year.

How likely is the FETP component to be able to achieve the estimated level of economic return? Alternatively, how much savings in medical care outlays of a Filipino family will have to be generated as a result of the FETP component? This will require an estimate of the average level of current health care expenditures of Filipino families. To make the analysis more conservative, expenditure data on rural families will be used. The National Census and Statistics Office's preliminary results for the 1985 Family Income and Expenditures Survey show rural Filipino families as spending an average 2.0 percent of their annual total expenditures for medical and health care expenses. Since the average total family expenditures in the rural areas in 1985 were ₱19,323 ($1,038), this means that about ₱386 had been allocated for health care and treatment. Adjusted for inflation, a rural family is estimated to be spending around ₱417 ($20), on the average, for medical care in 1986.

If it is assumed that all the 6.1 million rural families in the country will benefit from the FETP component uniformly, then only a 0.2 percent savings in the average medical and health care expenses per family (or about a peso from the average annual expense of ₱417 for health and medical services in 1986) will be necessary to attain an acceptable economic rate of return for investment in the FETP component.

Extending the same analysis to include the service delivery support component, a rural family's savings is estimated at 2.3 percent of average medical and health care expenses, i.e, ₱9.53 from the average per family annual expense of ₱417. The expected reductions in the most prevalent illnesses among rural families attributed to increased access to PHC services including the FETP component could conceivably result in more than a 5 percent decrease in real terms in the total health care expenditures of these families. If it is assumed that

only one-third of the rural families will have access to the PHC program under the two components, each beneficiary-household will have to generate savings equivalent to 6.9 percent (or ₱28.62 in 1986 prices) of the estimated average family outlay for health care services. This still seems to be easily attainable.

Following the PP economic analysis further, if it is alternatively assumed that both the FETP and the service delivery support components will result in an average 10 percent savings in the health care expenditures of the family-beneficiaries, then approximately 1.4 million rural families will have to be reached, representing only 23 percent of the total number of rural families. For the FETP component only, a mere 143,000 families need to be reached.

Given these various scenarios, the alternative economic rate of return analysis has shown that the FETP component and even the PHC service delivery support component as a whole should achieve a result that justifies the investment under presently more difficult Philippine economic conditions.

D. Administrative Analysis

The administrative analysis is incorporated into Part V - Implementation plan, Section A - Administrative Arrangements and Analysis. That Section discusses the administrative feasibility of the project and the administrative capability of the MOH to implement it.

VII. Evaluation Plan

There are three mechanisms for evaluation of the FETP: continuous evaluation of progress of individual trainees by CDC/CE and MOH/SE; annual review of FETP by a CDC visiting consultant epidemiologist; and, external reviews at completion of years three and five by an outside team of consultant epidemiologists.

The CDC/CE, and the MOH/SE, will continuously monitor and review progress of trainees on an informal basis. They will assess each trainee's ability to conduct outbreak investigations, set up surveillance systems, undertake research studies, and to coherently describe their work and recommend appropriate corrective interventions. The CDC/CE and MOH/SE will keep performance records of each individual trainee and will keep the Deputy Minister of Public Health advised of trainee progress through informal discussions and will recommend corrective action or appropriate recognition for trainees should either be indicated.

Progress of implementation will be reviewed annually by a CDC visiting consultant epidemiologist, and annual progress reports will be prepared. The first report will be made at the end of the first year's operation and annually thereafter. The report will be prepared by the CDC visiting consultant epidemiologist following review of the program status and consultations with CDC/CE, MOH/SE, MOH/HIS staff, and USAID Manila staff. The report will list objectives, accomplishments, problems and proposed solutions. This report will be made available to all parties involved but will be specifically used by MOH and CDC to determine if changes are needed in the program.

The report will be drafted and discussed before the visiting consultant leaves the country and a final version will be sent to MOH and AID within 2 weeks of the consultant's return to Atlanta.

An external review will be conducted two times during the FETP activity: once after three years and again after the five year life of the program. This external review will be made by a three-person team composed of a person familiar with CDC's-EIS and GEIS programs but not currently attached to either; an internationally recognized competent epidemiologist but with no prior history of CDC-EIS or GEIS involvement; and a host country national who is a recognized epidemiologist but not associated with the HIS Program. This three-person team will review all aspects of the program and its goals, appropriateness of goals to MOH needs, proposed methods of attainment, degrees of success or failure in attaining goals; and recommended changes.

