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**FINAL EVALUATION OF THE
FIELD EPIDEMIOLOGY TRAINING PROGRAM**

Philippines

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**Dr. Milagros Fernandez¹
Mr. Rhais Gamboa²
Dr. Mary Ann Lansang³
Dr. Steven Solter⁴**

¹ Regional Health Director, Region 9, Philippines

² Consultant, Former Undersecretary of Health

³ Deputy Director, Research Institute for Tropical Medicine

⁴ Advisor, Child Survival Program, Department of Health

Philippine FETP Evaluation

EXECUTIVE SUMMARY

The objective of this evaluation is to conduct an end-of-project assessment of the Field Epidemiology Training Program (FETP) component of the Primary Health Care Financing Project and to make recommendations to USAID and to the Philippines Department of Health (DOH) concerning two questions:

- (1) How well has FETP accomplished the goals set out in the original project paper (1986)?
- (2) How can FETP most effectively serve DOH in the future?

The answers to these questions will enable the DOH to reach an important policy decision:

- (a) Whether to continue FETP
- (b) If the answer to (a) is yes, how to institutionalize FETP (that is, how to situate the FETP as a permanent part of the DOH)

Background information about the Philippine FETP and a concise summary of its history can be found in the FETP Mid-Term Evaluation Report of May 1990. This evaluation will focus on the two questions raised above.

HAS THE FETP MET ITS ORIGINAL OBJECTIVES?

In the original FETP Project Paper (1986), 4 basic objectives were listed. These were to "improve the capacities" of the DOH to:

- Investigate disease outbreaks
- Report and analyze disease surveillance data
- Develop methodologies for disease control and prevention interventions
- Utilize epidemiologic information for planning, managing, and evaluating health services programs

The same Project Paper defined a two-fold strategy that FETP should pursue to achieve these four objectives:

- (1) Develop a cadre of trained field epidemiologists and provide them with the status, prestige, and financial incentives conducive to rendering effective epidemiologic services.
- (2) Develop a self-sustaining capacity within the DOH to continue training an adequate number of field epidemiologists with the necessary job incentives to remain with the program.

The Evaluation Team has concluded that, taking the project as a whole, the FETP has achieved its original objectives and has followed the proposed strategy. The Evaluation Team agrees strongly with the consensus among those interviewed that the FETP should not only be continued by the DOH but should be strengthened by being institutionalized in an effective manner.

The following is an individual assessment of the original 4 objectives of the FETP, i.e. to what extent they have been achieved when looked at one by one:

1- Investigate disease outbreaks

This objective has been met in spectacular fashion. More than 200 outbreak investigations have been conducted by FETP trainees. Nearly all of them resulted in public pronouncements made by the DOH and/or specific health interventions. The reports submitted have been used extensively by top-level management at the DOH because of their

reliability, clarity, conciseness, and scientific rigor. Most outbreak investigations have involved communicable diseases; gradually FETP trainees are getting experience with non-communicable diseases as well.

2- Report and analyze disease surveillance data

This objective also has been met with distinction. The weekly San Lazaro Sentinel Surveillance Reports have been timely, practical, and reliable. The recently established National Sentinel Surveillance System (hospital-based, presently functioning in 12 regions) promises to be a high-quality and useful addition. Because of FETP's expertise in disease surveillance, the prospects for polio eradication (with a boost from improved polio surveillance) and the control of AIDS (again, with the help of effective AIDS Surveillance) are much brighter than they would otherwise be. FETP trainees and graduates understand the art and science of disease surveillance and are able to apply their skills in the field.

3- Develop methodologies for disease control and prevention interventions

Although this objective has, by and large, been achieved it has not been as strong an element of FETP as outbreak investigations or disease surveillance. This has been deliberate, since FETP has focused primarily on the first two objectives. In some cases, usually as a result of outbreak investigations, disease control and/or prevention strategies have been recommended to program and area managers. Several FETP graduates have assumed responsibility for disease control programs and have been able to use some of their FETP-acquired skills. But, on the whole, relatively little energy has been expended to achieve this objective.

4- Utilize epidemiologic information for planning, managing, and evaluating health services programs

This has been the weakest of the four objectives for the FETP. The didactic portion of the 2-year training consists of six weeks -- with virtually nothing concerning how the DOH is organized and very little on planning, management, or evaluation. The FETP has chosen to specialize

on training competent field epidemiologists rather than well-rounded MPH-style generalists. The Evaluation Team feels that FETP has over-specialized and needs to be somewhat more balanced by including applied aspects of planning, management, and evaluation.

Moreover, it must be noted that FETP is essentially a training program and that the initiative in using epidemiological data for improved planning, managing and evaluating health services rests primarily with program managers and area managers (i.e. Regional Directors, Provincial Health Officers.)

HOW CAN FETP MOST EFFECTIVELY SERVE DOH IN THE FUTURE?

This question can be broken down into 4 sub-questions:

- What improvements in training program content and methodology need to be pursued?
- How can FETP provide better support to policy makers?
- How should FETP be institutionalized within DOH?
- What resources will be required for optimal development of FETP?

1. Improvements in Training Content and Methodology

Findings:

1.1 The basic approach of FETP -- to "learn by doing" and to stress fieldwork over lectures and theory -- is sound and has proven very effective. However, there are several weak areas that need improvement. These include: survey design and methodology (other than EPI cluster surveys), appropriate use of laboratory tests and services, research

management, biostatistics, and (as already described) the triad of planning, management, and evaluation.

1.2 The quality of supervision of FETP trainees is high but additional staff will be needed (in addition to the badly needed Dr. Roces) as the program expands. Dr. Dayrit's frequent unavailability (owing to competing demands for his time) makes the matter more urgent. FETP has proven very effective in dealing with disasters (especially regarding surveillance) but in some cases trainees have provided a valuable service without learning new skills. In general, the balance between didactics and field practice is sound but 6-weeks for didactics appears to be insufficient.

Recommendations:

- 1) The weekly seminars throughout the two-years training should be held on a regular basis, with more frequent use of outside experts, program managers, and field managers.
- 2) Additional didactic sessions are recommended, including biostatistics, planning, management, evaluation, survey skills, laboratory procedures, and an orientation to the DOH. For example, a one-week didactic session at the end of the first year might be a useful strategy.
- 3) Brief preceptorships should be considered (during the trainee's second year) with program managers (or with area managers located near Manila), with continuing supervision from Manila-based FETP trainers. The major research project during the second year should be continued.
- 4) A full-time FETP supervisor/manager is needed who can work as a counterpart to Dr. White (in addition to Dr. Roces).
- 5) Evaluation of trainees by the FETP Board of Directors should be more standardized, to reduce the subjective component of the interviews.

- 6) If agreement can be reached with the UPCPH, a master's degree in epidemiology should be granted to trainees after successful completion of their 2-year field program.

2. How to Provide Better Support to Policy Makers

Findings:

2.1 The present FETP class size of 6-7 trainees admitted each year is insufficient to have the kind of impact that the DOH desires. The difficulty, of course, is obtaining sufficient additional resources (especially skilled staff) while maintaining quality.

