

Meeting Report

2nd Workshop for Field Epidemiology Training Programme in the Western Pacific Region



Manila, Philippines
29 to 30 November 2010

WPDSE1005425-ESR

Report series number: RS/2010/GE/74(PHL)

English only

REPORT

2ND WORKSHOP FOR FIELD EPIDEMIOLOGY TRAINING PROGRAMME
IN THE WESTERN PACIFIC REGION

Manila, Philippines
29-30 November 2010

Convened by:

World Health Organization
Regional Office for the Western Pacific

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

October 2011

NOTE

The views expressed in this report are those of the participants who attended the 2nd Workshop for Field Epidemiology Training Programme in the Western Pacific Region and do not necessarily reflect the policies of the Organization.

This report has been prepared by the World Health Organization Regional Office for the Western Pacific for governments of Member States in the Region and for those who participated in the 2nd Workshop for Field Epidemiology Training Programme in the Western Pacific Region, which was held in Manila, Philippines from 29 to 30 November 2010.

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Keywords:

Epidemiologic methods – education/Epidemiology – organization and administration/Training programmes/Western Pacific
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SUMMARY

Field Epidemiology Training Programs (FETPs) are competency-based training and service programmes in applied epidemiology and public health. The programmes seek to develop the capacity of public health systems in countries by building competencies through on-the-job mentorship and training.

Traditional FETPs are of two years duration and a significant amount of time and human resources are required. Therefore, the conventional FETP training model needed to be modified, especially for some lower-income countries with limited local human resources and the need to build capacity rapidly. A modified approach of FETP (modified FETP) has been identified as a viable alternative to the conventional FETP. Modified FETPs (mFETPs) are shorter courses adapted to meet country situations and needs.

The first workshop on mFETP was held in November 2009 in Seoul to share the progress of newly- developed programmes and to identify needs for external support. Following this workshop's recommendation, the Western Pacific Regional Office made a commitment to conduct an annual workshop to share experiences and achievements among programmes, including assessment framework development and an assessment of programmes.

To support further improvement of field epidemiology training (FET) programmes, which are defined to include conventional FETP and mFETP, it will be critical to mobilize additional resources and share examples of best practice on how to enhance sustainability and improve the quality of FET programme fellows' skills and experiences. In view of this, a draft sustainable model for mFETP was developed following wide consultation and a reference to international initiatives. Essential elements of this model include obtaining long-term political support through advocacy, qualified programme components, programme-related output and outcome and national and international partnerships. The model shows interactions of these components that are required to create an enabling environment to support the sustainability of mFETPs.

A second workshop for FET programme in the Region was held in Manila, Philippines, from 29 to 30 November 2010. This workshop was viewed as a key milestone in the strategic long-term plan for capacity-building in the Region. The main objective of the workshop was to discuss how well conventional FETPs and mFETPs were addressing country needs and to examine the proposed sustainability model for mFETP.

The objectives of the workshop were to :

- (1) share experiences and achievements of FET programmes;
- (2) develop an assessment framework for mFETPs;
- (3) foster partnership among FET programmes; and
- (4) support newly-developed FET programmes.

The workshop was attended by participants or representatives of nine FET programmes from Cambodia, China, Japan, the Lao People's Democratic Republic, Malaysia, Mongolia, the Philippines, Singapore and Viet Nam. There were also international partner agencies such as the Training Programmes in Epidemiology and Public Health Interventions Network (TEPHINET); the United States of America Centers for Disease Control and Prevention (USCDC); the Public Health Agency of Canada (PHAC); Institute Pasteur du Cambodge and South-East Asia Field Epidemiology and Technology Network (SAFETYNET). Also present were WHO temporary advisers and WHO staff members serving as the secretariat.

The workshop presentations included a report from TEPHINET ; presentations from each of the six FET programmes and a number of FET programme graduates; and presentations of working papers on advocacy, an assessment tool of indicators for mFETP and a proposed model for sustainable mFETP . There were plenary discussions and group work to consider the working papers that had been presented. The workshop closed with a final plenary session and a discussion about achievements, challenges and conclusions and recommendations for future activities.

FET programmes are fulfilling a need and, where present, either in the classic or modified form, are contributing substantially to the strengthening of public health systems nationally. Many of the most important features of a strong FET programme, including advocacy, multisectoral engagement, funding and technical support and monitoring and assessment systems that allow for lessons learnt, are influenced by an enabling environment and a strong national political commitment.

The workshop participants concluded that:

- (1) The feasibility of the mFETP has been demonstrated through the growing experience and successful implementation of mFETP in different countries.
- (2) There is strong political and donor momentum behind FET programmes; several challenges are to be overcome in moving towards ensuring the sustainability of programmes.
- (3) Within 12 months of the workshop, an assessment of at least one mFETP should be conducted using the assessment tool.
- (4) The Asia Pacific Strategy for Emerging Diseases (APSED) should be used as an advocacy tool for FET programmes.
- (5) Activities to increase the visibility of the achievements of FET programmes should be carried out within each country.
- (6) Collaboration with other FET programmes should be encouraged to maximize effective use of resources.
- (7) The building of national and international collaborations, partnerships and networks should be encouraged.

1. INTRODUCTION

The key components of APSED include surveillance, risk assessment and response. Member States have scaled up efforts to build capacity in these areas. In 2008, the APSED Technical Advisory Group (TAG) recommended creating FET programmes in countries as a part of capacity-building. FET programmes are competence-based training and service programmes in applied epidemiology and public health. The programmes seek to develop capacity of public health systems in countries by building competencies through on-the-job mentorship and training.

