The 1993 review covered surveillance/data collection; diagnostic facilities/laboratory strengthening (including blood donation); strengthening of the STD program; information, education and training; and program management.

For this situation analysis a copy of the actual report as well as a summary of the findings and recommendations was made available.[3] Whenever feasible the data were compared to an assessment of the NAPCP done by the USAID mission in the Philippines in the course of producing the **AIDS Surveillance and Education Project, Project Paper** dated May 1992.

1. Surveillance/data collection [4]

1.1. Regular testing of one group

In 1992 the project paper for ASEP noted that HIV testing was being done on high-risk groups seeking services at social hygiene clinics (SHCs). It likewise observed that while over 200,000 screening tests had been done principally in Manila, Olongapo and Angeles, the current screening program was too biased to be reliable because only one segment of the population got tested and clients were counted twice each time they had the test.

The 1993 external review team report refers to the 1990-1992 Medium-Term Plan which already discouraged the *broad sero-survey being done among commercial sex workers* since it was yielding epidemiological information on only one group.

The review team noted that commercial sex workers were still being regularly tested and this was seen as an important control activity and a source of epidemiological data. The team wanted an urgent review of mandatory testing and the policy in general.

On another aspect, the review team discovered that the reporting system on AIDS/HIV violated confidentiality and there was lack of clarity of policy and procedure. Despite codes for confidentiality, the team members saw records where an infected person could easily be identified even without a name.

The team acknowledged that testing donated blood might indeed give information on epidemiology but recommended that health professionals or the public should not view the act of donating blood as a way of being tested for HIV infection.

1.2. Sentinel surveys

The ASEP paper pointed out in 1992 the insufficient attention being paid to developing systematic surveillance that can monitor HIV/AIDS infection nationwide.

The system can determine the prevalence of HIV infections yet a year after the ASEP paper, sentinel surveys were delayed partly due to discussions as to which agency within DOH should do surveillance.

It has since been decided that FETP has this responsibility and will continue to have it but the AIDS unit, which is responsible for presenting and publishing monthly statistics, would also like to have responsibility for surveillance.

The review team strongly suggested rapid implementation of sentinel surveys. However, it warned that this should not be the guide for the direction of AIDS prevention program in the immediate future since their value is really in showing trends over time.

The team also proposed that the Field Epidemiology Training Program (FETP) handle surveillance and data collection which has happened since the report was written.

1.3. The monthly report

Some clinicians reported to the team their lament about delayed monthly reports which prevented them from intelligently discussing matters pertinent to program developments.

Some workers mentioned that the monthly data on HIV/AIDS should have a brief commentary and could be better presented, perhaps with charts or diagrams.

The members stressed that the DOH should see if, as in the case of other diseases, the responsibility for presenting and commenting on the data should be FETP's in consultation with the AIDS unit.

2. Diagnostic facilities/ laboratory strengthening

2.1. The RITM and BRL

The review team commented that these two agencies of the DOH appear to be duplicating each other in supplemental or confirmatory testing, in evaluating testing kits, and in accrediting laboratories.

Thus, the team suggested that their roles and functions be re-studied so that only one might support and accredit private and government laboratories and only one to evaluate test kits. The team recommended that the BRL can possibly concentrate on ensuring safe blood supply with RITM providing laboratory support.

2.2. Diagnostics

The team commended the "excellent" training on HIV antibody testing techniques, however, it was also observed that laboratory staff could not use and consolidate their new diagnostic abilities because of shortages in equipment and reagents.

On a related aspect, the system for supplemental/confirmatory testing was found to be working well and hewing to procedures recommended by WHO for initial seropositive results.

However, the public has limited access to HIV testing, must pay for all tests, hardly knows of cheaper facilities at government agencies and may be unable to afford private doctors. Without explicitly stating how, the team also said that it may be possible that many HIV tests are done without explicit consent.

The team believes that the demand for testing will increase with the growth in awareness of HIV infection and AIDS. Thus it asked for ways to meet this demand and to ensure that blood donation does not become a way of getting a free and confidential test.

Also recommended is the training of health workers who may need to discuss HIV and AIDS with patients. This is in connection with the issue of pretest information and counseling. At the same time the team said that the topic should not be shrouded by the belief that only specialists can give pre- and post-test counseling.

2.3. Safe blood

The 1992 ASEP paper disclosed that some 40% of the blood supply was screened for HIV and that screening expertise and supplies for HIV laboratory testing have been devolved to the laboratories of the 14 regional hospitals and 5 medical centers and four social hygiene centers serving as regional referral centers.

The 1993 evaluation noted that figures on how much of donated blood is tested for HIV are not available but estimates range from 35% to 70% at the most because of the lack of reagents and testing equipment.

In any case the team interviewed many who said that private hospitals repeat all the tests done by the Red Cross and commercial blood banks for HIV, syphilis, hepatitis B and malaria.

One center was found using free testing for these diseases as a way to encourage blood donation, despite an increase in the number of voluntary donations.

The team learned too that Red Cross blood donors are asked about risky behaviors but hardly know of self-deferral, that they can postpone donating if they have been at risk for HIV infection.

The external review team believed that commercial blood banks and paid donors would be phased out by legislation within the next five years at the most.

It was also noted that successful education about rational use of blood components is taking place, but very little is being done to encourage doctors to ask whether a transfusion is necessary at all.

The team recommended that all these issues be considered and acted upon.