2.2 The FETP provides policy makers with high quality reports on relevant issues of public health concern (e.g. "red tide"). However, not everyone who should receive the reports are doing so. Media personnel are not always "educated" regarding epidemiology and its uses.

2.3 FETP does not have a "deployment plan" to assure a career path for trainees after graduation (with at least an MS-II position) so that their skills are well utilized to support programs and policies.

Recommendations:

- 1) FETP class size should be increased consistent with (a) DOH's plan of establishing a national organizational "backbone" for undertaking epidemiology activities; (b) availability of adequate resources, including trainers; and (c) maintenance of training quality.
- 2) Distribute FETP reports much more widely, with more effective use of the media.
- 3) Develop a "deployment plan" to assure a career path for trainees, in order to increase their effectiveness.

- 4) The DOH Regional Units should establish the position of Regional Epidemiologist (at the MS-III level if possible) which could be filled by FETP graduates. They would be responsible for outbreak investigations, disease surveillance, and disaster management for the region.

3. How to Institutionalize FETP Within DOH

Findings:

3.1 Plans have been developed for institutionalizing FETP within the DOH but no decision has yet been made.

3.2 The Child Survival Program (CSP)--with funding from USAID -- can support FETP through 1993. After that DOH funds must be used. This requires a long-term commitment on the part of the DOH (the DOH has already committed itself by agreeing to institutionalize FETP as one of the 1992 Performance Benchmarks of the CSP).

3.3 No clearly articulated policy/strategy on how to establish a national organization that will serve as the "backbone" for undertaking epidemiology activities.

3.4 Of the many alternatives for situating the FETP in the DOH on a permanent basis, the most logical is to merge the FETP with the Epidemiology Division of the Health Intelligence Service (HIS).

Recommendations:

- 1) FETP should be merged with the Epidemiology Division of HIS as soon as possible. This decision should be made by the existing top-level management of the DOH before there is a change of administration in order to maintain the momentum of success of FETP.

- 2) Concurrently, Regional Epidemiology Units (REU) with adequate laboratory support should be organized as soon as is practicable. These REUs will handle epidemiology activities and disaster management in the regions in conjunction with the program managers in the central office. Thus, the strategy for establishing the national "backbone" organization for epidemiology activities is for FETP to produce the graduates that will staff the REUs and the central office program managers. It is estimated that this will require a minimum total of 39 FETP graduates.
- 3) An institutionalized FETP needs sufficient resources beyond 1993 to remain a vigorous and effective part of the DOH. This will require building an important constituency both inside and outside the DOH to support the goals and objectives of the FETP.
4. What Resources are Required for Optimal Development of FETP?

Findings:

- 4.1 To answer this question an estimate must be made of the capital outlay and current operating expenses requirements of the FETP.
- 4.2 The estimated budgetary needs of institutionalizing FETP via the strategy of establishing a national organizational "backbone" for epidemiology activities in 1992 is about P38,750,000 of which about P18,000,000 is required for FETP activities in Metro Manila and the balance of P20,750,000 is for the REUs.
- 4.3 However, in terms of cashflow, the funding needs for Year 1 of institutionalization may only be P18,000,000--the budget for FETP Metro Manila. The cashflow requirements for the REUs is dependent on the availability of FETP graduates as well as on how fast the requisite administrative and laboratory support are put in place.

Recommendations:

- 1) USAID should consider funding capital outlay through 1993 so that when DOH takes over funding in 1994 it will mainly have to deal with recurrent expenses only.
- 2) If resources from CSP or PHDP for 1992 and 1993 are not sufficient for the proposed budget or cashflow requirements, it may be possible to phase in the regional laboratories or have certain regional laboratories provide services to adjacent regions in addition to their own regions.

In conclusion, the Evaluation Team found the FETP to be extraordinarily successful and in great need of becoming a permanent part of the DOH.

FETP EVALUATION REPORT

I. BACKGROUND AND EVALUATION METHODOLOGY

This end-of-project evaluation is being undertaken to basically answer 2 questions: (1) how well has FETP accomplished the goals set out in the original project paper? and (2) how can FETP most effectively serve DOH in the future?

The answers to these questions will allow DOH to come up with a policy decision on whether (a) to continue with FETP: and (b) if yes, how to proceed in institutionalizing FETP within the DOH organization.

The framework used for this evaluation is the Scope of Work provided to the Evaluation Team (See Annex 1). Because of time constraints, interviews were limited to Metro Manila and covered DOH top management, DOH service chiefs and staff, FETP trainers, FETP graduates and current trainees, USAID staff, and staff from other outside agencies (See Annex 2 for list of persons interviewed). The results of the Mid-Term Evaluation conducted in May 1990 also served as basic input to the Evaluation Team.

While very few field personnel were interviewed, their views are articulated by Dr. Milagros Fernandez, DOH Region IX Director, who is a member of the Evaluation Team. Similarly, no interviews of RITM key staff were undertaken since Dr. Mary Ann Lansang, who is also a member of this evaluation team, is a key official (Deputy Director) of RITM and is very knowledgeable about the RITM-FETP relationship.

II. HAS FETP MET ITS ORIGINAL PURPOSE?

To answer this question, one has to go back to the original project paper.

The FETP Project Paper (September 1986) identified 4 basic objectives of the project, namely: improve the capacities of the DOH to (1) investigate disease outbreaks; (2) report and analyze disease surveillance data; (3) develop methodologies for disease control and prevention interventions; and (4) utilize epidemiologic information for planning, managing and evaluating health services programs.

The same Project Paper defined the suggested strategy to be pursued by FETP to achieve the project objectives as: (a) developing a cadre of trained field epidemiologists and providing them with the status, prestige and financial incentives conducive to rendering effective epidemiologic services; and (b) developing a self-sustaining capacity within the DOH to continue training an adequate number of field epidemiologists with the necessary job incentives to remain with the program.

There is a consensus among the Evaluation Team members that, taking the project as a whole, the FETP has met its original objectives and has adhered to its defined strategy. The following is the Evaluation Team's assessment of each of the project's objectives and strategies.

A. FETP Objectives

Specifically, FETP has significantly developed DOH's capacity to investigate disease outbreaks and to undertake disease surveillance.

This capability was repeatedly demonstrated during the several recent calamities that have struck the Philippines as well as several "high profile" public health concerns like "red-tide" poisoning and the formalin-in-fish panic during 1987. To date, FETP has completed a total of more than 200 investigations, nearly all of which were used by DOH in making public pronouncements and/or health interventions.

In fact, FETP reports are viewed with respect and confidence by DOH top management due to the perceived scientific discipline that goes into report preparation. The head of HIS, Dr. Zenaida Ludovice, acknowledges the higher quality of the FETP graduates working in HIS in terms of technical competence to undertake epidemiology studies or investigations as compared to the staff of the HIS Epidemiology Division.