A conventional FETP is generally accepted to be the gold standard. At present, Australia, China, Japan, Malaysia, the Philippines, the Republic of Korea, Singapore and Viet Nam have established conventional FETPs in the Western Pacific Region. The programme in Viet Nam was established in 2008 and Singapore started the programme in 2010. Other programmes have more than a decade of experience each.

Considering limited human resources in several lower-income countries, the Western Pacific Regional Office conducted an informal consultation in October 2008 to explore feasible ways to fulfil capacity-building needs in these Member States. As a result of this consultation, mFETPs were introduced in 2009 in the Lao People's Democratic Republic and Mongolia and in Cambodia in 2010. An mFETP is defined as a training course that adopts the same training strategy of traditional FETPs, i.e. learning-by-doing or learning-through-service with mentorship or supervision but with a shorter duration and a focus only on some of the competencies in field epidemiology adapted to meet country situations and needs.

The first workshop on mFETP was held in November 2009 in Seoul to share the progress of newly-developed programmes and to identify needs for external support. Following this workshop's recommendation, the Western Pacific Regional Office made a commitment to conduct an annual workshop to share experiences and achievements among programmes, including assessment framework development and an assessment of programmes.

1.1 Objectives

The main objective of the second workshop for FET programme was to discuss how well conventional and modified FETPs were addressing country needs and to examine the proposed sustainability model. The specific objectives of the workshop were to:

- (1) share experiences and achievements of FET programmes;
- (2) develop an assessment framework for mFETPs;
- (3) foster partnership among FET programmes; and
- (4) support newly-developed FET programmes.

1.2 Opening remarks

Dr Takeshi Kasai, Director of the Division of Health Security and Emergencies, Regional Office for the Western Pacific, welcomed participants to the workshop. He emphasized the importance that WHO attaches to FET programme and that this was an internationally recognized way of building capacity. He concluded by elaborating a number of the challenges faced by FET programmes, including their sustainability.

Dr Dionisio Jose Herrera Guibert, Director of TEPHINET, gave a presentation via telephone on the role of TEPHINET and FET programme at the global level. He said TEPHINET is a global network, unique in the training programmes in epidemiology and public health interventions and it is an alliance of FET programmes in the world. The network has over 13 years of history and is a meeting point for FET programmes including Field Epidemiology and Laboratory Training Programme (FELTP) in the world. The training programmes are hosted in a ministry of health, in an independent research institute or with an academic institution. Graduating fellows are certified by the institutions in which their programmes function.

The mission of TEPHINET is to strengthen global public health capacity by supporting well-qualified professionals in field epidemiology through training and service opportunities. TEPHINET is a network of more than 48 training programmes in epidemiology worldwide. TEPHINET assures the quality of such training programmes through core competencies, curricula and continuing education opportunities for graduates and provides support and opportunities for collaboration for FET programmes.

2. PROCEEDINGS

2.1 Summary of presentations

The workshop commenced with opening remarks, a report from TEPHINET and a progress report on FET programmes in the Region. There also were reports from each of the six FET programmes represented at the workshop and presentations from a number of FET programme graduates. Participants were divided into two groups to carry out group work regarding advocacy. The first day ended with a plenary session at which each working group presented their results.

The second day of the workshop consisted of plenary discussions and small group work to consider and discuss an assessment tool for the mFETP, a proposed model for developing and maintaining sustainable mFETP and strategies for working out partnerships. The workshop reconvened for the closing plenary session and discussed achievements, challenges and recommendations for future activities. The full workshop programme is attached as Annex 2.

2.1.1 FET programmes and sustainability of mFETP

Dr Tamano Matsui opened the technical session of the workshop by outlining its general framework and objectives. She then presented the APSED (2010) biregional framework to strengthen capacity to respond to emerging infectious diseases and fulfil the International Health Regulations (IHR) (2005) core requirements. APSED (2010) consists of five objectives: to reduce the risk of emerging diseases; to strengthen early detection; to strengthen rapid response; to strengthen effective preparedness; and to build technical partnerships. To achieve these objectives, there are eight focus areas: surveillance, risk assessment and response; laboratory; zoonoses; infection prevention and control; risk communication; public health emergency preparedness; regional preparedness, alert and response; and monitoring and assessment. Successful FET programmes result in increased capacity in all of these areas but are a key component of the focus area surveillance, risk assessment and response.

FET programmes previously have been the subject of a number of workshops over the past two years and these deliberations have led to the establishment of new FET programmes in Cambodia, the Lao People's Democratic Republic, Mongolia, Singapore and Viet Nam.

To work out a sustainable programme, advocacy, a qualified programme and partnership are identified to be important following the drafting process of a regional sustainable model for mFETP.

2.1.2 Asia Pacific Strategy for Emerging Diseases

Dr Takeshi Kasai described the origins of APSED, which first was established in 2005 as a three-in-one strategy: first, to establish generic capacity for emerging infectious diseases; second, to build capacity for International Health Regulation (2005); and, third, for pandemic preparedness. He reported that progress as a result of APSED (2005) has been confirmed by independent review and that Member States have indicated that they wished to continue with APSED. A new strategy, APSED (2010), was endorsed in late 2010 and recognizes FET programme as a way to build human resources. Dr Kasai said that mFETP should be established for willing Member States.

