
2019-2023
**Food and Water-Borne Disease Prevention and
Control Program (FWBD-PCP) Strategic Plan**

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Foreword

Food and waterborne diseases (FWBD) are among the most common cause of diarrhea which remain one of the ten leading causes of morbidity and mortality in the country. Also, outbreaks from FWBD can be very massive and catastrophic. Since most of these diseases have no specific treatment modalities, the best approach to limit economic losses due to FWBD is prevention through health education and strict food and water sanitation.

In 1997, the Department of Health (DOH) issued AO No. 29-A s. 1997 “Creation of the Food and Waterborne Diseases Prevention and Control Program” which defines the roles and responsibilities of different agencies to ensure prevention and control of Food and Waterborne Diseases.

The goal of Food and Water-borne Diseases Prevention and Control Program is to reduce the morbidity rate and eliminate deaths due to diarrhea. The program also aims to reduce the number of all typhoid, paratyphoid, and cholera outbreaks to one percent or one per 100,000 populations annually. Since the occurrence of food and water-borne diseases is essentially related to economic and socio-cultural factors, the program recognizes that outbreaks will persist unless underlying social ills are corrected. Along with poverty comes the prevalence of infectious diseases. However, if specific interventions are employed, a drastic reduction of bacterial and parasitic infections can also be expected.

The Food and Waterborne Disease Prevention and Control Program 2019-2023 Strategic Plan supports the medium term strategic framework for 2019-2023 indicated in the Administrative Order 2018-0014 entitled Strategic Framework and Implementing Guidelines for FOURmula Plus (F1+) for Health. F1+ for Health expands the four pillars of health reforms (financing, service delivery, regulation and governance) and highlights greater focus on performance accountability towards the Filipino people. Following F1+ for Health, the implementation of the strategic plan also focuses on sustainable, manageable, and critical interventions for food and waterborne disease prevention and control.

Acknowledgement

This undertaking is a product of collaboration of many individuals from different institutions committed to address food and waterborne diseases in the country. These individuals shared their time, energy and expertise in the preparation of this strategic plan:

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The stakeholders consulted during the field validation visits, TWG meetings, and Expanded Consultation and Planning Workshops, who also actively participated during the planning process (see Annex 4 for the complete list).

Acronyms

ABD	Acute bloody diarrhea
AWD	Acute watery diarrhea
ARMM	Autonomous Region of Muslim Mindanao
BHS	Barangay Health Stations
BAI	Bureau of Animal Industry
BFAR	Bureau of Fisheries and Aquatic Resources
CPG	Clinic Practice Guidelines
CARI	Control of Acute Respiratory Illnesses
CDD	Control of Diarrheal Diseases
DA	Department of Agriculture
DOH	Department of Health
DALY	Disability Adjusted Life Years
EB	Epidemiology Bureau
ESR	Event-Based Surveillance and Response
FHSIS	Field Health System Surveillance
FDA	Food and Drug Administration
FWBDs	Food and Water-Borne Diseases
FWBD-PCP	Food & Waterborne Disease Prevention & Control Program
GIDAs	Geographically Isolated and Depressed Areas
GHO	Global Health Observatory
HSRA	Health Sector Reform Agenda
HH	Households
IYCF	Infant Young Child Feeding
IDO	Infectious Disease Office
IMCI	Integrated Management of Childhood Illnesses
IACHE	Inter-agency Committee for Environmental Health
IPCC	Inter-Personal Communication and Counseling
LGC	Local Government Code
LGUs	Local Government Units
MHCs	Main Health Centers
NDHS	National Demographic Health Survey
NHTS	National Household Targeting System
NMIS	National Meat Inspection Services
NOH	National Objectives for Health
NBB	No Balance Billing
NCDs	Non-Communicable Diseases
ORT	Oral Rehydration Therapy
PSP	Paralytic Shellfish Poisoning
PHA	Philippine Health Agenda
PIDSR	Philippine Integrated Surveillance and Response
RDT	Rapid Diagnostic Test
RITM	Research Institute for Tropical Medicine
RPRH	Responsible Parenthood and Reproductive Health
RHUs	Rural Health Units
SI	Sanitary Inspector
SDGs	Sustainable Development Goals
TWG	Technical Working Group
UHC	Universal Health Care
WINS	WASH in Schools
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Part 1

Introduction

It has been estimated that 1.8 million people worldwide die each year as a result of diarrheal diseases, most of which can be attributed to contaminated food or water. The occurrence of food and water-borne diseases (FWBDs) remains a significant health issue in both developed and developing countries. Illnesses and deaths from these diseases are a constant threat to public health security and socio-economic development of any country. FWBDs strain health care system, severely affect infants, young children, the elderly and the sick. They perpetuate a vicious cycle of diarrhea and malnutrition, hurting the national and local economy and international trade. In developing countries, about 80% of all the illnesses are caused by FWBDs with diarrhea being the leading cause of childhood death. In the Philippines, FWBDs are among the most common causes of diarrhea which remain as one of the 10 leading causes of morbidity and mortality in the country,

Though the full extent of the burden and cost of FWBDs is still unknown, it is surmised this to be substantial. According to the World Health Organization (WHO), the burden of diarrheal diseases alone is estimated to be 3.6% of the total Disability Adjusted Life Years (DALY) worldwide and estimated to cause 1.5 million deaths per year. From the latest data of DOH, acute watery diarrhea (AWD) ranked seventh among the top leading causes of morbidity at 76.3 per 100,000 population and is also the seventh leading cause of mortality among infants at 0.5 per 1,000 live births.

The prevalence of FWBDs can be greatly reduced by provision of clean drinking water and safe disposal of feces. These interventions must be equally supported with continuous health education and information dissemination, particularly in the promotion of healthy practices such as proper water, sanitation and hygiene (WASH). However, an estimated 1.1 billion people still lack access to improved drinking water sources and about 2.4 billion lack access to adequate sanitation worldwide. In the Philippines, the proportion of households with access to safe water reached the 90% 2015 Millennium Development Goal but failed to reach the desired proportion of households with sanitary toilet.

I. Background

Food and Water-Borne Diseases (FWBDs) caused by microorganisms is a large and growing global public health problem. This group of diseases is usually caused by infectious organisms like viruses, bacteria and parasites, and are transmitted from person to person through soiled hands and via food and water contaminated by human waste through the oral-fecal route. The incidence of FWBDs peaks during the rainy season and is usually high in areas where sanitation and hygienic practices are poor. It also increases along with poverty.

FWBDs are usually manifested as diarrhea. Based on the 2015 Global Health Observatory (GHO) data, diarrhea accounts for 9% of the total deaths among children below 5 years old. In the Philippines, a total of 11,876 cases of acute bloody diarrhea (ABD) were reported from sentinel sites nationwide in the same year. In addition, 830 Hepatitis A cases and 74 cases of paralytic shellfish poisoning were also reported. The Philippine Health Statistics data showed that diarrhea placed 5th as a leading cause of morbidity among general population in 2010 from being the top or second leading cause in the 1990s. Morbidity rate due to diarrhea has gone down from 1,520/100,000 population in 1990 to 347.3/100,000 population in 2010. Despite this decline however, several notable outbreaks continue to occur. It is believed that since the occurrence of FWBDs is essentially related to economic and socio-cultural factors, these outbreaks will continue to persist unless underlying social ills are corrected.

In 1997, the Department of Health (DOH), issued AO No. 29-A s. 1997 to “*Create the Food and Waterborne Diseases Prevention and Control Program.*” This stipulated the goal and objectives to be achieved including the components of the program to be operationalized and implemented. Since its inception, the FWBD-PCP has carried out several interventions in response to the increasing incidence of FWBDs. These notable interventions include: (i) institutionalization of Oral Rehydration Therapy (ORT) corners in both the hospitals and outpatient public health facilities for the immediate management and treatment of diarrhea cases, (ii) integration of the identification and management of diarrhea among the children in the Integrated Management of Childhood Illnesses (IMCI) protocol, (iii) design, installation and operationalization of a FWBD surveillance and response system to detect impending outbreaks and provide immediate investigation and response to these cases, (iv) provision of drugs/medicines and supplies augmentation to identified local government units (LGUs) with high incidence of FWBDs, and (v) currently developing clinic practice guidelines on the diagnosis, management and treatment of several FWBDs.

However, the Food and Water-Borne Disease Prevention and Control Program (FWBD-PCP) also recognizes that several enhancements are still needed to achieve its goal and objectives. Some interventions previously introduced seemed inadequate to curb other FWBD diseases. For this purpose, the DOH-Infectious Disease Office (IDO) embarked into a rapid assessment of the FWBD-PCP implementation status, the results of which became the basis for charting the direction, focus and priority over the next 6 years.

II. The Philippine Profile

The Philippines is an archipelago comprising of 7,107 islands clustered into Luzon, Visayas and Mindanao located in Southeast Asia. It is divided into 16 administrative regions with the Autonomous Region of Muslim Mindanao (ARMM) as the 17th region in the country. There are 81 provinces, 167 component cities, 16 chartered cities, 1,495 municipalities and 42,008 barangays. The Philippines is considered the 12th most populous country in the world, with an estimated population of 100.98 million (2016). The population comprises of multiple ethnic groups, several of which reside in remote, hard-to-reach mountainous areas that are quite difficult to reach for social services.

The Philippines is considered one of the most vulnerable countries in the world to extreme weather events, being first in vulnerability to tropical cyclones, third for the number of people exposed to these seasonal events, and fourth most vulnerable to natural disasters. It experiences an average of 20 typhoons per year and faces increasing disaster risks.¹ The country is also challenged by intermittent political instability and episodic armed conflict in the south and localized areas of Luzon which limit the delivery of social services and cause population displacement that may facilitate disease introduction or transmission.

In spite of the challenging global economic environment, the country's economic growth rate had increased in the last five years with the economy growing by 6.8% in 2016 compared to 5.9% in 2015. In 2013, total health expenditures as a percentage of Gross Domestic Product was at 4.4%. While the 2015 Human Development Report noted that the value of the Philippines' human development index increased by 20% between 1980 and 2014, the Philippines only ranked 115 out of 188 countries. Poverty incidence among Filipinos decreased from 25.1% in 2012 to 21.6% in 2015. The *Education for All 2015 National Review* showed that basic literacy rates among adults improved from 93.4% in 2003 to 95.6% in 2008, while functional literacy increased from 84.1% to 86.4% over the same time period.

Life expectancy at birth is 65.3 years for males and 72.0 years for females.² The national burden of disease is increasingly dominated by non-communicable diseases (NCDs). The country continues to experience rise in HIV cases and dengue cases remain unabated. Neglected Tropical Diseases continue to be a public health burden in the country, although the Philippines is now nearing the elimination of malaria.

Around 2,000 mothers die each year from pregnancy-related conditions. Under-5 mortality rate is at 27/1,000 live births while Infant Mortality was registered at 21/1,000 live birth (2015 National Demographic Health Survey (NDHS). Immunization coverage is quite low at 70.0% (2015 FHSIS) while more than 30% of children under 5 years of age are stunted.³

¹ World Disaster Report in 2015

² WHO (2016) *World Health Statistics*

³ UNICEF (2016) *Philippines Statistics*

III. The Philippine Health System

In 1991, the Philippine Legislature passed the Local Government Code (LGC) that transferred from DOH the primary responsibility of delivering health care and services to the LGUs. As provided for in the LGC, the DOH remains as the lead agency in the health sector and shall continue to formulate policies, guidelines and standards, design and manage technical training, operate an integrated surveillance and response system, monitor and evaluate health outcomes, and perform regulatory functions in support to health care delivery. The LGUs are to deliver basic health care and services, hire/ deploy their own health staff, upgrade/construct/maintain a network of health facilities with appropriate equipment and adequate supplies, and install/implement delivery and management support systems (e.g. planning and budgeting, information management system, referral, public-private coordination, monitoring and evaluation, etc.).

The country's overall health care delivery system is characterized by a network of both public and private health facilities at the provincial, municipal and barangay levels. Tertiary level health care services are provided by medical centers owned and managed by the private sector and some by DOH. Provincial and some municipal/city governments also run and operate their own hospitals. Public health services are provided through the Rural Health Units (RHUs) or Main Health Centers (MHCs) together with the private clinics. At the community level, Barangay Health Stations (BHS) exist staffed with midwives and supported by a cadre of volunteer community workers (BHWs, BNS, etc.).

While the LGC empowered the LGUs in health service delivery, a number of challenges were noted: (i) large variations in the access to quality publicly-provided health services among LGUs; (ii) most LGUs unable to maintain/upgrade facilities and not providing mandated benefits to devolved health workers; (iii) rare technical coordination between administrative levels and largely dependent on relationships between individual health care providers and facilities; and (iv) slow progress in the availment and utilization of PhilHealth benefit packages hence, health services are still financed mainly through out-of-pocket.

In response to these issues, several reforms were introduced. The Health Sector Reform Agenda (HSRA) in 1999 set the foundation for a holistic and strategic approach towards changes and development in the health sector. It highlighted the 4 pillars of reform namely: (i) service delivery, (ii) governance, (iii) financing, and (iv) regulations. Following this period was the adoption of the *FOURmula One for Health* (F1) Strategy which aimed to address the financial and service delivery fragmentation by providing centrally funded incentives in the form of grants to promote inter-LGU planning which included formation of Inter-local Health Zones and Provincial/City Investment Plans for Health (P/CIPH). More PhilHealth Benefit Packages were developed and operationalized to cover health care and needs of people accessing basic health care and services from the outpatient and in-patient facilities.

From 2010-2016, the health sector was guided with the *Kalusugan Pangkalahatan* (KP) or Universal Health Care (UHC) as its goal and which adopted the National Household Targeting System (NHTS) in targeting the poorest of the poor for full national premium subsidy. The Responsible Parenthood and Reproductive Health (RPRH) was also passed which mandated centrally-financed delivery of family planning services. The passage and operationalization of the Sin Tax Reform Law in 2012 which imposed increased excise tax on tobacco and alcohol products enabled the DOH to finance centrally-procured goods and services through the DOH Health Human Resource Augmentation Program which deployed centrally-contracted health staff (doctors, nurses, midwives, dentists and medical technologists) to augment local human resources and the Health Enhancement Facility Program (HEFP) supported the renovation/construction of DOH-retained and LGU hospitals including outpatient health facilities.

The Philippine Health Agenda (PHA) for 2016-2022 defined the national health sector policy and strategic priorities which maintain a strong identification with UHC principles, financial risk protection and achieving the sustainable development goals (SDGs). The PHA is built around three guarantees: (i) care during all life stages, addressing the triple burden of disease (infectious diseases, NCDs and diseases of rapid urbanization); (ii) a functional, responsive service delivery network; and (iii) financial risk protection through universal social health insurance.

The most recent policy reform, Administrative Order 2018-0014 entitled Strategic Framework and Implementing Guidelines for FOURmula Plus (F1+) for Health, provides the medium term strategic framework for 2019-2023. It expands the four pillars of health reforms (financing, service delivery, regulation and governance) and highlights greater focus on performance accountability towards the Filipino people. The implementation of F1+ for Health focuses on sustainable, manageable, and critical interventions that optimize available resources, supported by evidence and sufficient groundwork, and produce tangible results felt by Filipinos. The objectives of each pillar are as follows:

- Financing – to secure sustainable investments to improve health outcomes and ensure efficient and equitable use of health resources;
- Service delivery – to ensure the accessibility of essential quality ducts and services at appropriate levels of care;
- Regulation – to ensure high quality and affordable health products, devices, facilities and services; and
- Governance – to strengthen leadership and management capacities, coordination, and support mechanisms necessary to ensure functional, people-centered and participatory health systems.

In addition, the “PLUS” ensures that performance accountability cuts across the four pillars. Its objective is to use systems that would drive better execution of policies and programs in the DOH while ensuring responsibility to all stakeholders.

IV. Milestones in FWBD-PCP Development and Implementation

The FWBD-PCP was established in 1997 through DOH AO No. 29-A. Way before this issuance, several policies and guidelines were already developed in support to the prevention and control of FWBDs in the country, particularly diarrhea. A decade before 1997, the DOH implemented the Control of Diarrheal Diseases (CDD) which was focused on the prevention, management and treatment of diarrhea among underfive year old children until this was integrated into the Integrated Management of Childhood Illnesses (IMCI) Program together with the Control of Acute Respiratory Illnesses (CARI). The following are key milestones that supported the design and implementation of the FWBD-PCP as a public health program.

1975 PD No. 856	Code of Sanitation of the Philippines”
1996 DOH DC No. 110	Intensifying the Program on Food Handlers and Water Quality Surveillance to Curb Outbreaks of water and sanitation related diseases
1997 DOH AO No. 29-A	Creation of the Food and Water-Borne Disease Prevention and Control Program
1997. DOH DO No. 99-H	Designation of Ad Hoc Committee for the formulation of plans, policies and standards for the FWBD-PCP
2001. DOH DC No. 176	Revised of List of Notifiable or Reportable Diseases which included cholera, typhoid, and paratyphoid fever, paralytic shellfish poisoning, acute watery diarrhea, acute bloody diarrhea, food poisoning and chemical poisoning.
2005. AO No. 0012	Development of Guidelines for FWBD Surveillance
2007 AO No. 0012	Issuance of the Philippines National Standards for Drinking Water -
2007.	Manual of Procedures for the Surveillance, Outbreak Investigation and Response to Microbial Agents of Food and Waterborne Diseases supported by WHO and Research Institute for Tropical Medicine (RITM)
2010 AO No 2010-0037	Issuance of Diagnosis and Treatment Guidelines for Paragonimiasis
2012. RA 10611	Food Safety Act to strengthen the food safety regulatory system in the country to protect consumer health and facilitate market access of local foods and food product
2014	Development of Technical Reference on the Neglected Tropical Diseases in the Philippines

Part 2

Assessment of the FWBD – PCP Implementation Status

I. Assessment Objectives

Since its inception in 1997, this is the first time that the FWBD-PCP implementation status is being assessed. Results of this assessment are expected to guide the overall direction and strategic approaches to be pursued by the FWBD-PCP in the next 6 years. Specifically, the assessment aimed to:

- (1) establish FWBD-PCP performance level against the goals and targets set in the 2011-2016 DOH-National Objectives for Health (NOH);
- (2) determine the extent by which the FWBD's key strategies were operationalized and implemented;
- (3) identify the factors that influenced the performance levels and implementation status of the FWBD-PCP components;
- (4) summarize the gaps and challenges and come up with recommendations to address them.

II. Assessment Methodology

In 2016, the DOH-IDO started to assess the implementation status of the FWBD-PCP as the starting step to developing a 6-year Strategic Plan. Series of consultations were held with various groups of stakeholders which generated a list of strengths and gaps surrounding the implementation of the FWBD-PCP. Results of this initial assessment were used to form part of the overall program assessment.

The performance level and implementation status of the FWBD-PCP was further reviewed using a mix of data collection methodologies. Review of secondary data covering the following was undertaken: (i) laws, policies and guidelines issued, (ii) technical reference manuals on FWBD (draft MOP, draft Training Manual, draft communication plan, draft, (iii) disease surveillance data on various FWBDs, and (iv) results of surveys and special studies that were undertaken. Key Informant Interviews were also undertaken with DOH officials including regional program coordinators and development partners.

Field validation visits were undertaken in the following selected regions and LGUs to validate organizational support to the FWBD-PCP management and implementation, LGU support to the Program, management support systems in place and the extent by which the FWBDs are prevented, managed and treated at the facility level.

National Capital Region
Region 4A

Quezon City and Marikina
Tanay, Rizal and Mabitac, Laguna

A Technical Working Group (TWG) was created to anchor the assessment and provide overall technical guidance. The TWG is chaired by the Division, Chief of the DOH-IDO with members coming from other DOH central office officials and technical staff and

regional offices, partners from the academe and WHO. Please refer to Annex 1 for the list of people who were consulted in the assessment and planning for the FWBD-PCP.

III. Assessment Parameters

- A. FWBD-PCP Framework.** Prior to the assessment, the TWG saw the need to come up with the FWBD-PCP Framework where the vision, goals, objectives and strategies are spelled out and the various program components established and specified. In this FWBD-PCP Framework, the scope of FWBD diseases to be covered are also identified and defined. The scope of the assessment was guided by the overall direction specified in this Program Framework.
- B. 2011-2016 DOH- NOH.** In the absence of a FWBD-PCP Strategic Plan in the past 6 years, the assessment of program performance were referenced against the goals and objectives as well as strategies stipulated in the 2011-2016 DOH-NOH. The following are the goals, objectives and strategies of the FWBD-PCP:

Goals

1. Morbidity and mortality from food-borne and water-borne diseases are reduced; and
2. Outbreaks of food-borne and water-borne diseases are reduced.

Objectives

Table 1. Objectives and Targets of the FWBD-PCP, 2011-2016

Objectives	Indicator	Baseline	2016 Target
Morbidity and mortality rates due to food-borne and water-borne diseases are reduced	Morbidity rate from diarrhea per 100,000 population	288.7 (2010), FHSIS	230.0
	Mortality rate of diarrhea per 100,000 population	6.1 (2005, PSA)	No death
FWBD outbreaks is reduced or eliminated	Number of typhoid, paratyphoid and cholera cases as confirmed by the DOH	2008, DOH Surveillance Data Cholera: 800 cases Typhoid: 2,500 cases	Zero outbreak per Year

Strategies

- Strategy 1.** *Regulate and monitor food and water sanitation practices at the local level through enforcement of national and local legislations, application of appropriate technical standards and participation of non-government agencies.*

Strategy 2. *Sustain inter-agency collaboration to fast-track sanitation infrastructure development in poor urban areas and in rural areas with low access to safe water and sanitation facilities.*

Strategy 3. *Promote personal hygiene, food and water sanitation practices and the principles of environmental health.*

Strategy 4. *Promote the use of ORS in the management of diarrhea to prevent dehydration, especially among infants and children.*

Strategy 5. *Promote breastfeeding and other good feeding practices for infants and children.*

Strategy 6. *Continue training of health personnel in the early diagnosis and treatment of food-borne and waterborne diseases.*

Strategy 7. *Continue nationwide information campaign for the prevention and control of food-borne and waterborne diseases.*

C. Labeling Parameters. To visually reflect the performance levels of the FWBD-PCP vis-à-vis the 2016 target stated in the 2011-2016 DOH-NOH, the following color labels are adopted:

Table 2. Labels of Program Performance Levels Against 2016 FWBD-PCP Targets

Performance Against 2016 Target	Color Labels
2016 Performance already Met the Target	
2016 Performance within 1-10% off the target	
2016 Performance > 10% off the target	

Considering that there are no indicators specified for each strategy, the assessment of their implementation status were limited to qualitative description of activities undertaken. In some strategies where alternate indicators were possible, available data were used and analyzed to gauge the extent of implementation.

IV. Assessment of FWBD-PCP Performance Levels

A. Overall Performance

Performance of the FWBD-PCP over the past 6 years showed mixed results vis-à-vis the program targets set for 2016. While there has been a reduction in the morbidity rate due to diarrhea, several deaths continue to be reported from different parts of the country. As of 2016, 18 deaths due to diarrhea were obtained through the Philippine Integrated Surveillance and Response (PIDSIR) system. In addition, several events occurred over the same period due to diarrhea, typhoid, cholera and other diseases. These continuing outbreaks and occurrence of deaths indicate the difficulty of the local health system to sustain measures to prevent and control FWBDs in the country.