Although in a more limited way, FETP also met its third objective: i.e. to develop methodologies for disease control and prevention interventions. In the case of "new" diseases that were encountered in the Philippine setting (e.g. Ebola virus) FETP has responded quite adequately. For "old" diseases (e.g. rabies, cholera, Aeta measles outbreak), FETP did not necessarily come up with new methodologies but it did recommend approaches appropriate to the particular conditions obtaining at the outbreak sites. In short, in situations where it found itself operating, FETP was able to develop methodologies and prevention interventions that were adopted by DOH.

FETP had little, if any, success in achieving its fourth objective of utilizing epidemiologic information for planning, managing and evaluating health services programs. One wonders, however, whether such an objective is appropriate for the FETP at this time or whether it should be an objective in the near term. FETP is first and foremost a training program that only started in 1987 and has in effect produced only 3 graduating classes. Moreover, as a training program, it has not chosen to focus on program planning, management, or evaluation. The Evaluation Team feels that, in general, the initiative in using epidemiologic data properly rests with program managers. If program managers fail to appreciate or utilize epidemiologic data, or if they fail to properly utilize FETP graduates within their services, then such failure is no longer FETP's responsibility. Given the importance, however, of improving program planning, management, and evaluation, the Evaluation Team recommends that greater attention be given to these areas during both the didactic and field aspects of FETP training.

B. FETP Strategy

FETP has developed a cadre of trained field epidemiologists. That not more graduates were produced is a function of the original program design and of the resources devoted to the program---factors beyond FETP's control. By and large, FETP graduates are highly regarded in DOH as technically competent, particularly in outbreak investigations and disease surveillance. However, FETP has been unable to guarantee its graduates the appropriate positions in the DOH organization (i.e. at least MS II Level) that would have brought them concomitant status and financial incentives.

This problem of proper placement of FETP graduates as well as the desire to develop a self-sustaining capacity within the DOH to continue training field epidemiologists are related concerns that have to do with the unresolved issue of institutionalization of FETP within DOH. Institutionalization is discussed in greater detail in subsequent sections of this evaluation.

III. HOW CAN FETP MOST EFFECTIVELY SERVE DOH IN THE FUTURE?

This question will be answered by addressing the following issues:

- (A) What improvements in training program content and methodology need to be pursued?
- (B) How can FETP provide better support to policy makers?
- (C) How should FETP be institutionalized within DOH?
- (D) What resources will be required for optimal development of FETP?

A. Improvements In Training Content and Methodology

The balance of field training and didactics depends on the extent to which the 4 specific objectives of FETP need to be achieved. The current arrangement (6 weeks of didactics and subsequent hands-on training in the field for the rest of the 2-year training period) is more than adequate to achieve skills in investigating and analyzing disease outbreaks and surveillance data. However, didactics will have to be increased if the trainees are expected to be competent in other epidemiological methods for disease prevention and control and in program planning and evaluation.

The basic philosophy underlying FETP training is for the trainee to "learn by doing." While there is unanimity of opinion on the appropriateness of such an approach as validated by the experience of the past four years, there is a felt need among FETP trainees and graduates that the 6 weeks of didactics is inadequate, particularly since the scheduled weekly seminars are not strictly followed (owing to unexpected events, such as natural disasters).

Academically, FETP is quite strong and has effectively taught skills in disease surveillance, in outbreak investigation and control, EPI cluster surveys and in producing clear and concise reports and papers. In the teaching of survey skills and in the appropriate use of laboratory services, FETP is deemed to have achieved more limited success. However, FETP is acknowledged to be relatively weak in providing trainees skills in survey design and methodology other than the EPI cluster survey, appropriate use of laboratory tests and services; biostatistics; research management; and program evaluation. The Evaluation Team did not have time to assess whether FETP provides adequate training in epidemiological reasoning, including methods for control of confounding and bias.

The Evaluation Team recommends:

1. The weekly seminars on issues of current interest to the DOH and the public should be held on a regular basis. These forums can update the trainees on the management and control aspects of the disease as well as the methodologic issues encountered in carrying out the trainees' investigations. This regular exchange would also ensure that all trainees have

a balanced exposure to different investigations, even as they have the opportunity for hands-on experience in a number of these epidemiological activities.

2. Additional didactic sessions are recommended, perhaps at the end of the first year or in the second year of training, to cover more advanced concepts of epidemiology (including chronic disease epidemiology), biostatistics, research management and program planning and evaluation. These sessions may be conducted in collaboration with faculty from the University of the Philippines (whether or not a degree of M.S.P.H.-Epidemiology is granted) and management training institutes/services. These sessions would help trainees become better trainers in field units or at the central level. This capacity to train and replicate their skills is a key to promoting and sustaining epidemiology consciousness (or a "data culture") in various levels of DOH.

3. Orientation regarding common laboratory procedures should be part of the didactic sessions. Laboratory tests needed for specific disease investigations being carried out by the trainees deserve further discussions with the laboratories concerned regarding the nature of the epidemiological investigations, the proper collection of specimens and the correct interpretation of laboratory results.

4. During the early weeks of training, the trainees should be oriented to the various programs of the DOH. At some point, a short preceptorship in selected disease control programs can be arranged to introduce trainees to program operations and to open channels of communication and collaboration for subsequent disease investigations. This should enhance learning of program evaluation skills during the second year as well as improve work relationships between FETP and the control program.

The quality of supervision of FETP trainees is reflected in their excellent reports as well as the recommendations made to the DOH. Drs. Mark White and Manuel Dayrit are uniquely qualified to supervise FETP. The recent addition of Dr. Ma. Concepcion Roces as an instructor will greatly enhance the supervision of FETP trainees in field investigations and

report generation. However, Dr. Dayrit's other demanding responsibilities in DOH does affect the time he can devote for supervision. His frequent unavailability also impairs Dr. White's ability to join trainees in field activities as well as impedes the faster turnaround of papers/protocols submitted by trainees for comments from the 2 program supervisors.

The quality of FETP reports and recommendations is most appreciated by DOH top management. The concise, crisp, but technically solid reports are seen as representing a high level of professionalism, competence, and discipline for the people preparing the reports. Many of the reports have been published in Filipino scientific journals and a few are being considered for international publication.

The value and the soundness of FETP was highlighted during the several recent major calamities that have struck the country (e.g., the July 1990 earthquake, Typhoon Ruping, Mt. Pinatubo, Ormoc). The data collection, analyses, and recommendations provided by FETP became the basis of DOH's responses to the various public health concerns encountered. However, the invaluable role played by FETP during the disasters spawned a concern: how to balance FETP's training and service functions. The observation was made on several occasions that the training component suffered because the service dimension (assisting disaster surveillance, for example) demanded a great deal of the trainees' time. FETP's expectation was that once it had undertaken the investigation or that once it had established the surveillance system, either the relevant program managers or the concerned area managers would take over. Such expectations generally did not materialize.

Thus, the need to address the following issues with respect to FETP's training content and methodology:

(1) How to balance FETP's training and service functions?

One way of effecting the balance would be for FETP faculty to look at service demands as training opportunities. When a situation no longer meets training needs, then it is time for FETP trainees to move out.

On the other hand, to meet the legitimate needs of program managers and area managers for FETP skills, underutilized graduates can be tapped for specific tasks. This can be an ad hoc arrangement while sufficient FETP graduates are not yet available for posting to the various program offices and regional offices.