2.1.3 Current situation of newly-developed FET programmes in Western Pacific Region countries and mFETPs in China

2.1.3.1 *Cambodia*

Dr Bun Sreng presented Cambodia's plan to implement mFETP through a series of applied epidemiology courses. The first course is to be conducted in 2011. This will be a six-month course dealing with surveillance and outbreak response. Target participants are rapid response team members in provincial health departments. District-level staff from the provinces of the selected provincial fellows also will be invited to attend the one-month introductory didactic workshop. Each provincial fellow will be matched with a national supervisor (a Khmer national who is an FET programme graduate) and an international supervisor (an Epidemic Intelligence Service or FET programme graduate based in Cambodia). Trainees are expected to do one surveillance project, weekly analysis of their surveillance data and at least one outbreak investigation.

2.1.3.2 *The Lao People's Democratic Republic*

Dr Bounlay Phommasack informed the workshop that the Lao People's Democratic Republic field epidemiology training began after a needs assessment in 2007, with the first cohort enrolling in February 2009. The programme has a director, three deputy directors, an overall coordinator, a technical coordinator and other support staff, including WHO and the USCDC technical staff. International partners include WHO, the US CDC and the United States of America Agency for International Development (USAID). Eight fellows are selected yearly based on experience, training, English proficiency and recommendations.

The curriculum is competency-based, consisting of nine months of fieldwork and three months of classroom instruction. Fieldwork includes outbreak investigations, surveillance data analysis and operational research projects. In the first two cohorts, over 45 outbreaks have been investigated, including those of cholera, anthrax, diphtheria, typhoid, dengue fever, influenza, dysentery, measles, unexplained paralysis, and food poisoning.

Key achievements include conducting a pandemic influenza A (H1N1) 2009 vaccine adverse event survey, a rubella serosurvey, extensive chart reviews, anthrax risk assessments, mass gathering event surveillance, dengue mapping, diarrhoea laboratory network establishment and playing a key role in the response to the (H1N1) pandemic. Presentations and publications have been limited because the lack of English proficiency makes conference attendance a challenge. The budget is US\$ 350 000, supported by the US CDC primarily with USAID funds securing veterinary participation. The programme has had one external assessment and yearly internal assessments.

Strengths include enhanced human resource capacity, fellows from 12 among 17 provinces, animal and human health collaboration and rapid, high quality public health reports. Continuing challenges include limited supervisor participation, no 'champion' of Lao FET programme, no established pathway for accreditation and no FET programme graduate network.

2.1.3.3 *Mongolia*

Dr Baigalmaa Jantsansengee provided an overview of the Mongolian FET programme on behalf of the programme director. The programme was launched in October 2009. It is a one-year training programme which is funded by WHO and hosted by the National Center for Communicable Diseases. All fellows take a two-month introductory course followed by a 10-month field placement. The eight fellows of its first cohort graduated in October 2010 and 10 fellows of the second cohort were recruited in November 2010.

The Mongolian FET programme seeks to produce high-level field epidemiologists and core disease prevention and control staff equipped with technical competencies in order to promote more effective and efficient epidemiological surveillance and outbreak response systems and support operational research leading to better public health services in Mongolia.

Successful implementation of the Mongolian FET programme has been the result of a number of factors, including government political support and commitment; strong technical and financial support from WHO; and the transition from Mongolian FET programme graduates to fellows from learning-by-doing to learning-by-teaching.

Mongolian FET programme fellows' assignments are linked closely to current country public health needs and they responded to many major outbreaks during the period 2009–2010, including pandemic influenza A (H1N1) 2009; nosocomial infection outbreaks; food poisoning and foodborne disease outbreaks; hepatitis A outbreak; and anthrax outbreaks. They also carried out surveillance data analysis projects and operational research projects, some of which have contributed to national health policy changes

The Mongolian FET programme faces many challenges and urgently needs external technical and financial support to assure the quality of the programme and ensure its sustainability because the current agreement with WHO is to end in 2011.

2.1.3.4 *Viet Nam*

Dr Nguyen Thu Yen discussed the experiences of the Viet Nam FET programme, which was established in 2008 with the aim of minimizing the risks and impacts of communicable diseases in line with APSED and IHR (2005).

The objectives of the programme are to:

- (1) Equip staff working in preventive medicine services with essential skills and competencies for disease prevention and control achieved through three-week field epidemiology short courses (FESC) for staff at provincial and district levels and a conventional FETP for selected staff at regional and central levels.
- (2) Enhance preventive medicine services at local, provincial and national levels achieved through timely and effective responses to incidents and emergencies; analyse and interpret surveillance data to inform public health actions and policies; and conduct epidemiological studies and operational research.

(3) Strengthen systems for prevention, control and timely response to public health emergencies achieved through reports and recommendations of fellows that will include development of guidelines; institutionalize an evidence-based approach to inform decision-making; and form partnerships and network at local, national and international levels.

By December 2010, 13 FESC had been conducted for 271 staff from all provincial preventive medicine centres, major city health departments and regional institutes. After completion of the training, FESC trainees had reported over 110 field investigations and situation analyses.

Eleven FET programme fellows, five in the first cohort and six in the second, are in training. They have conducted field investigations and epidemiological studies covering a wide range of communicable disease issues and noncommunicable hazards and presented their results at national and international conferences.