3. Strengthening of the STD Program

The 1992 ASEP paper did not speak of the link between STDs and HIV, but the 1990-1992 Medium-Term Plan calls for expanded STD services and the integration of the AIDS and STD programs within the context of primary health care and integrated basic health services.

The order for the integration has been issued and its importance emphasized in a recent review of the STD program by Dr. John Gallwey, an external expert.

The external review team fully endorsed the study of Dr. Gallwey, citing how his report shows the need to regard HIV infection as a sexually transmitted disease; to give free, confidential STD services that are attractive and accessible; and to provide testing, counseling, and advice about HIV infection, and care and support for those affected.

4. Treatment, care and support for HIV-infected persons

Against the goal of the Medium-Term Plan to establish AIDS wards, outpatient services, day care center, community-based home nursing and stronger links with voluntary organizations, the review team pointed out that the number of people with HIV is beginning to have an impact on caring services.

Most cases go to DOH facilities. Some go to private hospitals only to be turned away since some health professionals fear infection or lack skills to care for HIV patients.

Another barrier is the lack of care and support in communities and more importantly, existing discrimination or stigmatization.

Patients truly cannot go home and when they do, they find it hard to return to Manila for health care and follow-up due to the distance involved.

One finding of the external review team is that with the classification of HIV as "highly infectious," patients are seen as needing special health care. After an operation the surgery area gets unnecessarily extensive disinfection. Thus, a surgical suite just for them is being considered.

The team concluded that this situation only reinforces or exaggerates fears of infection. The members would like DOH to adopt a policy that HIV-infected patients can be treated in any facility where the staff is duly trained on HIV/AIDS.

On fears of infections, health care professionals and managers should be reassured that standard procedures of preventing transmission of and infection against HIV will suffice and that special wards are not necessary.

The review team also stated that the care of people with HIV extends beyond nursing and medical needs and has to be coordinated with statutory and non-statutory bodies.

Such care and treatment should include the follow-up of cases who live far from centers of excellence and those being supported by NAMRU.

Care should also consider injecting drug users who, in the current epidemic of malaria, caught the disease from sharing injection equipment with peers. These drug users may then sexually spread it to non-drug users, since syringes could be another transmission mode for HIV, the team pointed out.

5. Information, education and training

The 1990-1992 Medium-Term Plan noted that health education and risk reduction are the most effective ways of preventing infection in the absence of a cure or vaccine for AIDS. It is along this line that the NAPCP has conducted its IEC activities.

5.1. IEC

The 1992 ASEP paper enumerated these activities: campaign services and drop-in centers. The paper also noted how IEC and surveillance programs have not had the attention and funding that can make them effective national operations. They must be expanded so that they can have a great impact on slowing down the transmission of the disease.

The 1993 review team identified information, education and training as the areas where the NAPCP has made the greatest progress.

Proofs include the general publics's higher degree of awareness of and interest in getting information on the HIV/AIDS problem; the endorsement of AIDS prevention and control as an urgent national concern coming from the President and the DOH leadership; the access by high-risk groups to IEC services from NGOs; working models of community-based, multi-sectoral IEC programs; and the integration of materials in the curricula of elementary and high school levels.

"Some very excellent" work has been performed by NGOs in IEC, but there is a need to synchronized their efforts.

Donor groups have given strong support to materials development. This resulted in the production of locally suited information materials and replicable schemes for both city and rural folks, and in the successful use of peer counselors and educators. Innovative IEC methods and programs clearly meant for critical groups have also been developed.

These IEC activities may now expand and be sustained by a five-year communication strategy with assured funding which addresses selected audiences.

The team also noted that there are some IEC materials that are based on research but research is also needed in new areas such as high-risk sexual behavior in rural areas and new forms of prostitution in Ermita, Clark and Subic.

Another area for genuine concerned is decreased capacity to plan and do IEC programs on AIDS as one goes down the regional and provincial levels. With devolution, governors and mayors should be targets for IEC. Support personnel must be included too.

On field-level work, AIDS coordinators face overlapping and competing assignments together with an almost total lack of funds and other resources. Thus they should get a minimum and realistic set of expectations about outputs from field-based IEC programs.

As for NGOs with limited resources, these "very important partners" should get active support from DOH in developing a strong network. The team recommended incentives and technical assistance to collaborating agencies.

It was also suggested that the DOH re-examine supervisory and regulatory functions over NGOs since these have been known to initiate larger proposals for funding after establishing their credibility.

5.2. Training

The team noted the good education and training for health care workers in both public and private sectors. Training of laboratory staff on HIV antibody testing was described as "excellent." Training of medical technologists and nurses in HIV testing were found proficient, as well as training of social hygiene workers. The only gap mentioned by many workers was the need for more training on counseling patients about HIV and the test.

The DOH has produced an "excellent" handbook on HIV and AIDS. But they also took note of prejudice in certain hospitals and the ignorance of at least one private hospital about the handbook, underscoring the need for more education, even among receptionists, porters and clerks.

However, training should be coordinated among government, private institutions and NGOs for uniform contents and unduplicated efforts.

On another aspect, health workers told the team that DOH must give guidelines or information on counseling, on their duty to patients with known or suspected HIV infection, on a person's ability to work if he or she is asymptomatic, and on the growing number of OCWs affected.

The team therefore suggested DOH guidelines and information on these matters and on confidentiality and consent to testing.

Attempts were made to obtain more statistics from the AIDS Unit regarding the type of trainings and number of trained personnel in the program, but no data could be obtained. *It seems that the Unit is just starting to undertake this kind of* inventory.