The final review will also assess the impact of the FETP on specific and overall activities of the MOH, i.e., have more or better surveillance systems been implemented?, are outbreaks investigated more effectively?, do outbreaks or surveillance data result in corrective intervention?, are epidemiologic principles used in more programmatic areas of the MOH? Broader issues will be reviewed, when practicable, such as improvement in the MOH's ability to meet its overall national goals, and how the FETP has improved cost effectiveness of health care.

During the final evaluation, the review will include an assessment of whether the program has attained self-sufficiency, i.e. whether the foreign consultant and external assistance can be withdrawn.

VIII. Conditions, Covenants and Negotiating Status

A. Conditions Precedent to First Disbursement

Prior to disbursement of any portion of the Grant assistance made available under the amendment to the Project Agreement providing for the FETP Component, or to the issuance by A.I.D. of documentation pursuant to which such disbursement will be made, the

GOP shall provide, except as A.I.D. may otherwise agree in writing, in form and substance satisfactory to A.I.D.:

(a) an opinion of counsel acceptable to A.I.D. that the Amendment to the Agreement has been duly authorized and/or ratified by, and executed on behalf of, the GOP and that it constitutes a valid and legally binding obligation of the GOP in accordance with all of its terms;

(b) a letter or letters from the Ministry of Health and the Office of Compensation and Personnel Classification expressing the intent of the GOP, subject to the availability of funds, by 1988, to assign all graduates of the FETP course to the position of epidemiologist in the Ministry of Health at least at the entry level of Medical Specialist I (or its equivalent from time to time thereafter) and to maintain such individuals thereafter in such positions at that level or higher.

(c) a Ministry Order duly issued by the Ministry of Health: establishing the FETP and defining its organizational location; designating the individuals to serve as members of the Advisory Committee to the FETP (to include the consulting epidemiologist to be provided by CDC); and appointing the senior epidemiologist of the Ministry of Health who will serve as co-manager of the FETP; and

(d) a Project Implementation Order/Technical Services approving the terms and conditions of a Participating Agency Services Agreement to be entered into between A.I.D. and the U.S. Centers for Disease Control ("CDC") providing for technical assistance from CDC for the Field Epidemiology Training Program.

B. <u>Covenants</u>

1. The GOP will agree, subject to the availability of funds, by 1988 and thereafter, to assign all graduates of the FETP course to the position of epidemiologist in the Ministry of Health at least at the entry level of Medical Specialist I (or its equivalent from time to time thereafter) and to maintain such individuals thereafter in such positions at that level or higher.

2. The GOP will agree that commencing in the year 1991 and in each year thereafter, the Ministry of Health shall allocate at least five positions under its Residency Training Program to support the continued training of field epidemiologists, and that commencing in 1992 the Ministry of Health shall make available such other resources as may be required to maintain and continue FETP as an activity supported entirely by the Ministry of Health.

C. Negotiating Status

The FETP component of the PHC Financing Project was requested by the MOH because of its desire to rationalize and improve the cost effectiveness of its disease control and prevention programs. The Deputy Minister for Public Health, the Health Information Service and the Research Institute of Tropical Medicine provided the major inputs to the development of the proposed program, particularly in prescribing the design of the training course and implementation arrangements and defining the career path of the future MOH epidemiologists.

The Minister of Health has been consulted on several instances during the design of this project, and has issued statements that developing the MOH capabilities to generate accurate information for sound health programming is high on the list of MOH priorities. The final project design is a reflection of the kind of assistance that the Philippine Government feels it needs in order to upgrade the epidemiologic services of the Ministry of Health.

Given the rationale for this project component and the manner in which it was designed, we anticipate no difficulties in concluding an agreement as soon as this project is authorized.

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ACTION COPY
Action Taken
No action necessary
Date: Initials:

AIDAC

E.O. 12356: N/A
TAGS: N/A
SUBJECT: [redacted]
(492-0371)

REF: ICS TRANSMITTAL DATED MAY 16, 1986

1. AA/ANE APPROVES SUBJECT PROJ. PP SUPPLEMENT MAY BE APPROVED BY MISSION IN ACCORDANCE WITH EXISTING REDELEGATIONS OF AUTHORITY.