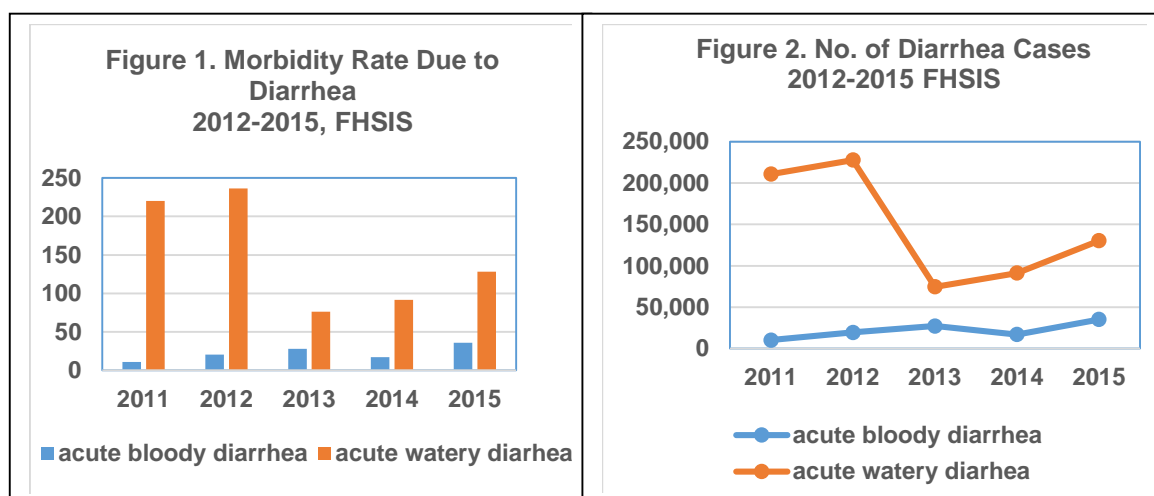
Table 3. FWBD Performance, 2011-2016

Indicator	Baseline	2016 Target	Accomplishment 2015/2016	Performance Status
Objective 1. Morbidity and mortality rates due to FWBDs are reduced				
1.1 Morbidity rate due to diarrhea per 100,000 population	288.7 per 100,000 (2010 FHSIS)	230.0 per 100,000 pop	2015 FHSIS <u>No. of Cases</u> Acute Bloody Diarrhea: 35,255 Acute Watery Diarrhea: 130,246 <u>Morbidity Rate</u> Acute Bloody Diarrhea: 35.62 Acute Watery Diarrhea: 127.98	
1.2 Mortality rate due to diarrhea per 100,000 population	6.1/100,000 (2005 PSA)	No death	Mortality Rate: 2014 PSA No. of deaths: 18 (2016 EB)	
Objective 2. FWBD outbreaks is reduced or eliminated				
2.1 Number of cholera cases as confirmed by DOH	Cholera: 800 cases (2008, DOH Surveillance Data)	Zero outbreak per/year	No. of Cases: 86 Rate: 0.08/100,000 2015 FHSIS No. of Confirmed Cases: 18 2016, EB	
2.2 Number of typhoid, paratyphoid as confirmed by DOH	Typhoid: 2,500 cases (2008, DOH Surveillance Data)	Zero outbreak per/year	No. of Cases: 11,369 Rate: 11.17/100,000 2015 FHSIS No. of Confirmed Cases: 269 2016 EB	

B. Morbidity and Mortality Rates By Specific Food and Water-Borne Diseases

Diarrhea

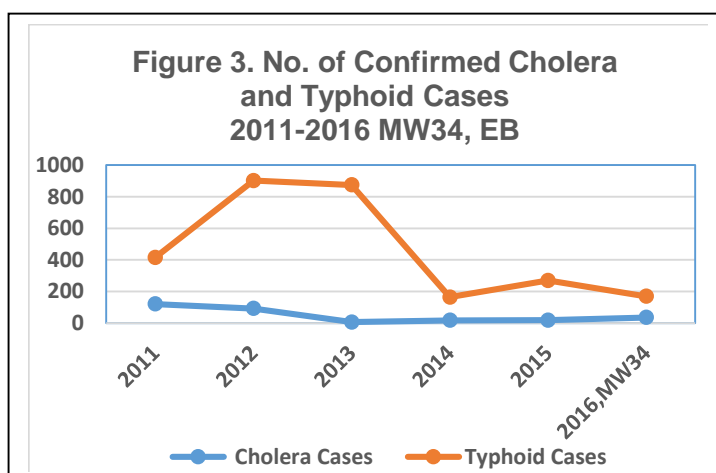
Morbidity Rate due to diarrhea has gone down almost by two thirds from its 2010 level of 288.7/100,000 population to only 166.8/100,000 population in 2015 (both acute bloody diarrhea and acute watery diarrhea). In 2013, both the number of acute bloody diarrhea and acute watery diarrhea cases reached their lowest but these again began to build up from 2014 to 2015. These fluctuating values reflect that the control and prevention of diarrhea has been difficult to sustain in the past 6 years,



Mortality. The desired zero death due to diarrhea was not realized. Surveillance data in 2015 showed 18 deaths due to diarrhea, which even increased to 44 in 2016.

Cholera and Typhoid

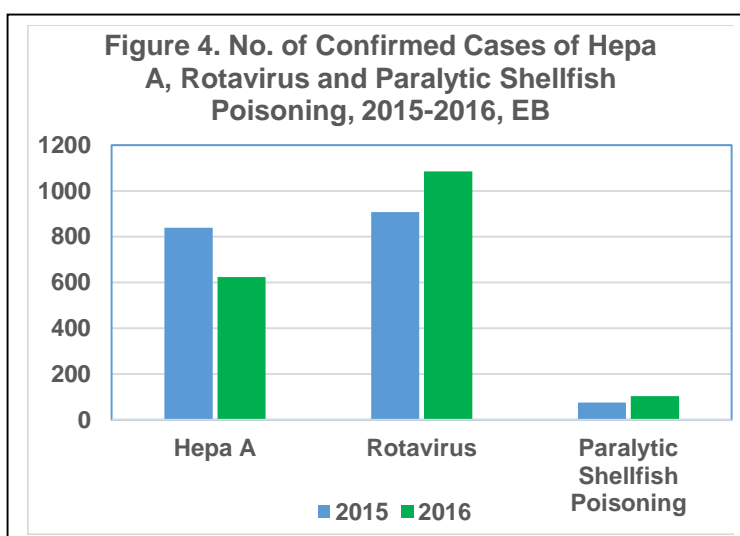
Morbidity. Though the number of confirmed typhoid and cholera cases decreased over the past 6 years, substantial number of cases continues to be reported. Cholera cases slightly increased from 2013 to 2016 while typhoid cases decreased from 2013 to 2014. However, this rose again in 2015.



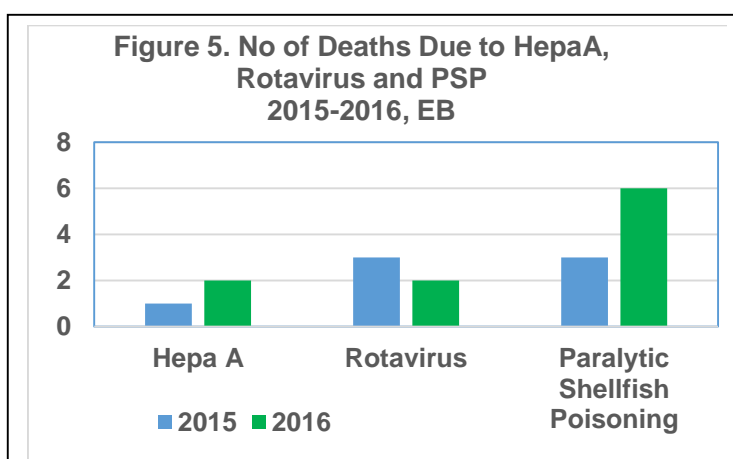
Mortality. There have been no deaths reported due to cholera from 2015 to 2016. No death was also reported due to typhoid in 2015. Two deaths were reported though from the National Capital Region (NCR) in 2016.

Other Food and Water-Borne Diseases

Morbidity. Surveillance data from 2015 to 2016 showed the occurrence of Hepa A, Rotavirus and Paralytic Shellfish Poisoning cases and deaths. The number of Hepa A cases went down from 2015 to 2016. Cases of rotavirus and paralytic shellfish poisoning increased over the same period. These increases could be a result though of increasing sentinel sites reporting during this period.

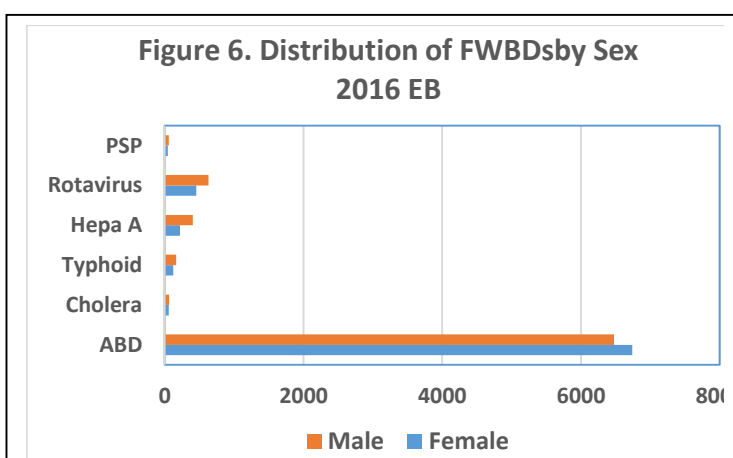


Mortality. There were a number of deaths reported due to Hepa A, rotavirus and paralytic shellfish poisoning (PSP) from 2015 to 2016. The number of PSP deaths doubled from 3 in 2015 to 6 in 2016 and so with deaths due to Hepa A from 1 in 2015 to 2 in 2016. Only 5 deaths were reported due to rotavirus over the same period.



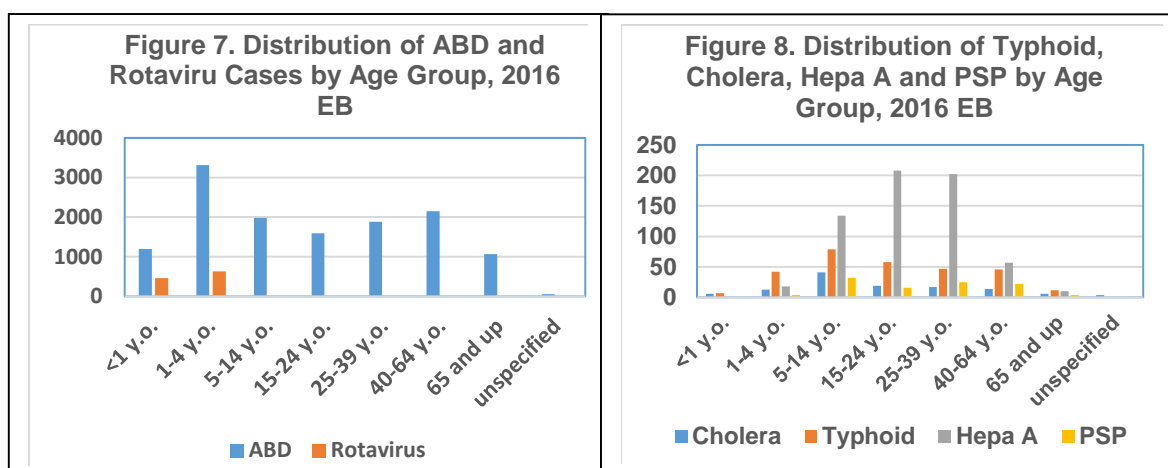
FWBDs by Sex

Based on EB's data in 2016, there were slightly more males generally experiencing FWBDs (cholera, typhoid, Hepa A, rotavirus and paralytic shellfish poisoning) than females. However, for acute bloody diarrhea, there were more females than males reported experiencing the disease in the same year.



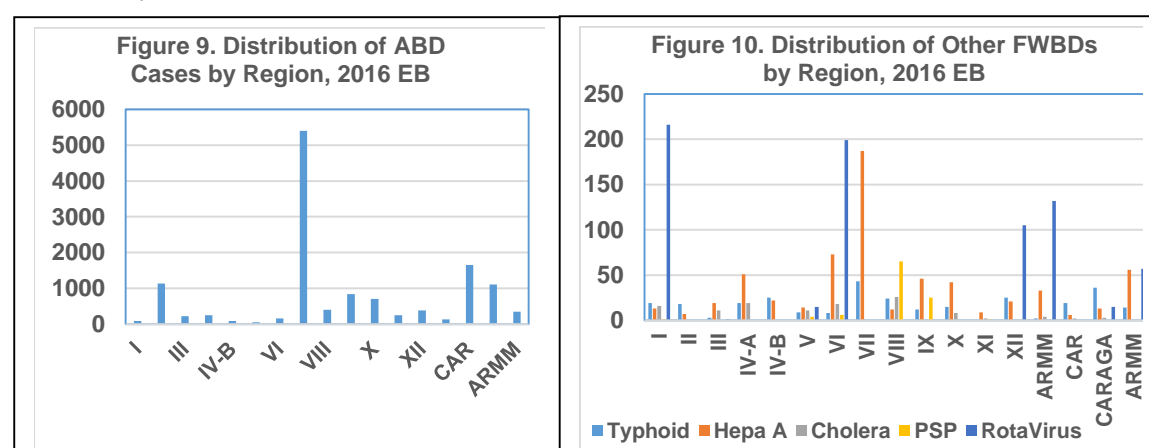
FWBDs by Age Group

Majority of the reported acute bloody diarrhea in 2016 were among the 1-4 year old children. Rotavirus as characterized occurs mainly among the same age group and those below 1 year old. As for Hepa A, mostly affected are the 15 to 39 year olds and also notable among the younger age group (5-14 years old). As for typhoid, cholera and paralytic shellfish poisoning, highest number of cases reported was among the 5-14 years old.



FWBDs by Geographical Areas

The Visayas Region particularly Regions 7 and 8 came out as hosts of the highest incidence of FWBDs in the country. Incidence of acute bloody diarrhea is highest in Region 7 and also the host of the highest number of reported Hepa A and Typhoid cases in 2016. Region 8 on the other hand had the highest incidence of cholera and paralytic shellfish poisoning. Region 1 came out highest in the incidence of rotavirus in the same year.



C. Outbreaks Due to FWBDs

The objective of the FWBD-PCP to eliminate FWBD outbreaks was not realized given the several reported FWBD-related events experienced in the various parts of the country from 2012 to 2016. A total of 115 food and waterborne illness health events were verified by the Event-Based Surveillance and Response (ESR) Unit from 2012 – 2016. In these events, a total of 17, 246 cases and 143 deaths were reported during the period.

Table 4. Summary of Food and Water-Borne Illness Health Events, 2012 – 2016

FWBD	2012			2013			2014			2015			2016		
	Events	Cases	Deaths	Events	Cases	Deaths	Events	Cases	Deaths	Events	Cases	Deaths	Events	Cases	Deaths
ABD	0	0	0	0	0	0	0	0	0	1	20	0	1	29	0
Shigella	2	194	1	4	2368	4	2	662	3	0	0	0	1	30	2
Salmonella	2	1036	4	4	317	5	2	41	0	3	29	2	1	4	0
Amoebiasis	6	385	5	4	83	0	10	389	3	12	284	5	20	2268	12
Rotavirus	0	0	0	2	300	0	1	710	1	0	0	0	2	1290	14
Hepa A	3	98	0	0	0	0	9	505	1	12	255	3	4	119	0
Paralytic Shellfish Poisoning	2	14	2	3	29	2	2	32	2	10	57	2	4	55	4
Capillariasis	0	0	0	0	0	0	4	4	0	0	0	0	3	3	1
Paragonimiasis	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Others	0	0	0	2	12	0	1	1447	10	2	221	0	2	3956	22
Total	15	1727	12	19	3109	16	31	3790	20	40	866	12	38	7754	55
Highest FWBD	Most (6, 40%) were Amoebiasis health events			Most (5, 26%) were Diarrhea and Typhoid Fever health events			Most (10, 32%) were Amoebiasis health events			Most (12, 30%) were Amoebiasis and Hepatitis A health events			Majority (20, 53%) were Amoebiasis health events		
Most Affected Regions	Region 6 had the most (17, 26%) number of Food-borne Illness health events reported			Region 1 had the most (23, 26%) number of Food-borne Illness health events reported			Region 1 had the most (19, 19%) number of Food-borne Illness health events reported			Region 12 had the most (32, 17%) number of Food-borne Illness health events reported					

D. Implementation Status of Proposed Strategies for 2011-2016

The proposed strategies for the prevention and control of FWBDs for 2011-2016 have not been consistently and expansively pursued. While Oresol with zinc continues to be the first line of management and treatment of diarrheal cases, the ORT corners in public health facilities and hospitals are no longer to be found. The proportion of mothers practicing breastfeeding remains low and the proportion of households practicing sanitation practices failed to reach the desired level of 90%. In addition, no training and nationwide information campaigns on FWBD prevention and control have been undertaken. While a number of national laws and policies have been passed to support prevention and control of FWBDs in the country, the extent of their enforcements had been weak and inconsistent. The same goes for the practice of water and sanitation including personal hygiene. Access to safe water has improved over the years achieving the 90% MDG target in 2015. Several units of toilet bowls were also distributed to communities with low access to sanitary toilets. Support structures such as the Inter-agency Committee for Environmental Health (IACHE) exist where issues relative to water and sanitation were discussed.

The following summarizes key achievements in each FWBD prevention and control strategy:

Table 5. Implementation Status of 2011-2016 FWBD-PCP Strategies

Strategy 1. <i>Regulate and monitor food and water sanitation practices at the local level through enforcement of national and local legislations, application of appropriate technical standards and participation of non-government agencies.</i>	
Implementation Status	<ul style="list-style-type: none"> There is a robust set of laws and policies that support food and water sanitation practices in the country; the extent of compliance and adherence however to these laws and policies cannot be fully ascertained given the absence of data relative to such practices: <ul style="list-style-type: none"> 2012. RA 10611 on Food Safety Act to strengthen the food safety regulatory system in the country to protect consumer health and facilitate market access of local foods and food product <ul style="list-style-type: none"> 2000 RA Act 9003. 200 providing for an ecological solid waste management program, creating the necessary institutional mechanisms and incentives declaring certain acts prohibited and providing penalties, appropriating funds therefore and for other purpose 1975 PD No. 856 Code of Sanitation of the Philippines
Strategy 2. <i>Sustain inter-agency collaboration to fast-track sanitation infrastructure development in poor urban areas and in rural areas with low access to safe water and sanitation facilities.</i>	
Implementation Status	<ul style="list-style-type: none"> Interagency Committee on Environmental Health with sub-task forces on Water, Solid Waste, Toxic Chemicals and Occupational Health
Strategy 3. <i>Promote personal hygiene, food and water sanitation practices and the principles of environmental health.</i>	
Implementation Status	<ul style="list-style-type: none"> 90% of HHs have access to safe water (2015) 86.7% of HHs with sanitary toilets (2015) No data available to establish extent of personal hygiene practices
Strategy 4. <i>Promote the use of ORS in the management of diarrhea to prevent dehydration, especially among infants and children.</i>	
Implementation Status	<ul style="list-style-type: none"> ORS continues to be the primary intervention of children with diarrhea as shown by the 2015 FHSIS Reports that 100% of diarrhea cases were given ORS.

	<ul style="list-style-type: none"> • However, facilities visited are already without ORT Corners • Likewise, some health facilities have inadequate supply of zinc
Strategy 5. <i>Promote breastfeeding and other good feeding practices for infants and children.</i>	
Implementation Status	<ul style="list-style-type: none"> • WHO discourages use of bottles with nipples for feeding during early infancy as it is usually associated with malnutrition and increased risk of infection, especially diarrheal disease, through unhygienic procedures in the preparation of the liquid or the feeding bottle and use of unsafe water. The 2013 NDHS showed that bottle-feeding is relatively still common in the Philippines with 27% of infants under age two months being fed using a bottle with a nipple.
Strategy 6. <i>Continue training of health personnel in the early diagnosis and treatment of food-borne and waterborne diseases.</i>	
Implementation Status	<ul style="list-style-type: none"> • No training has been conducted on the early diagnosis and treatment of FWBDs; the clinic practice guidelines are still currently being finalized which will be packaged into a Training Module for both hospital and public health facility staff
Strategy 7. <i>Continue nationwide information campaign for the prevention and control of food-borne and waterborne diseases.</i>	
Implementation Status	<ul style="list-style-type: none"> • No nationwide information campaign has been designed and mounted on the prevention and control of FWBDs in the past 6 years

E. Influencing Factors

The following summarizes the key factors that contributed (strengths) and limited (gaps/challenges) the performance of the FWBD-PCP based on consultations with several groups of stakeholders and field validation visits.

Table 6. Factors That Influenced FWBD-PCP Performance Level and Implementation Status

Reform Area	Strengths	Gaps and Challenges
Service Delivery – Supply		
	<ul style="list-style-type: none"> • management of diarrhea among underfive children part of IMCI • availability of Oresol and other support drugs/medicines • vaccine against rotavirus provided in 2011-2012 but not continued • health staff know when to refer cases to higher level of care • availability of hyposol for water chlorination • provision of toilet bowls 	<ul style="list-style-type: none"> • absence of CPGs on the diagnosis and management of FWBDs resulting to varying standards and protocols practiced by the different hospitals • ORT corners no longer found operational in health facilities • inadequate knowledge of service providers on diarrhea management • lack of trained staff on IMCI in the health facility • non-availability of vaccines for all cases of diarrhea • lack of trust and confidence on government health facilities • service delivery network for FWBDs unclear
Service Delivery - Demand		
	<ul style="list-style-type: none"> • Communication Plan for FWBD-PCP recently developed 	<ul style="list-style-type: none"> • poor health seeking behaviors of patients due to varying reasons (e.g. cultural beliefs)

Reform Area	Strengths	Gaps and Challenges
	<ul style="list-style-type: none"> Some IEC materials on food and water-borne disease prevention were distributed to the LGUs FWBD messages integrated in flip charts and other IEC materials of other health programs SIs provide orientations to community members (e.g. NHTS HHs on sanitation practices) 	<ul style="list-style-type: none"> community not aware of disease consequences due to lack of IEC resulting from inappropriate messages and ineffective information dissemination negative attitude of health workers untrained/uninformed health staff No KAP survey conducted
Governance		
Leadership	<ul style="list-style-type: none"> several LGUs with concrete support to water and sanitation projects: clean-up of surroundings and public areas, installation of sanitary toilets; delivering water to upland areas with poor access to safe water anecdotal reports from several LGUs on personal hygiene practices: (Paligo ni Mayor Belen for children in Dagupan City, provision of footwears in several LGUs in Region 5, etc.) some LGUs procure additional oresol, hyposol, etc. 	<ul style="list-style-type: none"> low priority on FWBD program in some LGUs lack of support from some LCEs lack of ownership of the program wrong perception of devolution particularly political will on health matters political problems/intervention/interest among departments lack of good governance and ethical leadership
Organizational Support Structure	<ul style="list-style-type: none"> National and Regional FWBD-PCP Coordinators in place FWBD-PCP point persons designated at the provincial level and in some municipalities/cities disease surveillance is lodged at EB with a network of surveillance units at the regional down to the city/municipal levels Environmental Health Division with regional and provincial coordinators and a network of sanitary inspectors management of diarrhea among underfive children is integrated in the IMCI Program managed by Family Health Office including the Infant Young Child Feeding (IYCF) Program where the promotion of breastfeeding as a key preventive measure of diarrhea among infants is a major component management of the Food Safety Program is placed under the environmental health program in coordination with FDA 	<ul style="list-style-type: none"> management of FWBD-PCP has been transferred from one DOH unit to another (from IDO to EH and back to IDO); management within IDO also transferred from NTD cluster to the other IDO unit National and Regional FWBD-PCP Coordinators only recently designated; all regional coordinators are handling other programs overall management of FWBD-PCP remains unclear at the local level; no overall coordinator assigned; in some areas, the program is placed either under the Sanitation Unit or the municipal/city surveillance and epidemiology unit but none has been designated to coordinate diagnosis, management and treatment including governance component Regional and local FWBD-PCP Coordinators not trained fast turn-over of coordinators
	<ul style="list-style-type: none"> Food Sanitation is placed under the environmental health program 	<ul style="list-style-type: none"> no clear-cut coordination among DOH offices involved in the program scope and limitation of FWBD-PCP vis-à-vis other programs not clearly streamlined