6. Program management

6.1. Staff, funds and positioning

The ASEP paper of 1992 said that the potential funders have been frustrated by the organizational problems affecting the NAPCP. The absence of an organizational focus "compromises the ability of DOH to implement the various elements of the Medium-Term Plan in a coordinated fashion."[5]

A year later the external review team cited how the NAPCP has been "hampered" by unstable funding and staffing and by the title "unit" that signifies a low-level agency.

Staffing has not been institutionalized. Personnel are borrowed from other units and the Program staff is contractual. Salary delays have adversely affected the motivation of the staff. Frequent repositioning within the DOH structure implied instability program staff items.

The team recommended that the NAPCP organization and staffing be stabilized and the appointments of current personnel assured. The unit has to be defined in terms of identity and leverage.

6.2. Leadership

Effective leadership at the NAPCP has been hampered by its frequent repositioning and by an unclear delineation of specific accountabilities and authority for its head. Effectiveness has been dependent on the program manager's personal skills, credibility and influence.

The review team called for a review of the heads' role, functions, accountabilities and authority and stipulated that the results of such review be communicated to all concerned.

The team added that indefiniteness can be eliminated if there are realistic performance expectations that are applied clearly and consistently.

It is critical that the Program Manager gets the support and confidence of DOH management. Thus, the designation must have a measure of this explicit support.

6.3. Program focus

The 1992 ASEP document called for an organizational focus in the AIDS program so that it would not "continue to languish."

A year later, the external review team called the process one of "rowing" rather than "steering," of direct implementation of activities rather than providing overall technical guidance, coordination and integration for NAPCP activities.

The review team has called for disengagement from less strategic technical work. It also draw attention to and urged implementation of the Department Order integrating the AIDS and the STD programs. The order was subsequently followed on March 28, 1994.

6.4. Relationships

Since the NAPCP depends a great deal on donor agencies, the review team recommended stronger relations especially in terms of technical coordination and administrative facilitation. As a gauge of the movement towards this direction, it suggested regular meetings of the PNAC and its technical secretariat, the AIDS unit itself.

A stronger basis for coordinating the program has emerged. The DOH leadership has made public a commitment to address the HIV/AIDS problem and sustained its advocacy by the NAPCP.

By placing the AIDS program under the Office of Special Concerns with its Assistant Secretary as Program Manager, DOH management has given NAPCP a new level of legitimacy together with the major programs of family planning, child survival and women's health.

The call of the review team for more effective mechanisms for inter-DOH coordination in the different components of the Program must be seen against these changes.

Local autonomy has added a new dimension in the relationships. In the light of devolution, the team recommended two things: (1) greater clarity and coordination with local governments and (2) more effective technical guidance to LGU initiatives so that Program management may more effectively steer projects through the government's bureaucratic maze.

7. Discussion

The report on the findings and recommendations has emanated from an external source relatively free of vested interest in the NAPCP. The WHO-based team members reported to Headquarters and to the Regional Office for the entire Western Pacific and had no personal stake in the results. It can be safely said that the team came up with unbiased field-based findings on programs, structures, facilities, data systems, relationships and management procedures.

Can the DOH readily carry out the proposals of the review team? Perhaps the Department can build on accomplishments, as for example, the training and laboratory accreditation for HIV testing, the completion of a five-year communications strategy, the high level of awareness on AIDS-related issues, and the avilability of a handbook on HIV/AIDS.

Other important questions relate to: (1) how fast the Department can remedy gaps in the skills of health workers or their attitudes towards the HIV-infected; (2)

putting into good use newly-acquired knowledge; (3) countering the little attention paid so far to psychosocial aspects of health care; (4) defining the roles of non-statutory bodies in health care; (5) supervision of NGOs without the bureaucracy hampering their capacity to experiment with innovative programs; (6) working out a harmonious relationship with funding agencies; and (7) the conduct of studies needed to guide planning, implementation, monitoring, evaluation and other activities.

Obviously same solutions would seem fairly easy to find but others may require more work, more funds and more political will.

In many ways the recommendations of the external review would put to test the ability of DOH to respond strategically and tactically to both short-term and long-term problems.

B. INTERVIEWS

The external review team completed its work almost a year ago - on July 15, 1993 to be exact - and inputted its final report to the NAPCP **Medium-Term Plan 1993-1998.**

Since then some of the recommendations have been implemented while others await action, as may be gleaned from interviews made for this situation analysis.

The interviewees head programs or sections at the DOH AIDS Unit, FETP, BRL and San Lazaro Hospital. They spoke on the activities of their units, the problems they face, and the priority needs they have. In some instances they generously gave copies of reports related to AIDS.

This subsection incorporates interviews with AIDS program coordinator Dr. Dennis Maducdoc; Mr. Geoff Manthey, WHO-GPA techical officer for NAPCP; Dr. Carmina Aquino, formerly with the USAID Mission in the Philippines Office of Population, Health and Nutrition and now with the lead agency for the education component of ASEP; the Seattle-based Program for the Adaptation of Technology for Health (PATH), and other key staff involved in the AIDS program of the government.

1. Surveillance

One of the recommendations of the external review team was a second look at the regular testing for commercial sex workers. A year after the proposal, CSWs must still get clearances from social hygiene clinics but not for HIV testing which remains voluntary and confidential, the interviewees revealed.