2. FOLLOWING COMMENTS ARE OFFERED WITH THE UNDERSTANDING THAT PP SUPPLEMENT IS ALREADY WELL ALONG AND RECOGNITION THAT MAJOR ISSUES HAVE ALREADY BEEN DISCUSSED INFORMALLY BETWEEN AID/W AND MISSION. WE ALSO UNDERSTAND THAT BART'S PAPER ON FIELD BASED, SERVICE ORIENTED EPIDEMIOLOGICAL TRAINING IN INDIA PROVIDED BY AID/W IS BEING DRAWN UPON DURING PP SUPPLEMENT PREPARATION. WE EXPECT ACCORDINGLY THAT PP IS GIVING CONSIDERATION TO THE DEVELOPMENT OF PILOT PROJECTS TO DEMONSTRATE INTEGRATION OF NEW EPIDEMIOLOGISTS, DEVELOPMENT OF SUPPORTING PUBLIC HEALTH LABORATORY AND IMPROVED HEALTH INFORMATION SYSTEMS INTO TOTAL HEALTH CARE DELIVERY SYSTEM.

DIV	ACT	INF
OD		✓
E		
PE		
PLA		✓
PO		✓
TD		
EO		
PER		
CSD		
LCS		
GSO		
TRM		
CO		
DMS		
OCD		
OPAL		✓
OFM		
CFF SVC		
RIG/A		
RIG/II		
AP		
DUE DATE		
8-27-86		

3. MISSION SHOULD CAREFULLY EVALUATE TOTAL GOP NEED FOR EPIDEMIOLOGISTS AND THE NUMBERS TO BE PRODUCED IN THIS CONTEXT AS WELL AS LIKELIHOOD OF SUSTAINING TRAINING CAPABILITY AT END OF PROJECT. HIGH COST OF TRAINING IS A CONCERN AS WELL AS MOH CAPABILITY TO EMPLOY FIELD EPIDEMIOLOGISTS TRAINED UNDER THIS PROGRAM.

4. WE ASSUME THAT ADEQUATE INCENTIVES WILL BE BUILT INTO PROGRAM TO ATTRACT QUOTE YOUNG PHYSICIANS WHO ARE INTERESTED IN PURSUING A GOVERNMENT CAREER UNQUOTE. ALTERNATIVELY, MISSION SHOULD EXPLORE LOWER COST TRAINING OPTIONS FOR FIELD EPIDEMIOLOGISTS SO THAT LARGE NUMBERS CAN BE PRODUCED WITH LOWER UNIT COSTS. WE AGREE THAT GIVEN PROPOSED DESIGN OF PROJECT, UPGRADING POSITION OF FIELD EPIDEMIOLOGISTS IS CRITICAL TO PROJECT SUCCESS AND THAT IT BE A CONDITION PRECEDENT TO DISBURSEMENT.

5. MAJOR ISSUE HAS BEEN THAT THIS NEW INITIATIVE BE

FULLY INTEGRATED INTO THE GOP'S HEALTH CARE DELIVERY SYSTEM. PID SEEMS TO SUGGEST IT IS BEING ADDED TO EXISTING INSTITUTIONAL FRAMEWORK WITHOUT ADEQUATE CONSIDERATION OF ITS RELATION TO, OR IMPACT ON, OTHER PROGRAMS. PARTICULAR CONCERN SHOULD BE GIVEN TO CONTEXT IN WHICH EPIDEMIOLOGISTS ARE EXPECTED TO WORK, I.E. PUBLIC HEALTH LABS AND AN ADEQUATE HEALTH INFORMATION SYSTEM. WOULD SUGGEST DETAILED ASSESSMENT OF THESE CONSIDERATIONS IN PP ANALYSES. ALSO, GIVEN STAFF AND RESOURCE CONSTRAINTS IN THE PHILIPPINES A CAREFUL REVIEW OF BOTH STAFF TIME AND OPERATIONAL EXPENDITURE REQUIREMENTS FROM RITM, UP-IPH, HIS AND BRL SHOULD BE MADE TO ASSURE ADEQUATE PROJECT SUPPORT. CARE SHOULD BE TAKEN THAT THERE IS CLEAR AGREEMENT WITH GOP ON EXTENT OF ANY AID CONTRIBUTIONS TO RECURRENT COSTS AND DEFINED DATE FOR FULL GOP RESPONSIBILITY FOR THESE.

6. SINCE SUBJECT PROJECT HAS LARGE PIPELINE AND SUPPLEMENT REPRESENTS ADDITIONAL RESOURCES AND UNITS OF MANAGEMENT TO ALREADY COMPLEX PROJECT, MISSION SHOULD SERIOUSLY REVIEW CURRENT IMPLEMENTING AND MONITORING ARRANGEMENTS FOR ADEQUACY DURING PP PREPARATION.