The FET programme in Viet Nam faces a number of challenges, including a limited number of qualified lecturers and supervisors; no award of an academic degree, which is not attractive to potential applicants in Viet Nam; ensuring sustainability of the programme; limited institutional support; extending partnership beyond health; including veterinarians in the FET programme; and support for fellows following graduation.

2.1.3.5 *Guangdong, China*

Dr Chin Kei Lee explained that the FET programme in Guangdong was founded in 2004 and was managed by the Guangdong Center for Disease Control (CDC). Although it was a one-year course, it was modelled on the training programme of two-year China FETP (CFETP). It recruited existing Guangdong CDC staff that had experience in working on infectious disease prevention and control. So far, it has recruited five cohorts of fellows, with about five to 15 fellows per cohort. The course consists of two months of classroom teaching and then 10 months of field work. The trainers are mainly provincial experts, with involvement of the national China Centers for Disease Control and Prevention (China CDC) and international experts. A midterm assessment demonstrated the success of the programme, and it is expected that the programme will continue to provide a platform for sustainable development of field epidemiology capacity in Guangdong.

2.1.3.6 *China*

Professor Guang Zeng described the CFETP, which was founded in 2001. It is a two-year programme based at the national China CDC. The programme has 95 graduates and has just recruited its tenth cohort of fellows. There are usually about 10 fellows per cohort. But the tenth cohort has expanded to 32 fellows.

In addition to the national CFETP, there are 44 mFETP (with 2173 fellows) in 15 provinces of China. These are based at provincial (12), prefectural (20) and county levels (12). These programmes built on the successful learning-by-doing model of the CFETP and provided a practical solution to demands for field epidemiologists at the local level. Challenges for these programmes include limited qualified mentors, more opportunity for field activities, improvement on quality and sustainability.

2.2 Presentations by mFETP graduates

2.2.1 Suspected anthrax in the southern Lao People's Democratic Republic

Ms Bouaphanh Khamphaphonghane from the Lao People's Democratic Republic FET programme (2009 graduate) presented the FET programme response to suspected anthrax cases occurring in the southern part of the country. She first provided background on anthrax in the country, which included the cessation of vaccination in 1996. The outbreak signal (reports of 36 cases of cutaneous anthrax from one province), the case definition used, results found (123 cases and 10 deaths, 3.2 % attack rate and 8.1% case fatality rate), outbreak response, public health recommendations and conclusions were given.

Key response efforts included active case-finding and treatment; an improved ability of animal and human health officials to detect and respond to anthrax outbreaks; education for villagers and village health volunteers about when and where to seek treatment; risk reduction measures such as the appropriate way to slaughter and bury or burn ill cattle, no consumption of ill animals and the thorough cooking of all meat; clinical management recommendations; vaccination strategy for animals in the area and a ban on the sale of meat from affected villages and markets. Strengthened animal and human health collaboration was an outcome of the efforts taken.

2.2.2 Outbreak of newborn nosocomial infections in a maternity hospital: Ulaanbaatar, Mongolia, January 2010

Dr Baigalmaa Jantsansengee from the Mongolia FET programme (2010 graduate) presented a cluster of cases of nosocomial infection that was reported to the National Center of Communicable Diseases (NCCD) from a maternity hospital in Ulaanbaatar in early January 2010. The event caused great political concern in Mongolia and four FET programme fellows were assigned by the Ministry of Health to identify the cause of the outbreak.

By reviewing the medical files in the hospital, FET programme fellows identified 21 cases of nosocomial infection in the hospital during the period 12–20 January 2010, including three deaths. Descriptive analysis demonstrated that 62% of the cases were from the newborn intensive care unit (ICU) and that those at high risk for illness had low birth weight, low birth score, early birth and delivery by caesarean section. They also revealed that all cases had been exposed to invasive procedures, including injections. Laboratory tests confirmed that four blood specimens were culture-positive for *Klebsiella pneumoniae*. The fellows also conducted a case-control study and stratified analysis indicated that injections were an independent risk factor for illness.

Using recommendations from the study, the Ministry of Health revised the Health Ministerial order on Infection Control and new standard operating procedures (SOPs) were disseminated to all hospitals in Mongolia. The Ministry of Health also established the National Infection Control Resource Center in the NCCD, which is to coordinate infection control and nosocomial infection surveillance.

2.2.3 Outbreak of multiple types of animal and human anthrax, Okhi Khundii, Zuunburen, Selenge, Mongolia, May to July 2010

Dr Oyun Munkhdavaa from the Mongolia FET programme (2010 graduate) presented an investigation of an outbreak of anthrax among animals and human which was reported to the National Center of Infectious Diseases with Natural Foci (NCIDNF) in July 2010. Two FET programme fellows were invited by the NCIDNF to investigate the incident, identify causes of animal anthrax outbreak and determine risk factors for human anthrax.

Based on the results of a household survey and laboratory investigations, the fellows concluded that the anthrax outbreak involved multiple herbivore animals. They concluded that the human and animal outbreaks were possibly caused by the localized contamination of dead animal carcasses and humans infected by direct contact and unprotected meat processing involving sick or dead animals.

Subsequent to recommendations by the FET programme fellows, the Ministry of Food and Agriculture updated its SOPs for response to anthrax outbreaks and the Ministry of Health also launched health education for anthrax nationwide.

2.3 Group work

2.3.1 Group Exercise 1: Advocacy for FET programmes

According to the drafting process of a sustainable model for mFETP, advocacy was identified to be one of key factors of programme sustainability.