Reform Area	Strengths	Gaps and Challenges
Policies/ Guidelines and Plans	<ul style="list-style-type: none"> • several national laws exist in support to the prevention and control of FWBDs - Sanitation Code (P.D 856) - 2007 AO No. 0012 Philippines National Standards for Drinking Water (AO 2007 0012) - Food Safety Act (RA 2012 10611) • Diagnosis and Treatment Guidelines for Paragonimiasis (AO No 2010-0037) • Clinic Practice Guidelines are currently being developed to guide diagnosis, management and treatment of FBDs • presence of LGU ordinances on sanitation 	<ul style="list-style-type: none"> • FWBD-PCP lacks overall program framework, hence implementation of components remain fragmented • absence of strategic plan to guide implementation • no manual of operations to provide standards to be followed • compliance/adherence to national policies and laws not monitored • management of other FWBDs (e.g. Hepa A, amoebiasis dysentery, etc.) still without CPGs • program not cascaded and institutionalized at regional and local levels; unaware of policies including roles and functions • lack of orientation on FWBD-PCP; preventive vis-à-vis curative not clear to all stakeholders
Health Human Resource	<ul style="list-style-type: none"> • preventive measures of FWBDs primarily carried out by the RSIs with the assistance of midwives and BHWs • health staff get by their own in identifying and managing diarrhea cases and other FWBDs • some NDPs utilized to assist in the prevention and control of FWBDs • medical technologists also available in several LGUs for parasitology tests 	<ul style="list-style-type: none"> • limited number of sanitary inspectors at the local level (e.g. Tanay, Rizal with > 100,000 population has only 1 SI) • some SIs are under contractual/job order employment; no plantilla position for SIs • most nurses and midwives lack training on IMCI while some are still not oriented on IYCF • no specific training on FWBD diagnosis, management, treatment
Monitoring and Evaluation	<ul style="list-style-type: none"> • management of diarrhea cases with oresol and zinc recorded and reported through FHSIS • FWBDs are covered by PIDSR • outbreaks are also tracked/monitored through PIDSR and Event-Based Surveillance • available Manual of Procedures for the Surveillance, Outbreak Investigation and Response to Microbial Agents of FWBDs • presence of functional surveillance teams (RESU, PESU, MESU) • M/CESU staff have undergone training on PIDSR which covered the case definition of each FWBD • Regions and LGUs able to respond to outbreaks 	<ul style="list-style-type: none"> • absence of overall M and E Framework on FWBD-PCP • no standard monitoring and evaluation tool • under reporting of cases due to various reasons (e.g. concern of tourism being affected) • poor reporting system, with issues on reliability of data, lack confirmation • R/P/M/CESU staff are multi-tasked • no clear communication structure from CO/RO to LGU level • delayed/poor feedback mechanism • late communication of LGUs (problem at the lower level is already unmanageable)
Logistics	<ul style="list-style-type: none"> • availability of drugs/supplies from DOH • LGUs procure oresol, hyposol 	<ul style="list-style-type: none"> • limited supply of drugs/medicines • logistics support from DOH not enough

Reform Area	Strengths	Gaps and Challenges
Multi-Sectoral Collaboration	<ul style="list-style-type: none"> • DOH participates in the IACEH meetings to address issues related to FWBDs • Other government agencies mandated to prevent and control FWBDs (DA, FDA, etc.) • DOH and LGUs coordinate with other agencies for special projects on environmental health and sanitation 	<ul style="list-style-type: none"> • no clear guidelines established relative to collaborative work among concerned government agencies especially at the local level • agencies/stakeholders work in isolation based on their own mandate • no one to spearhead collaboration • participation of NGOs, private sector not maximized
Financing	<ul style="list-style-type: none"> • DOH budget for FWBD-PCP more than doubled from Php 30.0 M in 2013 to Php 68.7 M in 2017 although allocation varied from year to year • Some LGUs provide funds for FWBD prevention and control 	<ul style="list-style-type: none"> • Lack of LGU fund • Small fund allocation • Financial constraints • Dependence on DOH for technical assistance and logistics • No etiologic cases, inadequate resources for diagnosis; not a priority
Regulations	<ul style="list-style-type: none"> • laws/policies exist to ensure quality and safety of food, drinking water • inspection of water refilling stations and food establishments undertaken by SIs at the local level 	<ul style="list-style-type: none"> • policies lack enforcements by the concerned agencies • licensing of food establishments not strictly implemented in some areas • proficiency of med techs on parasitology test not assured • efficient and appropriate management of specimen not in place or followed (e.g. labs lack capability to get specimen while still fresh to get the accurate source of the disease)

F. Summary of Gaps and Challenges

- (1) FWBDs remain a public health concern. Though significant reductions have been achieved over the past 6 years (e.g. diarrhea morbidity and mortality rate), cases and deaths due to FWBDs continue to occur. Outbreaks in several parts of the country remain uncontained;
- (2) The FWD-PCP as a whole lacks overall direction and focus given the absence of an overall program framework, strategic plan and manual of operations causing weak appreciation and limited understanding by coordinators and implementers at the regional and local level. Management and implementation of program components remain fragmented;
- (3) Being a multi-faceted program, the scope and limitation of FWBD-PCP vis-a-vis other programs has not been clearly defined and its link with the other programs not fully established;
- (4) The management and coordination of the FWBD-PCP has been transferred from one office to another at the national and regional levels resulting to slow progress

and development as a program. Several Regional FWBD Coordinators were just recently-designated with other con-current programs to manage. At the LGU level, the FWBD- PCP has been managed mainly as a preventive sanitation program (under the environmental health) or as a surveillance measure (under the P/C/MESU). There is no overall coordinator managing the diagnosis, management and treatment component and the governance component;

- (5) Low priority is given by the local leadership on the prevention and control of FWBDs. There is lack of ownership of the program and poor appreciation of FWBDs' consequences on the welfare and health of their constituents;
- (6) Diagnosis, management and treatment of FWBDs lack the necessary protocols and standards (except for diarrhea among underfive as incorporated in the IMCI guidelines and for paragonimiasis under 2010 AO No 2010-0037). While the hospitals continue to manage and treat FWBDs, they follow different protocols and guidelines as the DOH still has to finalize the CPGs;
- (7) Previously trained staffs on IMCI have long been replaced with new staff without the benefit of training/orientation. Proficiency of staff on diagnosis, management and treatment of other FWBDs (outside diarrhea cases) remains undeveloped. Newly-hired sanitation inspectors also lack the necessary formal training. Some of them only received brief orientation from co-workers from other municipalities;
- (8) Not all FWBD cases got confirmed with laboratory tests. Results of confirmatory tests are not readily available. Submission of specimen remains a challenge as most laboratories are distant from the national reference lab;
- (9) Management of preventive measures are spread out in different DOH offices: immunization and IYCF are placed under the DOH-Family Health Office, Food Safety and health sanitation practices are under the Environmental Health and Sanitation. Coordination with these offices requires further streamlining;
- (10) Promotion of personal hygiene and health sanitation practices has not been palpable. No survey has been carried out to establish the level of awareness, attitudes and practices of the population relative to personal hygiene and sanitary practices. Locally- initiated promotion and preventive measures were hardly sustained or rolled-out. IEC materials are very limited while other channels and avenues to promote awareness and practices have not been fully explored and maximized;
- (11) Compliance and adherence to national laws and policies is low while enforcements of sanctions and penalties by concerned authorities is weak. The increasing number of food and industrial establishments and growing population especially in urban areas against a stagnant number of sanitary inspectors available in the field prevent the conduct of regular inspections;

- (12) FWBD cases are under-reported. Some FWBD outbreaks were neither recorded nor reported. The program lacks an overall M and E framework to guide the tracking, reporting and assessment of the different program components' progress or status;
- (13) There has been no purposive surveys or special studies undertaken to measure the actual burden of FWBDs in the country and to identify and establish geographical areas as well as population segments most vulnerable to these diseases;
- (14) Logistics requirement for the diagnosis, management and treatment of FWBDs has not been fully established. Thus, some LGUs experience stock-outs of essential drugs and medicines including laboratory supplies;
- (15) Limited number of health staff is experienced by almost all LGUs particularly sanitary inspectors and medical technologists. While DOH has provided staff augmentation, their availability has not been fully maximized for the diagnosis, management and treatment of FWBDs, and also for preventive services;
- (16) Current DOH and LGU financing for the FWBD-PCP activities and logistics needs are inadequate. There is no budget separately allocated for the FWBD-PCP at the local level but there are some amounts in the disease surveillance and environmental health and sanitation which the local health staff can tap as needed. The DOH-ROs and LGUs have not formulated plans for FWBD-PCP as a whole;
- (17) Participation of other government agencies and non-government organizations including the private sector for FWBD prevention and control has not been maximized. The functionality of multi-sectoral task forces or committees on environmental health and sanitation where FWBD prevention issues could be raised and discussed is difficult to ascertain;

G. Recommendations

- (1) Fast track the development and issuance of the FWBD-PCP Framework including this 2019- 2023 FWBD Strategic Plan to guide regional and local coordinators and implementers in the management and implementation of the FWBD-PCP. Ensure the regionalization and localization of the 2019-2023 FWBD-PCP Strategic Plan and develop the Manual of Operations as reference for all groups of stakeholders at various levels of operations;
- (2) Organize and hold consultations with other DOH offices/units involved in the prevention and control of FWBDs and identify areas for collaboration. These consultations should evolve and clarify which office/unit should be responsible for each specific component of the program to avoid overlap and missing out leadership in certain areas. This should also include clarifications of collaboration of the FWBD-PCP components at the regional and local levels;

- (3) Map out and stratify the provinces according to the burden of the FWBDs including the use of other determinants (e.g. presence of IPs, highly congested areas, poverty is high, malnutrition is high, etc.) to have a focused set of interventions for each stratum. This will guide prioritization of resources, time and efforts to those areas with high burden of the diseases and population segments who are most vulnerable to FWBDs;
- (4) Finalize the CPGs on the FWBDs that will guide the various levels of health care on the proper diagnosis, management, treatment and referral of cases. The CPGs are expected to outline and specify the needed drugs/medicines, supplies, equipment required for each category of health facility. Consequently develop the Training Module covering these CPGs and roll out the training nationwide;
- (5) Support the expansion and capacitation of the national and sub-national laboratories as the reference lab for parasitology testing. Establish the Quality Assurance System on the diagnosis of FWBDs;
- (6) Establish full logistics requirements for the quality diagnosis, management and treatment of FWBDs. Define which of these requirements the DOH-C)/ROs can finance and which ones should be shouldered by the LGUs;
- (7) Strengthen FWBD surveillance and response. Support the establishment and sustainability of surveillance and epidemiology units at the local level. Ensure that case definitions of FWBDs are followed by the local health staff in reporting cases;
- (8) Develop the FWBD-PCP Monitoring and Evaluation Framework. Establish key indicators to be tracked and design appropriate data collection schemes and tools for each indicator. Enhance the data coverage of FHSIS to other FWBDs as needed.
- (9) Organize joint national-regional monitoring teams to track implementation status at the local level. Members of the joint monitoring team should include but not limited to FWBD coordinators, EB/RESU, Environmental Health staff including representative from the Family Health Office and Health Promotion Communication Services. Engage representatives from the academe, professional societies or other agencies/sectors;
- (10) Develop and update the FWBD-PCP research agenda to guide design and conduct of relevant surveys/special studies to improve operations as well as technologies in the prevention and control of FWBDs;
- (11) Given the recently-developed Communication Plan for the FWBD-PCP, establish the key messages to be disseminated peculiar on each FWBD and those common information to be promoted for their prevention and control. Consider special design/channels/media to reach the identified vulnerable groups;
- (12) Map groups of stakeholders whose expertise and contributions can be tapped to support the diagnosis, management, treatment and prevention of FWBDs;

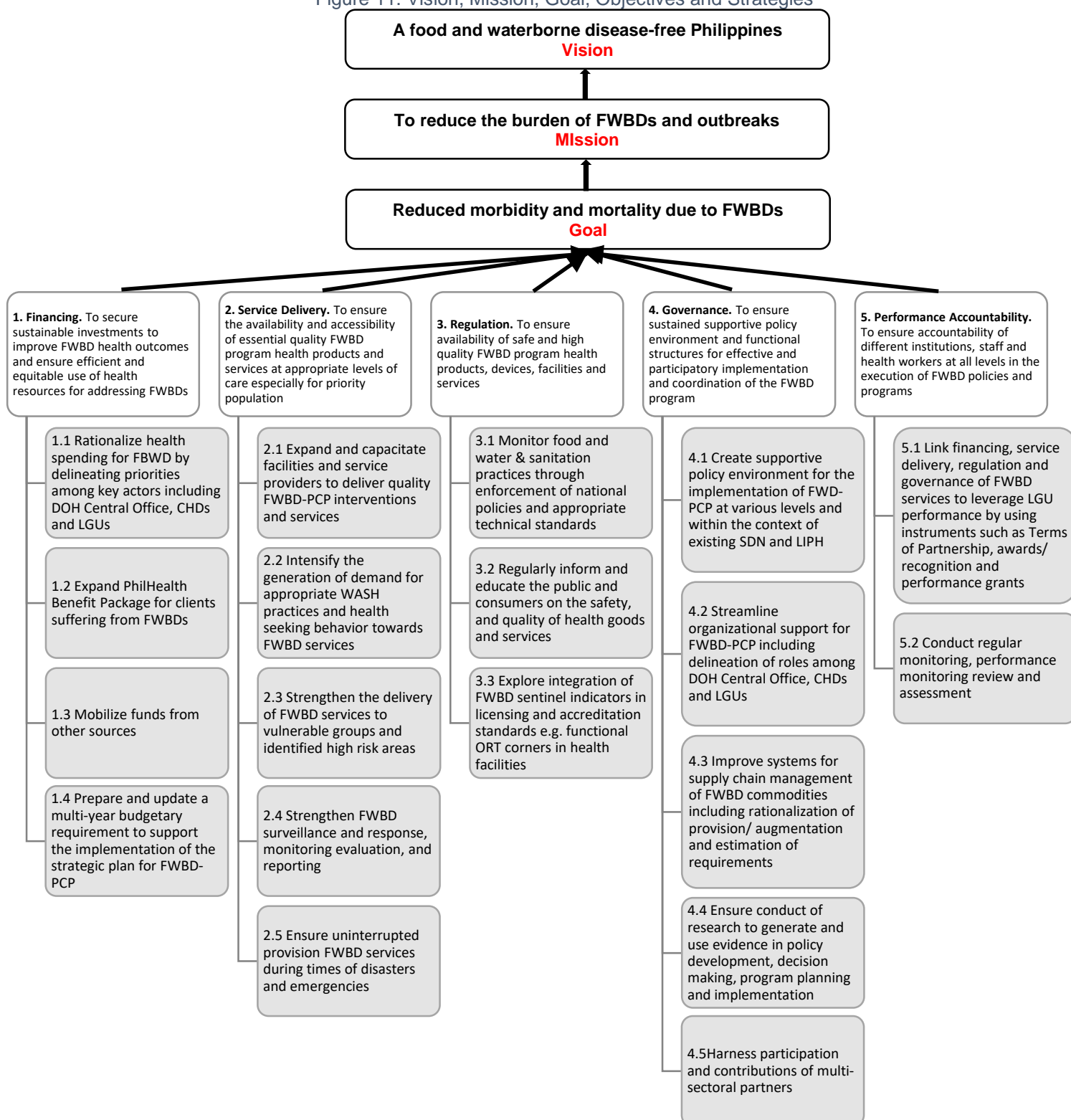
- (13) Establish regular coordination meetings among all concerned DOH offices involved in the FWBD prevention and control. Establish or sustain the TWG created on the FWBD- assessment and plan development to continue serving as the sound board for technical and policy issues relative to FWBDs;
- (14) Advocate for increased budget allocation for FWBD-PCP from the DOH budget. Undertake the same advocacy and fund mobilization at the LGU level. Tap the support of private companies and business corporations to support FWBD prevention and control as part of their corporate social responsibility. Explore possibility of establishing a PhilHealth Benefit Package for related FWBD management and treatment cost;
- (15) Develop recognition and awards system for LGUs which are able to reduce significantly the number of cases and deaths due to FWBDs;

Part 3

FWBD-PCP Strategic Plan 2019-2023

A. Vision, Mission, Goal, Objectives and Strategies

Figure 11. Vision, Mission, Goal, Objectives and Strategies



The FWBD-PCP envisions a food and waterborne disease-free Philippines by 2023. To attain this vision, the Program, in coordination with key stakeholders, commits itself to reduce the burden of FWBDs and outbreaks in the country to contribute to the overall goal of a reduced morbidity and mortality due to FWBDs.

Consistent with Administrative Order 2018-0014 entitled Strategic Framework and Implementing Guidelines for FOURmula Plus (F1+) for Health, the Program's key strategic objectives are:

1. In healthcare financing: To secure sustainable investments to improve FWBD health outcomes and ensure efficient and equitable use of health resources for addressing FWBDs
2. In service delivery: To ensure the availability and accessibility of essential quality FWBD program health products and services at appropriate levels of care especially for priority population
3. In regulation: to ensure availability of safe and high quality FWBD program health products, devices, facilities and services
4. In governance: To ensure sustained supportive policy environment and functional structures for effective and participatory implementation and coordination of the FWBD program
5. In performance accountability: To ensure accountability of different institutions, staff and health workers at all levels in the execution of FWBD policies and programs

To operationalize these strategic objectives in healthcare financing, the Program shall facilitate rationalization of health spending to address FWBDs by delineating priorities among key actors including DOH Central, CHDs, and LGUs. Specifically, it shall clarify with the stakeholders at all levels what its budget and commodities are for, and what are expected from regional and local spending. In addition, the Program shall look into the expansion of PhilHealth benefits for clients suffering from FWBDs in coordination with PhilHealth. Given the need for more funds, the Program shall explore sourcing funds from other sources e.g. ODA and private sources in collaboration with development partners and stakeholders from the private sector. To support this, the Program shall prepare and regularly update a multi-year budgetary requirement to support the implementation of this strategic plan.

In terms of service delivery, the Program shall facilitate the expansion and conduct of capacity building for health facilities and service providers to deliver quality interventions and services. To influence health-seeking behavior, the Program shall intensify demand generation activities for appropriate WASH practices and encourage the public to intensify availment of health services. Moreover, FWBD surveillance and response, monitoring and evaluation, and reporting shall also be improved to strengthen health services to address FWBDs. However, not all segments of the population have equal access to the same health services. Therefore, health service delivery shall be strengthened to improve access of vulnerable groups such as indigenous peoples and population in identified high risk areas. Lastly, the Program shall work with key stakeholders to ensure uninterrupted provision of health services to address FWBDs during times of disasters and emergencies.

In terms of regulation, the program shall endeavor to monitor food and water sanitation practices through its regional and local partners including the implementation of policies and standards. In addition, the program shall strive to inform and educate the public and consumers on the safety and quality of health

goods and services. These shall be done through the issuance of advisories and press releases to guide the general public. To help institutionalize FWBD initiatives , the Program shall also explore integration of key indicators in licensing and accreditation standards applied to health facilities such as functional ORT corners in health facilities.

In governance, the Program shall work with key stakeholders in DOH, other agencies, LGUs and private sector/civil society to ensure continuous supportive policy environment and functional structures. Specifically, the issuance of these supportive policy environment shall be facilitated within the context of SDN and LIPH. As much as possible, lessons from real world experiences shall be extracted from the conduct of pilot and demonstration studies prior to issuance and nationwide implementation of any FBWD policy. Thus, the Program shall conduct research to generate and use real world evidence in policy development, decision-making, program planning and implementation. Alongside with the supportive policy environment, the Program shall continuously assess how to streamline organizational support for the implementation of FWBD initiatives including clear delineation of roles of national, regional and local actors in critical functions such as planning, financing implementation and monitoring. Specifically, the Program shall facilitate the improvement of supply chain management of FWBD commodities including the rationalization of estimation, provision and augmentation of commodity requirements. Lastly, FWBD governance systems and structures shall harness the participation and contributions of multisectoral partners.

In performance accountability, the Program shall leverage LGU performance by exploring the use of instruments such as the annual Terms of Partnership between DOH and LGUs, awards/recognition and performance grants in the implementation of FWBD initiatives. As the Terms of Partnership spells out commitments from both DOH (represented by CHDs) and LGUs per year, these should include counterparts for resources (financial, technical assistance and commodities) provided by DOH. Clearly indicating such counterparts from both side shall facilitate monitoring and ensure adequate resources. In addition, the Program shall facilitate the use of awards, recognition and performance grants as incentives to effective implementation of FWBD initiatives. As its key function, the Program shall conduct regular monitoring, performance monitoring review and assessment of its activities.

B. FWBD-PCP Key Targets

The FWBD-PCP has identified key indicators to be used determining progress aims to achieve the following targets in the next 6 years. The different activities addressing FWBDs shall be linked to these indicators in the preparation of regular reports by the Program. These shall be reviewed annually for any proposed revision consistent with the annual DOH plans and strategies.

Table 7. FWBD-PCP Key Targets

1.	Indicator	Definition	Target	Remarks
	% increase in DOH budget allocation for FWBD per year	Increased amount of budget allocated by DOH (CO and ROs) for FWBD-PCP every year compared to the previous year	At least 20% increase per year	Also link with budget utilization
2.	% of health facilities with adequate drugs/ medicines and supplies for FWBD	Proportion of health facilities over total number of health facilities (by category) with no stockout of or expired FWBD medicines/ supplies in the last quarter	25% increase per year	Establish baseline during the first year, then target 25% increase

C. Budgetary Estimates

Estimated total budgetary requirement to execute the 2019-2023 FWBD-PCP Strategic Plan amounts to Php 1.7 billion. About two thirds (Php 1.1 billion) of the total amount is earmarked to support the expansion and strengthening of the provision of quality FWBD-PCP services, particularly in reactivating the ORT corners in every health facility, equipping both the public and private hospitals on the management and treatment of FWBDs according to the newly developed CPGs and in reaching out to the most vulnerable groups and high risk areas. Also included is the support for increasing demand for quality FWBD-PCP prevention, management and treatment services. Substantial amount is also allocated to strengthen FWBD surveillance through the PIDSR and ESR, the parasitology surveillance by RITM and that of the FDA. Surveys and special studies are also planned out to generate the information needed as basis in further enhancing the FWBD-PCP's direction and strategic approaches. The amounts for preventive measures such as installation of sanitary toilets, safe water facility and vaccine (e.g. for rotavirus) are not incorporated in the estimate. The estimated amounts under the LGU as a budget source are primarily for local transport and other operating expenses at the health facility level.

D. Implementation Arrangements

The DOH-IDO will take the lead in the overall management and implementation of the 2019-2023 FWBD-PCP Strategic Plan with support from the different DOH offices at the Central and Regional Level. The LGUs shall remain to be the primary providers of preventive, diagnosis, management and treatment services to patients with FWBDs.

At the national level, the DOH-IDO will be supported by the Environmental Health and Occupation Office (EOHO) and Health Promotion and Communication Services (HPCS) for the prevention of FWBDs and the promotion of WASH practices including personal hygiene. The Epidemiology Bureau (EB) will be responsible for FWBD surveillance, supported with the surveillance of pathogens by RITM, processed food by FDA and live animal/poultry by the DA- Bureau of Animal Industry. RITM together with the subnational reference laboratories shall serve as the confirmatory referral laboratories for FWBD tests. The Family Health Office (FHO) will continue to coordinate preventive measures through breastfeeding and the provision of vaccines. The same will continue to coordinate the management of children under five years old with diarrhea as part of the Integrated Management of Childhood illnesses. All the DOH-CO counterparts at the regional level will be tasked to carry out the same functions and tasks.

The hospitals (both the DOH-retained hospitals, other government and private hospitals) at the lower level will provide the necessary management and treatment services especially for FWBD cases that cannot be handled by the local health facilities – BHS/HCs and RHUIs/MHCs. The laboratories at these levels shall perform diagnostics tests (e.g. RDTs) and shall be confirmed with the national reference lab (RITM) and subnational reference laboratories once established.

As contained in the Plan, other government agencies as well as other groups of stakeholders will be mobilized and engaged by the DOH to provide their expertise, technical assistance, financial and other forms of assistance as needed especially in reaching out the vulnerable groups and other high risk areas.

E. Roles and Functions of Key Players on the Management and Implementation of the FWBD-PCP

The following outlines the roles and functions of concerned DOH offices, other government agencies, the LGUs and other partners in the management and implementation of the FWBD-PCP as contained in the FWBD-PCP Framework.

A. Department of Health – Central Office

1. Infectious Disease Office (IDO) - Disease Prevention and Control Bureau (DPCPB)

The overall management and coordination of the FWBD-PCP is lodged in the IDO-DPCB. It takes the lead in setting the overall direction and focus of the Program.