An important question that needs to be asked, however, is whether epidemiologic information has seeped down to the program managers and to the lower level--the area managers and field implementers. The answer is usually no and if the information comes at all, it comes in trickles. How to be able to make epidemiologic information available to the program and area managers to guide them in future planning, managing and evaluating health services should be addressed as a high priority by FETP.

There is therefore the need for a stronger and closer coordination and good working relationship devoid of personal animosity between FETP and other program and area managers within the DOH before, during and after implementation of epidemiologic studies.

(2) How to widen theoretical perspectives of trainees without diminishing hands-on-field-experience?

This can be addressed by (a) ensuring that the weekly lectures/seminars series are pursued; (b) by tapping experts from other institutions like UP-CPH and visiting experts from WHO, USAID, etc.; (c) having a better balance in the exposure of trainees to various types of diseases in the Philippines, including non-communicable diseases.

The following recommendations are also suggested in order to widen the theoretical perspectives of FETP trainees and strengthen the training program as a whole:

- (a) Lectures/didactics can include: (i) an orientation on the organization of the DOH, including health program targets and strategies, as well as general accounting and audit rules normally governing epidemiology support activities; (ii) management and administrative theories and skills; (iii)

principles of leadership and inter-personal relationship; (iv) greater attention to survey methodology, evaluation methods, and applied statistics.

(b) A full-time supervisor who can take the place of Dr. Manuel Dayrit. This will allow for closer supervision and lessen the lag time in commenting on the trainees' papers.

(c) Greater diversity in the assignment of cases to trainees. Considering that FETP's approach is to "learn-by-doing," this is essential so that by the time they graduate, trainees would have had as wide an experience as is possible and not be experts in only one particular type of disease.

(d) Evaluation of trainees by both the trainers and the FETP Board of Advisors should include an assessment of the trainees' theoretical knowledge of fundamental epidemiological principles. It should also include a technical assessment of the trainees' output to ensure that the determinant for graduation is not limited to impressions obtained during interviews. In addition, the evaluation of trainees by members of the FETP Board needs to be standardized. Guide questions and criteria for evaluating trainees should be provided to Board members.

(e) It is important that the new, valuable addition to the FETP faculty (Dr. Roces) be protected by providing a permanent DOH position (MS II at the least). Additional trainers need to be identified or developed, particularly if the intake of trainees increases in the future and if the communications network among FETP graduates is to be sustained.

B. How to Provide Better Support To Policy Makers?

As has been mentioned, there is a general consensus that the FETP has been providing valuable inputs to DOH policy-makers in the formulation of policy as well as in the adoption of health intervention measures.

A particular contribution of FETP that is greatly appreciated by DOH top management is that regarding health issues that rate high in public concern (e.g. Aeta measles outbreak, "red tide"). FETP's inputs have been

technically credible; DOH top management has used them with confidence and they have contributed to DOH's image as the source of ultimate technical knowledge and authority on prevailing health concerns.

However, policy making in the DOH does not exclusively emanate from top management. Program managers and area managers have their own inputs in the crafting of health policies. The FETP has yet to make its impact on health policy decision-making at this level of DOH management. This is not necessarily a reflection of FETP's failure. Rather, it represents more the inherent limitations of FETP as a training program and the inability of the DOH as a whole to institutionalize FETP and have its output properly utilized by the organization.

Thus, the issue arises as to whether FETP should graduate significantly more than the current average of 6-7 per year. At this rate, it will take decades before enough graduates are produced to staff the various services in the DOH central office as well as the regional, provincial, and district levels. The answer to this question is again related to the issue of institutionalization of FETP. Of particular relevance, also, are the additional resource requirements needed to support trained epidemiologists in the field, especially when one considers the effects on the DOH of the recently passed Local Government Code (LGC).

To ensure the proper dissemination to the field of all the completed epidemiological studies, a staff person within FETP should be given this responsibility, reinforced by Department Circulars and/or Administrative Orders.

The following can help in making FETP provide better support to policy makers:

1. *Optimal Use of Reports*

- (a) Provide key program managers and area managers with FETP reports on a regular basis.

Hopefully, this move will allow such managers to better appreciate FETP. If necessary, a workshop can be undertaken to describe how FETP reports can be used in the managers' day-to-day activities.

(b) Provide concerned local officials with FETP reports.

The reports can perhaps be simplified for easier understanding by non-technical people. With the predominant role that local officials will play in disease control under the LGC, FETP reports will be essential in guiding local officials in their health initiatives.

(c) Provide media with FETP reports

The media can be an invaluable ally in disseminating health information to the general public. Mechanisms can be developed and/or improved so that the media can better understand FETP reports. Some ideas to "educate" media include: (a) conducting seminars/workshops; (b) including them in actual disease investigations/surveillance; (c) establishing a telephone system whereby media personnel can clarify technical terms/issues.

2. *Optimal Use of Graduates*

The optimal use of graduates requires that the DOH has a clear organizational plan for FETP graduates as well as a "deployment plan." This means that FETP trainees must have a specific place/position to go to after graduation where their training can be best put to use. This deployment plan for FETP graduates, including the requisite support mechanisms, is not currently apparent and is necessarily part of the institutionalization issue of FETP.

Program managers and area managers have yet to fully appreciate the value of trained field epidemiologists in the context of the service functions of their specific programs or offices.

The career path for graduates is currently limited because of a dearth of available MS II items. MPH graduates with only a year of training seem to have a slight advantage in terms of promotion, underscoring the lack of appreciation of FETP graduates by their superiors.

The Evaluation Team recommends:

1. FETP training should be included as a qualification standard for MS II positions. In areas of high need, exceptional FETP graduates can qualify for MS III positions.
2. A deployment plan for graduates should be developed for the next 5 years. This would guide recruitment of trainees from various levels. A priority would appear to be the provision of regional field units with field epidemiologists (with MS II or III positions) to coordinate disease surveillance, outbreak investigations and disaster services at the regional level. This would be particularly important as the DOH services devolve to the local governments.
3. The annual conferences for FETP graduates and trainees is an excellent venue for monitoring their progress and updating them on current issues of interest. Program and area managers should be invited to these annual conferences to increase appreciation of FETP capabilities. As the FETP faculty increases, other schemes for maintaining communications within the network of FETP graduates can be developed.

C. How to Institutionalize FETP Within DOH?

The FETP Mid-Term Evaluation Report identified the major components of institutionalization of FETP to include (a) program financing and operational budget; (b) appointment of a national director; (c) organizational identity; (d) operational budget/authority; (e) self-sustaining cycle from recruitment to graduation; (f) certification/credentialing for graduates; (g) career path for graduates; (h) an epidemiology bulletin; (i) and establishment of an annual epidemiology conference.

For purposes of this end-of-project evaluation, basically the same criteria will be used, although they will be recast somewhat.

Since the mid-term review (May 1990), there has been some progress on the issue of FETP institutionalization in the sense that specific plans/programs have been formulated and budget estimates have been prepared. What has not been achieved basically is to get DOH top management's decision on these plans/programs.