In February 1994 the DOH joined hands with at least two NGOs to discretely promote and provide for free testing after office hours and on week-ends. Dr. Maducdoc fears that some local government units may be using the Sanitation Code, the basis of STD clearances for employees, to press for HIV testing.[6]

As for the sentinel surveillance, the first round was undertaken soon after its fast-tracking was recommended by the external review. Less than four months after the recommendation, results of the pilot phase and the initial round were presented on November 12 at a national conference coordinated by FETP.

In an interview for this situation analysis, Dr. Timoteo Badoy, Jr., AIDS Registrar, outlined steps taken to ensure confidentiality of results, one of the recommendations of the external review team.

The anonymous, confidential method is used for five groups - female commercial sex workers, freelance sex workers, females with STDs, injecting drug users and men who have sex with men. The unlinked, anonymous method applies to males with STDs. Code numbers are used, a step which also serves as identity verifiers.

Dr. Badoy adds that so far there have been no problems of confidentiality. According to him, informed consent is assured by pre-blood extraction counseling. Counseling is part of the training for surveillance teams.

Post-testing counselling is not mandatory because the surveillance does not release results unless a client requests it. This is according to a paper read by Dr. Florante Magboo at the national conference last November. He is coordinator of the National HIV Surveillance Program.[7]

The interview with Dr. Badoy also highlighted the reason for the delay in the second round of the surveillance system: lack of reagents, which has been noted during the external review.

The issue is self-sufficiency as stressed by Dr. Marietta Baccay, BRL director, who urges the manufacture of inexpensive reagents to eventually eliminate import of this indispensable item. [8]

Along these lines Dr. Mary Rose Aplasca, OIC of the AIDS Research Group of RITM, mentioned the on-going search by the technical staff on filter paper and other materials on which sera may be collected. [9]

As for the monthly case update, the AIDS Registrar cross-tabulates gender, AIDS, occupation and other socio-economic factors with HIV infection. This carries out a suggestion from the field to make the FETP document more attractive to readers.

Aside from the ASEP sentinel surveillance system, the social hygiene clinic network has been undertaking passive surveillance. With the STD Program integrated with the AIDS Program, it can now fully implement a recommendation of the external review team for more sites for HIV testing.

According to a briefing material from Dr. Marlene Borromeo, STD Program Manager, the nine-model clinics which can test for HIV can also be venues for health education programs.

1.2 Diagnostics/laboratory facilities

Still unresolved is the frequent shortage of equipment and reagents that was noted by the external review team in 1993.

Referring to equipment, training specialist Minda Quitoriano needs a portable cold storage unit that can keep sera fresh for out-of-town updates with medical technologists.

To amplify on this lack of equipment, there is but one computer at the Laboratory Licensing and Regulation Division of BRL. According to Dr. Antonio Erese, division chief, this slows down their accrediting, monitoring and supervising various types of laboratories: clinical, blood banks, HIV testing, those which train laboratory technicians, and those which test the safety of water.

At the time of the interview for this situation analysis, the Division had just been asked by the Quezon City government for a list of registered as well as unregistered laboratories within the City.

The request indicates the capacity of local governments to monitor entities that check the status of health - or the lack of it - of the ordinary citizen.

The computer-literate staff member who could generate the list had to go on forced leave so that the Government would not have to pay him cash for leave credits.

So the need is not just for equipment but also for manpower, said Dr. Erese in an interview, to run equipment for both the central office and the year-round field checks on laboratories.

On another matter, equipment like the fluocytometer can check CD4 cells but the one and only machine available will leave with NAMRU-2 when the unit withdraws from the country. When that happens, Dr. Santiago fears that DOH medical technologists testing the patients at the AIDS Ward might then have to resort to manual counting.

The external review team was not amiss in warning about the effects of the phase-out. The Philippine government was appealed for a reconsideration but has received no definite response four months before the July 1994 schedule.

A fluocytometer machine alone costs PhP 1 million, Dr. Santiago estimates, without the centralized air-conditioning units which are essential day and night, the reagents and the trained medical technologists. Also indispensable to the AIDS Ward is an electromicroscope for viewing slides of cultures on health levels of blood components.

As to blood, samples and donations are routinely screened for HIV but a large percentage simply is not, it was reported by the external review team. This has relevance to a report that has made Sec. Flavier consider closing all commercial blood banks.[10]

A study team from the New Tropical Medicine Foundation studied 426 blood units from all over the country and found two positive for HIV. Both were from the Visayas-Mindanao batch, one from a government hospital-based bank and the other from a blood center of the Philippine National Red Cross (PNRC).

Confirmatory testing by RITM later reduced the number to one, but the contamination rate of the lots - at least 4% - is still not acceptable, contends the study team headed by Dr. Asuncion Paraan of RITM.

The team also noted that, based on an inventory of their facilities, the blood banks in question could fully screen for all four mandatory diseases.

It now appears that present procedures cannot eliminate potentially infective blood. The study team suggests that BRL should brace itself for a full range of work that is "overwhelming".[11]

First of all, the Bureau has to review its categories of blood banks (primary, secondary and tertiary) to better reflect the natural rather that the theoretical differentiation of blood banking operations.

According to the study team, BRL must review licensing processes to ensure that all blood banks do all the mandated screening tests and that at least one bank per major city and province can prepare most of the blood components.

The BRL must then visit, reassess and reclassify blood banks with a criteria that should include this ability to do all the required tests; staff proficiency; appropriate and adequate facilities, equipment and supplies especially for blood storage, handling and distribution; appropriate practices and procedures for donor and blood screening, blood processing, handling and use including biosafety precautions; and the ability to manage at least 10 voluntary donors per day.