- Formulate and disseminate national policies, standards and guidelines governing the management and implementation of the FWBD-PCP
- Develop strategic plans and cascade this to the regional offices for adoption
- Ensure the provision/delivery of quality diagnosis, management and treatment services of FWBDs
- Design and undertake training program on various components of the program
- Manage the logistics requirements of the Program
- Secure financing for the FWBD-PCP
- Establish partnership with other national government agencies and other partners in the private sector
- Undertake monitoring and evaluation of the status and performance of the FWBD-PCP
- Coordinate with HPCS and other entities in promoting WASH practices and key messages on prevention and control of FWBDs
- Monitor together with EB any outbreak due to FWBD and coordinate with HEMB for the immediate response

2. Environmental Health and Occupation Office

- Provide technical assistance to the regions and LGUs to comply with the provisions and requirements of the Sanitation Code in the Philippines;

- Formulate policies, guidelines and standards in promoting increased access to safe water and sanitation services
- Design strategic approaches to achieve zero open defecation areas nationwide
- Develop and promote guidelines on healthy wash, sanitation and hygiene practices among food handlers, and other concerned institutions
- Coordinate with the Department of Environment and Natural Resources (DENR) for interventions that will support the prevention and control of FWBDs

3. Health Promotion and Communication Services (HPCS)

- Formulate and design a communication plan to address the poor health seeking behavior of the community and their unhealthy food and water practices including personal hygiene
- Develop key IEC messages for various groups of audiences relative to the prevention and control of FWBDs
- Design appropriate media channels and materials to communicate the key FWBD prevention and control messages
- Track improvement in the awareness, attitudes and practices of the targeted population on FWBD prevention and control

4. Epidemiology Bureau (EB)

- Enhancement of FWBD surveillance nationwide
- Support LGUs in case investigation of reported FWBD cases and in providing immediate and proper response if technical assistance is requested
- Inform/communicate with the DOH-IDO and other offices concerned of any impending or notable FWBD outbreaks through ESR and PIDSR
- Generate timely FWBD surveillance reports and disseminate to concerned DOH offices through ESR and PIDSR
- Notify the WHO through the National IHR (International Health Regulations) Focal Point when the assessment indicates a food or waterborne disease event is notifiable pursuant to paragraph 1 of Article 6 and Annex 2 and to inform WHO as required pursuant to Article 7 and paragraph 2 of Article 9 of IHR (Annex 3.8A).

5. Health Emergency Management Bureau (HEMB)

- Provide technical assistance in developing plans in times of emergencies and disasters.
- Mobilize WASH resources through Regional DRRM-H Manager to ensure adequate and safe water through water quality surveillance, disinfection / treatment in coordination with DPCB-EOH.
- Augment logistic support to FWBD during emergencies and disaster situations.

6. Research Institute for Tropical Medicine (RITM) and National Reference Laboratories (Parasitology, Bacterial Enterics and Viral Enterics)

- Perform laboratory testing for samples referred for the FWBD surveillance and outbreak investigation
- Provide technical support for specimen collection, transport and storage for the referring hospitals
- Provide laboratory technical support, training and quality assurance to the subnational, regional and other laboratories
- Provide linelist of laboratory results to EB and RESU, and individual laboratory results to the RESU, in the form of transmittals (for distribution to the DRUs)
- Refer a subset of samples to the designated Regional Reference Laboratory (RRL) for quality assurance purpose
- Perform further studies to determine other etiologies of FWBD
- Maintain continuous coordination/communication with stakeholders to promote information exchange
- Train laboratory personnel in the diagnosis of FWB pathogens
- Provide external quality assurance program for laboratory diagnosis for FWB pathogens
- Evaluate test kits and reagents in coordination with FDA
- Develop and offer confirmatory assays for other FWB pathogens
- Conduct research relevant to FWB program
- Provide recommendation to LRD office as to the need for activation of Outbreak Codes to mount multidepartment, division-level response as appropriate
- Conduct laboratory surveillance for the FWB pathogens

7. Food and Drug Administration (FDA)

- Perform microbiologic tests on food samples submitted to the laboratory
- Provide EB with a monthly report of etiologic agents of food and waterborne diseases on food samples tested
- Monitor the safety of pre-packaged food in the market and issue Public Advisory / Warning to prevent consumption of contaminated food

B. DOH – Regional Offices (RO)

1. Infectious Disease Prevention and Control Cluster

- Disseminate national policies, standards and guidelines governing the management and implementation of the FWBD-PCP
- Develop local plans and cascade to LGUs
- Undertake training related to FWBD-PCP to local government unit
- Provide logistic support on FWBD-PCP to LGU
- Monitor and evaluate the implementation of the program to LGU
- Coordinate with the regional environmental and Occupational Health on the implementation of the FWBD-PCP
- Assist RESU in monitoring incidence of FWBDs
- Coordinate with other partners in the region for the management of the FWBD-PCP

2. Regional Epidemiology and Surveillance Unit (RESU)

- Encode data on patients with laboratory confirmed Salmonella and other food and waterborne infections
- Analyze surveillance data and activate EICT outbreak investigation when deemed necessary
- Provide technical assistance during trainings on laboratory-based surveillance to be conducted among hospital staff or sentinel sites
- Fill up laboratory request forms and submit appropriately-labeled stool specimens from patients and samples of suspected food/water vehicles to the appropriate DOH or DA laboratory for microbiologic tests
- Encode and collate epidemiologic data from LGUs (Provincial/City Epidemiology Surveillance Unit, P/CESU), and hospital sentinel sites on the occurrence of Salmonella and other food and waterborne diseases and submit to EB
- Submit monthly report to EB on notifiable diseases (PIDSR Report)
- Notify EB through the National IRR (International Health Regulations) Focal Point when the assessment indicates a food or waterborne disease event is notifiable pursuant to paragraph 1 of Article 6 and Annex 2 and to inform WHO as required pursuant to Article 7 and par 2 of Article 9 of IHR (Annex 3.8A)

3. Environmental Health and Sanitation Unit

- Provide technical assistance to LGUs to increase HHs with access to safe water and with sanitary toilet, and achievement of zero defecation area
- Implement the preventive measures of FWBD
- Assist in the investigation of FWBD Outbreaks
- Support campaign of prevention and control of FWBD

4. Provincial DOH Office (PDOHO)

- Advocate for LCEs' support to FWBD-PCP
- Lobby to LGU s for funds/budget for FWBD-PCP through inclusion in the annual budget
- Ensure adaption of DOH policy by LGU through ordinances
- Monitor implementation of FWBD
- Provide logistic / fund to EOH for FWBD prevention campaign.

C. Other Government Agencies

1. Department of Interior and Local Government (DILG)

- Support the DOH and DA in the collection and documentation of food-borne illness data, monitoring and research
- Participate in training programs, standards development and other food safety activities to be undertaken by the DA, DOH and other concerned national agencies

2. Department of Education

- Integrate messages on proper water, food and sanitary practices including personal hygiene in the school curriculum
- Support and expand the implementation of WINS in public schools
- Integrate hand-washing practices during school feeding programs

3. Department of Agriculture (DA)

- Develop and transfer technologies that will improve and sustain the development of the livestock industry which ensure food security and competitiveness of the local produce in the global market
- Plan, coordinate and implement research and development programs on swine, beef cattle, poultry, small ruminants and equine on areas of genetics and breeding system, animal nutrition and feed resources utilization, herd management, animal health and disease control, containment and eradication of diseases, post-production, value-added meat products and by-products technology and animal waste management
- Submit report of all investigations involving foodborne disease
- Undertake surveillance of microbiologic agents of food and waterborne diseases which are transmissible to humans
- Alert the Department of Health agencies in cases of unusual increase in the number of reported organisms known to cause foodborne disease in humans (DA, BAI)

4. Department of Social Welfare and Development (DSWD)

- Proper water, food and sanitary practices including personal hygiene of DSWD residential centers, canteen, caterers
- Support and expand implementation of hand-washing practices during feeding programs
- Ensure that DSWD residential centers, canteen, caterers, and DSWD-food for work and feeding programs use and serve fortified foods with Sangkap Pinoy Seal, if available
- Use and serve fortified foods such as rice, wheat, flour, oil and refined sugar in DSWD relief operations and encourage LGUs and NGOs to follow the same
- Authorize food manufacturers to use the DOH seal of acceptance as guide for consumers in selecting nutritious foods (DSWD)

5. Department of Environment and Natural Resources (DENR)

- Control the construction and maintenance of waterworks, sewerage, and sanitation systems and other public utilities
- Prohibit dumping of waste products detrimental to the plants and animals or inhabitants therein
- Prohibit leaving an exposed or unsanitary conditions refuse or debris or depositing in ground or in bodies of water
- Raise awareness on the importance of maintaining reliable and effective treatment of wastewater
- Endeavor to achieve social justice by ensuring the integrity of our ecosystems on which local communities depend for food and livelihood

- Strive to recycle wastewater to benefit communities and not to allow untreated wastewater that will harm people (DENR)

D. Local Government Units (LGUs)

The LGUs are primarily responsible in the delivery of quality FWBD diagnosis, management and treatment and conduct of preventive and control interventions at the local level. Specifically, the LGUs are expected to:

- Enforce the implementation of the “Code of Sanitation of the Philippines” (PD No. 856, December 23, 1975): (i) sanitation particularly in public markets, slaughterhouses, micro and small food processing establishments and public eating places, (ii) codes of practice for production, post-harvest handling, processing and hygiene, (iii) safe use of food additives, processing aids and sanitation chemicals and (iv) proper labeling of prepackaged foods
- Ensure access of households to safe drinking water, safe water and sanitation facilities
- Inspect food establishments on adherence to standards sanitation practices
- Provide training to food handlers and regulate
- Ensure proper waste disposal
- Establish, operate and sustain local epidemiology and surveillance units with the following tasks:
 - Register cases of laboratory confirmed Salmonella and other food and waterborne infections identified from the local government unit (LGU) in the surveillance.
 - Fill up laboratory request forms and submits appropriately labeled specimens from patients and samples of suspected food/water vehicles to the appropriate DOH or DA laboratory for microbiological tests
 - Provide technical support for training on laboratory-based surveillance to hospital staff of sentinel sites
 - Encode and collate epidemiologic data on the occurrence of Salmonella and other food and waterborne infections to the EB
 - Submit monthly reports of food and waterborne diseases to RESU
 - Notify RESU when the assessment indicates a food and waterborne disease event is notifiable pursuant to paragraph 1 of Article 6 and Annex 2 of IHR and to inform WHO as required pursuant to Article 7 and paragraph 2 of Article 9 of IHR (Annex 3.8A)

E. Hospitals

- Attend to cases of diarrhea (no signs, some signs, severe signs of dehydration)
- Request for basic laboratory workups in case of complications
- Carry out further investigation as deemed necessary
- Refer cases appropriately to specialties/sub-specialties when needed
- Observe proper hydration and monitoring of hemodynamic status Encourage oral rehydrating solution as soon as patient can tolerate
- Give appropriate anti-microbial if indicated

- Provide health education including handwashing, sanitation, hygiene will be provided
- Give IEC materials to patient/s prior to discharge

F. Laboratories

1. Subnational Laboratories

- Perform laboratory testing of samples from FWBD cases referred by the disease reporting units, as well as from cluster/outbreak investigations.
- Participate in monitoring visits by FWBD-PCP Monitoring Team
- Participate in the laboratory quality assurance program
- Provide lab results to the National Reference Laboratories and RESUs
- Coordinate with the National Reference Laboratories for technical concerns (specimen collection, transport, storage, testing and troubleshooting)

2. Regional Laboratories

- Perform direct fecal smear, modified acid fast staining, formalin ether concentration technique, kato-katz and RDT for detection of FWB parasites

3. Tertiary Hospitals

- Perform direct fecal smear, modified acid fast staining, formalin ether concentration technique, kato-katz and RDT for detection of FWB parasites

4. Level 3 Laboratories

- Perform direct fecal smear, modified acid fast staining, formalin ether concentration technique, kato-katz and RDT for detection of FWB parasites

5. Level 2 Laboratories

- Perform direct fecal smear, kato-katz and modified acid fast staining for detection of FWB parasites

6. Level 1 Laboratories

- Perform direct fecal smear and kato-katz for detection of FWB parasites

7. Rural Health Units

- Perform direct fecal smear and kato-katz for detection of FWB parasites

ANNEXES

Annex 1. Annual Performance Targets and Indicative Action Points

Objective 1
To guarantee universal access to quality FWBD-PCP information, intervention, and services at all life stages

Guaranteeing universal access to quality FWBD prevention and control services necessitates the expansion and capacitation of service providers and health facilities delivering said services (Strategy 1.1). Strengthening measures include the training of service providers both in the public and private health facilities on the FWBD-PCP CPGs including referral, reactivation of ORT corners in public and private health facilities and improving the capacity of government and private laboratories on FWBD diagnosis with corresponding expansion of reference labs for parasitology confirmation test. Provision of preventive services will be expanded by introducing immunization of children against rotavirus and focusing preventive efforts to geographic areas with high FWBD incidence and low proportion of households with access to safe water and sanitation facilities.

The other strategy towards universal access to FWBD prevention and control services is to generate demand for such services through health promotion and advocacy (Strategy 1.2). Series of promotion and advocacy activities will be guided by the Health Promotion and Communication Plan recently developed by the Program and soon to be regionalized. Generating demand will encompass empowering the mothers and caregivers to help household members observe healthy safe water and sanitation practices including personal hygiene, and knowing the signs and symptoms of FWBDs to prompt them seek diagnosis, management and treatment at once. Promotion of desirable healthy behaviours shall be expanded outside the home as in the expansion of the DepEd's WINS (WASH in Schools) Initiative in the public and private schools. Moreover, health workers will also be equipped with Inter-Personal Communication and Counseling (IPCC) skills to be able to guide community members more effectively in preventing and controlling FWBDs. Likewise, advocacy will be intensified among local government officials to provide the necessary support for preventing and controlling FWBDs from occurring in their respective localities.

It is highly recognized that the incidence of FWBDs thrives more likely among the poorest segments of the population, in high population-congested areas like the slum areas and jails/prisons where sanitation facilities are limited, the Indigenous Peoples (IPs) and those residing in geographically isolated and depressed areas (GIDAs), conflict areas or flood-prone barangays and islands. FWBD prevention and control measures shall be prioritized and focused to these vulnerable groups and high risk areas (Strategy 1.3). For this purpose, the DOH will proactively engage the participation of concerned agencies and relevant non-government organizations to help establish alternative service delivery approaches and innovative measures to prevent and control FWBDs.

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Strategy 1.1 <i>Expand and capacitate health facilities and service providers to deliver quality FWBD-PCP interventions and services</i>							
Annual Target	2016 Baseline	2017	2018	2019	2020	2021	2022 - 2023
Performance Indicator 1.1.1 <i>% of health facilities with staff trained on FWBD-PCP CPGs</i>							
• BHS/HCs (MWs)	No data	No data	No data	TBD	50%	70%	90%
• RHUs/MHCs (doctors and nurses)	No data	No data	No data	TBD	50%	70%	90%
• Public hospitals (doctor and nurses)	No data	No data	No data	TBD	50%	70%	90%
• Private hospitals (doctors and nurses)	No data	No data	No data	TBD	50%	70%	90%
Indicative Actions							
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source Unit Responsible
1. Finalize FWBD CPGs	●						DOH IDO
2. Develop referral protocol	●						DOH IDO
3. Train health providers on CPG and referral protocol							
3.1 BHS midwives				●	●	●	DOH IDO/ CHDs
3.2 RHU doctors and nurses				●	●	●	DOH IDO/ CHDs
3.3 Public hospital doctors and nurses				●	●	●	DOH IDO/ CHDs
3.4 Private hospital doctors and nurses				●	●	●	DOH IDO/ CHDs
4. Support IMCI Training of health care providers				●	●	●	DOH IDO
5. Develop CPGs for other FWBDs (Hepa A, PSP, FB-Trematode, Food Poisoning)				●			DOH IDO
6. Train health care providers on new CPGs					●	●	DOH IDO/ CHDs
6.1 BHS midwives					●	●	DOH IDO/ CHDs
6.2 RHU doctors / nurses					●	●	DOH IDO/ CHDs
6.3 Public Hospital doctors/ nurses					●	●	DOH IDO/ CHDs
6.4 Private hospital doctors /nurses					●	●	DOH IDO/ CHDs

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023
Performance Indicator 1.1.2 % of health facilities with functional ORT corners							
• BHS				60%	80%	90%	100%
• RHUs				60%	80%	90%	100%
• Public hospitals				60%	80%	90%	100%
• Private Hospitals				20%	80%	90%	100%
Indicative Actions							
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source Unit Responsible
1. Review/update guidelines on establishment of ORT Corners		●					DOH IDO
2. Advocate establishment of ORT corners		●	●	●	●	●	DOH CHDs
3. Mobilize LGUs to provide space for ORT Corners		●	●	●	●	●	LGU DOH CHDs
4. Procure ORS and other ORT supplies		●	●	●	●	●	DOH DOH
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023
Performance Indicator 1.1.3 Number of FWBD Referral Labs established and functional							
Indicative Actions							
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source Unit Responsible
1. Capacitate NRLs with diagnostic tools and supplies		●	●	●	●	●	DOH- IDO RITM
2. Develop FWBD diagnostic protocols and training module for TRAINORS		●	●				
2.1 Pilot TOT of FWBD diagnostic protocols and training module			●	●			DOH- IDO RITM/ DOH/ RESU
2.2 Printing of training modules			●				DOH- IDO RITM
2.3 Orientation of FWBD diagnostic protocols and training module in regional level (DOH ROs, hospitals and selected provincial hospitals)		●	●	●	●	●	DOH- IDO DOH/ RITM
3. Capacitate subnational/ regional health facilities for detection of FWBD			●	●	●	●	
3.1 Assess health facilities and human resources		●	●	●			DOH- IDO RITM
3.2 Train medtech and microscopists on FWBD diagnostic protocols		●	●	●			DOH IDO RITM/ DOH
3.3 Procure equipment and supplies for subnational/ regional facilities				●	●	●	DOH- IDO DOH CHDs/ RITM
3.4 Develop lab network				●	●	●	DOH- IDO DOH- CHDs/ RITM

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

4. Monitoring and Evaluation if established health facilities and trained personnel				●	●	●		
4.1 Visit regional labs for monitoring and evaluation of health facilities		●	●	●	●	●	DOH-IDO	RITM
4.2 Establish proficiency testing of regional labs on laboratory tests					●	●	DOH-IDO	RITM
4.3 Analysis of M and E and proficiency test					●	●	DOH-IDO	RITM
4.4 Recommend interventions for continuous improvement					●	●	DOH-IDO	RITM
Annual Target	Baseline 2016	2017	2018	2019	2020		2021	2022 - 2023
Performance Indicator 1.1.4 % of regional labs performing RDT for the following FWBDs								
a. Cholera	none		20%	40%	60%		80%	100%
b. giardia, Entamoeba, clyclospora, cryptosporidium	none	After RITM research is achieved and ready for implementation.			20%		40%	60%
c. TB-Parago	none				20%		40%	60%
d. rotavirus, norovirus, enteric adenovirus and hepatitis A	none				20%		40%	60%
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Protocol development for selected RDT		●	●	●	●	●	DOH-IDO	RITM
2. Sample banking		●	●	●	●	●	DOH-IDO	RITM
3. Evaluation of selected RDTs		●	●	●	●	●	DOH-IDO	RITM
4. Finalization of guidelines in the use of selected RDT		●	●	●	●	●	DOH-IDO	DOH-IDO/RITM
5. Procure selected RDTs and supplies		●	●	●	●	●	DOH-IDO	DOH-IDO/RITM
6. Assess regional labs			●	●			DOH-IDO	DOH-IDO/RITM
7. Train regional in use of selected RDTs		●	●	●	●	●	DOH-IDO	RITM
8. Roll out of selected RDTs		●	●	●	●	●	DOH-IDO	DOH-IDO
9. QC / QA of selected RDTs		●	●	●	●	●	DOH-IDO	RITM
10. M and E of health facilities and trained personnel			●	●	●	●	DOH-IDO	DOH-IDO/RITM
Annual Target	Baseline 2016		2017	2018	2019	2020	2021	2022 - 2023
Performance Indicator 1.1.5 % of identified areas with high FWBD incidence and low access to safe water and sanitation facilities covered with WASH promotion activities and services	No data		TBD	50%	70%	80%	90%	100%

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Develop stratification criteria and guideline to identify high-risk areas to FWBD and develop package of interventions			●	●	●		DOH	IDO / ERDD / EB
2. Document good safe water and sanitation practices including personal hygiene and advocate adoption by other LGUs		●					DOH	ERDD / HPCS
3. Promote the following preventive measures in identified high risk areas		●	●	●	●		DOH/ LGU	IDO/ ERDD/ FHO/ NNC
- Breastfeeding practices								
- Personal hygiene								
- Proper sanitation practices								
- Safe water use and practices								
4. Procure logistics support for water treatment/ chlorination, disinfection (hyposol, gerry can, troclosene, etc.)	●	●	●	●	●	●	DOH	IDO – ERDD / HEMB / Region
5. Mandatory provision of sanitary toilets		●	●	●	●	●	DOH/ LGU	IDO/ ERDD – Coordination
6. Coordinate with water agencies / providers for installation of safe water services as needed		●	●	●	●	●	DOH/ LGU	IDO/ ERDD – Coordination
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Indicative Actions								
Strategy 1.2 Intensify the promotion of and demand for appropriate WASH practices and health seeking behavior towards FWBD services								
Annual Target	2016 Baseline	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 1.2.1 % of parents/ caregivers able to detect early signs and symptoms of FWBDs and bring patients to the nearest health facility	No data	No data	TBD	40%	60%	80%	85%	
Performance Indicator 1.2.2 % of parents/caregivers with diarrhea cases able to give ORT	No data	No data	TBD	40%	60%	80%	85%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Conduct KAP Survey					●	●	DOH	IDO
2. Develop, produce and distribute IEC materials (advisories, flyers, komiks, fans, etc.)		●	●	●	●	●	DOH	DOH-CHDs

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

3. Develop TV and radio commercials					●		DOH	HPCS
4. Procure media placements for TV and Radio ads				●	●	●	DOH CO/ CHDs	DOH- CHDs
5. Produce Pinoy Health TV AVPs for health facilities			●	●	●	●	DOH- CO/ CHDs	DOH- CHDs
6. Evaluate impact of campaign						●	DOH	HPCS/ IDO
7. Coordinate with DSWD re integration of FWBD-PCP messages and practices in the following:		●	●	●	●	●	DOH	IDO/ DOH CHDs
7.1 Family Development Sessions								
7.2 Day Care Center Feeding Program								
8. Coordinate with DepEd re integration of FWBD – PCP messages and practices in the following:		●	●	●	●	●	DOH	IDO/ DOH CHDs
8.1 school curriculum			●	●	●	●		
8.2 school feeding program								
8.3 Healthy school settings - WINS								
9. Identify and assist LGUs to organize CBOs in support to FWBD prevention and control		●	●	●	●	●	DOH	IDO / BLHD / CHDs
9.1. Map out								
9.2. Organize								
9.3. Train								
9.4. Monitor - incentives								
Annual Target	2016 Baseline	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 1.2.3 % of health workers providing correct and appropriate information to FWBD patients			60%	70%	80%	90%	100%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Develop prototype materials flipcharts, referral guidelines, FAQs	●	●	●				DOH	IDO/ HPCS
2. Reproduce aids/materials		●	●	●	●	●	DOH- CHDs	DOH- CHDs
3. Orient/re-orient Health workers on FWBD-PCP		●	●	●	●	●	DOH- CHDs	DOH- CHDs
4. Train health workers on IPCC			●	●	●		DOH- CHDs	DOH- CHDs
Strategy 1.3 Strengthen the delivery of FWBD services to vulnerable groups, identified high risk areas and during emergencies/disasters								
Annual Target	2016 Baseline	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 1.3.1 % of targeted IP communities reached with FWBD prevention and control measures			20%	40%	60%	80%	100%	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Coordinate with NCIP for partnership of FWDB-PCP in selected IP community			●	●	●	●	DOH	IDO
2. Map out strategic IP communities and GIDAs				●	●		DOH	IDO
3. Assess FWBD-PCP needs				●	●		DOH	DOH-CHDs
4. Provide necessary services:				●	●	●	DOH/LGUs	DOH IDO/ERDD / BLHD / CHDs
- home-made ORESOL								
- access to safe water								
- water disinfectant								
- sanitary toilets								
- free slippers								
- hygiene kits								
- provision of drugs/ medicines								
5. Establish Mobile Clinics / Community Outreach			●	●	●	●	DOH/LGUs	DOH-CHDs
6. Organize Health Caravans			●	●	●	●	DOH/LGUs	DOH-CHDs
7. Provide relevant IEC messages								
7.1 Advocate recruitment of IP members as health advocates for their respective tribes				●	●		DOH	IDO/HPSCS
7.2 Develop prototype materials flipcharts, referral guidelines, FAQs				●	●	●	DOH	DOH
7.3 Produce appropriate IEC materials for IPs					●			
7.4 Reproduce IEC materials						●	DOH-CHDs	DOH-CHDs
7.5 Train/reorient recruited IP members					●		DOH-CHDs	DOH-CHDs
8. Post KAP survey on IP behavior change						●	DOH-CO	HPSCS/IDO
10. Semi-annual meeting between DOH and NCIP				●	●	●	DOH-CHD/CO	IDO
Annual Target	2016 Base line	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 1.3.2 <i>% of targeted jails with FWBD – PCP in place</i>			20%	40%	60%	80%	100%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Coordinate with BJMP for partnership of FWDB-PCP			●	●			DOH	IDO
2. Map out strategic jails/prisons (highly congested)			●	●			DOH	IDO/DOH-CHDs

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

3. Assess FWBD-PCP needs			●				DOH	DOH-CHDs
4. Orient BJMP officials on FWBD - PCP			●					
5. Train prison clinic staff on FWBD CPGs			●				DOH	DOH-CHDs
6. Provide necessary preventive measures			●	●	●	●	DOH/BJMP	DOH-CHDs / BJMP
6.1 access to safe water								
6.2 with sanitary toilets								
6.3 provision of drugs/meds								
7. Provide IEC materials				●	●		DOH	IDO / HPCS / CHDs
8. Semi-Annual meetings between DOH and BJMP			●	●	●	●	DOH	IDO
Annual Target	2016 Baseline	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 1.3.3 <i>% of targeted high risk areas reached with FWBD-PCP prevention and control measures</i>								
- GIDAs	No data	No data	No data	20%	40%	75%	90%	
- Conflict areas	No data	No data	No data	20%	40%	75%	90%	
- Flood-prone areas	No data	No data	No data	20%	40%	75%	90%	
- High-population congested areas	No data	No data	No data	20%	40%	75%	90%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Mapping of high risk areas			●				LGU	P/C/MHO
2. Assess FWBD-PCP needs			●				LGU	P/C/MHO
3. Provide necessary interventions - access to safe water - water disinfection - with sanitary toilets - provision of drugs/meds			●	●	●	●	DOH/LGU	DOH-CHDs
4. Establish Mobile Clinics /Community Outreach				●	●	●	DOH/LGU	DOH-CHDs
5. Organize Health Caravans				●	●	●	DOH/LGU	DOH-CHDs
6. Provide IEC materials				●	●	●	DOH/LGU	DOH-CHDs
Annual Target	2016 Baseline	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 1.3.4 <i>% evacuation centers without FWBD outbreak</i>	No data	No data	80%	85%	90%	95%	100%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

1. Preposition of WASH supplies		●	●	●	●	●	DOH/ LGU	HEMB/IDO /ERDD
2. Training on WASH		●	●	●	●	●	DOH/ LGU	HEMB/IDO /ERDD
3. Monitor FWBD outbreaks in ECs		●	●	●	●	●	DOH/ LGU	HEMB/IDO /ERDD

Objective 2

To guarantee financial risk protection for clients availing diagnosis, management and treatment for FWBDs

The other objective of the 2019-2023 FWBD-PCP Strategic Plan is to protect every HH member suffering from FWBD especially the poor from financial risks when accessing diagnosis, management and treatment. This means that they should be able to seeking and availing health care must be able to do so without any financial constraint or difficulty. In this regard, affordable but quality FWBD prevention and control services must be readily available to the targeted population groups regardless of their income status, area of residence or social-cultural orientation.