Institutionalizing FETP requires 2 fundamental policy decisions, namely: (1) How does FETP fit in DOH's overall organizational plan/strategy for undertaking epidemiologic activities nationwide? and (2) where should FETP be lodged in the DOH organizational structure?

By answering the first issue, FETP's relationship with service offices in the central office and with regional and provincial units will be clarified. The resolution of the concern of proper balance between FETP's training and service components will also be better guided. The desire of having a self-sustaining cycle from recruitment to graduation should be realized since trainees will have a defined role and position waiting for them after graduation.

On the other hand, the answer to the second policy issue will ensure the continued existence of FETP since annual budgets will be obtained from general appropriations rather than be dependent upon donor funding.

1. How to fit FETP in DOH's overall plan/strategy to undertake epidemiological activities nationwide?

The development of an overall plan/strategy for DOH to undertake epidemiological activities countrywide requires the establishment of a nationally cohesive organizational structure that links the efforts at the central office with that of the field offices (i.e. regions and provinces).

To achieve this, 3 concurrent initiatives need to be done. One is to institutionalize FETP as part of HIS (this will be discussed in greater detail in

the next section.) Second is to strengthen the utilization of epidemiology data for planning, managing, and evaluating health programs by the program managers at the central office. The third is to establish Regional Epidemiology Units with concomitant administrative and laboratory support.

The idea is to distinguish FETP as a training program whose primary purpose is to train epidemiologists with a preponderant emphasis on field experience. Upon graduation, FETP trainees will be "placed" with the various program managers at the central office as well as with the Regional Epidemiology Units. Over time, FETP graduates may be appointed at the provincial and district levels consistent with the ability of DOH to provide the requisite administrative and laboratory support at such lower levels of the organizational structure. With this strategy, there is a clear linkage between FETP activities and the strengthening of a national organizational "backbone" for epidemiology concerns. There should also be every reason for FETP to accept trainees from outside of the DOH provided the basic staffing needs of DOH for trained field epidemiologists has been met.

At the same time, clear policy pronouncement must be made by the DOH that FETP is essentially a training program. The handling of epidemiologic activities must rest with the program managers in the central office in conjunction with the Regional Epidemiology Units. For disease outbreaks that the central office program managers are incapable of handling, the regional office concerned may ask for assistance directly from FETP.

The positive ramifications of this overall strategy for undertaking epidemiological activities include:

- (a) FETP's strength in training field epidemiologists is not diluted.

It will provide support to services/programs, rather than undertake service itself. Whatever service activity trainees will do will be primarily to satisfy training needs.

(b) There will be systematic development of epidemiological capability within DOH.

With priorities given to strengthening service/program managers and Regional Epidemiological Units, the basic backbone of a technically competent national set-up within the DOH to handle epidemiological activities will be given priority and systematically pursued.

Moreover, limited resources can be focused by developing adequate support infrastructure (e.g. vehicles, computers, laboratory, library, etc.) in the regions and the central office first.

At the same time, depending upon resources available and on the pace at which the DOH top management would like the "national epidemiology backbone" to be established, the decision on the number of annual graduates that the FETP should have can easily be decided.

In this regard, the Evaluation Team estimates that a minimum total of 39 FETP graduates is needed to staff the DOH national epidemiology "backbone" previously described. The breakdown of the total is as follows:

1. Regional Epidemiology Units

(13 Regions @ 2 FETP graduates each;
CAR provinces assumed to be serviced
by regions where they were previously
aligned)

2. Central Office Program Managers

(10 for Office of Public Health Services, 1 for
HOMS, 1 for IPS, 1 for Community Health Service)

Given FETP's current average of 7 graduates annually, it will take DOH about 6 years to provide all the required epidemiologists. Should DOH desire a much shorter period, say 2 or 3 years, then DOH must be prepared to pour in the necessary incremental resources.

(c) Self-sustaining cycle from recruitment to placement.

Since priorities have been identified, the regional offices and the service/program managers can determine the number of trained epidemiologists they would require. Consequently, they will have to make available the plantilla items for their required FETP graduates. The consensus is that a minimum of an MS II category should be granted to FETP graduates.

Undersecretary Mario Taguiwalo has expressed the view that under the new regulations of DBM, FETP graduates can be appointed to MS II positions simply by DOH decreeing that graduation from FETP is a qualification standard for MS II positions.

Where no plantilla positions are available, realignment of existing vacant positions can be requested from the Department of Budget and Management (DBM). The reorganization of the regional offices under the Local Government Code may present opportunities to create positions for epidemiologists. Undersecretary Antonio Periquet has also given indications that it may be possible to provide one MS II item from the Medical Specialists Pool under the Office of the Secretary to each of the regional offices.

The assurance of placement at least at the MS II level upon graduation should enhance the recruitment efforts of the FETP. Applicants will see in FETP an alternative career path.

(d) Enhance DOH's influence over local governments.

In the light of the provision of Section 105 of the recently approved Local Government Code, which mandates the Secretary of Health to exercise direct national supervision and control over health

operations in any local government unit in cases of epidemics, pestilence, and other widespread public health dangers, it is likely that there shall be a felt need for more field epidemiologists nationwide.

Epidemiological functions are activities that local governments may not be inclined to pursue. Consequently, DOH may wish to consider such functions as among the key activities that the reorganized regional offices will undertake. In so doing, DOH, as a national agency, will have one clear possibility for a sphere of influence vis-a-vis local governments.

2. Where should FETP be lodged in the DOH organization?

The various options include: (a) merge FETP with the Epidemiology Division of the Health Intelligence Service (HIS); (b) place FETP under HIS but as a new division; (c) place FETP under the Internal Planning Service (IPS); (d) place FETP under the Undersecretary for Public Health as a new office; (e) place FETP directly under the Secretary of Health as a new office; (f) place FETP as a new division in the Research Institute for Tropical Medicine; and (g) merge FETP with the Bureau of Research and Laboratories (BRL).

Given the various choices, the recommendation of the Evaluation Team is to adopt option (a); i.e. merge FETP with the Epidemiology Division of HIS. The reasons for this recommendation are as follows:

(a) Easy to implement legally.

A DBM letter dated August 22, 1991 (see Annex 3) cited Section 48 of the General Provisions of the 1991 General Appropriations Act (GAA) as the legal justification for the recommendation. Said provision mandates each department/agency to "...restudy its programs and projects to determine which could be scaled down and discontinued, AND WHICH PROGRAM NEEDS AUGMENTATION..." (underscoring ours.)

While the 1992 GAA is not yet available at the time of the writing of this evaluation report, it is reasonable to assume that the same legal basis will appear in the 1992 GAA since said provision has always been contained in previous GAAs.

Thus, effecting the merger with HIS may only require DBM approval. In contrast, the other options that envision the creation of a new office outside of HIS may be construed as partaking of a DOH reorganization and would require legislative approval.

(b) Consistent with HIS legal mandate.

In the DOH organization, HIS is the unit tasked with overall epidemiology functions, encompassing both public health and clinical epidemiology. Specifically, HIS has a Division of Epidemiology whose capabilities will be enhanced by the integration of FETP.