Banks which fail to meet all these criteria should be categorized as mere blood collection centers and should not be allowed to test and process the blood that they had collected.

Releasing assumes testing, the study said. A blood bank which releases blood should test it making sure that no untested blood should be released. In addition, hospitals should document, investigate and forward reports on all transfusion reactions to the national sentinel surveillance system.

The team also studied BRL forms and found them confusing and in need of additional data like monthly donor examination, bleeding and blood purchases. It proposed that reports should be analyzed regularly for limitations, status of services in catchment areas, and improvement of these services.[12]

There are many issues in blood banking system. Three are among the recommendations of the external review team: encouraging blood donations, ensuring donor self-deferral in case of risky behavior, and encouraging doctors to rethink the necessity of orders for blood transfusion. It remains to be seen how soon these will be implemented.

1.3. Clinical management and care

The San Lazaro Hospital and the RITM are in the Metro Manila area but it was in the Visayas-Mindanao area that the RITM study team found two blood samples infected with HIV.

Allowing for the window period of the individuals who gave the blood, it seems that the regions will soon require fully-equipped care systems for AIDS.

To meet this need doctors and nurses from government regional hospitals should be trained at San Lazaro. Last year there were six courses of ten days each. Lectures and laboratory work filled the first week; the second week was a practicum at the AIDS Ward.

Dr. Mina Manalo, medical specialist at the AIDS Ward, cites the draft Department Order that standardizes across hospitals the procedures for admission, care, counseling, support and treatment of both out-patient and confined cases.

These moves strengthen regional capabilities, part of the change of NAPCP response to AIDS - from what Dr. Mina Aquino had descried as "knee-jerk" to one that is multi-faceted.[13]

Thus, the answer to the increase in the number of people with AIDS is more than just increasing the number of hospital beds, a priority expressed by Dr.

Santiago who manages a free ward on an extremely tight budget, but what she herself calls helping patients find a reason to live.

According to her the HIV/AIDS core team must motivate patients to lead normal lives, generate their own income from self-help projects, and willingly take AZT, anti-TB medications and other drugs against opportunistic infections.

Recalling Dolzura Cortez, the most famous patient of the Ward, Dr. Santiago muses on the fine balance between allowing them week-end passes and working out breaches in discipline ("nag-escapo minsan kung busy ang nurse") with one-on-one counseling ("you are our responsibility; why did you come back so late?).

On another front, NAPCP is testing a home care program, perhaps to explore the feasibility of managing opportunistic diseases of the AIDS-related complex at a patient's residence as long as there are provisions for care there. This was one of the recommendations of the external review team. RITM statistics show that in 1990 it had more out-patient consultations than admissions.

There are other aspects to care and support which, Dr. Aplasca believes, is more than the availability of information or on knowledge, attitudes and practices or access to condoms. She sees usefulness in nurturing in the young moral strength to say no to irresponsible sexuality with a values education program. Refusal skills for at-risk situations might in the end lessen the number of people with AIDS who are now beginning to impact on caring services.

1.4. Information, education and training

The information component is the most developed sector of the Program, said the external review team.

RITM for instance may be said to have leaped from print to videotape in the form of lectures that are now being played back at the departure area of the Ninoy Aquino International Airport. For the past three years RITM has also been training medical technologists from other countries on HIV testing skills.

But there have also been gaps. At times the coordination mandate of HEMADETS for training has at times been disregarded by certain units - duplicating efforts within the same program.

Yet much remains to be done in training, states the NAPCP program manager. Hospital staff need training on clinical care and management. Field staff need training on counseling and on the psycho-social impact of AIDS.[14]

Equally pressing is the need for technical training. RITM has a "long list" of applicants from the staff of private hospitals for the twice-yearly course on proficiency in HIV testing. She has BRL from the government sector.

But BRL now faces a shortage of reagents for its training programs since WHO has not yet released funds this year and since the World Bank ends its support this year. Ms. Minda Quitoriano, training specialist, said in an interview: "For three years I did not have to worry about supplies. We were able to meet field demands and even overshoot goals. But now ..."

The interview with Ms. Quitoriano brought to light a ban on peer training by medical technologists accredited by the BRL to test for HIV. Also surfacing was the need to re-train employees of 20 years' standing who repeatedly fail to recognize Hepatitis B virus despite re-tests.

In the case of San Lazaro, the training of embalmers against infections from handling corpses of AIDS cases is long overdue, said Dr. Santiago.

WHO has not yet been able to release funds for 1994. Soon the World Bank ends support for the Philippine Health Development Program. The picture one can paint is that of over-reliance on international funds for a most basic need - health.

1.5. Program management

To carry out its mandate NAPCP must have a cash flow. But once again it seems to be in the situation uncovered in 1993 by the external review team. The lack of funds is occurring despite the articulation of a goal by Dr. Maducdoc for the entire NAPCP: expansion and intensification of operations beyond Metro Manila.

To be sure, certain activities may be postponed without unduly affecting Program goals. But a shortage of a very basic ingredient such as reagents can ultimately set back effective care and support of patients.

Positive developments have not been lacking. Role definitions have been set, according to Dr. Maducdoc. The NAPCP technical staff tracks technical aspects of the program - in reference to the recommendation of the external review team for a "steering" approach - as NGOs generate social support and disseminate information to target audiences identified by the 1992 communication strategy document.