7. PLEASE NOTE THAT PASA WITH CDC WILL REQUIRE MISSION CERTIFICATION THAT THE USE OF CDC MEETS THE CRITERIA OF FAA SECTION 621(A), INCLUDING NON COMPETITION WITH PRIVATE ENTERPRISE. SEE HANDBOOK 12, CHAPTER 1B.

8. APPROVAL OF THE FIVE YEAR LOP FOR THIS COMPONENT DOES NOT CONSTITUTE APPROVAL TO EXTEND PACD OF ALL OTHER PROJECT COMPONENTS BEYOND CURRENT PACD OF DECEMBER 31, 1989. IF SUCH EXTENSION IS NECESSARY, WE WOULD BE PLEASED TO REVIEW JUSTIFICATION.

9. FYI ST/H IS PLANNING A WORLDWIDE PROJECT IN FIELD EPIDEMIOLOGY TRAINING AND HEALTH INFORMATION SYSTEMS RECOGNIZING THEIR IMPORTANCE TO HEALTH CARE DELIVERY SYSTEMS AND STRONG LINK TO AID'S CHILD SURVIVAL GOALS. ST/H WILL KEEP MISSION INFORMED OF PROGRESS ON THIS PROJECT AND EXPLORE POSSIBLE LINKAGES TO MISSION'S PROPOSED PROJECT. END FYI.

10. REGRET DELAY IN RESPONDING TO MISSION'S PID AND HOPE NO MAJOR INCONVENIENCE WAS CAUSED. WHITEHEAD

BT
#4995

NNNN

AID 1020-25 (1-73)

Annex "B"

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Project Title & Number: Primary Health Care Financing Project - Field Epidemiology Training Program Component (492 - 0371)

Life of Project:
From FY 1986 to FY 1992
Total U. S. Funding 11,500,000
Date Prepared: July, 1986

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: (A-1) To reduce infant and young child mortality and morbidity in the Philippines.	**Measures of Goal Achievement: (A-2)** - Reduction in infant mortality rates. - Reduction in mortality among children aged 1-5 years - Decline in prevalence of infectious diseases of public health importance.	**(A-3)** - Census data - Data from MOH Health Information Service	**Assumptions for achieving goal targets: (A-4)** - Mortality and morbidity reduction services provided by the MOH will be utilized by the population. - The technology for the diagnosis, treatment and prevention of diseases responsible for high infant and young child mortality and morbidity is always available and affordable.
Project Purpose: (B-1) To improve and strengthen the epidemiologic services of the Ministry of Health, and develop a self-sustaining capability within the MOH to continue training an adequate number of field epidemiologists.	**Conditions that will indicate purpose has been achieved: End-of-Project status. (B-2)** 1. A functional system for reporting and investigating disease outbreaks is in place. 2. MOH communicable disease control programs are formulated on the basis of information obtained through epidemiologic research. 3. Laboratory and library services capable of servicing diagnostic and informational needs of field epidemiologists. 4. An adequately staffed and equipped Health Information Service of the MOH capable of continuing the FET program after the US advisor leaves.	**(B-3)** - Health Information Service records - Evaluation reports - Project reports - Field visits	**Assumptions for achieving purpose: (B-4)** - The MOH will institutionalize the FET Program. - Upgrading the Epidemiologist position is an adequate incentive to keep FETP graduates in the program. - The hardware requirements for automating disease recording and reporting will be provided by other donors.
Project Outputs: (C-1) 1. A cadre of competent field epidemiologists; 2. Upgraded laboratory and library services to support the investigation of epidemics and epidemiologic research; 3. A faculty of trained specialists capable of continuing the FET program by the end of the project.	**Magnitude of outputs: (C-2)** 1. 18 trained and functional epidemiologists; 144 epidemiologic investigation reports completed. 2. 3 regional laboratories upgraded to perform complete bacteriological examinations; 1 functional epidemiologic research library established. 3. 5 full time MOH-HIS faculty trained and capable of continuing the program after AID assistance phases out.	**(C-3)** - Project monitoring documents - Annual progress reports - Project evaluations	**Assumptions for achieving outputs: (C-4)** - There is an adequate number of qualified applicants to the FET program. - The Ministry of Health will upgrade the position of Epidemiologist to Medical Specialist level. - Selected graduates will be willing to serve in the FETP faculty..
Project Inputs: (D-1) 1. Technical Assistance 2. Training Support Costs (trainees' allowances, trainees' fees, training supplies and materials, travel and transportation) 3. Program Support Staff (salaries of administrative staff, office improvements, office equipment, materials and supplies, etc.) 4. Participant Travel 5. Purchase of laboratory equipment and supplies 6. Purchase of library materials and maintenance of epidemiologic research library 7. Evaluations	**Implementation Target (Type and Quantity) (D-2)** 1. $ 990,000 2. 125,000 3. 235,000 4. 70,000 5. 30,000 6. 20,000 7. 30,000 AID Total - $ 1,500,000 GOP Total - 600,000 Grand Total - $ 2,100,000	**(D-3)** - Project implementation documents	**Assumptions for providing inputs: (D-4)** - Development of its epidemiologic services will continue to be a priority of the MOH so that full support will be provided to the program; - CDC can recruit a qualified epidemiologist who is willing to serve as the in-country consulting epidemiologist.