2.3.1.1 *Advocacy for FET programme in the Philippines*

Dr Enrique Tayag gave a presentation about the experience of advocacy for the FET programme in the Philippines. The FET programme in the Philippines was established in 1987 as a two-year programme with the goal of improving the practice of epidemiology in the government public health sector. Since then, the FET programme has been involved in many key public health events. In 2000, the FET programme was institutionalized in the National Epidemiology Centre, providing access to decision-makers, access to the media, authority to conduct investigations and allowed easy mobilization of fellows. The FET programme also networks with other sectors such as nongovernmental organizations (NGOs), international agencies, other government agencies, media, professional societies and academia.

2.3.1.2 *Advocacy for FET programme in Japan*

Dr Takaaki Ohyama presented a description of the FET programme in Japan and highlighted advocacy efforts for the programme. The FET programme was established in Japan in 1999 as a two-year programme after the experience of a large-scale outbreak of enterohaemorrhagic *Escherichia coli* O 157 (EHEC) in Osaka in 1996 and the establishment of the Infectious Disease Control Law in 1999. In the beginning, advocacy for the programme focused on informing key decision-makers of the activities of the FET programme and involving them in the process of public health action.

Now that the programme has matured, advocacy focuses on achievements of the FET programme and making the best use of graduates. The driving force for support of the FET programme has been emerging issues such as severe acute respiratory syndrome (SARS), avian influenza, outbreaks in health care settings. The advice for other FET programmes was to get stakeholders involved, make the best use of FET programme graduates, the alumni's network and use international partnerships.

Following these presentations, participants were divided into two groups each with an assigned facilitator. Each group was to discuss advocacy efforts in their country, share their experiences in obtaining political commitment for their training programmes and discuss the following three questions:

- (1) What are the main experiences and lessons that you have learnt in obtaining political commitment for your programme?

(2) How do you think we can improve the political commitment for FET programme building on these lessons learnt?

(3) How can a newly-developed programme obtain political commitment?

The results of the group work were reported at a plenary session, and there were several similar contributions from each group. A number of these were the need to identify an “champion” of FET programme; use outbreaks and analysis of surveillance systems and public health issues as an opportunity to demonstrate the quality of fellows and graduates of FET programme; document, communicate and ensure recognition of achievements; explain the difference between FET programme and Master of Public Health (MPH) programmes; and the FET programme should have a close relationship with the Ministry of Health.

During the plenary, participants also had the opportunity to suggest ways in which political commitment might be measured, and this included FET programme being invited to attend key meetings; FET programme referenced at key meetings; FET programme called upon when a public health problem occurs or a question needs answering; the government should provide funding for FET programme; and the allocation of appropriate human and financial resources.

2.3.1 Group Exercise 2: Assessment tool for mFETP

According to the drafting process of the sustainable model for mFETP, the qualified programme was identified to be one of key factors of programme sustainability.

2.3.2.1 *Assessment tool for mFETP*

Dr Tamano Matsui and Dr Alden Henderson presented a proposed assessment tool of indicators for the mFETP. An assessment tool currently exists for the two-year FET programme. This existing tool should be adapted for mFETP, with consultation from stakeholders for its effective use. The workshop was informed that the indicators of the proposed assessment tool for mFETP were based on recommendations from the TEPHINET meeting held in Paris in July 2010 and the draft assessment tool by USCDC for a two-year FET programme.

After the presentation, participants were divided into two groups to discuss the assessment tool of indicators and to come up with recommendations. Each group was to address the following two questions:

- (1) What are the main components of the mFETP that are required to maintain quality and sustainability?
- (2) What kind of assessment framework is preferable for all stakeholders?

The results of the group work were reported at a plenary session. It was agreed broadly that competencies for the mFETP should be similar to those for the conventional FETP but that there should be flexibility. Suggestions were made that resulted in the rewording of indicators, the loss of some indicators by combining them with others that appeared similar and a bid for an additional indicator.

The final assessment tool of indicators with measurements taking into consideration comments from workshop participants and peer review is found in Annex 3. It is suggested as a model for the capture of a standardized minimal dataset to evaluate an mFETP. Additional indicators or measurements may be identified at the local level to ensure the tool captures the local context. However, the tool in Annex 3 is considered to contain the minimal information required at

the regional level to be able to provide reliable, consistent and comparable information regarding mFETP within the Region.

Participants also discussed the type of assessment framework which they believed would be preferred by stakeholders. It was agreed generally that the tool could be used by FET programme staff for regular self-assessment and also could provide the framework for external assessments. These preferably should be carried out by other FET programme fellows in order to build and foster partnerships and promote learning. It also was suggested that information collected following an assessment could be gathered by WHO and disseminated to other FET programmes, donor agencies and the relevant ministry of health. Participants went further and suggested times that external assessments could be conducted every three to five years, depending on the maturity of the respective FET programme.

2.3.3 Group Exercise 3: A model for a sustainable mFETP

2.3.3.1 *A model for sustainable mFETP and partnership development*

Dr Tamano Matsui introduced the proposed regional model for a sustainable mFETP. The model was developed following broad consultation and reference to international initiatives. The model is multidimensional and seeks primarily to facilitate understanding of the interactions required to create an enabling environment to support the sustainability of mFETP.