The Secretary of Health continues to have enthusiasm in leading the endorsement of AIDs prevention and control as a national priority. This is according to Mr. Geoff Manthey, WHO-GPA technical officer for NAPCP who enumerates another asset: the ability and willingness of NAPCP staff to view matters with an open mind.

But Mr. Manthey also notes that within DOH the Program is not yet institutionalized. It has not found its niche yet, having been placed within the Office of the Secretary, the Assistant Secretary for Public Health, the Communicable Disease Control Service, and now the Assistant Secretary for Special Concerns.

Mr. Manthey refers to its "ad-hoc nature" that is not helped by the dwindling of funds and that can erode its credibility. AIDS is acknowledged as a special concern - yet is not fully part of DOH by this very nature: special, not yet institutionalized within the Department.[15]

Table 1 Reported HIV Seropositives by Year of Diagnosis, AIDS/HIV Registry 1984 - February 1994

Year	Asymptomatic HIV	AIDs			Unclassified*	TOTAL
		Alive	Dead	Total		
1984	0	0	2	2	0	2
1985	6	0	4	4	0	10
1986	21	1	7	8	0	29
1987	26	4	8	12	0	38
1988	21	4	10	14	0	35
1989	32	2	5	7	0	39
1990	52	2	14	16	0	68
1991	66	4	9	13	0	79
1992	52	8	9	17	0	69
1993	61	23	8	31	8	100
1994	6	3	1	4	4	14
Total	343	51	77	128	12	483

* Reported cases that are seropositives but we cannot say if they are asymptomatic or symptomatic

Source: Department of Health AIDS Registrar's Office

Table 2 HIV Seropositives by Gender for Age group AIDS/HIV Registry, 1984 - February 1994

Agegroup (years)	Female	Male	Unknown	TOTAL
0-14	4	7	0	11
15-29	155	68	0	223
30-44	42	118	0	160
45>	6	25	0	31
Unknown	23	31	4	58
TOTAL	230	249	4	483

Source: Department of Health AIDS Registrar's Office

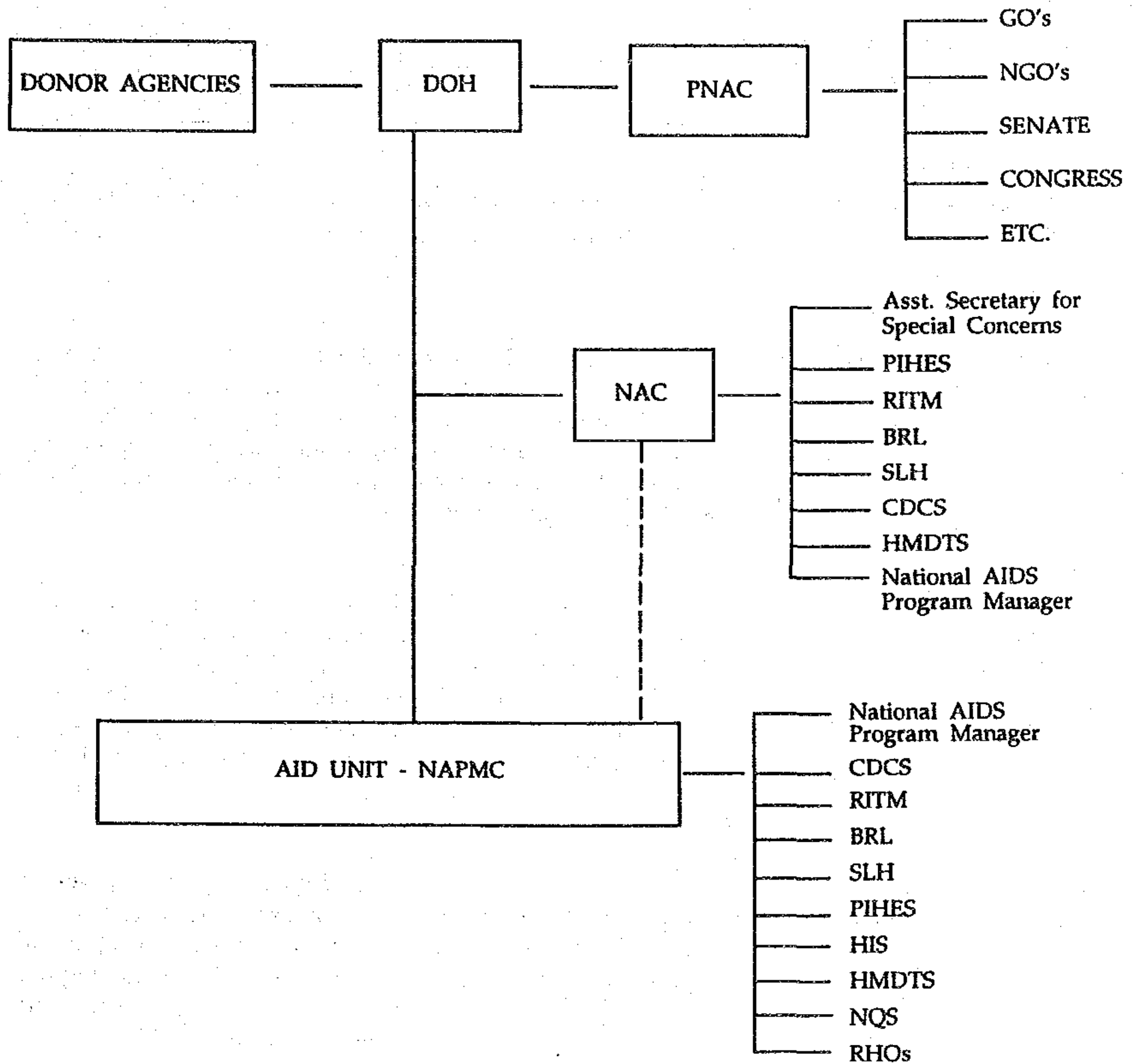
Table 3 Reported Modes of Transmission of HIV/AIDS Cases AIDS/HIV Registry, 1984 - February 1994

