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ORIGINAL ARTICLE

The Philippines Field Management Training Program (FMTP): strengthening management capacity in a decentralized public health system

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Abstract
Objectives The decentralization of the Philippines' health sector in 1991 sought to improve the efficiency of local health resource allocation; however, local officials were unprepared for the increased responsibility. In 1999 the Philippines Department of Health, with assistance from the US Centers for Disease Control and Prevention (CDC), implemented the Philippines Field Management Training Program (FMTP) to provide local health officials with the managerial skills needed to perform their new, more responsible jobs. This paper addresses whether the FMTP has provided participants with useful managerial skills needed for their more responsible positions.
Methods The method involved reviewing program outcomes, including results of applied management improvement projects the participants completed to solve managerial problems.
Results Between 2000 and 2010, 294 participants completed the FMTP and many were later promoted to more responsible positions. The participants also completed 204 applied management improvement projects resulting in documented improvements in service delivery, information systems, logistics, health insurance, policy and laboratory outcomes. Examples of their successes are included in this paper.
Conclusions The results provide compelling evidence that managers are using the skills learned to solve significant managerial problems.

Keywords Devolution · Decentralization · Management capacity building · Sustainability

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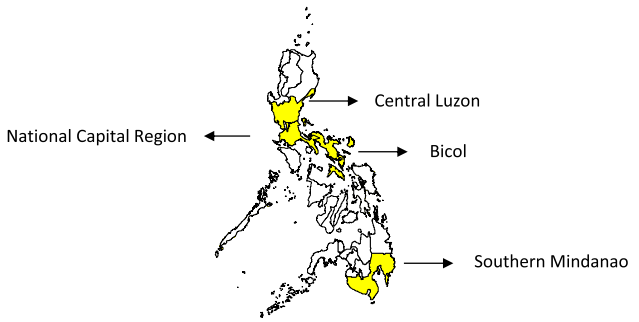

Fig. 1 Areas covered by regional Field Management Training Sites—Philippines 2014

Introduction

During the 1980s, the World Bank recommended decentralization of the health sector for developing countries with large National Ministries of Health (World Bank 1991). The anticipated benefits of decentralization included: (a) improved efficiency and quality of services (technical efficiency, resource distribution and quality of services); and (b) improved space for learning, innovation, community participation and adaptation of public services to local circumstances. (Mills and Vaughn 1990; Lakshminarayanan 2003). In the Philippines, devolution was seen as a solution for improving service delivery and health outcomes for the highly diverse and dispersed populations throughout the archipelago of 17 regions, 78 provinces, 83 autonomous cities, 1,527 municipalities and 41,351 villages (Fig. 1).

Prior to devolution, the Philippines Department of Health (DOH) managed health services through a vertical program approach. Government hospitals controlled expenditures at the local level, and local government involvement in health services was minimal (Grundy et al. 2003). Post-devolution, local governments were expected to be more capable of addressing those issues and making services more constituent oriented. Devolution aimed to increase local participation in decision making and resolve political alienation among the residents and policy makers outside the country's capital. When devolution was implemented in 1991, it was anticipated that a decentralized health sector would become more efficient, effective, and equitable and that core public health functions previously performed by the national level would be performed at the local level (Lakshminarayanan 2003) (Table 1).

Despite the hoped-for benefits, the first years of implementation in the Philippines proved to be detrimental, rather than beneficial, to the functioning of the country's healthcare system and healthcare consumers. Local government units (LGUs) and their managers were unprepared for the abrupt change in clinical and public health roles and responsibilities. Notably, the decentralized health sector was placed under control of individuals who were not knowledgeable about public health or clinical practice and who lacked managerial skills as well.

Table 1 Core public health functions of the national and local pre- and post-devolution—Field Management Training Program—Philippines 2014

Core public health functions	Pre-devolution		Post-devolution	
	National	Local	National	Local
Assessment	Yes	No	No	Yes
Policy development	Yes	No	No	Yes
Assurance	Yes	No	No	Yes

The problems of devolution were highlighted in a 1999-case study of eight municipalities implementing the National Tuberculosis Control Program (Lariosa 1999). By 1999, devolution was supposed to be in the stabilization phase, but it was not working well. The case study revealed that municipal health officers' responsibilities had expanded to include a range of new activities such as multiprogramme monitoring for which none of the officers had received any management training. Without requisite leadership and management, the LGUs soon faced a number of problems. They included decreased hospital occupancy and health center utilization rates; problems procuring drugs and other supplies; inadequate funding for maintenance and operating expenses for the health facilities; and loss of managerial and fiscal control of hospitals. Staff morale was often low and many health personnel resigned (Grundy et al. 2003). Patient satisfaction suffered because of unavailability of essential drugs, negative provider attitudes toward patients, and lack of privacy at health facilities (Lakshminarayanan 2003). Health personnel at the regional level needed relief from the heavy burden of support and technical assistance they were providing to the LGUs (Grundy et al. 2003).