For this purpose, the DOH-IDO would continue to advocate for increased budget allocation from the government for the FWBD-PCP (Strategy 2.1). The DOH budget for FWBD-PCP more than doubled from Php 30.0 M in 2013 to Php 68.7 M in 2017, although the allocation fluctuated in between the years. Despite the increase in 2017, it is believed that the FWBD-PCP needs much more as indicted in the budgetary estimates in Section F of this document. Hence the need to advocate among top DOH management officials and oversight agencies to further augment the budget for the FWBD-PCP. The DOH-Regional FWBD-PCP Coordinators likewise will proactively advocate among their respective management committee to also increase their budget allocation for the Program. On the other hand, recognizing that the LGUs are primarily responsible for the delivery of basic health care and services as provide for in the 1991 LGC, it is equally important to strongly advocate for LGUs to also allocate funds for the FWBD-PCP activities and interventions.

The government's resources may not be adequate enough to support the implementation of the 2019-2023 FWBD-PCP Strategic Plan. It is necessary that resources from other sources be mobilized (Strategy 2.2). This would entail mapping and assessing of potential donors and contributors of either cash or in-kind. Other sources would encompass the development partners, non-government organizations and the private sector such as business corporations and other companies. In this regard, the DOH-IDO must spearhead the development of proposals, organize donors' forum or stakeholders meetings where the various needs of the Program are presented.

Another option being looked into is to explore the possibility of expanding PhilHealth Benefit Package for FWBDs, especially for in-patient care (Strategy 2.3). The No Balance Billing (NBB) benefit will be promoted while the inclusion of other diagnostic tests required for different types of FBDs be incorporated in the PCB 1 package.

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Strategy 2.1 Advocate for increased budget allocation from the national and local government for FWBD-PCP implementation								
Annual Target	2016 Baseline	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 2.1.1 DOH budget allocation for FWBD-PCP increased by at least 20% per annum	50.0 M	68.7 M	82.4M	98.9M	118.7M	142.5M	170.9M	
Indicative Action								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Presentation of strategic plan to EXECOM		<div></div>					DOH	IDO
2. Advocate increase in DOH-CO budget allocation		<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	DOH	IDO
3. Advocate increase in DOH-RO budget for FWBD		<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	DOH-CHDs	DOH-CHDs
Annual Target	2016 Baseline	2017		2018	2019	2020	2021	2022 - 2023
Performance Indicator 2.1.2 % of LGUs allocating budget for FWBD-PCP	No data	TBD		50%	60%	70%	80%	80%
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Develop advocacy kits and AVP for LGU officials					<div></div>	<div></div>	DOH	HPCS/IDO
2. Reproduce advocacy kits and AVP					<div></div>	<div></div>	DOH	DOH-HEPO
3. Brief overview for LGU stakeholders on FWBD-PCP					<div></div>	<div></div>	DOH	DOH-RO/LGU Coordinator
Strategy 2.2 Expand PhilHealth Benefit Package for clients suffering from FWBDs								
Annual Target	Baseline 2016	2017		2018	2019	2020	2021	2022 - 2023
Performance Indicator 2.2.1 FWBDs covered by PhilHealth In-patient and out-patient benefit package	AGE Typhoid			Cholera Hepa A		Amoe- biasis	Rotavirus	Other FWBDs
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

1. Review existing PhilHealth policies on FWBD benefit package (AGE and Typhoid)			<div></div>				DOH	IDO
2. Lobby to PhilHealth the expansion of benefit package for clients with FWBDs				<div></div>	<div></div>		DOH	IDO
3. Develop guidelines/policies for the expanded FWBD PhilHealth benefit package				<div></div>	<div></div>	<div></div>	DOH	IDO/Phil Health
4. Orient ROs and LGU stakeholders on expanded PhilHealth FWBD package						<div></div>	DOH	IDO
5. Implement expanded PhilHealth package						<div></div>	DOH	IDO/Phil Health
Strategy 2.3 Mobilize funds from other sources								
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 2.3.1 Assistance from development partners, private corporations, NGOs mobilized	No data	TBD	/	/	/	/	/	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Identify/map development partners, corporations, NGOs, others as potential partners				<div></div>	<div></div>	<div></div>	DOH	IDO
2. Prepare proposals for possible technical / funding assistance support				<div></div>	<div></div>	<div></div>	DOH	IDO
3. Conduct development partners forum						<div></div>	DOH	IDO

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Objective 3

To guarantee a responsive service delivery network for the prevention and control of FWBDs

The 2019-2023 FWBD-PCP Strategic Plan seeks each Filipino to have ready access to quality prevention and control services against FWBDs without financial restraint or difficulty. The same document also aspires that the needs of clients with FWBDs are addressed and services they need are delivered in a timely manner, with dignity and respect. This requires a functional service delivery network to ensure continuum of care, readily available and accessible health services and highly satisfied clients.

The 2019-2023 FWBFD-PCP Strategic Plan aims to establish a supportive policy environment for the implementation of FWBD-PCP at all levels of administration (Strategy 3.1). This calls for the development of new policies or updating the old ones to make them more relevant. Advocacy for the adoption and compliance of LGUs to these laws, ordinances/resolutions will be strengthened. Moreover, this 2019-2023 FWBD-PCP Strategic Plan will be regionalized and localized so that local officials will be guided what to pursue and support in the next 6 years in their respective localities.

The 2019-2023 FWBD-PCP Strategic Plan also recognizes that the health care delivery system can only become responsive if the needed personnel are in place and the logistics are available every time the clients would avail of services (Strategy 2.2). It is therefore important that the quantity of ORS, antibiotics and other supplies are determined, procured and distributed on time. No health facility should be experiencing stock-outs of these essential drugs and supplies throughout the year.

The responsiveness of the health service delivery network for FWBD-PCP services also hinges on the availability of quality information (complete, accurate, timely as the basis for decision-making, resource prioritization and designing of interventions. This necessitates the strengthening of the monitoring and evaluation system of the FWBD-PCP (Strategy 2.3) which begins with the development of an overall M and E Framework, review and updating the FHSIS data collection and reporting system. More importantly, the incidence of FWBDs in each locality has to be tracked regularly so that any impending outbreak will be monitored and appropriate response is mounted immediately. For this purpose, the FWBD surveillance system has to be strengthened alongside the surveillance done by RITM, FDA and the Bureau of Animal Industry of the Department of Agriculture.

Lastly, the DOH shall endeavor to mobilize the participation and contributions of the various groups of stakeholders from all relevant sectors (Strategy 3.4). The DOH recognizes that the prevention and control of FWBDs goes beyond the mandate of the health sector. It is highly essential that the DOH engages and forges partnerships with other government agencies, the private sector and development partners.

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Strategy 3.1 Create supportive organizational and policy environment for the implementation of FWBD – PCP a various levels of administration								
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.1.1 <i>Policies/guidelines developed and issued</i>		FWBD PCP Framework	FWBD-PCP MOP / M & E	Policy on FWBD Surveillance	CPGs on FB-Trematode			
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Develop and issue FWBD-PCP Framework	●						DOH	IDO
2. Develop FWBD-PCP MOP		●					DOH	IDO
3. Review and update existing policies and guidelines	●	●	●	●	●	●	DOH	IDO
3.1 FWBD Surveillance		●					DOH	EB/IDO/ RITM
3.2 FB-Trematode/ Cestodes (Paragonimiasis, Capillariasis, etc.)			●	●			DOH	IDO
4. Develop Coordination Guidelines/MOA between DOH-IDO and other OGOs in support to FWBD-PCP implementation			●				DOH	IDO
- DA- NMIS (National Meat Inspection Services) on raw meat			●				DOH	IDO
- DA-BFAR (Bureau of Fisheries and Aquatic Resources) on sea animals			●				DOH	IDO
- DA- BAI (Bureau of Animal Industry) on live animals, livestock and domestic animals			●				DOH	IDO
- FDA on processed meat			●				DOH	IDO
5. Develop Coordination Guidelines between IDO and other concerned DOH offices involved in FWBD-PCP			●	●			DOH	IDO

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Annual Target	Baseline 2016		2017	2018	2019	2020	2021	2022 - 2023
Performance Indicator 3.1.2 <i>% of DOH-ROs with FWBD-PCP Strategic Plan</i>	No data		No data	100%				100%
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Print/reproduce 2017-2022 FWBD-PCP Strategic Plan			<div></div>				DOH	IDO
2. Regionalize Strategic Plan		<div></div>	<div></div>				DOH	IDO
Annual Target	Baseline 2016		2017	2018	2019	2020	2021	2022 - 2023
Performance Indicator 3.1.3 Coordination and Management of FWBD-PCP in all regions and provinces placed under the Infectious Disease Control Program/ Cluster								
- Regions				100%	100%	100%	100%	100%
- Provinces					50%	60%	70%	80%
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Issue policy/guideline re overall coordination of FWBD in the regions and LGUs		<div></div>	<div></div>	<div></div>			DOH-CO	DOH-IDO
2. Region/LGU designation of program coordinators			<div></div>	<div></div>	<div></div>		DOH-CO	DOH-IDO/CHDs

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Strategy 3.2 Strengthen FWBD surveillance and response, monitoring evaluation and research								
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.2.1 <i>% of LGUs with functional FWBD disease surveillance system</i>								
<ul style="list-style-type: none">Province	No data	TBD	100%	100%	100%	100%	100%	
<ul style="list-style-type: none">HUCs	No data	TBD	100%	100%	100%	100%	100%	
<ul style="list-style-type: none">Municipality/city	No data	TBD	60%	70%	80%	90%	100%	
Performance Indicator 3.2.2 <i>% of outbreaks detected, investigated and responded on time</i>	No data	TBD	100%	100%	100%	100%	100%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Hiring of FWBD SO in the regions		<div></div>					CHDs	CHDs
2. Enhance surveillance for FWBDs (PIDSR and ESR), to include ability to capture food borne trematodes on parasites, notifiable diseases/health events with outbreak potential/events with public health risk		<div></div>					DOH	EB
3. Capacitate RESUs for the enhanced FWBD surveillance	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	DOH	EB/DOH-CHDs
4. Conduct capability building activities (e.g. Basic Epidemiology and Surveillance Training) to local ESUs		<div></div>		<div></div>		<div></div>	CHDs	RESUs
5. Organize outbreak investigation team from the DOH-CHD to the M/CHO to comprise: RSI, PSE, RESU, Program Coordinator, HEMB		<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	DOH	DOH-CHD Coordinator
6. MOP on Outbreak Investigation Updates		<div></div>					DOH	EB
7. Procure stockpile of laboratory supplier for case investigation (i.e. carry blair transport media, Cholera RDT)	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	DOH / RITM	RITM

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

8. Train ESUs and government lab and allied medical personnel on accurate laboratory, diagnosis of common parasites		<div></div>		<div></div>		<div></div>	CHDs	RESUs
Annual Target	Baseline 2016		2017	2018	2019	2020	2021	2022 - 2023
Performance Indicator 3.2.3 % of local labs oriented on algorithm for lab diagnosis of FWBD								
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Meeting of RITM-FWBD TWG (start 2017)	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	RITM	RITM
2. Participate in the development of FWBD-PCP Framework (start 2017)	<div></div>						DOH-IDO	IDO / RITM / RO
3. Participate in the development of MOP		<div></div>					DOH-IDO	DOH-IDO / RITM / RO
4. Participate in the review and update of existing policies and guidelines on diagnosis and surveillance	<div></div>	<div></div>	<div></div>				DOH-IDO	DOH-IDO / RITM / RO
5. Participate in the coordination guidelines for DOH and other agencies		<div></div>					DOH-IDO	RITM
6. Orient subnational/regional labs on the algorithm for lab diagnosis of FWBDs			<div></div>				DOH-IDO	RITM
7. Orientation of local labs (c/o regional labs)			<div></div>	<div></div>	<div></div>	<div></div>	DOH-IDO	DOH-RO
Annual Target	Baseline 2016		2017	2018	2019	2020	2021	2022 - 2023
Performance Indicator 3.2.4 % of labs involved in the lab surveillance of FWB pathogens (Prevalence of FWB viruses and parasites)								
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Send out of samples to subnational labs / RITM	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	DOH	Laboratories

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

2. Processing of samples (PCR Serology)	●	●	●	●	●	●	DOH	RITM
3. Genetic Characterization	●	●	●	●	●	●	DOH	RITM
4. Release of results	●	●	●	●	●	●	DOH	RITM
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.2.5 <i>% LGU with FWBD Surveillance and investigation system in place – RITM SU</i>		/	/	/	/	/	/	/
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Develop and publish manual on outbreak investigations		●					DOH-IDO	RITM-SU
2. Train epidemic investigation team and government lab and allied medical personnel on accurate laboratory diagnosis of FWB pathogens		●	●	●	●	●	DOH-IDO	RITM-SU/NRLs
3. Orient regional coordinators surveillance officers on MOP on Outbreak investigation		●	●				DOH-IDO	RITM-SU/NRLs
4. Conduct Lab Outbreak Investigation	●	●	●	●	●	●	DOH-IDO	RITM-SU/NRLs
5. Genetic Characterization of Pathogens of outbreak	●	●	●	●	●	●	DOH	RITM-SU/NRLs
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.2.6 <i>% LGU with FWBD Surveillance and investigation system in place – FDA</i>		/	/	/	/	/	/	/
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Development of FDA Outbreak Manual on Collection of Food Sample		●					DOH	FDA

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

2. Conduct Lab Outbreak Investigation/Roll-out of manual and training of SI and RESU							DOH	FDA
3. Training of FDA accredited laboratories for protocols on collection and analysis of outbreak food samples							DOH	FDA
4. MOA with LGU and accredited laboratories							DOH	FDA
5. TOT program on LGU level							DOH	FDA
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.2.7 <i>% of regions and LGUs monitored on FWBD-PCP implementation</i>	No data	No data						
• Regions monitored by the DOH at least once a year			100%	100%	100%	100%	100%	
• Provinces/HUCs by the DOH-ROs at least 2X/year			100%	100%	100%	100%	100%	
• Municipalities/cities by the PHOs quarterly			80%	80%	80%	80%	80%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Develop M and E Framework							DOH	IDO
2. Design M and E Tools data collection forms, and reporting forms							DOH	IDO
2.1 Development of Monitoring tools							DOH	IDO
2.1 Reproduction of Forming Tools							DOH	IDO
3. Orient regional and local coordinators on the M and E Framework/Tools							DOH	IDO
4. Conduct field monitoring							DOH	IDO
5. Conduct PIR							IDO	IDO

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

5.1 National								
5.2 Regional								
6. Conduct midterm and end-term evaluation			●			●	IDO	IDO
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.2.8 <i>% of LGUs submitting timely FHSIS Reports on FWBDs</i>	No data	No data	No data	80%	80%	80%	80%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Review and upgrade FHSIS on selected FWBD service coverage and Morbidity and Mortality data/Define FWBD indicators to be included in FHSIS reports	●	●					DOH	IDO/EB
2. Orient DOH-RO and Provincial/City Coordinators on the updated FHSIS for FWBDs		●					DOH	IDO/EB
3. Support EB in training of local service providers on the updated FHSIS		●					DOH	IDO/EB
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.2.9 <i>% of targeted relevant researches and studies related to FWBDs completed</i>	No data	TBD	40%	70%	80%	90%	100%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Develop FWBD-PCP research agenda			●				DOH	IDO
2. Conduct Prevalence Survey on Selected FWBDs			●			●	DOH	IDO
3. Conduct KAP Survey			●			●	DOH	IDO/HPCS
4. Design and conduct FWBD-related researches (ARSRL, Bacteriology, Virology, Parasitology)			●	●	●		DOH	RITM

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

5. Supportive data for researches, surveillance and monitoring from BAI			●	●			DA	BAI
6. Client Satisfaction Survey			●			●	DOH	IDO/ HPCS
Strategy 3.3 Streamline organizational and logistics support for FWBD-PCP								
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.3.1 <i>% DOH-ROs and LGUs (province and HUCs) with designated FWBD-PCP Point Persons</i>								
• DOH ROs	80%	80%	90%	100%	100%	100%	100%	
• PHOs/HUCs	No data	TBD	80%	80%	80%	80%	80%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Inventory designations of coordinators at regional and provincial	●						DOH	IDO
2. Augment national management/ coordination team		●					DOH	IDO
3. Advocate for specific designation of point persons in the province/HUC		●					DOH-CHDs	DOH-CHD Coordinators
4. Attendance to International Conference/ Training on FWBD			●		●		DOH	IDO
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.3.2 <i>% of health facilities with adequate drugs/medicines and supplies for FWBD service delivery</i>								
- Government hospitals	No data	TBD	50%	75%	75%	100%	100%	
- BHS/RHUs/MHCs (ORESOL, zinc, Vitamin A, antibiotics)	No data	TBD	50%	75%	75%	100%	100%	
Indicative Actions								

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Procure essential drugs/medicines	●	●	●	●	●	●	DOH	IDO
• ORS								
• Zinc								
• Antibiotics								
• RDT and Cary Blair for cholera								
2. Advocate to LGUs to procure lab supplies (reagents, culture media, gloves, slides, etc.)	●	●	●	●	●	●	DOH-CHDs	DOH-CHDs
3. Procure microscopes, centrifuge, (as needed)				●			DOH	IDO/RITM
4. Provide augmentation for transport allowance for monitoring and investigation during outbreaks			●				DOH-CHDs	IDO/DOH-CHDs
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.3.3								
<i>% of LGUs with the essential health personnel for FWBD prevention and control</i>								
• RSI (1:20,000 pop)	No data	TBD	50%	60%	70%	80%	80%	
• Medical technologist (at least 1 per LGU)	No data	TBD	50%	60%	70%	80%	80%	
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Map out LGUs with RSIs and Medtech		●					DOH	IDO
2. Advocate hiring of additional SI by the LGU		●	●	●	●	●	DOH-CHDs	DOH-CHDs
3. Advocate with HHRDB to consider developing augmentation program of RSI		●					DOH	IDO
4. Mobilize DOH MedTech augmentation Program for areas without medtech		●	●	●	●	●	DOH	IDO
5. Mobilize NDPs, MWS for FWBD service delivery and prevention activities		●	●	●	●	●	DOH-CHDs	DOH-CHDs

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Strategy 3.4 Harness participation and contributions of multi-sectoral partners								
Annual Target	Baseline 2016	2017	2018	2019	2020	2021	2022 - 2023	
Performance Indicator 3.4.1 No. of targeted multi-sectoral groups engaged by DOH in support to FWBD-PCP implementation	No data	TBD	DepEd DA DSWD DILG NCIP	DepEd DA DSWD DILG NCIP	DepEd DA DSWD DILG NCIP	DepEd DA DSWD DILG NCIP	DepEd DA DSWD DILG NCIP	DepEd DA DSWD DILG NCIP
Indicative Actions								
Actions	2017	2018	2019	2020	2021	2022 - 2023	Budget Source	Unit Responsible
1. Actively participate in the IACHE at national and regional levels		●	●	●	●	●	DOH	IDO/ EHS
2. Coordinate with Food Safety Coordinating Board		●	●	●	●	●	DOH	IDO/ EHS
3. Coordinate with Professional Societies for CPG development and training	●	●	●	●	●	●	DOH	IDO/ EHS
4. Regular FWBD TWG meeting	●	●	●	●	●	●	DOH	IDO/ EHS
5. Regular meeting of the Expert Group on FWBD	●	●	●	●	●	●	DOH	IDO/ EHS

Annex 2. Budget Estimates to Execute the 2017-2023 FWBD-PCP Strategic Plan

Objective/Strategy	2017	2018	2019	2020	2021	2022 - 2023	Total	DOH	LGU
Grand Total	77,146,367	357,823,100	338,479,100	371,829,684	296,832,775	317,544,725	1,739,394,750	1,674,228,450	65,166,300
Objective 1	36,758,867	248,708,433	210,334,733	240,330,917	198,854,475	214,931,225	1,129,657,650	1,098,183,350	31,474,300
Strategy 1.1	7,525,405	108,229,906	161,908,590	176,711,191	199,819,811	192,593,905	849,809,809	846,788,808	28,547,100
Strategy 1.2	0	19,463,840	52,820,360	84,454,320	48,295,760	61,474,980	266,009,260	266,009,260	0
Strategy 1.3		0	11,703,867	30,469,133	25,849,133	21,982,200	21,582,200	111,586,533	111,586,533
Objective 2		817,000	1,982,050	2,882,050	1,454,050	4,583,050	11,714,450	11,714,450	0
Strategy 2.1		175,000	1,967,050	1,967,050	1,151,050	1,967,050	7,223,450	7,223,450	
Strategy 2.2	0	30,000	15,000	303,000	303,000	2,004,000	2,655,000	2,655,000	
Strategy 2.3		612,000		612,000		612,000	1,836,000	1,836,000	
Objective 3	40,292,500	86,027,767	131,018,592	135,672,092	118,638,100	125,395,300	646,571,850	625,202,850	33,692,000
Strategy 3.1	60,000	2,902,200	38,962,325	47,023,425	19,529,300	19,529,300	128,006,550	128,021,550	12,308,000
Strategy 3.2	7,500	28,537,900	28,537,900	41,537,000	56,643,800	55,421,000	236,031,700	214,647,700	21,384,000

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Strategy 3.3	40,000,000	54,002,667	47,114,267	46,526,667	41,880,000	49,860,000	279,383,600	279,383,600	0
Strategy 3.4	225,000	585,000	585,000	585,000	585,000	585,000	3,150,000	3,150,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Annex 3. Budgetary Estimates to Execute 2019-2023 FWBD-PCP Strategic Plan