Modes of Transmission	February 1-28, 1994 (n = 8)			Cumulative: 1984-Feb. 1994			TOTAL
	HIV	AIDS	Unknown	HIV	AIDS	Unknown	
Sexual							
Heterosexual	1	2	0	185	62	2	249
Homo/Bisexual	0	1	0	33	53	0	86
Blood/blood products	0	0	0	2	3	0	5
Needles & syringes	0	0	0	2	1	0	3
Mother to Infant	0	0	0	4	4	0	8
Unknown	0	0	4	117	5	10	132
	1	3	4	343	128	12	483

Source: Department of Health AIDS Registrar's Office

FIGURE I

ORGANIZATIONAL STRUCTURE OF THE NATIONAL AIDS PREVENTION AND CONTROL PROGRAMME (NAPCP)



PNAC - Philippine National AIDS Council

NAC - National Advisory Committee

NAPMC - National AIDS Programme Management Committee

FIGURE 2

PROFILE OF NGO's

NGOs	Agency Profile
Health Action Information Network (HAIN)	Established in 1985, HAIN gives education and information to sex workers, gay people, students and other groups. It is a referral center for the AIDS hotline.
Population Services Pilipinas Inc. (PSPI)	Founded in 1990, PSPI is the local partner of Marie Stopes International, the largest private sector founder of family planning services in Britain. PSPI deliver FP and reproductive health services, which includes HIV/AIDS. It has **AIDSCHECK** which serves female commercial sex workers and male homosexuals.
Remedios AIDS Foundation Inc.	Remedios was established in 1991 to encourage initiatives from NGOs on HIV prevention. The Foundation administers the Remedios AIDS Information Center (RAIC). The center was established in 1991 with funds from the Agency for Educational Development, a subcontractor of the U.S. Agency for International Development (USAID).
Reach Out AIDS Education Foundation	Established in May, 1990, the foundation is composed of artists, actors, directors, film makers, writers and other concerned citizens who have banded together to stop the spread of HIV/AIDS and to minimize the social impact of AIDS. Its services include advocacy, education programs and community empowerment.
Marching for Life Coalition (MCL)	Founded in 1992 as a reaction to the renewed mobilization of pro-lifers/anti-choice segment, responsible sexuality, family planning, HIV/AIDS advocacy and networking.

NGOs	Agency Profile
Foundation for Adolescent Development (FAD)	Founded in 1991, the foundation manages a youth and sexuality drop-in centers in Quiapo, runs monthly medical missions, manages a telephone counselling project (Dial a Friend) and promote family planning.
KABALIKAT ng Pamilyang Pilipino	Founded in 1979, Kabalikat ng Pamilyang Pilipino Foundation, Inc. means "Assistance to the Filipino Family." It is dedicated to the cause of improving the health status of Filipino families by increasing their awareness and access to information, products and practices. Its scope of services include research, product introduction and adaptation, development of communication materials, and technical assistance on health-related technologies, and pilot-testing of health products/interventions.
Institute for Social Studies and Action (ISSA)	Established in 1983, ISSA help respond to the health needs and concerns of women, youth and children. Its activities are centered on five (5) identified programs: maternal and child health; fertility management and contraception; health of the reproductive systems such as reproductive tract infections (RTIs), STDs and AIDS and other reproductive organs of both males and females; violence against wome; and sexuality.
Woman Health Philippines	Founder in 1987 as a reaction against the proposed constitutional provision on the right of the unborn over the woman. This NGO has advocacy and networking as its goals for women centered health. It has a pilot project for a community-based health management and improvement.

NGOs	Agency Profile
Third World Movement Against the Exploitation of Women (TW-MA-EW)	Founded in 1987 against the commercialization of the tourism industry for the IMF-World Bank meeting in the Philippines, the movement runs home for prostituted women, those in transition and those with STDs and AIDS. It was developed for international linkages for women's rights and against sexual slavery/trafficking of women.
Family Planning Organization of the Philippine (FPOP)	Established in August, 1969, the agency engaged in the promotion of family planning and maternal and child health and responsible parenthood. This private, voluntary, non-profit organization is one of the Family Planning Associations (FPAs) associated with the London-based International Planned Parenthood Federation (IPFF). Since January, 1994 FPOP integrates AIDS education, counselling and referral services and provision of condom in their MCH program.
Institute for Maternal and Child Health (IMCH)	IMCH was established in 1968 to complement the teaching hospital founded by Dr. Fe del Mundo, internationally known pediatrician. The institute runs clinics throughout the country and train service providers for family planning and maternal and child health, and recently, STDs including HIV/AIDS.
Philippine NGO Council on Population, Health and Welfare, Inc.	Established in 1987, PNGOC is a council of NGOs involved in population, health and welfare activities for the betterment of the Filipino nation. The five (5) program thrusts of PNGOC are networking; sub-granting of projects; social advocacy; self-reliance and institutional building.