Other countries that have partnered with CDC have documented favorable experience with building management capacity to strengthen public health programs in Bolivia, Cameroon, Mexico, the Philippines (Pappaioanou et al. 2003), Croatia (Sogoric et al. 2009), Vietnam (Umble et al. 2009), and Nicaragua (McEwan et al. 2001).

The Director of the National Epidemiology Center (NEC), regional health directors, and LGU managers recognized the need to develop a cadre of trained front-line health managers as one way to begin to improve the devolution dilemma. The research question was to assess whether the Philippines Field Management Training Program provided local health workers with skills they could use to carry out their management responsibilities in the newly devolved health system.

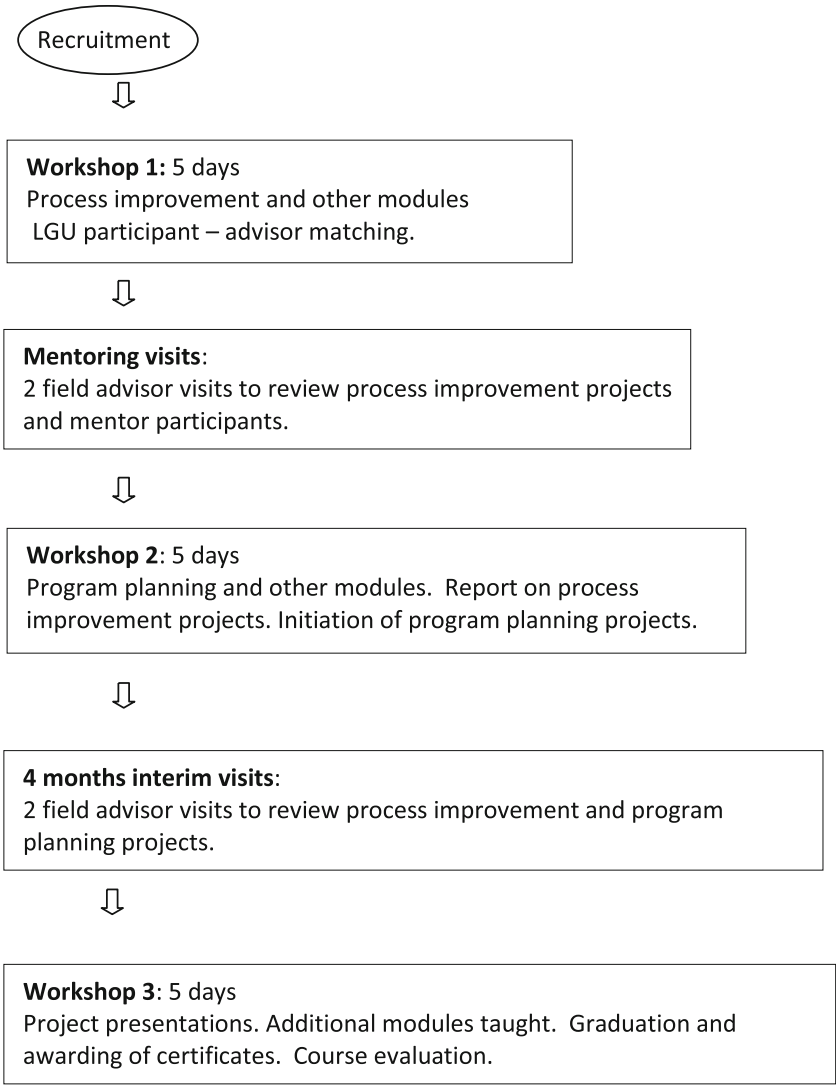

Fig. 2 Design of the Field Management Training Program course—Philippines 2014

Methods

The NEC, in collaboration with CDC, designed a 10-month in-service applied Field Management Training Program (FMTP) to equip participants with the skills to develop and lead work teams and carry out the three core public health functions effectively. FMTP designers wanted to avoid problems that had appeared in management training programs in Latin American and Asia after decentralization, in particular being more theoretical or academic than practical, and, consequently failing to overcome participants' deficits of practical skills and management competencies (Kolehmainen-Aitken and Newbrander 1997). The FMTP was modeled after two public health workforce development programs. One was the Philippines Field Epidemiology Training Program (FETP), a 2-year epidemiology training program (Fernandez et al. 1990). The other was the CDC Sustainable Management Development Program (SMDP) (Setliff et al. 2003). Several Philippines FETP graduates had attended SMDP's Management for International Public Health (MIPH) course in Atlanta, Georgia, USA. They returned home and taught the SMDP management modules to FETP residents and other epidemiologists.

The FMTP was organized according to the steps shown in Fig. 2, a combination of classwork, field work, and mentoring visits that is still in use today. Topics covered in Workshop 1 include: an overview of public health practice, behavioral analysis, team development, leadership, process improvement, effective communication, negotiation, conflict management, and Force Field Analysis. After Workshop 1, participants return to their workplace and organize a project team to implement a process improvement project that their team selects based on the Theme Selection and Multivoting Matrix tool taught in the Process Improvement workshop, which helps them to prioritize

problems based on importance and feasibility. During the project, the team receives supervision and mentorship from FMTP faculty. During Workshop 2, participants study program planning, effective supervision, and public health advocacy, and provide updates to the class on their process improvement projects. After Workshop 2, participants and their teams implement a program planning project with field supervision and mentorship by FMTP faculty. Some participants from the same LGU or region work together on course projects. During Workshop 3, participants present the results of their program planning projects. A graduation ceremony at which certificates are awarded completes the 10-month program.