Activity	Assumptions	2017	2018	2019	2020	2021	2022 - 2023	Total	DOH	LGU
Strategy 1.1 Expand and capacitate health facilities and service providers to deliver quality FWBD-PCP interventions and service										
Performance Indicator 1.1.1 % of health facilities with at least 1 staff trained on FWBD-PCP CPGs										
1.Finalize/print FWBD CPGs	Printing: At Php 500/ copy/facility X 24,191 facilities (2017)									
	BHS: 20,160		2,016,000	4,032,000	6,048,000	8,064,000	10,080,000	30,240,000	30,240,000	
	RHUs: 2,592		259,200	518,400	777,600	1,036,800	1,296,000	3,888,000	3,888,000	
	Public Hospitals: 475		47,500	95,000	142,500	190,000	237,500	712,500	712,500	
	Private Hopitals: 964		96,400	192,800	289,200	385,600	482,000	1,446,000	1,446,000	
	total: 24,191								0	
subtotal			2,419,100	4,838,200	7,257,300	9,676,400	12,095,500	36,286,500	36,286,500	
2. Develop referral protocol	Meetings: At 500/pax X 20 pax X 8mtgs = 80,000	20,000	23,000	26,600	31,920	38,304.00	45,964.80	185,788.80	165,789	
	Printing Referral Guide: At Php 50/copy X 24,191 facilities			1,209,550	1,209,550	1,209,550	1,209,550	4,838,200	4,838,200	
	Printing Referral slip: At 0.50/copy X 50 copies/month X 12 months X 24191 facilities)			7,257,300	7,257,300	7,257,300	7,257,300	29,029,200	29,029,200	
Subtotal		20,000	23,000	8,493,450	8,498,770	8,505,154	8,512,815	34,053,189	34,033,189	
3. Train health providers on CPG and referral protocol	Board and Lodging: At Php 1600 x 3 days									
3.1 midwives	17,649 (2015 FHSIS)		3,529	7,058	10,587	11,999	14,116	47,289	47,289	
3.2 nurses	6,520 (2015 (FHSIS)		6,259,200	6,259,200	14,083,200			26,601,600	26,601,600	
3.3 doctors	3,182 (2015 FHSIS)		3,054,720	3,054,720	6,873,120			12,982,560	12,982,560	
3.4 no. of government hospitals: 719	719 (at least 1 trained)		690,240	690,240	1,553,040			2,933,520	2,933,520	
3.5 no. of private hospitals: 1,202	1,202 (at least 1 trained)		1,153,920	1,153,920	2,596,320	865,440	865,440	6,635,040	6,635,040	
	Total no. of facilities: 27,351									
	Training Supplies: At Php 50/pax x 28070 X .6 and X .2 plus 1202 X .2		854,120	292,720	292,720	12,020	12,020	1,463,600	1,463,600	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022 - 2023	Total	DOH	LGU
	Transportation : At Php 150/pax x 28070 X .6 and X .2 plus 1202 X .2		1,708,240	585,440	585,440	24,040	24,040	2,927,200	2,927,200	
	Board and Lodging: At Php 1600 x 3 days		13,723,969	12,043,298	25,994,427	913,499	915,616	53,590,809	53,590,809	
subtotal			3,529	7,058	10,587	11,999	14,116	47,289	47,289	
4. Support IMCI Training of health care providers	Logistics (Oresol) 24,191 facilities x 10 cases x 5 sachets x Php 5 php x 12 months = 72,573,000			36,286,500	18,143,250	18,143,250	18,143,250	90,716,250	90,716,250	
5. Develop CPGs for other FWBDs (Hepa A, PSP, FB-Trematode, Food Poisoning)	Meetings: At 1600/pax X 30 pax X 12 mtgs X 2 days = 1,296,000			1,152,000	1,152,000			2,304,000	2,304,000	
	Honorarium: 1,600/consultant X 8 hrs X 20 consultants X 12 meetings			3,072,000	3,072,000			6,144,000	6,144,000	
subtotal				4,224,000	4,224,000	0	0	8,448,000	8,448,000	
6. Train health care providers on new CPGs	Board and Lodging: At Php 1800 x 3 days									
3.1 midwives	17,649 (2015 FHSIS)					31,768,200	31,768,200	63,536,400	63,536,400	
3.2 nurses	6,520 (2015 FHSIS)					11,736,000	11,736,000	23,472,000	23,472,000	
3.3 doctors	3,182 (2015 FHSIS)					5,727,600	5,727,600	11,455,200	11,455,200	
3.4 no. of government hospitals: 719	719 (at least 1 trained)					1,725,600	1,725,600	3,451,200	3,451,200	
3.5 no. of private hospitals: 1,202	1,202 (at least 1 trained)					4,329,000	4,329,000	8,658,000	8,658,000	
total	27,351									
	Training Supplies: At Php 50/pax					683,775	683,775	1,367,550	1,367,550	
	Transportation at Php 100/pax					1,367,550	1,367,550	2,735,100	2,735,100	2,735,100
Subtotal						57,337,725	57,337,725	114,675,450	114,675,450	2,735,100

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Total Performance Indicator 1.1.1		20,000	16,166,069	65,885,448	64,117,747	94,576,028	97,004,906	337,770,197	337,750,197	2,735,100
Performance Indicator 1.1.2 % of health facilities with functional ORT corners										
• BHS			40%	60%	80%	100%	100%			
• RHUs			40%	60%	80%	100%	100%			
• Public hospitals			40%	60%	80%	100%	100%			
• Private Hospitals			40%	60%	80%	100%	100%			
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Actions	FORMULA FOR ORESOL (FROM FHO): Total population x (2.7%) percentage of eligible population x percentage of incidence x target coverage ;									
	IDO 2017 ORS - Unit Cost : 4.28 X 5 sachets per patient x 2.7% of eligible population x percentage of incidence x target coverage									
1. Review/update guidelines on establishment of ORT Corners	Meetings: At 250/pax X 10 pax X 5mtgs = 24,000		12,500					12,500	12,500	
2. Advocate establishment of ORT corners	Orientation: At 800/pax x 24,191 facilities x 3 pax		6,450,933	40,318,333	40,318,333			87,087,600	87,087,600	
3. Mobilize LGUs to provide space for ORT Corners	space: divider/curtain/table/chair at Php 1000/facility		24,191,000	8,064,000	8,064,000			40,319,000	40,319,000	24,192,000
4. Procurement of ORS	ORS sachet unit cost - 4.28 x 5 sachets x 2.7% x 50% x 15 %	7,505,405.42 *based on given budget for procurement of ORS IDPCP Budget	13,971,204 *based on given budget for procurement of ORS 2018 IDPCP Budget	14,175,809	14,244,010	17,381,283	18,063,299	85,341,011	85,341,011	
4. Procurement of ORT supplies	Logistics (supplies - cups/glasses, mixers, pitcher, tary, spoon, etc.) for 24,191 FACILITIES x Php 700 /facility		4,838,200	7,257,300	12,095,500	16,933,700	16,933,700	58,058,400	58,058,400	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Total for Performance Indicator 1.1.2		7,505,405	49,463,837	69,815,442	74,721,844	34,314,983	34,996,999	270,818,511	270,818,511	24,192,000
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 1.1.3 Number of FWBD Referral Labs established and functional		1 RITM					5 SNRLs			
1. Capacitate NRLs with diagnostic tools and supplies/ 1.1 Optimization of serology & PCR	Supplies, reagents, equipment, human resources									
	Multiplex PCR for rotavirus, adenovirus, norovirus and Hepatitis A		2,500,000					2,500,000	2,500,000	
	PCR for Cholera		1,500,000	500,000	500,000	500,000	500,000	3,500,000	3,500,000	
	PCR for Salmonella		1,500,000	500,000	500,000	500,000	500,000	3,500,000	3,500,000	
	Multiplex PCR for Giardia, Cryptosporidium, Cyclospora, Entamoeba		3,000,000					3,000,000	3,000,000	
	Genetic Characterization of FWB Pathogens		5,000,000					5,000,000	5,000,000	
	Serology for Giardia, Cryptosporidium, Cyclospora, Entamoeba		1,500,000					1,500,000	1,500,000	
subtotal			15,000,000	1,000,000	1,000,000	1,000,000	1,000,000	19,000,000	19,000,000	
2. Develop FWBD diagnostic protocols and training module for TRAINORS										
2.1 Pilot TOT of FWBD diagnostic protocols and training module	per diem, transportation expenses, training materials, function room							500,000	500,000	
2.2 Printing of training modules	training modules		500,000	250,000				250,000	250,000	
2.3 Orientation of FWBD diagnostic protocols and training module in regional level (DOH ROs, hospitals and selected provincial hospitals)	function room, accomodation, transportation expenses, per diem			1,276,800				1,276,800	1,276,800	
subtotal			500,000	1,526,800	0	0	0	2,026,800	2,026,800	
3. Capacitate subnational/ regional health facilities for detection of FWBD										

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
3.1 Assess health facilities and human resources	per diem, transportation expenses			810,000	810,000			1,620,000	1,620,000	
3.2 Train medtech and microscopists on FWBD diagnostic protocols	function room, accommodation, transportation expenses, per diem, reagents, supplies			1,116,000	1,116,000			2,232,000	2,232,000	
3.3 Procure equipment and supplies for subnational/ regional facilities	reagents, supplies				15,000,000	15,000,000	15,000,000	45,000,000	45,000,000	
3.4 Develop lab network	meals, transportation expenses, accommodation, per diem				500,000	500,000	500,000	1,500,000	1,500,000	
subtotal				1,926,000	17,426,000	15,500,000	15,500,000	50,352,000	50,352,000	
3.4 Develop lab network	meals, transportation expenses, accommodation, per diem				500,000	500,000	500,000	1,500,000	1,500,000	
subtotal				1,926,000	17,426,000	15,500,000	15,500,000	50,352,000	50,352,000	
4. Monitoring & evaluation of established health facilities & trained personnel										
4.1 Visit regional labs for monitoring & evaluation of health facilities	meals, transportation expenses, accommodation, per diem				810,000	810,000	1,620,000	3,240,000	3,240,000	
4.2 Establish proficiency testing of regional labs on laboratory tests	courier, reagents, supplies, samples				850,000	850,000	1,700,000	3,400,000	3,400,000	
4.3 Analysis of M and E and proficiency test	analysis, courier				60,000	60,000	120,000	240,000	240,000	
4.4 Recommend interventions for continuous improvement	analysis, courier				50,000	50,000	100,000	200,000	200,000	
subtotal					1,770,000	1,770,000	3,540,000	7,080,000	7,080,000	
Total for Performance Indicator 1.1.3		0	15,500,000	4,452,800	20,196,000	18,270,000	20,040,000	78,458,800	78,458,800	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Performance Indicator 1.1.4 % of regional labs performing RDT for the following FWBDs										
<i>a. Cholera</i>										
<i>b. giardia, Entamoeba, clyclospora, cryptosporidium</i>										
<i>c. Taenia</i>										
<i>d. TB-Parago</i>										
<i>e. rotavirus, norovirus, enteric adenovirus and hepatitis A</i>										
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
For Cholera										
1. Protocol development	meals, function room		100,000					100,000	100,000	
2. Sample banking	field collection, transportation, supplies			700,000				700,000	700,000	
3. Evaluation of RDTs	RDTs, transportation		2,000,000	2,000,000	2,000,000			6,000,000	6,000,000	
4. Finalization of guidelines in the use of RDT	meals, function room				100,000			100,000	100,000	
5. Procure RDTs and supplies	RDTs and supplies					2,500,000		2,500,000	2,500,000	
6. Assess regional labs	transportation, per diem		500,000	500,000				1,000,000	1,000,000	
7. Train regional in use of RDTs	per diem, accomodation, transportation expenses, RDTs					550,000		550,000	550,000	
8. Roll out of RDTs	RDTs					7,200,000	7,200,000	14,400,000	14,400,000	
9. QC / QA of RDTs	RDTs, courier, reagents, supplies					450,000	450,000	900,000	900,000	
10. M and E of health facilities and trained personnel	per diem, accomodation, transportation expenses, RDTs					500,000	500,000	1,000,000	1,000,000	
Subtotal			2,600,000	3,200,000	2,100,000	11,200,000	8,150,000	27,250,000	27,250,000	Subtotal
For giardia, Entamoeba, clyclospora, cryptosporidium										
1. Protocol development	meals, function room		200,000					200,000	200,000	
2. Sample banking	field collection, transportation, supplies		3,000,000	700,000	700,000	700,000	700,000	5,800,000	5,800,000	
3. Evaluation of RDTs	RDTs, transportation		4,000,000	2,000,000	2,000,000			8,000,000	8,000,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
4. Finalization of guidelines in the use of RDT	meals, function room				100,000			100,000	100,000	
5. Procure RDTs and supplies	RDTs and supplies		3,000,000	2,000,000		2,500,000		7,500,000	7,500,000	
6. Assess regional labs	transportation, per diem		500,000	500,000				1,000,000	1,000,000	
7. Train regional in use of RDTs	per diem, accomodation, transportation expenses, RDTs					550,000		550,000	550,000	
8. Roll out of RDTs	RDTs					7,200,000	7,200,000	14,400,000	14,400,000	
9. QC / QA of RDTs	RDTs, courier, reagents, supplies					450,000	450,000	900,000	900,000	
10. M and E of health facilities and trained personnel	per diem, accomodation, transportation expenses, RDTs					500,000	500,000	1,000,000	1,000,000	
Subtotal			10,700,000	5,200,000	2,800,000	11,900,000	8,850,000	39,450,000	39,450,000	
For Taenia										
1. Protocol development	meals, function room		200,000					200,000	200,000	
2. Sample banking	field collection, transportation, supplies		700,000	700,000	700,000			2,100,000	2,100,000	
3. Evaluation of RDTs	RDTs, transportation		3,000,000	2,000,000	2,000,000			7,000,000	7,000,000	
4. Finalization of guidelines in use of RDTs	meals, function room				100,000			100,000	100,000	
5. Procure RDTs and supplies	RDTs and supplies		3,500,000	500,000	700,000	500,000		5,200,000	5,200,000	
6. Assess regional labs	transportation, per diem		1,000,000	1,000,000	500,000	500,000	500,000	3,500,000	3,500,000	
7. Train regional in use of RDTs	per diem, accomodation, transportation expenses, RDTs					2,500,000	1,000,000	3,500,000	3,500,000	
8. Roll out of RDTs	RDTs					7,200,000	7,200,000	14,400,000	14,400,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
9. QC / QA of RDTs	RDTs, courier, reagents, supplies					450,000	450,000	900,000	900,000	
10. M&E of health facilities and trained personnel	per diem, accomodation, transportation expenses, RDTs					1,000,000	1,000,000	2,000,000	2,000,000	
Subtotal			8,400,000	4,200,000	4,000,000	12,150,000	10,150,000	38,900,000	38,900,000	
For TB-Parago										
1. Protocol development			200,000.00					200,000.00	200,000.00	
2. Sample banking			1,000,000.00	700,000.00	500,000.00	500,000.00		2,700,000.00	2,700,000.00	
3. Evaluation for Zeihl neelsen technique for parago			1,000,000.00	1,000,000.00	1,000,000.00			3,000,000.00	3,000,000.00	
4. Finalization of guidelines in use of Zeihl neelsen for parago					100,000.00			100,000.00	100,000.00	
5. Procure reagents and supplies			500,000.00	500,000.00	500,000.00	500,000.00	500,000.00	2,500,000.00	2,500,000.00	
6. Assess regional labs			1,000,000.00	500,000.00	500,000.00	500,000.00	500,000.00	3,000,000.00	3,000,000.00	
7. Train regional in microscopy detection of parago			1,000,000.00	500,000.00	1,000,000.00	500,000.00	500,000.00	3,500,000.00	3,500,000.00	
9. QC / QA of Zeihl neeser for parago						450,000.00	450,000.00	900,000.00	900,000.00	
10. M&E of health facilities and trained personnel						1,000,000.00	500,000.00	1,500,000.00	1,500,000.00	
Subtotal			4,700,000	3,200,000	3,600,000	3,450,000	2,450,000	17,400,000	17,400,000	
For rotavirus, norovirus, enteric adenovirus and hepatitis A										
1. Protocol development			200,000					200,000	200,000	
2. Sample banking				700,000				700,000	700,000	
3. Evaluation of RDTs				2,000,000	2,000,000			4,000,000	4,000,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
4. Finalization of guidelines in use of RDTs					100,000			100,000	100,000	
5. Procure RDTs and supplies (500 test kits per pathogen)						2,500,000		2,500,000	2,500,000	
6. Assess regional labs (Php 15,000 per activity/site for 2 pax)			500,000	500,000				1,000,000	1,000,000	
7. Train regional in use of RDTs (2 events to be conducted at RITM)						550,000		550,000	550,000	
8. Roll out of RDTs						7,200,000	7,200,000	14,400,000	14,400,000	
9. QC / QA of RDTs						450,000	450,000	900,000	900,000	
10. M&E of health facilities and trained personnel						500,000	500,000	1,000,000	1,000,000	
Subtotal			700,000	3,200,000	2,100,000	11,200,000	8,150,000	25,350,000	25,350,000	
Total for Performance Indicator 1.1.4		0	27,100,000	19,000,000	14,600,000	49,900,000	37,750,000	148,350,000	148,350,000	
Performance Indicator 1.1.5 <i>% of identified areas with high FWBD incidence and low access to safe water and sanitation facilities covered with WASH promotion activities and services</i>			50%	100%	100%	100%	100%			
1. Develop stratification criteria and guideline to identify high-risk areas to FWBD and develop package of interventions	Meetings: At 500/pax X 10 pax X 3 mtgs = 15,000		15,000					15,000	15,000	
	Printing of Stratification Guide: Php 200/copy X 17 regions, 81 provinces and 38 HUCs/independent cities = 136			27,200.00				27,200	27,200	
	Orientation of DOH-ROs down to provincial/HUC level at Php1,600/pax X 5/region/HUC/IC = 5pax per region for 2 days			272,000	272,000			544,000	544,000	
subtotal		0	15,000	299,200.00	272,000.00			586,200	586,200	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
2. Document good safe water and sanitation practices including personal hygiene and advocate adoption by other LGUs	Consultancy: At Php 500,000			500,000				500,000	500,000	
	Transportation: Php 3 national staff X Php 10,000/staff X 17 regions			510,000				510,000	510,000	
	Printing: At 500/copy X 1000 copies			500,000				500,000	500,000	
	Orientation of DOH-ROs and PHOs on the stratification criteria and guide at Php 1600/pax X 5 pax per region for 2 days			272,000				272,000	272,000	
	actual stratification/validation: Transp o At Php 800 / staff X 2 DOH-RO/Province/HUC/IC (136)				652,800			652,800	652,800	
subtotal			0	1,782,000	652,800			2,434,800	2,434,800	
3. Promote the following preventive measures in identified high risk areas	Assumption: 45 Provinces/HUC/lcs as high priority (1/3 of total): IEC / health promo activities at Php 50,000 X 45 high priority areas			2,250,000	2,250,000	2,250,000	2,250,000	9,000,000	9,000,000	
- Breastfeeding practices - Personal hygiene - Proper sanitation practices - Safe water use and practices	Transpo Expenses: At 800/health staff X 45 Priority areas/month X 12 months			302,400	345,600	388,800	432,000	1,468,800	1,468,800	1,620,000
4. Procure logistics support for water treatment/ chlorination, disinfection (hyposol, gerry can, troclosene, etc.)	c/o Environmental Health Office									
5. Mandatory provision of sanitary toilets	c/o Environmental Health Office									
6. Coordinate with water agencies / providers for installation of safe water services as needed	Meetings: At Php 500/pax X 10 pax X 3 mtgs = 15,000 per priority area X 45 priority areas			202500 13 areas	480,000 16 areas	120,000 8 areas	120,000 8 areas	922,500 45 priority areas	922,500	
Total for Performance 1.1.5		0	0	2,754,900	3,075,600	2,758,800	2,802,000	14,412,300	14,412,300	1,620,000
Total for Strategy 1.1		7,525,405	108,229,906	161,908,590	176,711,191	199,819,811	192,593,905	849,809,809	846,788,808	28,547,100

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Performance Indicator 1.2.1 % of parents/ caregivers able to detect early signs and symptoms of FWBDs and bring patients to the nearest health facility								90%		
Performance Indicator 1.2.2 % of parents/caregivers with diarrhea cases able to give ORT								90%		
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
1. Conduct KAP Survey	to be contracted out				10,000,000			10,000,000	10,000,000	
2. Develop, produce and distribute IEC materials (advisories, flyers, komiks, fans, etc.)	HPCS COSTING AND PLANNING OUTPUT									
a) Advisories	5 kinds x P3 x 15,000 copies			675,000	675,000	675,000	675,000	2,700,000	2,700,000	
b) Flyers	5 kinds x P3 x 15,000 copies			675,000	675,000	675,000	675,000	2,700,000	2,700,000	
c) Komiks	5 kinds x P20 x 15,000 copies			1,500,000	1,500,000	1,500,000	1,500,000	6,000,000	6,000,000	
d) Fan	1 kind x 5 x 15,000 copies			75,000	75,000	75,000	75,000	300,000	300,000	
subtotal			0	2,925,000	2,925,000	2,925,000	2,925,000	11,700,000	11,700,000	
3. Develop TV and radio commercials	3 kinds x P500,000 production cost			1,500,000		1,500,000		3,000,000	3,000,000	
4. Procure media placements for TV and Radio ads					20,000,000.00		20,000,000.00	40,000,000	40,000,000	
5. Produce Pinoy Health TV AVPs for health facilities	3 kinds x P500,000 production cost				1,500,000.00		1,500,000.00	3,000,000	3,000,000	
6. Evaluate impact of campaign							10,000,000.00	10,000,000	10,000,000	
7. Coordinate with DSWD re integration of FWBD-PCP messages and practices in the following:	meetings: at Php 800/staff X 10 staff X 136 provinces/HUCs/lcs									
7.1 Family Development Sessions										
7.2 Day Care Center Feeding Program			1,088,000		1,088,000		680,000	2,856,000	2,856,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
8. Coordinate with DepEd re integration of FWBD – PCP messages and practices in the following:	meetings: at Php 800/staff X 10 staff X 136 provinces/HUCs/lcs									
8.1 school curriculum										
8.2 8.2 school feeding program										
8.3 8.3 Healthy school settings - WINS			1,088,000		1,088,000		680,000	2,856,000	2,856,000	
9. Identify and assist LGUs to organize CBOs in support to FWBD prevention and control	1.1. Map out 1.2. Organize 1.3. Train 1.4. Monitor - incentives				91800	91800	91800	275400	275400	
Subtotal			2,176,000	1,500,000	23,767,800	1,591,800	32,951,800	61,987,400	61,987,400	
Total for Performance 1.2.1/1.2.2		0	2,176,000	4,425,000	36,692,800	4,516,800	35,876,800	83,687,400	83,687,400	
Performance Indicator 1.2.3 % of health workers providing correct and appropriate information to FWBD patients			60%	70%	80%	90%	100%			
1. Develop prototype materials flipcharts, referral guidelines, FAQs	Development of Flipcharts, FAQs, guidelines Php 500,000		500,000							
2. Reproduce aids/materials										
2.1 FlipCharts	At 2,000/copy X 24191 facilities			19,352,800	17,416,800	15,483,200	4,033,800	56,286,600	56,286,600	
2.2 FAQs	At Php10/copy X 24191 facilities X 100 copies; Reproduction at Php 5/copy X 100/facility X 24191 facilities			9,676,400	8,708,400	7,741,600	2,016,900	28,143,300	28,143,300	
2.3 Updated Layman's Guidelines	Update: At Php 200 X 24191 facilities X 2 copies			5,805,840	3,870,560.00	1,935,280.00	967,640.00	12,579,320	12,579,320	
subtotal		0	500,000	34,835,040	29,995,760	25,160,080	7,018,340	97,009,220	97,009,220	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