Moreover, by merging FETP with HIS's existing Epidemiology Division, there will be an organizational cohesiveness in the standards to be followed in epidemiology functions.

Also, the FETP can concentrate on its training functions, with some of the service component expected of FETP undertaken by the non-training elements of the HIS Epidemiology Division. While said non-training elements may not yet have the level of technical competence of FETP graduates, their efforts can be easily supervised by the FETP trainers. Over time, such non-training elements should themselves be trained to the same level of technical expertise as FETP graduates.

(c) Consensus among various levels of staff in the DOH Central Office.

Top management, service chiefs, and rank and file employees interviewed agreed on this option, thereby minimizing any morale problems that are inherent in any action that involves tinkering with the organizational structure.

With the clarification of the 2 fundamental policy issues on (a) how FETP should fit in DOH's overall organizational plan/strategy to undertake epidemiology activities nationwide, and (b) on where FETP should be lodged in the DOH organizational structure, the following concerns need to be addressed as soon as possible to ensure FETP's institutionalization:

1) Appointment of a full-time counterpart to the CDC Consultant

The person to be appointed to this position may be the head of the reorganized HIS. Alternatively, it could be the division chief of the reorganized Epidemiology Division of HIS or Dr. Ma. Concepcion Roces, the newly appointed training assistant at FETP.

It should be noted that any reorganization presents the opportunity of casting the right person for the right position. In this regard, there are also existing vacancies in other key services of the central office. The filling up of all vacant positions must be considered in their totality and candidates can come not only from the DOH central office but also from the field offices, especially with the availability of regional staff affected by the Local Government Code.

In any event, the personnel decisions regarding FETP and DOH should be made before any change of administration within the DOH.

2) Provision of adequate administrative and laboratory support.

By and large, the current administrative support provided to FETP is adequate. However, the FETP office support staff are perceived by the trainees as wanting in the area of written communication skills. Moreover, the need for getting cash advances for travel expenses on short notice is a recurring problem. There is also great disappointment among FETP trainees and drivers in the reduction of per diem from P 250/350 to P 135. Notwithstanding an existing COA memorandum, concerned health authorities should make

representations to COA for an exemption from said memorandum so that the FETP trainees and drivers who work more than the required 8 hours per day and travel to more than one province in a day (especially during disasters) can receive the higher per diem. Additional vehicles would also be most welcome especially when there are outbreak investigations and disease surveillance activities being conducted at the same time.

DOH management should also consider providing immunization to trainees sent to undertake investigations of highly contagious diseases. The provision of health and accident insurance to trainees may also be indicated due to the trainees' frequent field visits and exposure to various risks.

Laboratory support to FETP in Metro Manila is primarily provided by RITM and BRL. The laboratory of the Department of Science and Technology (DOST) is also utilized for occupational diseases while that of the Bureau of Food and Drugs (BFAD) is tapped for food poisoning outbreaks. Laboratory support in the regions is generally weak, with most regional labs unable to do enteric bacteriology tests.

In Metro Manila, the physical distance of RITM from DOH/San Lazaro creates considerable inconvenience in transporting specimens and in obtaining lab results. At the same time, RITM's and BRL's operating budgets are impaired by having to pay for the laboratory supplies and reagents consumed and FETP is unable to make reimbursements to the laboratories on time.

Ultimately, the administrative and laboratory support inadequacies encountered by FETP can be reduced to (a) the ability of personnel to understand and work around government administrative rules, (b) better operating systems and procedures, and (c) availability of resources.

FETP relies primarily on the RITM and BRL for Manila-based laboratory testing of specimens. The laboratory support required for as many as 60 disease investigations in a year is tremendous. There have

been logistic constraints in the laboratories, neither of which has an additional personnel and MOOE budget for outbreak investigations. Inadequate communication among the parties involved regarding study protocols, collection of specimens and epidemiological data collected has also hampered operations.

The program provided seed money for the establishment of 3 regional laboratories. None of them are functional for FETP at present. Thus although the National Sentinel Surveillance System has recently been started in 12 regions, the disease surveillance is largely based on clinical diagnoses.

Regarding laboratory support, the Evaluation Team recommends:

1. Provision of appropriate budgetary support. (The details of this are discussed in the ensuing Section D of this report.)
 2. Visits and discussions between the FETP trainees and the laboratory staff in the context of a disease investigation should be encouraged. This would improve communications and appreciation of procedures undertaken by either side.
 3. BRL staff should undergo short-term training at RITM for special tests (e.g., dengue serology, viral isolation) with the end of carrying out such tests at BRL.
 4. The Institutional Strengthening Program (ISP) of RITM for regional hospitals can be expanded to serve the laboratory training needs of regional laboratories that shall be established.
3. Provision of adequate capital outlay (CO) and current operating expense (COE) budget.

By CO is meant capital expenditures for equipment and building construction/renovation. By COE is meant recurrent expenses for (a) salaries or Personal Services (PS); and for (b) Maintenance and Other

Operating Expenses (MOOE) such as laboratory supplies, travelling expenses, gasoline, equipment maintenance, and conference expenses.

The total budget requirements for FETP institutionalization can be divided into (a) that needed at HIS after absorbing FETP; (b) that necessary to provide fully for the administrative and laboratory support services of FETP in Metro Manila; and (c) that required to establish Epidemiological Units in the regions with their own appropriate manpower complement and requisite administrative and laboratory support.

FETP will be funded by the Child Survival Program through 1993. Thereafter, FETP is expected to be funded by the DOH through its regular appropriations, unless some other external funding is obtained (a doubtful prospect at this time.) Consequently, to increase FETP's chances of being eventually funded out of the GAA, the initiative must be taken to have the FETP budget included in the 1993 GAA. The idea is if efforts are unsuccessful in 1993, then there is still 1994 as a last try for lobbying. In addition, DOH has relatively good rapport with the present leadership in DBM as well as with key members of the Appropriations Committees of both Houses of Congress, a situation that is not assured with the new government leadership that will handle the 1994 budget.

Submission to DBM of the 1993 budget proposal will be around April-May 1992. Hence, total budget estimates will have to be made by DOH within the first-quarter of 1992.

4. Recognition of FETP as a professional qualification.

This is an essential action to characterize FETP training as a distinct career path. The advantage of formal recognition is that it confers on the graduate credentials that could be utilized even when he or she leaves the DOH.

The options for recognition, including those identified in the Mid-Term Review, are (a) trainees to undergo a third year at UPCPH, with

the trainee awarded an MPH degree; (b) graduates examined by an expert committee, similar to the board certification in clinical specialties; (c) special arrangements where some of the lectures/didactics of FETP trainees are conducted by UPCPH, with the trainee eventually given a Masters degree in Epidemiology after the two-year FETP program.

Option (a) does not look attractive to trainees for it lengthens their study period. Options (b) and (c) look feasible if pursued vigorously and if DOH used its influence and good offices. Specifically, the suggestion for DOH to help resurrect the Epidemiology Society of the Philippines could be a vehicle for achieving Option (b). On the other hand, Dean Jane Baltazar of UPCPH appears supportive of Option (c) and what needs to be done is to convince other key officers of UPCPH.