We reviewed completed applied learning projects carried out both during and after the formal FMTP training to identify examples that demonstrated how training skills were used by local health officials to solve managerial problems. While these projects provide tangible evidence of how the FMTP is meeting these goals, it was not our purpose here to formally evaluate the program in terms of parameters like sustainability, or long-term impact on health outcomes.

Results

Three phases characterized FMTP development, paralleling devolution and taking more than a decade to achieve. From 1999 to 2003, FMTP courses were conducted at the national level. Philippine graduates of the SMDP MIPH course in Atlanta conducted five training-of-trainer (TOT) workshops in Manila. Between 2003 and 2005, training was decentralized to the regions of Central Luzon, Bicol, National Capital, and Southern Mindanao to increase the number of health officers and other managers trained. Funding for the regional level programs was provided from a national level account and from participant registration fees paid by the LGUs. Regional trainers, recruited from among past FMTP graduates and mentored by national level staff, facilitated the 10-month regional FMTP. During the third phase from 2005 to the present, the FMTP has created a network of sub-national training programs and added annual conferences to bring together graduates for continuing education, networking, and recognition. All along, the national staff have supported the regional programs by awarding a Certificate of Completion of Training signed by the Secretary of the Philippines Department of Health, the NEC Director and the participant's Regional Director.

Between 2000 and 2010, 294 participants graduated from the Philippines FMTP. Of those, 130 (44 %) were physicians, 87 (30 %) were nurses, 51 (16 %) were from the non-health sector (councilors, administrative or budget officers, and human resource staff), and 29 (10 %) performed other health-related work. FMTP graduates have been promoted to positions as directors, heads of offices, and supervisors in their respective units and organizations. Several FMTP graduates now work as management consultants for international organizations.

FMTP participants have completed 204 applied management improvement projects, working alone or with other course participants from their LGU. Of those, 132 (65 %) were process improvement projects and 55 (27 %) were program planning and management projects. Projects addressed improvements in service delivery, information systems, logistics, health insurance, policy, and laboratory systems. The management projects, in combination with technical training and development, improved the quality and speed of service delivery, decreased errors, and established needed health and workforce regulations. When FMTP participants recruited teams to help them implement their applied management projects, the team members who participated also learned to use the new management tools.