Best Available Document

Table 1
Summary Financial Table
Primary Health Care Financing Project
($000)

Component	Grant	USAID Loan	Total	MOH	GOP PCHRD	Total	TOTAL (GOP & AID)
1. Financing Schemes	3,000	-	3,000	-	532	532	3,532
a. Grants to Institutions	2,550	-	2,550	-	-		2,550
b. Administrative Costs	450	-	450	-	532	532	982
2. Special Studies	1,150		1,150	-	168	168	1,318
3. Service Delivery	11,966	1,034	13,000	13,800	-	13,800	26,800
a. Botica sa Barangay Program	1,989	11	2,000	1,000		1,000	3,000
b. BHW/Midwifery Programs	1,600	-	1,600	3,000		3,000	4,600
c. PHC Commodities	1,896	704	2,600	1,200		1,200	3,800
d. IEC	981	319	1,300	5,000		5,000	6,300
e. ORT Program	4,000	-	4,000	3,000		3,000	7,000
f. FETP*	1,500		1,500	600		600	2,100
4. Other Support Costs	300	-	300	-	-	-	300
5. Project Evaluations	50	-	50	-	-	-	50
TOTAL	$16,466	1,034	17,500	13,800	700	14,500	32,000

* $547,000 will be obligated in the future subject to availability of funds.

Table 2
BUDGET SCHEDULE - FETP COMPONENT
($000 - Grant)

	1986	1987	1988	1989	1990	1991	FX	LC	TOTAL
I. AID Contribution									
1. Technical Assistance	-	214	197	193	206	-	810		810
2. Local Support Cost for CDC/CE		35	35	35	35	-		140	140
3. Training Support Costs									
a. Trainees' Allowance	-	5	15	15	15	15		65	65
b. Trainers' Fees	-	2	2	2	2	2		10	10
c. Travel & Transportation	-	5	5	5	5	5		25	25
d. Trg. Supplies & materials		5	5	5	5	5		25	25
4. Program Support Staff									
a. Personnel Services	1	7	7	7	6	6		34	34
b. Office Equip.& Supplies	2	20	4	4	4	4		38	38
c. Office Improvements and and Furniture	50	25	-	-	-	-		75	75
d. Communications	2	2	2	2	2	2		12	12
e. Transportation & Travel	1	6	6	6	6	6		31	31
f. Conferences	-	3	3	3	3	3		15	15
g. Vehicles	30	-	-	-	-	-		30	30
5. Participant travel	-	8	8	8	8	8	40		40
6. Laboratory Equipment and Supplies	-	20	10	12	14	14	15	55	70
7. Library books, journals, materials & supplies	-	12	7	7	7	7	25	15	40
8. Evaluation			20			20	30	10	40
Total AID Contribution	86	369	326	304	318	97	920	580	1500

	1986	1987	1988	1989	1990	1991	FX	LC	TOTAL
II. GOP Contribution									
1. Personal Services including trainees' salaries	10	65	72	82	35	96		410	410
2. Travel & Transportation	1	7	8	8	8	8		40	40
3. Laboratory Supplies		4	4	4	4	4		20	20
4. Office Maintenance and Operating Expenses	8	20	24	25	26	27		130	130
Total GOP Contribution	19	96	108	119	123	135		600	600
TOTAL PROJECT COST	105	465	434	423	441	232	920	1180	2100

Annex "D"