2.3.3.2 *Supervising system development*

Dr Robert Ellery Fontaine gave a presentation about the building of a mentor and supervisory system for the CFETP. He suggested that the critical components of an effective FET programme are a pool of high quality graduates, a team of experienced mentors and a continuing stream of opportunities. The goal of the CFETP programme is to increase the number of FET programme fellows from 15 in 2010 to 70 to 80 in 2015 to meet the need for epidemiologists at the prefecture, provincial and national levels. This will in turn produce a need for mentors. To meet this need, suitable placements with quality graduates and mentors from the USCDC staff will be identified. The duties of a mentor are to ensure that the programme requirements are met, to guide projects and technical communications, to identify and obtain expertise in specialty topics and to ensure public health relevance.

Participants were divided into two groups and each was given the task of reviewing the sustainable model for mFETP and providing recommendations for specific amendments. They also were asked to discuss and provide recommendations about building partnerships before reporting to the plenary session.

Participants during the plenary agreed that the model was useful and discussed suggestions for further developing it. Essential elements of this model include obtaining long-term political support through advocacy, qualified programme components, programme-related output and outcome and national and international partnerships. The model shows interactions of these components required to create an enabling environment to support the sustainability of mFETP.

It also was suggested that the model particularly would be useful if linked to the assessment tool (Annex 3). Some participants felt that nontechnical users might find the model confusing and that it should be simplified. However, it was acknowledged that the model is a simplified version of the overall approach and contained the “key ingredients”. The consensus model provided in Annex 4 was agreed upon, taking into consideration comments from workshop participants and peer review.

In relation to partnership development, WHO was proposed as a resource for identifying potential key partners, providing work experience opportunities and assisting in programme development. In summary, the overall view of participants was that partnerships should:

- (1) Be strategic, rather than ad hoc, and built into FET programmes such that partners show demonstrable commitment, act as advocates and communicate the value of the programme to others, provide access to technical, administrative, financial and logistical support and exchange information and ideas.
- (2) Be formed at the national and international levels and provide access to surveillance data, field placement opportunities, staff (instructors, mentors and supervisors), support planning and development of the programme and contribute to the achievement of goals and objectives of the programme.
- (3) Be diverse and intersectoral, including partnerships with organizations, institutions and individuals such as nonhealth government ministries, media, NGOs, universities, professional societies, health care facilities, politicians, the military, law enforcement agencies, travel authorities, private industry and noncommunicable disease colleagues of WHO and other parts of the United Nations.
- (4) Include other FET programmes in order to reduce costs and foster mutual support and linkages among FET programmes.

3. CONCLUSIONS AND NEXT STEPS

The main conclusions of the workshop were as follows:

3.1 General

FET programmes are fulfilling a need and, where present, either in the classic or modified form, are contributing substantially to the strengthening of public health systems nationally. Many of the most important features of a strong FET programme, including advocacy, multisectoral engagement, funding and technical support and monitoring and assessment systems that allow for lessons learnt, are influenced by an enabling environment and a strong national political commitment.

FET programmes are now established throughout the Region and have a key role to play in promoting and protecting health. Having considered the information presented during the workshop, a number of achievements and challenges were identified and are summarized here.

3.1.1 Achievements

- (1) The feasibility of the mFETP has been demonstrated through the growing experience and successful implementation of mFETP in different countries.
- (2) There is strong political and donor momentum behind FET programmes; several challenges are to be overcome in moving towards ensuring the sustainability of programmes.
- (3) There is recognition of FET programme as a means of building epidemiological capacity.

(4) There has been recognition of the contribution made by FET programme fellows as a result of a supporting response to public health emergencies and incidents such as pandemic influenza A (H1N1) 2009, contributing to the evidence base through publications and influencing policy change.

(5) There was a strong presence at the sixth TEPHINET Global Scientific Conference, with a substantial number of abstracts accepted for oral and poster presentation.

3.1.2 Challenges

- (1) Ensuring the sustainability of programmes for continued success.
- (2) Promoting and capitalizing on existing efforts and achievements to advocate for continued support.
- (3) Improving the quantity and quality of supervisors and mentors.
- (4) Identifying financial resources to continue supporting programmes.
- (5) Encouraging increased or new funding support from governments.
- (6) Exploring different formal and informal partnerships with different sectors.
- (7) Continuous support beyond graduation.

3.2 Next steps and recommendations

3.2.1 Programmes

- (1) Ensure quality of training and manpower development of programmes.
- (2) Within 12 months of the workshop, an assessment of at least one mFETP should be conducted using the assessment tool.
- (3) Develop a system for following up of FET programme graduates.

3.2.2 Advocacy

- (1) The Asia Pacific Strategy for Emerging Diseases (APSED) should be used as an advocacy tool for FET programmes.
- (2) Activities to increase the visibility of the achievements of FET programmes should be carried out within each country.
- (3) Identify, develop and support champions of FET programmes.
- (4) Advocate for FET programme at all high-level meetings.

3.2.3 Partnerships

- (1) Collaboration with other FET programmes should be encouraged to maximize effective use of resources.
- (2) The building of national and international collaborations, partnerships and networks should be encouraged.