3. Train HW on IPCC and re-orient them on FWBD-PCP										
a. DOH-Ros/Province/HUCs/lcs HEPOs and FWBD Coordinators	Php 1,600 x 3 days x 2/region/provinces/HUCs/ICs X 136)		1,305,600	1,175,040	1,044,480	783,360	522,240	4,830,720	4,830,720	
b. 1 staff per health facility	24191 health facilities X 1 staff X Php 1,600/staff per day X 2 days		15,482,240	12,385,280	16,721,280	17,835,520	18,057,600	80,481,920	80,481,920	
subtotal		0	16,787,840	13,560,320	17,765,760	18,618,880	18,579,840	85,312,640	85,312,640	
Total for Performance Indicator 1.2.3		0	17,287,840	48,395,360	47,761,520	43,778,960	25,598,180	182,321,860	182,321,860	0
Total for Strategy 1.2		0	19,463,840	52,820,360	84,454,320	48,295,760	61,474,980	266,009,260	266,009,260	0
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Strategy 1.3 Strengthen the delivery of FWBD services to vulnerable groups, identified high risk areas and during emergencies/disasters										
Performance Indicator 1.3.1% of targeted IP communities reached with FWBD prevention and control measures			50%	75%	100%	100%	100%			
1. Coordinate with NCIP for partnership of FWDB-PCP in selected IP community	Meetings: AT Php 500/pax X 10 Pax X 3 meetings		15,000					15,000	15,000	
2. Map out strategic IP communities	Transpo: At 1,000/day X 2 days X 30 communities		60,000	60,000	60,000	60,000	60,000	300,000	300,000	
3. Assess FWBD-PCP needs	At Php 500/day X 2 days X 15 pax X 30 communitiies		450,000	450,000	450,000	450,000	450,000	2,250,000	2,250,000	
4. Provide necessary services:	Php 100,000/community X 30 communities		3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	15,000,000	15,000,000	
- home-made ORESOL - access to safe water - water disinfectant - sanitary toilets - free slippers - hygiene kits - provision of drugs/ medicines										

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

5. Establish Mobile Clinics/outreach team	transportation/gasoline: Php 5,000/outreach X 2 times a year X 15 communities			150,000	150,000	150,000	150,000	600,000	600,000	
	meals: Php 2,500/outreach X 2 times a year in 15 communities			75,000	75,000	75,000	75,000	300,000	300,000	
subtotal			3,525,000	3,735,000	3,735,000	3,735,000	3,735,000	18,465,000	18,465,000	
6. Organize Health Caravans	Php 15,000/caravan/IP community X 30 communities per year		450,000	450,000	450,000	450,000	450,000	2,250,000	2,250,000	
7. Provide relevant IEC messages										
7.1 Advocate recruitment of IP members as health advocates for their respective tribes	Meetings: At 500/pax X 10 pax X 3 X 30 IP communities		150,000	150,000	150,000	150,000	150,000	750,000	750,000	
7.2 Develop prototype materials flipcharts, referral guidelines, FAQs	Consultancy: At Php 500,000		500,000	500,000				1,000,000	1,000,000	
7.3 Produce appropriate IEC materials for IPs/Translate flip charts to IP dialect	At 150,000/type of material X 3 types			450,000				450,000	450,000	
7.4 Reproduce IEC materials										
a. flip chart	At Php 1000/copy X 5 copies per IP community X 30 communities			150,000	150,000	150,000	150,000	600,000	600,000	
7.5 Train/reorient recruited IP members	Orientation: At 800/pax X 30 pax/identified IP community X 30 IP communities			720,000	450,000	450,000	450,000	2,070,000	2,070,000	
subtotal			1,100,000	2,420,000	1,200,000	1,200,000	1,200,000	7,120,000	7,120,000	
8. Post KAP survey on IP behavior change	to be contracted out						3,000,000	3,000,000	3,000,000	
9. Semi-annual meeting between DOH and NCIP	Meeting: at Php 500/pax X 10 pax X 2 mtgs in a year =		10,000	10,000	10,000	10,000	10,000	50,000	50,000	
Total for Performance Indicator 1.3.1			4,635,000	6,165,000	4,945,000	4,945,000	7,945,000	28,635,000	28,635,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 1.3.2 <i>% of targeted jails with FWBD – PCP in place</i>			50%	75%	100%	100%	100%			
1. Coordinate with BJMP for partnership of FWBD-PCP	Meetings: AT Php 500/pax X 10 Pax X 3 meetings		15,000					15,000	15,000	
2. Map out strategic jails/prisons (highly congested)	Transpo: At 1,000/day X 2 days X 1 jail/province/HUC/IC (136)			90,667	90,667			181,333	181,333	
3. Assess FWBD-PCP needs	Assessment Meeting at Php 500/day X 2 days X 15 pax X 1/province/HUC/lcs			680,000	680,000			1,360,000	1,360,000	
4. Orient BJMP officials and Train prison clinic staff on FWBD CPGs on FWBD - PCP	Training: At Php 1,600/day X 2 days X 5 clinic staff per jail X 136/3			1,088,000	1,088,000			2,176,000	2,176,000	
5. Train prison clinic staff on FWBD CPGs				816,000	816,000			1,632,000	1,632,000	
6. Provide necessary preventive measures	Php 100,000/jail X 136jails/3 years			4,533,333	4,533,333			9,066,667	9,066,667	
6.1 access to safe water										
6.2 with sanitary toilets										
6.3 provision of drugs/meds										
7. Provide IEC materials	Php 50,000/jail X 136 jails/3 years		2,266,667	2,266,667	2,266,667	6,800,000	6,800,000	20,400,000	20,400,000	
8. Semi-Annual meetings between DOH and BJMP	Meeting: at Php 500/pax X 10 pax X 2 mtgs in a year =			10,000	10,000	10,000	10,000	40,000	40,000	
Subtotal			2,281,667	9,484,667	9,484,667	6,810,000	6,810,000	34,871,000	34,871,000	
Total for Performance Indicator 1.3.2			2,281,667	9,484,667	9,484,667	6,810,000	6,810,000	34,871,000	34,871,000	34,871,000

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 1.3.3% of targeted high risk areas reached with FWBD-PCP prevention and control measures			50%	75%	100%	100%	100%			
- GIDAs										
- Conflict areas										
- Flood-prone areas										
- High-population congested areas										
1. Mapping of high risk areas	Transpo: At 1,000/day X 5 days X 2 staff X 1 province/HUC/IC X 136 in 3 years			453,333	453,333			906,667	906,667	
	Per Diem: At Php 800/day X 3 days X 2 staff X 136/3 years			217,600	217,600			435,200	435,200	
subtotal		0	0	670,933	670,933			1,341,867	1,341,867	
2. Assess FWBD-PCP needs	Assessment Meeting at Php 500/day X 2 days X 15 pax X 1/province/HUC/lcs			680,000	680,000			1,360,000	1,360,000	
	Supplies: At 100/pax X 15 pax X 136 Province/HUC/IC in 3 years			68,000	68,000			136,000	1,360,000	
subtotal			0	748,000	748,000			1,496,000	2,720,000	
3. Provide necessary interventions	Php 100,000/area X 136 Provinces/HUCs/lcs in 3 years			4,533,333	4,533,333			9,066,667	9,066,667	
- access to safe water										
- water disinfection										
- with sanitary toilets										
- provision of drugs/meds										
4. Establish Mobile Clinics/conduct outreach	transportation/gasoline: Php 5,000/outreach X 2 times a year X 136 provinces/HUCs/lcs in 3 years			453,333	453,333	1,360,000	1,360,000	3,626,667	3,626,667	
	meals: Php 2,500/outreach X 2 times a year in 15 communities			226,667	226,667	680,000	680,000	1,813,333	1,813,333	
subtotal				5,213,333	5,213,333	2,040,000	2,040,000	14,506,667	14,506,667	
Total for Performance Indicator 1.3.3		0	0	6,632,267	6,632,267	2,040,000	2,040,000	17,344,533	17,344,533	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Performance Indicator 1.3.4% evacuation centers without FWBD outbreak			100%	100%	100%	100%	100%			
1. Preposition of WASH supplies	toilet/water: c/o Environmental Health									
	Oresol, vitamin A, antibiotics, hygiene kit. Slippers at Php 25,000/evacuation center X 1 DEC/province/HUC/IC		3,400,000	3,400,000	3,400,000	3,400,000	3,400,000	17,000,000	17,000,000	
subtotal			3,400,000	3,400,000	3,400,000	3,400,000	3,400,000	17,000,000	17,000,000	
2. Training on WASH	Meals: At Php 1,200/day X 2 days X 10 staff/EC/ province/HUC/IC			3,264,000		3,264,000		6,528,000	6,528,000	
	supplies : At Php100/pax X 10 pax X 1 EC/ provinceHUC/IC X 136			136,000		136,000		272,000	272,000	
subtotal				3,400,000		3,400,000		6,800,000	6,800,000	
3. Monitor FWBD outbreaks in ECs	Transpo: At Php 1,000 X 3 PHO/CHO staff X 1 EC/province/HUC/EC X 136		408,000	408,000	408,000	408,000	408,000	2,040,000	2,040,000	
	Per Diem: At 800/pax/day X 3 staff X 3 days X 1EC/province/HUC/IC X 136		979,200	979,200	979,200	979,200	979,200	4,896,000	4,896,000	
subtotal			1,387,200	1,387,200	1,387,200	1,387,200	1,387,200	6,936,000	6,936,000	
Total for Performance Indicator 1.3.4			0	4,787,200	8,187,200	4,787,200	8,187,200	4,787,200	30,736,000	30,736,000
Total for Strategy 1.3			0	11,703,867	30,469,133	25,849,133	21,982,200	21,582,200	111,586,533	111,586,533
Objective 1		7,525,405	139,397,613	245,198,083	287,014,644	270,097,771	275,651,085	1,227,405,602	1,224,384,601	28,547,100
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 2.1.1 <i>DOH budget allocation for FWBD-PCP increased by at least 20% per annum</i>		68.7 M	82.4M	98.9M	118.7M	142.5M	170.9M			
1. Presentation of strategic plan to EXECOM	in-house		3,750							
2. Advocate increase in DOH-CO budget allocation among NEDA, DBM/ RCC	Meetings: At Php250/pax X 15 pax X 3 meetings every year		11,250	11,250	11,250	11,250	11,250	56,250	56,250	
3. Advocate increase in DOH-RO budget for FWBD	Meetings: At Php1600/pax X 50 pax DOH and RO X 2 days every year		160,000	160,000	160,000	160,000	160,000	800,000	800,000	
Total for Performance Indicator 2.1.1			175,000	171,250	171,250	171,250	171,250	856,250	856,250	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 2.1.2		TBD	50%	60%	70%	80%	80%			
% of LGUs allocating budget for FWBD-PCP										
1. Develop and produce advocacy kits and AVP for LGU officials	Php 5,000/advocacy kit with AVP per province/HUCs/lcs X 136			680,000	680,000		680,000	2,040,000	2040000	
2. Advocacy (Orientation) on FWBD to RO -Program Managers and PDOHO-DMOs	At Php 800/pax/day X 10pax/region X 17 regions; Target pax: FWBD, RESU, EOH PM, Div. Chief, DMOs/Top Management			136,000	136,000		136,000	408,000	408,000	
3. Orient/Brief overview of LGU stakeholders on FWBD f	At 500/pax X 6pax/municipality/city X 1,600 Target pax: DMOs, LCE, MHO, FWBD, SB on Health, Budget, 1489 municipalities + 144 cities = 1633			979,800	979,800	979,800	979,800	3,919,200	3,919,200	
Total for Performance 2.1.2			0	1,795,800	1,795,800	979,800	1,795,800	6,367,200	6,367,200	
Total for Strategy 2.1			175,000	1,967,050	1,967,050	1,151,050	1,967,050	7,223,450	7,223,450	
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 2.2.1 FWBDs covered by PhilHealth In-patient and out-patient benefit package		AGE Typhoid		Cholera HepaA	Amobeiasis	Rotavirus	Other FWBDs			
1. Review existing PhilHealth policies on FWBD benefit package (AGE and Typhoid)	in-house		15,000					15,000	15,000	
2. Lobby to PhilHealth the expansion of benefit package for clients with FWBDs	Meetings: At Php 500/pax X 10 pax X 3 meetings		15,000	15,000	15,000	15,000	15,000	75,000	75,000	
3. Develop guidelines/policies for the expanded FWBD PhilHealth benefit package	Consultative Meetings: At Php 1,600/day/ pax X 30 pax X 2 days X 3 Workshops				288,000	288,000		576,000	576,000	
4. Orient ROs and LGU stakeholders on expanded PhilHealth FWBD package	One-Day Orientation: At 800/day X 10 pax/region/province/HUCs/ICs (153)						1,224,000	1,224,000	1,224,000	
5. Promote and Implement expanded PhilHealth package	At Php 10.00/copy X 500 copies/17 region plus 136 prov/HUCs/lcs						765,000	765,000	765,000	
Total for Performance Indicator 2.2.1		0	30,000	15,000	303,000	303,000	2,004,000	2,655,000	2,655,000	
Total for Strategy 2.2		0	30,000	15,000	303,000	303,000	2,004,000	2,655,000	2,655,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 2.3.1 Assistance from development partners, private corporations, NGOs mobilized			TBD							
1. Identify/map development partners, corporations, NGOs, others as potential partners	in-house									
2. Prepare proposals for possible technical / funding assistance support	Consultancy Fee: Php 500,000		500,000		500,000		500,000	1,500,000	1,500,000	
	Consultative Meetings: At Php800/pax/day X 5 mtgs X 10 staff		24,000		24,000		24,000	72,000	72,000	
	Supplies: Php 1000/mtg X 3 mtgs		3,000		3,000		3,000	9,000	9,000	
3. Conduct development partners forum	1 -day forum: At 800/pax/day X 100 pax (development partners, NGOs, academe) X		80,000		80,000		80,000	240,000	240,000	
	Supplies: At Php 5000/mtg per forum		5,000		5,000		5,000	15,000	15,000	
Total for Performance Indicator 2.3.1			612,000		612,000		612,000	1,836,000	1,836,000	
Total for Strategy 2.3			612,000		612,000		612,000	1,836,000	1,836,000	
Total for Objective 2			817,000	1,982,050	2,882,050	1,454,050	4,583,050	11,714,450	11,714,450	0
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.1.1 Policies/guidelines developed and issued		FWBD PCP Framework	FWBD-PCP MOP	Policy on FWBD Surveillance	CPGs on FET Trematode					
1. Develop and issue FWBD-PCP Framework	Meetings: Php 500/pax X 15 pax X 2 meetings	15,000						15,000	15,000	
2. Develop FWBD-PCP MOP	Consultancy Fee: Php 500,000		500,000					500,000	500,000	
	Meetings: At Php 500/pax X 15 pax X 4 small group meetings		30,000					30,000	30,000	
	Field Visit: At 1200/staff X 2 staff/consultant X 3 trips		7,200					7,200	7,200	
	Expanded consultation meeting: At 1,600/pax/day X 2 days X 50 pax		160,000					160,000	160,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

	Transportation: At Php10,000/pax X 20 pax from local offices		200,000					200,000	200,000	200,000
	Printing of MOP: At Php 500/copy/facility X 24,191 facilities			2,419,100				2,419,100	2,419,100	
	Orientation on MOP: TOT at Php 1,800/staff/day X 50 pax (2/17 regions plus 16 national staff) X 3 days			270,000				270,000	270,000	
	Transportation: At Php10,000/pax X 34 pax from regional offices			340,000				340,000	340,000	
	Supplies: At 100/pax X 50 pax			5,000				5,000	5,000	
	Local Orientation: At Php 1,600 X 2 days X 24, 191 (At least 1 staff oriented on MOP)			19,352,800	19,352,800	19,352,800	19,352,800	77,411,200	77,411,200	
	Supplies: At 50/pax X 24191			604,775	604,775			1,209,550	1,209,550	
	Local Transpo: At 500/pax X 24191			6,047,750	6,047,750			12,095,500	12,095,500	12,108,000
subtotal		15,000	897,200	29,039,425	26,005,325	19,352,800	19,352,800	94,662,550	94,662,550	12,308,000
3. Review and update existing policies and guidelines	TWG Meeting: At Php 500/day X 15 pax/mtg X 3 mtgs X 2 policies	45,000	45,000	45,000	45,000	45,000	45,000	270,000	270,000	
3.1 FWBD Surveillance	Printing- At Php 100/copy X 24,216 X 2 policies			4,843,200				4,843,200	4,843,200	
3.2 FB-Trematode/ Cestodes (Paragonimiasis, Capillaries, etc.)	One-day Orientation: At 800/pax X 2 policies X 4719 pax (2/region X 17 regions = 34, 10 pax/province (2PDHO, 2PHO, 6 DMOs) X 136 province/HUC/ICs = 1360; 2/mun X 1600 municipalities = 3,200 plus 719 hospital staff and 1,200 private hospital staff = 6513				10,420,800			10,420,800	10,420,800	
	Supplies: At Php 50/pax X 6513 X 2 policies			4,888,200	10,465,800	45,000	45,000	15,444,000	15,444,000	
Subtotal		45,000	45,000	9,776,400	20,931,600	90,000	90,000	30,978,000	30,978,000	
4. Develop Coordination Guidelines/MOA between DOH-IDO and other OGOs in support to FWBD-PCP implementation	Meetings: At Php 500/pax X 15 pax X 4 small group meetings X 2 groups (FDA and DA)			60,000				60,000	60,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

- DA- NMIS (National Meat Inspection Services) on raw meat	Annual Coordination Meetings: At 800/day X 25 pax X 2 groups			40,000	40,000	40,000	40,000	160,000	160,000	
- DA-BFAR (Bureau of Fisheries and Aquatic Resources) on sea animals	Supplies: At Php 50/pax X 25 pax X 2 groups			2,500	2,500	2,500	2,500	10,000	10,000	
- DA- BAI (Bureau of Animal Industry) on live animals, livestock and domestic animals										
- FDA on processed meat										
subtotal			0	102,500	42,500	42,500	42,500	230,000	230,000	
5.Develop Coordination Guidelines between IDO and other concerned DOH offices involved in FWBD-PCP	Meetings: At Php 500/pax X 20 pax (FHO, HPCS, EOHO, IDO) X 4 small group meetings		40,000	40,000	40,000	40,000	40,000	200,000	200,000	
	Supplies: At Php 50/pax X 20 pax X 4 meetings		4,000	4,000	4,000	4,000	4,000	20,000	20,000	
subtotal			44,000	44,000	44,000	44,000	44,000	220,000	220,000	
Total for Performance 3.1.1		60,000	986,200	38,962,325	47,023,425	19,529,300	19,529,300	126,090,550	126,105,550	12,308,000
Performance Indicator 3.1.2 <i>% of DOH-ROs with FWBD-PCP Strategic Plan</i>			100%							
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
1. Print/reproduce 2017-2022 FWBD-PCP Strategic Plan	Printing: At 500/copy X 100 copies		50,000					50,000	50,000	
2. Regionalize Strategic Plan	Regional Strategic Planning Workshop: At 1,600 X 3 days X 17 regions X 20 pax/region		1,632,000					1,632,000	1,632,000	
	Transpo: At Php 10/00/pax X 5 DOH-RO pax X 4 clusters		200,000					200,000	200,000	
	Supplies: At Php 100/pax X 20 pax X 17 regions		34,000					34,000	34,000	
Total for Performance 3.1.2		0	1,916,000	0	0	0	0	1,916,000	1,916,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Total for Strategy 3.1		60,000	2,902,200	38,962,325	47,023,425	19,529,300	19,529,300	128,006,550	128,021,550	12,308,000
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.2.1 % of LGUs with functional FWBD disease surveillance system										
· Province		TBD	100%	100%	100%	100%	100%			
· HUCs		TBD	100%	100%	100%	100%	100%			
· Municipality/city		TBD	60%	70%	80%	90%	100%			
Performance Indicator 3.2.2 % of outbreaks detected, investigated and responded on time		TBD	100%	100%	100%	100%	100%			
1. Enhance surveillance for FWBDs (PIDSR and ESR), to include ability to capture food borne trematodes /Creation of Technical Guidelines on Diarrhea Surveillance (One D)	(Amoebiasis) (Cryptosporidium) ... Typhoid for EB -Stool culture - confirmatory test (Blood -RITM SLH)									
	15 pax xPhp 500 x 1 day x 10 meetings		75,000					7,500	7,500	
	15 pax x Php 500 x 1 day X 10 meetings		75,000					7,500	7,500	
*Meeting (Review of 1st Draft)										
*Meeting (Finalization of the Guidelines)										
subtotal		0	150,000	0	0	0	0	15,000	15,000	
2. Capacitate RESUs for the enhanced FWBD surveillance	per diem: 3 pax x 4 days x php 3,600		43,200		43,200		43,200	129,600	129,600	
2.1. Technical Assistance Visit in RESUs (ESU Monitoring)	transpo: 3 pax x php10,000		30,000		30,000		30,000	90,000	90,000	
2.2. Training on Outbreak Investigation	Php 1600/pax x 4 days x 50 pax	0	320,000	0	320,000	0	320,000	960,000	960,000	
Subtotal		0	393,200	0	393,200	0	393,200	1,179,600	1,179,600	
3. Conduct TOT for Basic Epidemiology and Surveillance	Board and Lodging: Php 1600/pax x 4 days x 60 pax		384,000					384,000	384,000	
	Transpo: 1 bus=Php 30,000 (within Luzon)		30,000					30,000	30,000	
	Plane Fare: Php 10,000 X 40 pax		400,000					400,000	400,000	
Subtotal			814,000			0	0	814,000	814,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

4. Develop MOP on Outbreak Investigation										
4.1. Meetings (Inter-office)	Php500/pax x 20 px/mtg x 3mtgs		30,000					30,000	30,000	
4.2. Writeshop Activity	Php 1600/pax x 4 days x 60 pax		384,000					384,000	384,000	
	Transpo: 1 bus=Php 30,000 (within Luzon)		30,000					30,000	30,000	
4.3. Workshop Activity	Php 1600/pax x 4 days x 60 pax		384,000					384,000	384,000	
	Transpo: 1 bus=Php 30,000 (within Luzon)		30,000					30,000	30,000	
4.4. Dissemination of MOP on Outbreak Investigation	Reproduction: Php 5/page x 300 pages x 500 copies			750,000				750,000	750,000	
5. Procure stockpile of laboratory supplier for case investigation (i.e. carry blair transport media, Cholera RDT)			500,00	500,000.00	500,000	500,000.00	500,000.00	2,500,000	2,500,000	
6. Train ESUs and government lab and allied medical personnel on accurate laboratory, diagnosis of common parasites	Board and Lodging: Php 1600/pax x 4 days x 60 pax		384,000				384,000	768,000	768,000	
subtotal			1,242,000	1,250,000	500,000	500,000	884,000	4,876,000	4,876,000	
Total for Performance Indicator 3.2.1 and 3.2.2		7,500	2,599,200	750,000	893,200	500,000	1,277,200	6,884,600	6,884,600	
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.2.3 <i>% of local labs oriented on algorithm for lab diagnosis of FWBD</i>										
1. Meeting of RITM-FWBD TWG (start 2017)	meeting room, meals		30,000	30,000	30,000	30,000	30,000	150,000	150,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

2. Participate in the development of FWBD-PCP framework (start 2017)	in-house									
3. Participate in the development of MOP	in-house									
4. Participate in the review and update of existing policies and guidelines on diagnosis and surveillance	in-house									
5. Participate in the coordination guidelines for DOH and other agencies	in-house									
6. Orient subnational labs / regional labs in the algorithm for lab diagnosis of FWBDs	meeting room, meals, accomodation, transportation, airfare			1,020,000				1,020,000	1,020,000	
7. Orientation of local labs (c/o regional labs)	meeting room, meals, accomodation, transportation, airfare				450,000	450,000	450,000	1,350,000	1,350,000	
Total for Performance 3.2.3			30,000	1,050,000	480,000	480,000	480,000	2,520,000	2,520,000	
Performance Indicator 3.2.4 <i>% of labs involved in the lab surveillance of FWB pathogens (Prevalence of FWB viruses and parasites)</i>										
1. Send out of samples to subnational labs / RITM	courier		3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	15,000,000	15,000,000	
2. Processing of samples (PCR Serology)	supplies, reagents, staff		5,860,000	5,860,000	5,860,000	5,860,000	5,860,000	29,300,000	29,300,000	
3. Genetic Characterization	courier		500,000	500,000	500,000	500,000	500,000	2,500,000	2,500,000	
4. Release of results										
Total for Performance Indicator 3.2.4			9,360,000	9,360,000	9,360,000	9,360,000	9,360,000	46,800,000	46,800,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.2.5 <i>% LGU with FWBD Surveillance and investigation system in place – RITM SU</i>										
1. Develop and publish manual on outbreak investigations			500,000					500,000	500,000	
2. Train epidemic investigation team and government lab and allied medical personnel on accurate laboratory diagnosis of FWB pathogens				1,000,000	1,000,000	1,000,000	1,000,000	4,000,000	4,000,000	
3. Orient regional coordinators surveillance officers on MOP on Outbreak investigation	function room, per diem, accomodation, transportation, airfare			1,000,000	1,000,000			2,000,000	2,000,000	
4. Conduct Lab Outbreak Investigation	staff, reagents, supplies		8,000,000	8,000,000	3,000,000	3,000,000	3,000,000	25,000,000	25,000,000	
5. Genetic Characterization of Pathogens of outbreak	reagents, supplies		1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	5,000,000	5,000,000	
Total for Performance Indicator 3.2.5			9,500,000	11,000,000	6,000,000	5,000,000	5,000,000	36,500,000	36,500,000	
Performance Indicator 3.2.6 <i>% LGU with FWBD Surveillance and investigation system in place – FDA</i>										
1. Development of FDA Outbreak Manual on Collection of Food Sample			500,000					500,000	500,000	
2. Conduct Lab Outbreak Investigation/Roll-out of manual and training of SI and RESU			3,000,000	2,000,000	2,000,000			7,000,000	7,000,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