STATUTORY CHECKLIST

PROJECT CHECKLISTS

A. GENERAL CRITERIA FOR PROJECT

1. FY 1986 Continuing Resolutic Sec. 524; FAA Sec. 634A Describe how authorizing and appropriations committees of Senate and House have been o will be notified concerning the project.	1. Advised by STATE 271063 dated 08/28/86 that CN had expired without comment.
2. FAA Sec. 611(a)(1). Prior t obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estima of the cost to the U.S. of the assistance?	2. Yes
3. FAA Sec. 611(a)(2). If further legislative actions required within recipient country, what is basis for reasonable expectation that such action will be complete in time to permit orderly accomplishment of purpose of the assistance?	3. N/A
4. FAA Sec. 611(b); FY 1986 Continuing Resolution Sec. 501. If for water or water-related land resource construction, has project me the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See AID Handbook 3 for new guidelines.)	4. N/A

5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to effectively maintain and utilize the project?	5. N/A
6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	6. No
7. FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	7. a. N/A b. N/A c. N/A d. N/A e. N/A
8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private	8. Nature of project would not lend itself to U.S. private trade or investments.

trade channels and the services of U.S. private enterprise).

9. FAA Sec. 612(b), 636(h); FY 1986 Continuing Resolution Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

9 GOP will provide 29% of project costs in local currencies. Foreign currencies owned by the U.S. are not available to this project.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

10. No.

11. FAA Sec. 601(e). Will the project utilized competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

11. Yes

12. FY 1986 Continuing Resolution Sec. 522. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

12. N/A

13. FAA 118(c) and (d). Does project comply with the environmental procedures set forth in AID Regulation 16. Does the project or program

13. Yes

take into consideration the problem of the destruction of tropical forests?

14. FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated therefrom)?

14. N/A

15. FY 1986 Continuing Resolution Sec. 533. Is disbursement of the assistance conditioned solely on the basis of the policies of any multilteral institution?

15. No

16. ISDCA of 1985 Sec. 310. For development assistance projects, how much of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantage (including women)?

16. Project component is comprised of activities requiring specialized services of the Centers for Disease Control provided under a PASA and activities requiring local cost financing for which local procurement is appropriate.

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Project Criteria

a. FAA Sec. 102(a), 111, 113, 281(a). Extent to which activity will (a) effectively involve the

1.a. The project seeks to gain a better understanding of the disease conditions affecting various population groups, to serve as basis for formulation of improved and more effective health inter-

poor in development, by extending access to economy at local level, increasing labor intensive production and the use appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status, (e) utilize an encourage regional cooperation by developing countries?

vention on programs which will redound to the benefit of the rural poor, especially mothers and children.

b. N/A

c. The project will assist the host country to develop a self-sustaining capability to train field epidemiologists.

d. Women will be afforded equal opportunity to participate in training programs.

e. N/A

b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?

b. Yes

c. FAA Sec. 107. Is emphasis on use of appropriate technology

c. N

relatively smaller cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

d. FAA Sec. 110(a). Wil' the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed country)?

d. The Project Agreement will commit the GOP to contribute at least 25% of total project costs.

e. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

e. Yes

f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

f. Yes

g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in governmental processes essential to self-government.	g. Program was designed with the active participation of the Ministry of Health (MOH), taking into serious account the country's particular needs, desires and capacities of the MOH to train field epidemiologists, at the same time strengthening its epidemiologic services.
2. Development Assistance Project Criteria (Loans Only)	
a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan, at a reasonable rate of interest.	a. N/A
b. FAA SEc. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20% of the enterrise's annual production during the life of the loan?	b. N/A
3. Economic Support Fund Project Criteria	
a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of part I of the FAA?	a. N/A

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b. FAA Sec. 531(c). Will assistance under this chapter be used for military, or paramilitary activities?

b. N/A

c. ISDCA of 1985 Sec. 207. Will ESF funds be used to finance the construction of, or the operation or maintenance of, or the supplying of fuel for, a nuclear facility? If so, has the President certified that such country is a party to the Treaty on the Non-Proliferation of Nuclear Weapons or the Treaty for the Prohibition of Nuclear Weapons in Latin America (the "Treaty of Tlatelolco"), cooperates fully with the IAEA and pursues nonproliferation policies consistent with those of the United States?

c. N/A

d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

d. N/A

STANDARD ITEM CHECKLIST

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?	Yes
2. FAA Sec. 604(a). Will all procurement be from the U.S. except as otherwise determined by the President or under delegation from him?	2. Procurement will be fr the U.S. and the Philippin
3. FAA Sec. 604(d). If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?	3. Yes
4. FAA Sec. 604(e); ISDCA of 1980 Sec. 705(a). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.).	4. N/A
5. FAA Sec. 604(g). Will construction or engineering services be procured from firms of countries which received direct economic assistance under the FAA and which are othewise eligible	5 N/

under Code 941, but which have attained a competitive capability in international markets in one of these areas? Do these countries permit United States firms to compete for construction or engineering services financed from assistance programs of these countries?