WORLD HEALTH
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ORGANISATIONS MONDIALE
DE LA SANTE

**2nd Workshop for Field Epidemiology
Training Programme in the
Western Pacific Region**

**WPR/DSE/CSR(19)/2010.1
29 November 2010**

**Manila, Philippines
29–30 November 2010**

ENGLISH ONLY

PROGRAMME OF ACTIVITIES

Day 1 – 29 November (Monday)

- 08:00 – 08:30 Registration
- 08:30 – 09:00 Opening Session**
(Chairperson: Dr Takeshi Kasai, Director, DSE, WHO/WPRO)
- Opening remarks
 - Self introduction
 - Overview of objectives and agenda
 - Administrative announcement
- 09:00 – 10:15 **Plenary 1-1: Progress report of modified FETP**
(Chairperson: Dr Takeshi Kasai)
- WPRO (APSED and FETP)
 - Cambodia
 - Lao PDR
 - Mongolia
- 10:15 – 10:45 *Coffee break and group photo*
- 10:45 – 11:25 **Plenary 1-2: Progress report of FETP / provincial modified FETP**
(Chairperson: Dr Takeshi Kasai)
- Viet Nam
 - Guangdong (China)
- 11:25 – 11:50 **Plenary 1-3: Modified FETP in China**
(Chairperson: Dr Takeshi Kasai)
- Dr Guang Zeng
- 12:00 – 13:30 Lunch break**

- 13:30 – 14:00 **Plenary 2: Advocacy**
(*Chairperson: Dr Enrique Tayag*)
- Dr Enrique Tayag
 - Dr Takaaki Ohyama
- 14:00 – 15:30 **Group Work (1): Advocacy**
- 15:30 – 16:00** *Coffee break*
- 16:00 – 17:00 **Feedback presentation on Group Work (1)**
(*Chair person: Dr Enrique Tayag*)
- 18:30** *Reception*

Day 2 – 30 November (Tuesday)

- 08:30 – 09:30 **Plenary 3: Presentation by modified FETP graduates**
(*Chairperson: Dr Robert Ellery Fontaine*)
- Lao PDR
 - Mongolia
- 09:30 – 09:50 **Plenary 4: Assessment tool of modified FETP**
(*Chairperson: Dr Guang Zeng*)
- WPRO / US CDC
- 09:50 – 12:00 **Group Work (2) on Assessment Tool/Framework Development of modified FETP**
- Coffee break during GW (2)*
- 12:00 – 12:30 **Feedback presentation on Group Work (2)**
(*Chairperson: Dr Guang Zeng*)
- 12:30 – 13:30** *Lunch break*
- 13:30 – 13:50 **Plenary 5: Supervising system development**
(*Chairperson: Dr Alden Henderson*)
- Dr Robert Ellery Fontaine
- 15:30 – 16:00** *Coffee break*
- 16:00 – 16:30 **Feedback presentation on Group Work (3)**
(*Chairperson: Dr Alden Henderson*)
- 16:30 – 16:50 **Closing**
(*Chair person: Dr Takeshi Kasai*)
- Closing Remarks

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ASSESSMENT INDICATORS

Assessment Tools for Modified Field Epidemiology Training Programme*Indicators for assessment*

<Input indicators>

Indicator 1	Ministry of Health or Ministry of Health-related agency's ownership of the training programme; framework of managing training programme (programme management)
Measurement	<p>Describe the role of the Ministry of Health or Ministry of Health -related agency in supporting the training programme. Consider these factors:</p> <ul style="list-style-type: none"> • Is the training programme administratively placed within the Ministry of Health or Ministry of Health -related agency? • Is there an official document on the establishment and role of the training programme in Ministry of Health or Ministry of Health -related agency? • Is the training programme physically placed within the Ministry of Health or Ministry of Health -related agency? • What are the financial contributions by the Ministry of Health to the training programme? Please include in-kind contributions of staff time, office space, etc. • When investigating and controlling outbreaks; <ul style="list-style-type: none"> a. What functions does the Ministry of Health have? b. What is the role of the training programme? • Describe how the Ministry of Health facilitates routine access and use of national surveillance data by trainees. • How many full time and part time Ministry of Health staff is assigned to the training programme? Please include their main functions for the programme. • Is there a steering committee for the training programme? <ul style="list-style-type: none"> a. If so, what is the composition of the committee members? ; How frequent are meetings held and what is the agenda of the meetings (e.g., budget, planning, disciplinary)? ; Are there decisions taken regarding the master plan for the training programme? b. If not, is there alternative mechanism to manage the training programme? • Describe the frequency and contents of technical meetings to oversee/direct programme activities? • What are the outcomes of the technical meetings or key advices to trainee?
Data sources	Interviews with training programme director, resident advisor, Ministry of Health staff who oversee the training programme and review of records.

Indicator 2	Budget and planning (programme management)
Measurement	<ul style="list-style-type: none"> • Is there a written plan ensuring integration of the training programme within the Ministry of Health? • Is there a written budget for the training programme? <ul style="list-style-type: none"> a. If so, are the funds sufficient for the organizational and financial needs of the training programme? • Are there issues to be improved regarding budget and planning?

Data sources	Interviews with training programme director, Ministry of Health staff who oversee the programme and review records; program files.
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Indicator 3	Training plan (linked to indicator 6) (technical)
Measurement	<ul style="list-style-type: none"> List desired competencies of the programme Does the training plan provide adequate methods of training (e.g. lectures, case studies, field projects) to develop the desired competencies? Provide number of lectures given by national staff vs. international. Does the training plan provide adequate opportunities for trainees to develop the desired competencies? Are there issues to be improved regarding training plan?
Data sources	Review of training curriculum, discussions with training staff (including lecturers and field <i>supervisors</i>), trainees and graduates.