For the recognition of FETP as a professional qualification to be realized, it is recommended that an Undersecretary of Health be specifically tasked to attend to the problem.

D. What Resources Are Required For Optimal Development of FETP?

For purposes of this report, resources requirement is equated with budgetary support. The Evaluation Team recognizes that the availability of capable trainers/instructors is a major resource need of FETP. However, it is assumed that such type of resource can be accessed if the necessary funding support is obtained.

It is estimated that for Year 1, assuming FETP is institutionalized as described in Section C.1 above, the total budget needs as follows:

AGENCY	PS	MOOE	CO	TOTAL (in Pesos)
A. METRO MANILA-BASED ACTIVITIES				
1. FETP Proper	762,959	4,911,141	2,460,000	8,134,100
2. Sentinel Surveillance System	965,693	364,000	2,380,000	3,709,693
Subtotal	1,728,652	5,275,141	4,840,000	11,843,793
3. RITM (as support lab)	139,572	555,500	2,465,000	3,160,072
4. BRL (as support lab)	139,572	347,500	2,465,000	2,952,072
Subtotal	279,144	903,000	4,930,000	6,112,144
B. REGIONAL EPIDEM. UNITS				
1. Regional Office	2,799,942			2,799,942
2. Regional Laboratory		3,000,000	15,000,000	18,000,000
Subtotal	2,799,942	3,000,000	15,000,000	20,799,942
TOTAL	4,807,738	9,178,141	24,770,000	38,755,879

Annexes 4, 5, 6, 7 and 8 respectively give the breakdown of the total per Agency indicated above.

It should be noted that the figures cited above refer to the present training capabilities of FETP. It may require closer scrutiny for possible synergies resulting in lower budgetary needs. Should it be decided that the annual number of graduates be increased from the current average of about 7, then necessarily, the budget has to be correspondingly increased.

A budget for laboratory support is essential. Manila-based laboratory support alone is estimated at roughly 2.5 million pesos for additional capital outlay in each laboratory and 1.14 million per year for personnel and MOOE. The establishment of regional laboratories would each require an estimated additional capital outlay of P 1 million and another P 1 million for personnel and MOOE per laboratory.

Moreover, the amounts are budgetary estimates and actual cashflow may be different since (a) the setting up of the Regional Epidemiology Units may be accomplished over a period of time; and (b) the operationalization of the regional support laboratories may have to be staggered or paced consistent with the availability of trained epidemiologists and laboratory personnel (e.g. in enteric bacteriology.)

Cashflow-wise, therefore, DOH may need about P18,000,000 to immediately fund in Year 1 (i.e. 1992) all the needs of FETP being merged with HIS, as well as for providing the requirements of the support laboratories in Metro Manila (i.e. RITM, BRL, BFAD, DOST, etc.) The cashflow needs of the Regional Epidemiology Units (REU) with the requisite laboratory support will have to be determined by DOH based on its decision on how fast the REU's can be established. If funds are insufficient to maintain all 15 regional laboratories, one possibility might be to have certain regional labs provide services to adjacent regions as well as to their own regions. For example, if only 5 regional laboratories are upgraded (instead of 15), budgetary needs would be reduced by more than P13,000,000 in 1992.

Based on the experience with the GAA approvals the past two years (i.e. 1990 and 1991) when the government encountered serious budgetary deficits, it may be judicious to assume that DOH will have difficulty obtaining appropriations for Capital Outlay (CO) in 1993. (The details of the 1992 budget are not yet available at the time of the writing of this report although indications are that CO expenses will not be given priority.)

Since institutionalization of FETP is expected to be funded basically from USAID grants and DOH budgetary appropriations, DOH may want to consider as a matter of strategy to have USAID fund as much of the CO expenses as is possible, with the DOH picking up COE or recurrent expenses. With this approach, the likelihood of sourcing the funding of FETP institutionalization is enhanced.

SCOPE OF WORK FOR FETP EVALUATION
December 9-15, 1991

BACKGROUND:

I. Title

Primary Health Financing Project (492-0371--Field Epidemiology Training Program (FETP) Component)

II. Objective

To conduct an end-of-project (PHC Financing) evaluation of the FETP project and make recommendations to USAID and the Philippines Department of Health (DOH) on two questions: How well has FETP accomplished the goals set out in the original project paper? How can FETP most effectively serve DOH in the future?

III. Statement of Work

The evaluation will address the following areas with particular attention to areas identified as problems in the mid project evaluation. For each of the area, an evaluation will be made of how FETP's present progress and a recommendation about how FETP should address the area in the future.

1. The Role of FETP in serving DOH:

A. Policy

1. Is FETP useful in identifying issues needing policy decisions?
2. Is FETP providing support to policy makers?

B. Academics

1. Appropriate balance of field training and didactics.

2. Does the program teach appropriate skills in the following areas:

- a. epidemiological reasoning, especially methods for control of confounding and bias.
- b. surveillance
- c. surveys
- d. outbreak investigation and control
- e. use of laboratory services
- f. program evaluation
- g. writing clear reports and papers.

3. Is the level of supervision adequate?

C. Quality of output

1. Reports and recommendations
2. By-products of FETP output and activities
3. Publications
 - a. local
 - b. international

D. Disaster Services

1. Is data collection in disasters timely?
2. Is appropriate data collected?
3. Is data useful to disaster control managers?

E. DOH Goals

1. Is FETP meeting the goals set by DOH?
2. Should DOH goals for FETP be modified?

2. **Institutionalization**

- A. Where should FETP be institutionalized in order to provide optimum support for policy makers.
- B. Appointment of a full-time counterpart to the CDC consultant.
- C. Progress on institutionalization since the mid project evaluation.

- D. Is there adequate administrative support for FETP to fulfill its role?
 - 1. Personnel
 - 2. Vehicles
 - 3. Telephones and other communications
 - 4. Others
- E. Laboratory support.
 - 1. Is present laboratory support adequate?
 - 2. Are relations with laboratories optimal?
- F. Is FETP in the 1992 DOH budget?
- G. Graduates
 - 1. Optimal utilization of graduates
 - 2. Recognition of FETP graduation as a professional qualification
- H. What steps should be taken to fully institutionalize FETP?

IV. Resources

What resources will be required from USAID and DOH for optimal program development?

V. Reports

Evaluators will produce a report of no more than five pages summarizing their findings and recommendations on the key points listed above before December 31, 1991.

11

VI. Other Requirements

A. Level of Effort

Estimated level of effort is up to 5 days.

B. Qualifications of Evaluators

1. One evaluator should be a practicing epidemiologist who is familiar with the health problems of the Philippines and with the structure of the Department of Health.
2. One evaluator should be from a DOH field office.
3. One evaluator should be familiar with the Child Survival Program and with issues of epidemiology and program planning.