A project initiated in Sultan Kudarat province in 2000 that was presented at the 4th Biennial SMDP Global Conference in 2007 illustrates the types of results achieved. The project's goal was to reduce pneumonia deaths in children 0–5 years old from 37/100,000 in 2000 to less than 25/100,000 by 2005. Using the management tools learned during the training such as project management and quality improvement approaches, the Sultan Kudarat team designed and implemented three intervention strategies:

(1) institutional, including (a) upgrading health facilities, (b) training health workers on pneumonia case detection, (c) mobilizing resources for acquiring medicines, (d) establishing health and nutrition posts in strategic villages, and (e) improving service delivery, immunizations, supplemental feeding, deworming and family planning programs;
(2) policy, including provision of health insurance for indigents; and
(3) community, including (a) mobilization and training community health volunteers on Integrated Maternal and Child Health (IMCH), Infant and Young Child Feeding (IYCF) and (b) providing health education for mothers, fathers and caregivers.

Two years after implementation of the interventions, pneumonia deaths in young children had declined to less than 25/100,000.

Another process improvement project combining managerial and technical improvements in Sultan Kudarat province addressed blood screening in a hospital setting. At the beginning of the project, no blood units (0 %) were fully screened for malaria, hepatitis B and C, HIV, and syphilis prior to transfusion to patients. After the team

Table 2 Examples of Field Management Training Program quality improvement projects done between 2003 and 2010—Philippines 2014

Problem	Interventions	Post-implementation Results
1. Only 39 % of live births in Motong, West Samar are registered within 30 days	1. Conduct orientation for rural health personnel 2. Formulate health unit policy 3. Allocate budget 4. Outreach activities for live birth registration	Live birth registration increased from 39 to 75 %
2. The percentage of fully immunized children in Tarangnan, Samar is only 38 %	1. Village health workers submit list of eligible children for vaccination 2. Health workers conduct outreach vaccination in hard-to-reach areas 3. Health workers use target client list as record 4. Midwives meet with mothers	Percentage of fully immunized children increased to 92 %
3. 14 % of health insurance claims were returned to Valenzuela Medical Center, for a loss of approximately $7,000 (US)	1. Modify steps in flowchart in processing health insurance claims 2. Conduct orientation for billing staff 3. Reassign selected personnel 4. Provide monthly feedback to management on status of returned claims 5. Renew contracts of clerks 6. Review policies and orientation of new employees	Percentage of returned hospital claims reduced to 2 %, with loss reduced to approximately $1,600 (US)
4. 83 % of medical patients at the Emergency Room of Bicol Medical Center had an average waiting time of more than about 3 h, 55 min	1. Reassign additional personnel to attend to ER patients 2. Revise replenishment system for drugs and medicine in the ER 3. Revise ER flowchart 4. Include ER charges for medical patients in the hospital bill prior to discharge	77 % of ER patients had an average waiting time of less than 2 h; only 23 % had a waiting time of more than 2 h
5. Only 34 % of patients with medical insurance at Davao Medical Center had complete charts	1. Nurses attend orientation seminar on nursing documentation 2. Revise medical records policy on documenting patient charts 3. Monitor and supervise nurses on improving documentation 4. Issue non-compliance slips to nurses when they do not follow documentation guidelines	Percentage of patients with medical insurance at Davao Medical center with complete charts increased to 84 %

received training on process improvement, including Force Field Analysis, the team identified root causes it then addressed through: additional training for medical technologists on HIV and malaria testing and blood screening; additional budget for the Voluntary Blood Program; additional donor interviews; and additional follow-up for hospital patients. As a result of these interventions, by the end of the project, 100 % of blood units were being fully screened, as reported at the 2nd Biennial SMDP Global Conference in 2004.

FMTP graduates have continued to use quality improvement and other management tools to implement new projects after the initial, mentored projects. For example, the Philippines Food and Drug Administration (FDA) team from Bicol region in its first project reduced stock-outs of three essential drugs (paracetamol, amoxicillin, and co-trimoxazole) by an average of 50 % (from 67 to 33 %) in 24 village drugstores in Bicol, as presented at the 2nd Philippines FMTP Annual Conference in 2006. Interventions included: training and reorientation of village drugstore operators; prioritized procurement of essential medicines; simplified procurement process flow; and improved communication between drugstore sponsors and the regional health office program coordinator.