6. FAA Sec. 603. Is the shipping excluded from compliance with requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates?

6. No

7. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? If the facilities of other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

7. Yes

8. International Air Transportation Fair Competitive Practices Act,

8. Yes

1974. If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available?

9. FY 1986 Continuing Resolution Sec. 504. If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the covenience of the United States?

9. Yes

B. Construction

1. FAA Sec. 601(d). If capital (e.g., construction) project, will U.S. engineering and professional services be used?

1. N/A

2. FAA Sec. 611(c). If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

2. Yes

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed $100 million (except for productive enterprises in Egypt that were described in the CP)?

3. N/A

C. Other Restrictions

1. FAA Sec. 122(b). If development loan, is interest rate at least 2% per annum during grace

1. N/A

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period and at least 3% per annum thereafter?

2. FAA Sec. 301(d). If fund is established soley by U.S. contributions and administrered by an international organization, does Comptroller General have audit rights?

2. N/A

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

3. Yes

4. Will arrangements preclude use of financing:
   a. FAA Sec. 204(f); FY 1986 Continuing Resolution Sec. 526. (1) To pay for performance of abortions as a method of family planning or to motivate or coerce persons to practice abortions; (2) to pay for performance of involuntary sterilization as method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization; (3) to pay for any biomedical research which relates, in whole or in part, to methods or the performance of abortions or involuntary sterilization as a means of family planning; (4) to lobby for abortion?

4. a. Yes

b. FAA Sec. 488. To reimburse persons, in the form of cash payments, whose illicit drug crops are eradicated?	b. Yes
c. FAA Sec. 620(g). To compensate owners for expropriated nationalized property?	c. Yes
d. FAA Sec. 660. To provide training or advise or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?	d. Yes
e. FAA Sec. 662. For CIA activities?	e. Yes
f. FAA Sec. 636(i). For purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained?	f. Yes
g. FY 1986 Continuing Resolution, Sec. 503. To pay pensions, annuities, retirement pay, or adjusted service compensation for military personnel.	g. Yes
h. FY 1986 Continuing Resolution, Sec. 505. To pay U.N. assessments, arrearages or dues?	h. Yes
i. FY 1986 Continuing Resolution, Sec. 506. To carry out provision of FAA section 209(d)	i. Yes

(Transfer of FAA funds to multilateral organizations for lending)?

j. FY 1986 Continuing Resolution, Sec. 510. To finance the export of nuclear equipment, fuel, or technology?

j. Yes

k. FY 1986 Continuing Resolution, Sec. 511. For the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

k. Yes

l. FY 1986 Continuing Resolution, Sec. 516. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?

l. Yes

INITIAL ENVIRONMENTAL EXAMINATION

Project Location	:	Republic of the Philippines
Project Title	:	Primary Health Care Financing - FETP Component
Funding	:	FY 86 $953,000
Life of Project	:	FY 86 - FY 91 $1,500,000
IEE Prepared by	:	Rosendo R. Capul, Public Health Advisor
Date	:	May, 1986

Environmental Action Recommended: A negative determination is recommended.

Concurrence: RICHARD S. STEVENSON
Environmental Officer

Date : MAY 21 1986

Assistant Administrator's Decision

Approval of Environmental Action Recommended Date :

Disapproval of Environmental Action Recommended Date :

I. Examination of Nature, Scope, and Magnitude of Environmental Impacts

A. Description of Project:

The project proposes to strengthen the capabilities of the Ministry of Health to investigate disease outbreaks, report and analyze disease surveillance data, develop methodologies for disease control and prevention activities and utilize epidemiologic information for planning, managing and evaluating health service programs. Improving the epidemiologic services of the Ministry of Health will be achieved by strengthening the country's capabilities to train field epidemiologists, developing a cadre of trained field epidemiologists and providing them with the status, prestige and incentives conducive to rendering effective epidemiologic services.