Indicator 4	Logistics (technical)
Measurement	<ul style="list-style-type: none"> Does the training programme have sufficient equipment, classroom space, computers, internet, books, and training materials? <ul style="list-style-type: none"> a. If not sufficient, how to improve?
Data source	Discussions with training staff and trainees

<Process indicators>

Indicator 5	Applicants to the training programme (programme management)
Measurement	<ul style="list-style-type: none"> How many applicants apply to the training programme? What are the characteristics of those that are accepted and those that are not accepted? Consider the training programme's approach to recruiting applicants when interpreting how many applicants apply to the training programme. What is the drop-out rate? Why did trainees drop-out? Describe selection process of the training program. What are the criteria for trainees in terms of education, previous experience in public health, and position in the government. Do you have any idea to have more qualified trainees?
Data sources	Review programme records, interviews with training programme director, resident advisor, Ministry of Health staff that oversee the training programme, interviews with trainees that drop out (if possible).

Indicator 6	Competencies required of training programme graduates (technical)
Measurement	<ul style="list-style-type: none"> List desired competencies of the programme How does the training programme assess the ongoing development*¹ and final status of the trainees' or graduates' competencies?
Data sources	<ul style="list-style-type: none"> Review training programme records including trainee assessment reports; examination record (if available); interviews trainees and graduates

*¹ Important to add 'ongoing development': because this should be part of the monitoring system, and the final activity is the evaluation of the competencies achieved.

Indicator 7	Supervisor/mentor system (programme management /technical)
Measurement	<p><u>programme management</u></p> <ul style="list-style-type: none"> What are the criteria for selection of supervisor/mentor? What is the TOR of supervisor/mentor? How many qualified <i>supervisors</i>/mentors are available? (national, international)

	<ul style="list-style-type: none"> • How keep quality of lecturer regarding better understanding of program expectations? • Does the training program have a training session for field <i>supervisors</i>? <p><u>Technical</u></p> <ul style="list-style-type: none"> • What is the accessibility, timeliness and regularity of meetings with trainee's <i>supervisors</i> and mentors especially in the process of acute health event related activities and surveillance projects? • Is there feedback from graduates/trainees on the support they received from their <i>supervisors</i>/mentors to use for improvement/renewal? • Has regular assessment opportunities been provided to trainees to evaluate their ongoing achievement? (this again refers to monitoring) <p>programme <u>management/technical</u></p> <ul style="list-style-type: none"> • Are there issues to be improved regarding supervisor/mentor system?
Data sources	Interview with training programme director, <i>supervisors</i> and trainees; list of <i>supervisors</i> /mentors

<Output indicators>

Indicator 8	Involvement in acute health events (technical)
Measurement	<ul style="list-style-type: none"> • Did each trainee have the opportunity to lead an investigation of at least one acute health event or emergency? • Were official written reports of events investigated submitted within an appropriate time to use the report for action? • Was each report presented to peers/<i>supervisors</i> for critical review and feedback? • Were official reports presented to appropriate public health decision makers with recommendations for action and/or policy-making? • Did peers/<i>supervisors</i> and appropriate public health decision makers offer feedback or response to trainee? • Is there archiving system of reports on acute health events for future practices by trainees? • Are there issues to be improved regarding acute health involvement by the programme?
Data sources	Interview with training programme coordinator, supervisor and trainees; review of records

Indicator 9	Involvement in surveillance activities (linked to indicator 12)(technical)
Measurement	<ul style="list-style-type: none"> • Did each trainee have routine access and use of national surveillance data by trainees? • Did each trainee complete a surveillance project following careful planning and assistance from a supervisor/mentor in assessing the public health importance and feasibility of the project? • Did every trainee analyze and use one or more surveillance data sets and submit a written report with recommendations? • Was each report presented to peers/<i>supervisors</i> and appropriate public health decision makers for critical review and feedback? • Did peers/<i>supervisors</i> and appropriate public health decision makers offer feedback or response to each trainee? • Is there an archiving system of surveillance reports for future reference and use by trainees? • Are there issues to be improved regarding surveillance activities by trainees?
Data source	Interview with training programme coordinator, supervisor and trainees; review records

Indicator 10 (optional)	Planned investigation related to priority public health issues (technical)
Measurement	<ul style="list-style-type: none"> • Do trainees conduct operational research following careful planning and consultation with supervisor/mentor to assess the public health importance and feasibility of the research? • Was each report presented to peers/<i>supervisors</i> and appropriate public health decision makers for critical review and feedback? • Did peers/<i>supervisors</i> and appropriate public health decision makers offer feedback or response to trainees? • Are there issues to be improved regarding planned investigations?
Data sources	Interview with training programme coordinator, supervisor and trainees; records review

Indicator 11	Post-graduate follow up (programme management)
Measurement	<ul style="list-style-type: none"> • Did graduates have opportunities to use and further develop the skills they gained during the course? • Is there a plan for post-graduate training? • What is the impact of the training programme on graduates' career development? • Does the programme utilize graduates as trainers for subsequent cohorts? • Is there alumni networking?
Data sources	Interview with training programme director, training program coordinator and stakeholders (e.g., local governments)

<Outcome indicators>

Indicator 12	Public health action in response to the recommendations by the training programme (programme management)
Measurement	<ul style="list-style-type: none"> • Provide examples of improvement in management and response to acute health event by training programme /trainees • How has the Government used reports of acute health events from trainees? • Provide examples of substantial improvement in surveillance programme due to action/recommendations by programme and/or trainees
Data sources	Interviews with training programme coordinator, training director, and stakeholders; review of records

SUSTAINABLE MODEL FOR MODIFIED FETP PROGRAMMES