The team then implemented a second project that increased food manufacturers' compliance with licensing requirements in the region from 60 to 100 %. Interventions included: delegating non-regulatory activities; orientation and seminars for food manufacturers; modified checklist for licensing requirements; and internet installation. After 1 year, 90 % of food manufacturers in Bicol were complying with licensing requirements. The team continued to address the problem until 100 % compliance was achieved, as reported at the 3rd Philippines FMTP Annual

Conference in 2009. Using the same process improvement methodology, the team implemented a third project in the municipality of Daraga, an LGU in Albay Province. Food manufacturers' compliance with licensing requirements nearly doubled, from 46 % during the baseline period to 86 % after only 6 months of intervention, as reported at the 3rd Philippines FMTP Annual Conference in 2009. Table 2 provides additional examples of quality improvement projects and results achieved.

Over the decade, FMTP participants and their teams won SMDP's Best Management Training Program award and five SMDP Applied Management Improvement Project awards. Management Sciences for Health (MSH) recognized the work of FMTP graduates by giving them first prize in the Leadership and Management Award (LMA) category of the MSH Leader Net Project for reducing stock-outs of essential drugs; reducing return-to-hospital insurance claims; and improving rural health unit performance.

Discussion

Since its inception in 1999, the Philippines Department of Health has worked to achieve the FMTP vision of "competent local government personnel delivering quality public health service" and its mission—"to equip local health staff with necessary skills through applied management training courses." Institutionalized within the NEC, the FMTP has its own part-time staff and a corresponding annual budget to help support management training activities in four regions. LGUs pay a per-participant registration fee. Willingness to pay on the part of the LGUs is evidence they have seen of substantial benefits returned from their investments, including improvements in the graduates' professionalism, such as improvements in their work attitudes, commitment, and interpersonal relationships.

While it was beyond the scope of this paper to formally evaluate the FMTP, the results of the applied learning projects cited here provide compelling near-term evidence of how the skills from the training are being used by participants to identify, prioritize, and solve day-to-day managerial problems. These findings are consistent with the experience in other countries that also implemented management capacity-building programs based on CDC's SMDP model.

The evidence-based results achieved by these project teams support the conclusion that "In the everyday work in the municipalities, health managers and political leaders have to be aware of their possibilities to affect the level of evidence used in local public health work. If they emphasize the importance of evidence use the administrations will be more likely to include evidence in their work" (Larsen et al. 2012). In addition, useful and practical results such as those obtained by the Philippines project teams would lend themselves well to inclusion in evidence-based web directories for use "to support sound knowledge translation and exchange practice and the integration of science-based evidence into public health" (Potvin 2013).

The Philippines FMTP has benefited both from being institutionalized within the NEC and from the NEC's collaboration with CDC. At the time the FMTP was initiated, the FETP had been functional for more than a decade and had already trained a critical mass of field epidemiologists. This institutional arrangement allowed the FMTP to build on the already-established FETP network, access its talent pool, and share other NEC resources. Since the FETP was eventually institutionalized under the Department of Health, it had in place infrastructure, staff, and budget which have continued through five Secretaries of Health and three Presidents. Having a successful program like the FETP as a model and source of support enabled the FMTP to take root far more quickly than it might have otherwise. CDC technical support to the FETP and FMTP has also lent credibility and prestige to them. Perhaps most importantly, the FMTP has demonstrated that the acute need for improved health management at the local level can be addressed with a practical skills development training program that includes relevant curricula, applied management improvement projects, and supportive mentoring. Fifteen years after it started, FMTP can look back with pride on its accomplishments.

As it looks to the future, FMTP and its stakeholders are assessing how the FMTP can expand its reach and impact and at the same time confront challenges to its sustainability. Those challenges include lack of full-time dedicated staff at the national level, insufficient budget to institutionalize the program in the four regions and expand to the rest of the country, and difficulty recruiting FMTP regional supervisors and mentors for team projects. More than two decades have passed since the initiation of devolution. It may be time for the NEC to conduct a health system-wide assessment of current needs to determine where limited resources can be best brought to bear to improve health management. In that interval, non-communicable diseases (NCDs) have emerged as a serious problem, accompanied by their own set of management challenges (WHO Western Pacific Region 2013). New learning channels such as the internet and cell phones could be harnessed to deliver management training at lower cost, alone or in combination with classroom learning, throughout all regions of this geographically dispersed country, perhaps in partnership with local universities that could award certificates for professional development.

The FMTP was created to respond to an urgent need for trained health managers at the local level in the wake of

devolution in the Philippines in the 1990s. It has continued to provide local health professionals with tools they use to achieve health service delivery improvements at the local and regional levels.

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