B. Impact Identification and Evaluation Form

Impact Areas and Sub-areas[1]	Impact Identification and Evaluation[2]
a. Land Use	
1. Changing the character of the land through:	
a. Increasing the population	N
b. Extracting natural resources	N
c. Land clearing	N
d. Changing solid character	N
2. Altering natural defenses	N
3. Foreclosing important uses	N
4. Jeopardizing man or his works	N
5. Others factors	
_____	_____
_____	_____
b. Water Quality	
1. Physical state of water	N
2. Chemical and biological states	N
3. Ecological balance	N
4. Other factors	
_____	_____
_____	_____

1/ See Explanatory Notes for this form
2/ Use the following symbols:
N - No environmental impact
L - Little environmental impact
M - Moderate environmental impact
H - High environmental impact
U - Unknown environmental impact

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c. Atmoshperic

1. Air additives ..... N
2. Changes in population ..... N
3. Changes in cultural pattern ..... N
4. Other factors

d. 1. Diversion, altered use of water ..... N
2. Irreversible, inefficient commitments ..... N
3. Other factors

e. Cultural

1. Altering physical symbols ..... N
2. Dilution of cultural traditions L
3. Other factors

f. Socio-economic

1. Changes in economic/employment patterns ..... N
2. Changes in population ..... N
3. Changes in cultural patterns L
4. Other factors

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g. Health

1. Changing a natural environment ..... N
2. Eliminating an ecosystem element ..... N
3. Other factors

h. General

1. International impacts ..... N
2. Controversial impacts ..... N
3. Larger program impacts L
4. Other factors

i. Other possible impacts (not listed above)

See attached Discussion of Impacts

C. Discussion of Impacts

There will be no major project impact on the physical, cultural or socio-economic environment.

D. Conclusion

As outlined, the activities to be undertaken under this project component are unlikely to have significant direct environmental impacts.

II. Recommendation for Environment Action

A negative determination is recommended.

CDC PASA Budget Breakdown

Annex "F"

PASA BUDGET Item	' 87 Year 1	'88 Year 2	'89 Year 3	'90 Year 4	Total
Salary of CDC/CE	66,500	68,495	70,552	72,668	278,215
Backstop costs for CDC/CE	22,500	23,175	23,870	24,586	94,131
Benefits for CDC/CE	17,323	17,842	18,896	19,462	73,523
Travel for CDC/CE PCS		5,700	5,800	5,776	17,276
Supervisory visits from CDC	9,200	11,500	10,400	9,700	40,800
Return visit to Atlanta for CDC/CE		4,925		5,370	10,295
Transport of HH goods Atlanta to Manila	16,190		17,175		33,365
Transport of HH goods Manila to Atlanta		17,800		18,884	36,684
Transport of other materials Atlanta to Manila	400	412	424	437	1,673
Computer communications (Office)	3,600	3,708	3,819	3,933	15,060
Other communications (Office)	900	927	954	982	3,763

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PASA BUDGET Item	' 87 Year 1	'88 Year 2	'89 Year 3	'90 Year 4	Total
Computer communications (Library)	2,880	2,966	3,054	3,145	12,045
3 IBM/XT computers with softwares	30,000				30,000
Shipment of computers Atlanta to Manila	1,800				1,800
Sub-Total	171,293	157,450	154,944	164,943	648,630
CDC Overhead	42,625	39,165	38,540	41,040	161,370
TOTAL	213,918	196,615	193,484	205,983	810,000

Annex "G"

Commodities To Be Pro

2 Vehicles

1 Overhead Projector

1 Slide Projector

2 Photo copiers

1 Mimeo machine

3 Electric Typewriters

1 Scanner

6 Filing cabinets

8 1-1/2 HP airconditioners

1 Tape recorder (casette)

1 Megaphone

1 Screen

1 Blackboard

Annex "H"

REPUBLIC OF THE PHILIPPINES
NATIONAL ECONOMIC AND DEVELOPMENT AUTHORITY
NEDA sa Pasig, Amber Avenue
Pasig, Metro Manila

Cable Address: NEDAPHIL
P.O. Box 419, Greenhills
Tels. 673-50-31 to 50

27 August 1986

Mr. Frederick W. Schieck
Director, USAID Mission
M a n i l a

Dear Mr. Schieck,

Subject: Primary Health Care Financing Project
Project No. 492-0371

We would like to endorse the proposal from the Ministry of Health (MOH) for additional USAID grant funding to the Field Epidemiology Training Component of the subject project.

The additional grant funding of US$2.1 million is being requested to improve and strengthen the epidemiologic services of the MOH towards reducing high fertility and infant and young child mortality rate.

Thank you for your support to the national development efforts of the Government.

Sincerely yours,

SOLITA COLLAS-MONSOD
Minister of Economic Planning &
Director-General