ANNEX 2

LIST OF PERSONS INTERVIEWED

<u>NAME</u>	<u>Position</u>
1. Dr. Enrique Tayag	FETP Trainee
2. Dr. Grace Abad-Viola	FETP Trainee
3. Dr. Ilya Abellanos	FETP Trainee
4. Dr. Ruth Surmieda	FETP Trainee
5. Dr. Luz Pascual	FETP Trainee
6. Dr. Rio Magpantay	FETP Trainee
7. Dr. Florante Magboo	FETP Trainee
8. Mrs. Felilia White	Program Manager, FETP
9. Dr. Nancy Zacarias	Technology Info Officer, FETP
10. Dr. Ma. Concepcion Roces	FETP Graduate and Trainer
11. Dr. Manuel M. Dayrit	FETP Program Manager, Trainer
12. Dr. Mark White	CDC Consultant & Trainor
13. Mrs. Lourdes Alegre	Adm. Officer III
14. Ms. Suzette R. Manuel	Librarian III
15. Dr. Antonio Lopez	PHO, Tarlac
16. Dr. Juan Lopez, Jr.	FETP Graduate
17. Dr. Revelyn U. Rayray	FETP Graduate
18. Dr. Mary Elizabeth G. Miranda	FETP Graduate
19. Dr. Manuel G. Roxas	DOH Undersecretary
20. Mr. Mario M. Taguiwalo	DOH Undersecretary
21. Dr. Zenaida Ludovice	Service Chief, HIS
20. Mr. Vidal Pantillano	Nurse II, Epid. Div., HIS
21. Ms. Criselda Reyes	Statistician, HIS
22. Mr. Arnel Sangalang	Statistician, HIS
23. Dr. Antonio Periquet	DOH Undersecretary
24. Dr. Alfredo R.A. Bengzon	DOH Secretary
25. Dr. Francisco Valeza	Service Chief, TB
26. Ms. Tess Hilario	Service Chief, Finance
27. Ms. Adelisa Ramos	Service Chief, Nutrition
28. Dr. Vivian Lofranco	FETP Graduate
29. Ms. Patricia Moser	Chief, OPHN/USAID Manila
30. Dr. Rosendo Capul	Program Manager, CSP-OPHN/ USAID Manila



ANNEX 3

REPUBLIC OF THE PHILIPPINES
DEPARTMENT OF BUDGET AND MANAGEMENT
MALACANANG, MANILA

M-67-d
OFFICE OF THE SECRETARY
RECEIVED
BY Rumfo
DATE 10/14/91

August 22, 1991

12/15
M 132-3
OFFICE OF THE SECRETARY

HONORABLE ALFREDO R.A. BENGZON
Secretary of Health
Department of Health
Rizal Avenue, Metro Manila

Dear Sir:

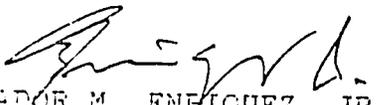
This refers to a petition-letter dated June 11, 1991 of Concerned Employees of the Health Intelligence Service, DOH Manila, which we are forwarding to your office for appropriate action.

Inasmuch as there has been no official and formal request for any modification in the Reorganized Structure of DOH as provided in Executive Order No. 119, we are referring said letter as the petition contained therein could be properly addressed only by the DOH.

Please be informed also that under Section 48 of the General Provisions, GAA for CY 1991, each department/agency is required to restudy its programs and projects to determine which could be scaled down and discontinued, and which program needs augmentation. The DOH may, therefore, use this provision as a basis for reassessing its commitments and program thrust, just to make sure that the reforms being contemplated do consider priority concerns of the DOH.

Best wishes.

Very truly yours.


SALVADOR M. ENRIQUEZ, JR.
Undersecretary

Annex 4

FETP TRAINING AND
SENTINEL SURVEILLANCE SYSTEM

PERSONAL SERVICES

Administrative Staff

(1) AO3	94318	
(1) AO1	57961	
(1) Librarian 3	80702	
(2) Clerk 3	80178	
(2) Driver 2	77300	390459
Trainer's Fee	12500	
Training Allowance	360000	372500

Sentinel Surveillance Staff

(1) Program Manager	176329	
(4) Public Health Nurse 3	393068	
(1) Information Technical Officer 2	134050	
(1) Computer Programmer 3	94318	
(2) Clerk 2	73610	
(1) Project Development Officer 3	94318	965693

MOOE

Travelling	2916141	
Communication Service	204000	
Repair of Govt. Facilities	100000	
Transportation	18000	
Other Services	904000	
Supplies & Materials	750000	
Maintenance Motor Vehicle	383000	5275141

CAPITAL OUTLAY

Scanner/Mimeo	380000	
Opaque projector	75000	
Uninterrupted power supply	360000	
Library Books/Journals	700000	
Video tape player/recorder	25000	
Laptop computers	600000	
Bubble jet printers	600000	
386 Personal Computers	1800000	
Epson Printers	300000	4840000

TOTAL

11843793

Annex 5

RESEARCH INSTITUTE FOR TROPICAL MEDICINE

PERSONAL SERVICES

(2) Medical Technologists	103922	
(1) Laboratory Aide	35650	139572

MOOE

Laboratory supplies & reagents for FETP outbreak investigations and surveillance activities.	555500	555500
--	--------	--------

CAPITAL OUTLAY

Clean Bench laminor	500000	
Safety Cabinet	750000	
Dry Incubator	250000	
Centrifuge table top	150000	
Autoclave	80000	
Dry Sterilizer	60000	
Refrigerator	10000	
Liquid Nitrogen tank	150000	
Freezer 20 C	15000	
Freezer 70 C	500000	2465000

Total		3160072
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Annex 6

BUREAU OF RESEARCH AND LABORATORIES

PERSONAL SERVICES

(2) Medical Technologists	103922	
(1) Laboratory Aide	35650	139572

MOOE

Laboratory supplies & reagents for FETP outbreak investigations and surveillance activities.	555500	555500
--	--------	--------

CAPITAL OUTLAY

Clean Bench laminor	500000	
Safety Cabinet	750000	
Dry Incubator	250000	
Centrifuge table top	150000	
Autoclave	80000	
Dry Sterilizer	60000	
Refrigerator	10000	
Liquid Nitrogen tank	150000	
Freezer 20 C	15000	
Freezer 70 C	500000	2465000
Total		3160072

Annex 7

REGIONAL HEALTH OFFICE

PERSONAL SERVICES

(11) Public Health Nurse 3	1080937	
(11) Clerk 2	404840	
(15) Medical Technologist	779415	
(15) Laboratory Aide	534750	2799942

MOOE -

CAPITAL OUTLAY -

TOTAL 2799942

REGIONAL HEALTH LABORATORIES

PERSONAL SERVICES

MOOE

CAPITAL OUTLAY

Microscope ordinary	1500000	
Centrifuge 600rpm	2250000	
Water berth	900000	
Incubator	1275000	
Dry Sterilizer	900000	
Autoclave	1800000	
Refrigerator	150000	
Freezer, 20C	142500	
Airconditioner	270000	
Liquid nitrogen tank	2250000	
Pipettors, multichannel	2036250	
Pipettors, single channel	1076250	
Typewriter	450000	15000000
TOTAL		15000000