3. Training of FDA accredited laboratories for protocols on collection and analysis of outbreak food samples				1,000,000	1,000,000			2,000,000	2,000,000	
4. MOA with LGU and accredited laboratories					500,000			500,000	500,000	
5. TOT program on LGU level					1,500,000	1,500,000	1,500,000	4,500,000	4,500,000	
Total for Indicator 3.2.6			3,500,000	3,000,000	5,000,000	1,500,000	1,500,000	14,500,000	14,500,000	
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.2.7										
<i>% of regions and LGUs monitored on FWBD-PCP implementation</i>										
· Regions by the DOH at least once a year			100%	100%	100%	100%	100%			
· Provinces/HUCs by the DOH-ROs at least 2X/yea e			100%	100%	100%	100%	100%			
· Municipalities/cities by the PHOs quarterly			100%	100%	100%	100%	100%			
1. Develop M and E Framework	Consultancy Fee: Php 500,000		500,000					500,000	500,000	
2. Develop M and E Guides and Tools										
2.1 Design tools/forms	Meetings: At Php 500/pax X 15 pax X 5 meetings		37,500					37,500	37,500	
	Expanded Consultation with regional and local representatives: At Pgp 1600/day X 3 days X 30 pax		144,000					144,000	144,000	
	Supplies: At Php 100/pax X 30 pax		3,000					3,000	3,000	
	Transportation: At Php 10,000 X 20 pax		200,000					200,000	200,000	
2.2 Production of M and E Framework and Guide	Php 500/copy X 53 (3/region X 17) plus 3 copies per province/HUCs/lcs = 136 X 3= 408 plus 394 national = 500 copies			200,000				200,000	200,000	
2.3 Reproduction of Forming Tools	At Php 100/copy X 4 sets/year per region/province/HUC/lcs =153 plus 7 copies at the national = 160 for 3 monitors			192,000	192,000	192,000	192,000	768,000	768,000	
Subtotal			884,500	392,000	192,000	192,000	192,000	1,852,500	1,852,500	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

3. Orient regional and local coordinators on the M and E Framework/Tools	5 DOH-CO and other arters) plus 3/region X 3 = 51, plus 3/province/HUCs/lcs X 136 = 408 Total = 484									
	DOH-CO, parftners and regions = 25 +34 59=60 pax At Php 1600/day X 2 days			192,000				192,000	192,000	
	Supplies: At Php 10,000 X 60 pax			6,000				6,000	6,000	
	Transpo: Php 10,000/regional pax X 51 pax			510,000				510,000	510,000	
	Local Orientation: Php 800/day X 408			326,400				326,400	326,400	
	Supplies: At Php 50/pax X 408			20,400				20,400	20,400	
	Transpo: At Php 500/pax X 408			204,000				204,000		204,000
Subtotal				1,258,800				1,258,800	1,054,800	204,000
4. Conduct field monitoring	National to Regions: once/year at php 10,000/monitor X 3 montiors X 17 regions				510,000	510,000	510,000	1,530,000	1,530,000	
	Per Diem: At php 1,200/pax/day X 3 days X 17 regions				61,200	61,200	61,200	183,600	183,600	
	Regional to Provinces/HUCs/lcs: 2x a year									
	Transpo: Php 1,000/monitor X 3 monitors X 136 provinces/HUCs/lcs X 2 times a year				816,000	816,000	816,000	2,448,000	2,448,000	
	Per Diem: At 1,200/monitor/day X 3monitors X X 2 days X 136 provinces/HUCs/lcs				1,958,400	1,958,400	1,958,400	5,875,200	5,875,200	
	Province/HUC/lcs: Transpo at Ph 500/day X 2montiors X 1600 mun/cities X 2 times a year				1,600,000	1,600,000	1,600,000	4,800,000		4,800,000
	Per Diem: At 800/monitor X 2 monitors X 1600 municipalities/cities X 1 day X 2 times a year				5,120,000	5,120,000	5,120,000	15,360,000		15,360,000
Subtotal					10,065,600	10,065,600	10,065,600	30,196,800	10,036,800	20,160,000

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

5. Conduct PIR										
5.1 National	Board and Lodging at Php 1600 X 3 days X 70 pax		336,000	336,000	336,000	336,000	336,000	1,680,000	1,680,000	
	Transpo: Php 10,000/regional staff X 3 staff X 17 regions		510,000	510,000	510,000	510,000	510,000	2,550,000	2,550,000	
	Supplies: At Php 100/pax X 70 pax		7,000	7,000	7,000	7,000	7,000	35,000	35,000	
5.2 Regional	Transpo: At 500/pax X 136 provinces/HUCs/lcs X 3 pax = 408		204,000	204,000	204,000	204,000	204,000	1,020,000		1,020,000
	Board and Lodging: at Php 1200 X 3 days X 408 pax		1,468,800	1,468,800	1,468,800	1,468,800	1,468,800	7,344,000	7,344,000	
	Supplies: At 50/pax X 408 pax		20,400	20,400	20,400	20,400	20,400	102,000	102,000	
Subtotal			2,546,200	2,546,200	2,546,200	2,546,200	2,546,200	12,731,000	11,711,000	1,020,000
6. Conduct midterm and end-term evaluation				5,000,000			5,000,000	10,000,000	10,000,000	
Total for Performance Indicator 3.2.7		0	3,430,700	9,197,000	12,803,800	12,803,800	17,803,800	56,539,100	35,155,100	21,384,000
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.2.8 % of LGUs submitting timely FHSIS Reports on FWBDs			80%	80%	80%	80%	80%			
1. Review and upgrade FHSIS on selected FWBD service coverage and Morbidity and Mortality data/Define FWBD indicators to be included in FHSIS reports	Meetings: At Php 500/pax X 10 pax X 3 meetings		15,000					15,000	15,000	
2. Orient DOH-RO and Provincial/City Coordinators on the updated FHSIS for FWBDs	Orientation: At 500/pax X 2 pax from 17 regions and 136 provinces/HUCs/ICS = 206 pax		103,000					103,000	103,000	
Total for Performance Indicator 3.2.8		0	118,000					118,000	118,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.2.9 % of targeted relevant researches and studies related to FWBDs completed			100%	100%	100%	100%	100%			
1. Develop FWBD-PCP research agenda	Php 10,000 x 17 regions			170,000				170,000	170,000	
2. Conduct Prevalence Survey on Selected FWBDs	Php 15,000,000 once in 5 years					15,000,000		15,000,000	15,000,000	
3. Conduct KAP Survey	Php 10,000,000 (pre and post)			10,000,000			10,000,000	20,000,000	20,000,000	
4. Supportive data for researches				10,000,000		10,000,000		20,000,000	20,000,000	
4. Design and conduct FWBD-related researches (ARSRL, Bacteriology, Virology, Parasitology)						2,000,000				
5.1 Purchase of reagents and kits	reagents, kits,				4,000,000			4,000,000	4,000,000	
5.2 Hiring of staff	staff				1,000,000			1,000,000	1,000,000	
5.3 Orientation & field collection	per diem, transporation, airfare				2,000,000			2,000,000	2,000,000	
5.4 Processing of samples	orientations and other activities									
6. Client Satisfaction Survey	Php 10,000,000 (post)						10,000,000	10,000,000	10,000,000	
subtotal				20,170,000	7,000,000	27,000,000	20,000,000	72,170,000	72,170,000	
Total for Performance Indicator 3.2.9		0	0	20,170,000	7,000,000	27,000,000	20,000,000	72,170,000	72,170,000	0
Total for Strategy 3.2		7,500	28,537,900	28,537,900	41,537,000	56,643,800	55,421,000	236,031,700	214,647,700	21,384,000
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.3.1 % DOH-ROs and LGUs (province and HUCs) designated FWBD Point Persons										
· DOH ROs		TBD	80%	90%	100%	100%	100%			
· PHOs/HUCs		TBD	80%	80%	80%	80%	80%			
1. Inventory designations of coordinators at regional and provincial	in-house									
2. Augment national management/ coordination team	Hire: 1 M and E Technical Staff at Php 40,000/month X 13 months		520,000	520,000	520,000	520,000	520,000	2,600,000	2,600,000	
3. Advocate for specific designation of point persons in the province/HUC	National DOHTranspo: At Php 10,000 X 10 regions/LGUs X 1 National FWBD-PCP Coordinator		100,000	70,000				170,000	170,000	

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

	Per Diem: At 1,200/day X 2 days X 10 regions		36,000	36,000				72,000	72,000	
	Regional FWBD-PCP Coordinator: At 2,000/ trip X 50 provinces/HUCs/lcs		100,000	172,000				272,000	272,000	
	Per Diem: At Php 1,200 X 3 days X 50/86 provinces/HUCs/lcs		180,000	309,600				489,600	489,600	
Subtotal			936,000	1,107,600	520,000	520,000	520,000	3,603,600	3,603,600	
4. Attendance to International Conference/ Training on FWBD	Php 500,000 X 2 national/regional staff every 2 years			1,000,000	1,000,000		1,000,000	3,000,000	3,000,000	
Total for Performance Indicator 3.3.1			936,000	2,107,600	1,520,000	520,000	1,520,000	6,603,600	6,603,600	
Activity	Assumptions	2017	2018	2019	2020	2021	2022-2023	Total	DOH	LGU
Performance Indicator 3.3.2 <i>% of health facilities with adequate drugs/medicines and supplies for FWBD service delivery</i>										
- Government hospitals		TBD	50%	75%	100%	100%	100%			
- BHS/RHUs/MHCs (ORESOL, zinc, Vitamin A, antibiotics)		TBD	50%	75%	100%	100%	100%			
1. Procure essential drugs/medicines	Php 25,000/municipality X 1600 municipalities	40,000,000	40,000,000	40,000,000	40,000,000	40,000,000	40,000,000	240,000,000	240,000	
• ORS • Zinc • Antibiotics • RDT and caryBlair for cholera										
2. Advocate to LGUs to procure lab supplies (reagents, culture media, gloves, slides, etc.)	Meetings/Advocacy: At Php 500/pax X 10 pax per municipality X 1600 municipalities		2,000,000	2,000,000	2,000,000			6,000,000	6,000,000	
3. Procure microscopes, centrifuge, (as needed)	At 60,000/microscope X 17 microscopes/ centrifuge					1,020,000		1,020,000	1,020,000	
4. Provide augmentation for transport allowance for monitoring and investigation during outbreaks	Php 10,000/area with estimated 25% of total 136 (province/HUC/lcs) with outbreak per annum		340,000	340,000	340,000	340,000	340,000	1,700,000	1,700,000	
Total for Performance Indicator 3.3.2		40,000,000	42,340,000	42,340,000	42,340,000	41,360,000	40,340,000	248,720,000	248,720,000	0
Performance Indicator 3.3.3 <i>% of LGUs with the essential health personnel for FWBD prevention and control</i>										
• RSI (1:20,000 pop)		TBD	50%	60%	70%	80%	80%			

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Medical technologist (at least 1 per LGU)		TBD	50%	60%	70%	80%	80%			
1. Map out LGUs with RSIs and Medtech	in-house									
2. Advocate hiring of additional SI by the LGU	Meetings: At Php 500/day X 10 pax X 1600 municipalities		2,666,667	2,666,667	2,666,667			8,000,000	8,000,000	
3. Advocate with HHRDB to consider developing augmentation program of RSI	Meetings: At Php 500/day X 10 pax X 3 meetings		15,000					15,000	15,000	
4. Mobilize DOH MedTech augmentation Program to areas without medtech	Meeting with HHRDB and DOH-Ros: At Php 500/pax X 5 staff X 18 regions and national		45,000					45,000	45,000	
5. Mobilize NDPs, MWS for FWBD service delivery and prevention activities	Oreint DOH staff on FWBD-PCP: At Php 500/pax X 1600 municipalities X 10/mun		8,000,000				8,000,000	16,000,000	16,000,000	
Total for Performance 3.3.3		0	10,726,667	2,666,667	2,666,667	0	8,000,000	24,060,000	24,060,000	
Total for Strategy 3.3		40,000,000	54,002,667	47,114,267	46,526,667	41,880,000	49,860,000	279,383,600	279,383,600	0
Performance Indicator 3.4.1		TBD	DepEd DA	DepEd DA	DepEd DA	DepEd DA	DepEd DA			
<i>No. of targeted multi-sectoral groups engaged by DOH in support to FWBD-PCP implementation</i>			DSWD	DSWD	DSWD	DSWD	DSWD			
			DILG	DILG	DILG	DILG	DILG			
			NCIP	NCIP	NCIP	NCIP	NCIP			
1. Actively participate in the IACHE at national and regional levels	Meeting: Php 500/pax x 10 pax x 18 regions x 4 quarters		360,000	360,000	360,000	360,000	360,000	1,800,000	1,800,000	
2. Coordinate with Food Safety Coordinating Board	Meeting: Php 500/ pax X 15 pax/mtg X 3mtgs	22,500	22,500	22,500	22,500	22,500	22,500	135,000	135,000	
3. Coordinate with Professional Societies for CPG development and training	Meeting: Php 500/ pax X 15 pax/mtg X 3mtgs	22,500	22,500	22,500	22,500	22,500	22,500	135,000	135,000	
4. Regular FWBD TWG meeting	TWG Meetings: Php 500/ pax X 15 pax/mtg X 12mtgs	90,000	90,000	90,000	90,000	90,000	90,000	540,000	540,000	
5. Regular meeting of the Expert Group on FWBD	Meetings: Php 500/ pax X 15 pax/mtg X 12mtgs	90,000	90,000	90,000	90,000	90,000	90,000	540,000	540,000	
Total for Performance Indicator 3.4.1		225,000	585,000	585,000	585,000	585,000	585,000	3,150,000	3,150,000	
Total for Strategy 3.4		225,000	585,000	585,000	585,000	585,000	585,000	3,150,000	3,150,000	
Total for Objective 3		40,292,500	86,027,767	131,018,592	135,672,092	118,638,100	125,395,300	646,571,850	625,202,850	33,692,000
Grand Total		77,146,367	357,823,100	338,479,100	371,829,684	296,832,775	317,544,725	1,739,394,750	1,674,228,450	65,166,300

Note: The Annexes provide additional details which shall be updated in coordination with key stakeholders for the period 2019-2023.

Annex 4. List of People Consulted in the FWBD-PCP Assessment and Strategic Plan Development

Members of the FWBD-PCP Assessment and Planning TWG

FWBD Program Team Component:

Adviser:	Dr. Myrna C. Cabotaje, MPH, CESO III, Undersecretary of Health
	Dr. Maria Rosaria S. Vergeire, MPH, CESO IV, Undersecretary of Health
	Dr. Lyndon Lee Suy, MPH, Assistant Secretary of Health
	Dr. Napoleon L. Arevalo, MPH, CESO IV, OIC-Director IV
	Dr. Ruby Constantino, MPH, CESO IV, OIC-Director IV
	Dr. Mario Baquilod, MPH, CESO IV, OIC-Director IV
Division Chief:	Dr. Franklin C. Diza, MPH, MPH, Medical Officer V
	Rosalind Vianzon, MPH, Medical Officer V
	Dr. Leda Hernandez, MPH, Medical Officer V
Program Manager:	Theodora Cecile Magturo, MD, MHA, Medical Specialist IV
Consultant:	Ms. Eireen Villa
Members:	Ms. Rae Hanna Guiaber, RN
	Ms. Marvie Porcioncula, RN

List of People Consulted During Field Validation Visits

1. Dr. Dana Nicole De la Cuesta, MO III, DOH-NCRO
2. Ms. Eirhona Kye Dumpit, MT II, DOH NCRO
3. Dr. Lorenzo Sarmiento, FWBD-PCP Coordinator, DOH-RO 4A
4. Dr. Verdades P. Linga, MPH, CHO, Quezon City CHO
5. Mr. Melvin Abrigo, Nurse, Quezon City CHO
6. Mr. Gomez Johnnyboy, SI III, Quezon City CHO
7. Mr. Marcial Jordan Jr., Nurse III, Quezon City CHO
8. Ms. Ma. Chelina Lusanta, SI III, Quezon City CHO
9. Ms. Ma. Carmencita Maramihan, SI V, Quezon City CHO
10. Dr. M. L. Eleria, MO IV, Quezon City CHO
11. Ms. Charlotta Joyce Oliveros, SI V, Quezon City CHO
12. Dr. Alma Abila, MO III, Quezon City CHO
13. Mr. Raffy Viado, SI, Quezon City CHO
14. Ms. Carmencita Uy, Nurse III, Quezon City CHO
15. Dr. Alberto P. Herrera, MPH, CHO, Marikina CHO
16. Dr. Honnielyn Terrano, Assistant CHO, Marikina CHO
17. Mr. Erick Cruz, SI, Marikina CHO, Marikina CHO
18. Ms. Rose Shiene Lagunday, Nurse, Marikina CHO
19. Ms. Rowena Andres, Midwife III, Marikina CHO
20. Mr. Ronald Daluson, SI V, Marikina CHO
21. Ms. Racel Noriega, Nurse, Marikina CHO
22. Engr. Roberto Talavera, SI V, Tanay, Rizal MHO
23. Ms. Haydee San Andres, Midwife II, Tanay, Rizal MHO
24. Ms. Cristita Porciuncula, MT II, Tanay, Rizal MHO
25. Ms. Abielle Cerda, Nurse II, Mabitac, Laguna RHU
26. Ms. Ely Maria Bilog, SI, Mabitac, Laguna RHU

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27. Ms. Julia Eliza Ellanil, MT I, Mabitac, Laguna RHU

First TWG Meeting, April 18, 2017

1. Dr. Lydia Leonardo, Professor, UPM CPH
2. Dr. Dana Nicole De la Cuesta, MO III, DOH NCRO
3. Ms. Denisse Lou Manalili, Nurse II, EB
4. Ms. June Corpuz, SO, EB
5. Mr. Edgar Hilario, HEPA, DPCB
6. Ms. Evelyn Perez, ITO I, HPCS
7. Dr. Rommel Lizan, MO IV, RO IVB
8. Ms. Rowena Capistrano, Surveillance Officer, RITM
9. Engr. Bonifacio Magtibay, Technical Officer, WHO
10. Ms. Marvie Porcioncula, Nurse I, DPCB
11. Dr. Mariel Dejesa, MO IV, EB
12. Ms. Rae Hanna Guiaber, SrHPO, DPCB
13. Dr. Theodora Cecile Magturo, MS IV, DPCB
14. Dr. Ronald Law, MO V, HEMB
15. Dr. Winston Palasi, MO IV, DPCB
16. Dr. Nimfa Putong, SLH PHO Head, SLH PHO

Second TWG Meeting. June 29, 2017

1. Ms. Kris Pauline Martinez, Nurse II, EB
2. Ms. Diana Marie Sadiasa, Nurse II, EB
3. Ms. Aileen Joy Gonzales, Nurse II, EB
4. Ms. Marvie Porcioncula, Nurse I, DPCB
5. Engr. Luis Cruz, SHPO, ERDD DPCB
6. Ms. Mara Blaise Cervania, HPO II, HEMB
7. Ms. June Corpuz, SO, EB
8. Dr. Winston Palasi, MO IV, DPCB
9. Ms. Dulce Elfa, Nurse IV, FHO
10. Dr. Theodora Cecile Magturo, MS IV, DPCB
11. Ms. Rae Hanna Guiaber, SHPO, DPCB

Expanded Consultation and Planning Workshop, July 19-21, 2017

1. Mr. Mark Philip Bugayong, SSRS, RITM
2. Dr. Elvie Villalobos, MS III, DOH RO VI
3. Dr. Sarah Sze, Veterinarian II, DA BAI
4. Ms. Jezza Jonah Crucena, Nurse III, EB
5. Ms. Jeihan Jein Gulo, Nurse IV, DOH ARMM
6. Dr. Lorenzo Sarmiento, Prog. Coordinator, DOH RO IVA
7. Ms. Melissa Mondoy, SSRS, RITM
8. Ms. Diana Marie Sadiasa, Nurse II, EB
9. Ms. Kris Pauline Martinez, Nurse II, EB
10. Ms. Ma. Francia Geñorga, Nurse V, DOH ROV
11. Ms. Charity Lascano, Admin. Asst., SLH PHO
12. Ms. Rowena Capistrano, Surveillance Officer, RITM
13. Ms. Cindy Palafox, CFRR, FDA
14. Engr. Dioscorro Navarro, Engr. III, DOH RO XIII
15. Engr. Jose Ziapagan, Engr. III, DOH RO II
16. Dr. Ali Tumama, MO IV, DOH RO XII
17. Dr. Hansel Amoguis, Prog. Coordinator, DOH RO XI
18. Engr. Gloria Raut, Engr. III, DOH RO XI

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19. Mr. Edgar Hilario, HEPA, DPCB
20. Ms. Evelyn Perez, ITO I, HPCS
21. Ms. Clariza Domingo, Prog. Coordinator, DPCB
22. Dr. Glendine Porteza, Prog. Coordinator, DOH RO VIII
23. Dr. Nimfa Putong, MS IV, SLH PHO
24. Dr. Mariel Dejesa, MO IV, EB
25. Ms. Eirhona Kye Dumpit, MT II, DOH NCRO

Third TWG Meeting, October 2, 2017

1. Dr. Anthony Cu, HFDB
2. Mr. Ray Justin Ventura, BLHD
3. Dr. Theodora Cecile Magturo, MS IV, DPCB
4. Ms. Rae Hanna Guiaber, SrHPO, DPCB
5. Ms. Marvie Porcioncula, Nurse I, DPCB
6. Ms. Rowena Capistrano, Sureveillance Officer, RITM
7. Dr. Ferdinand De Guzman, PAFP
8. Ms. Marishel Mejia-Samonte, PAFP
9. Dr. Rosalie Paje, FHO
10. Ms. Dulce Elfa, Nurse IV, FHO
11. Engr. Luis Cruz, ERDD
12. Dr. Nimfa Putong, MS IV, SLH PHO
13. Ms. Rowena Capistrano, RITM-SRU
14. Dr. Lorenzo Sarmiento, FWBD Coordinator, RO IVA

Expanded Consultation and Planning Workshop, October 18-19, 2017

1. Dr. Theodora Cecile Magturo, MS IV, DPCB
2. Ms. Rae Hanna Guiaber, SrHPO, DPCB
3. Ms. Marvie Porcioncula, Nurse I, DPCB
4. Mr. Edgar Hilario, HEPA, DPCB
5. Dr. Lorenzo Sarmiento, FWBD Coordinator, DOH RO IVA
6. Dr. Rommel Lizan, FWBD Coordinator, DOH RO IVB
7. Ms. Ma. Francia Geñorga, FWBD Coordinator, DOH RO V
8. Dr. Elvie Villalobos, FWBD Coordinator, DOH RO VI
9. Engr. John Ray Labandero, Engineer III, DOH RO VII
10. Dr. Glendine Porteza, FWBD Coordinator, DOH RO VIII
11. Engr. Percival De Paz, Engineer III, DOH RO VIII
12. Dr. Hansel Amoguis, FWBD Coordinator, DOH RO XI
13. Dr. Ali Tumama, Infectious Cluster Head, DOH RO XII
14. Ms. Sittie Alma Sampayan, Nurse Coordinator, DOH RO XII
15. Ms. Eirhona Kye Dumpit, MT II, DOH NCRO
16. Ms. Jeihan Jein Gulo, FWBD Coordinator, DOH ARMM
17. Dr. Nimfa Putong, MS IV, SLH PHO
18. Ms. Jecery De Guzman, Nurse II, SLH PHO
19. Ms. Jezza Jonah Crucena, Nurse III, EB
20. Ms. Diana Marie Sadiasa, Nurse II, EB
21. Ms. Kris Pauline Martinez, Nurse II, EB
22. Dr. Sonia Sia, MS IV, RITM
23. Ms. Rowena Capistrano, Surveillance Officer, RITM
24. Ms. Melissa Mondoy, SSRS, RITM
25. Ms. Katherine Navaroo, SRS II, RITM
26. Mr. Joseph Bonifacio, SSRS, RITM
27. Mr. Jhobert Bernal, MT II, RITM