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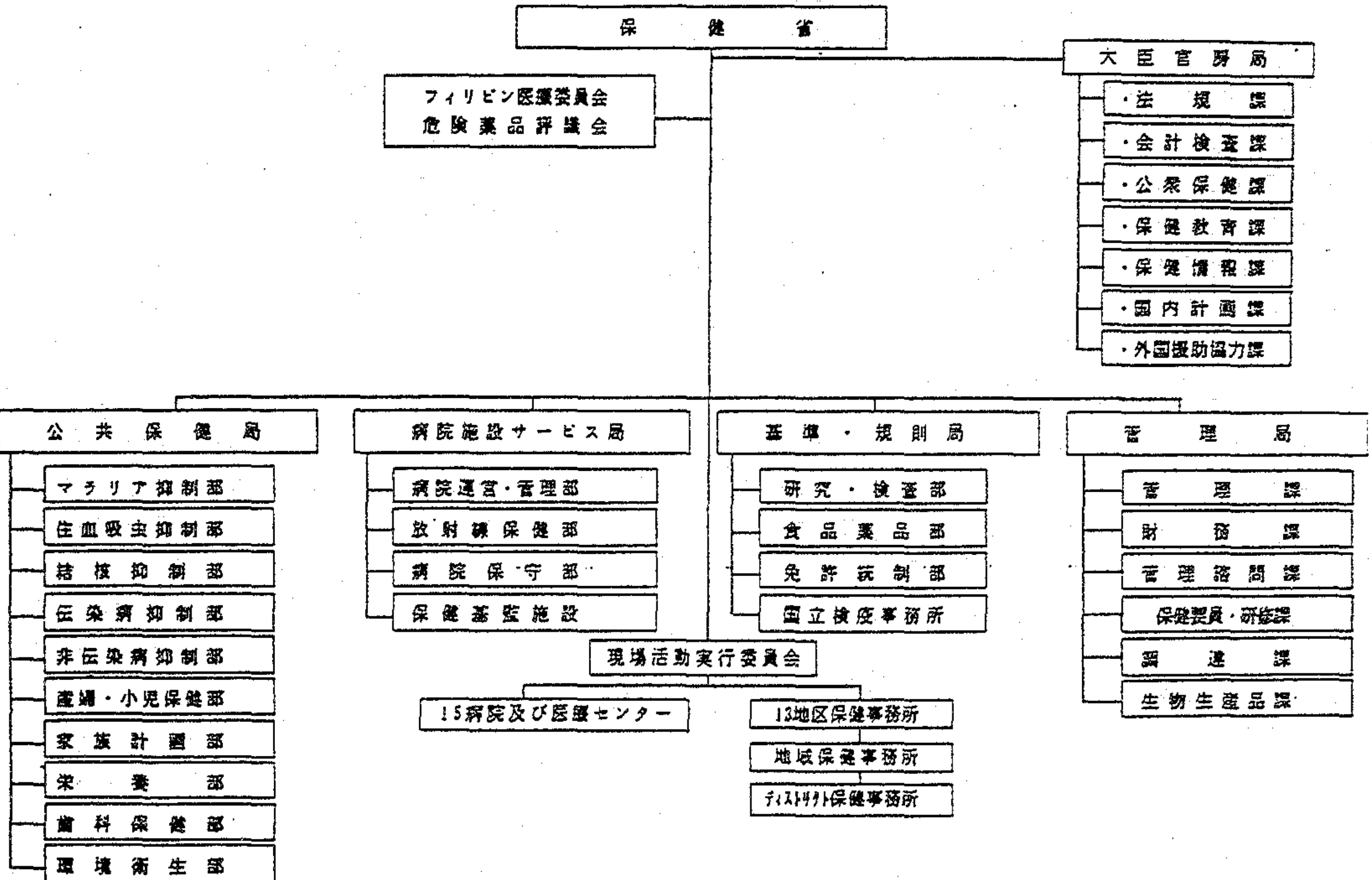
2. 保健省機構図

保健省機構図



3．保健省エイズ班作成エイズ関連資料

HIV/AIDS SITUATION IN THE PHILIPPINES

NATIONAL STD - AIDS PREVENTION AND CONTROL PROGRAM

LONG TERM OBJECTIVES:

1. Reduce transmission of HIV (human immunodeficiency virus) and STDs (sexually transmitted disease).
2. Prevent development of STD complications.
3. Reduce impact of HIV infection, AIDS (acquired Immunodefiency disease syndrome) and STDs on the individual, family, community and society.

MEDIUM TERM OBJECTIVES;

1. Monitor the spread of HIV and STDs among identified sentinel groups and the general population.
2. Promote health education.
3. Promote condom use among persons with high risk sexual behaviors and STD health care seeking behavior.
4. Develop and propose specific guidelines for screening of blood products.
5. Institute HIV, HBV (hepatitis B virus) and Syphilis screening of all blood
6. Enforce appropriate sterilization practices for skin-piercing instruments.
7. Reduce impacts of HIV infection and STDs on individuals, groups and society thru provision of clinical management, counselling, alternative occupation or social support.
8. Support diagnostic facilities of SHCs and public laboratories for early diagnosis and treatment of STDs.
9. Upgrade knowledge and skills of health workers providing STD/AIDS basic services.

STRATEGIES:

1. Prevention of transmission of HIV and STDs thru sex, blood and perinatal routes.
2. Reduction of the impact of HIV infection and STDs on individuals, family, community, and society.

An estimated 5,000 - 50,000

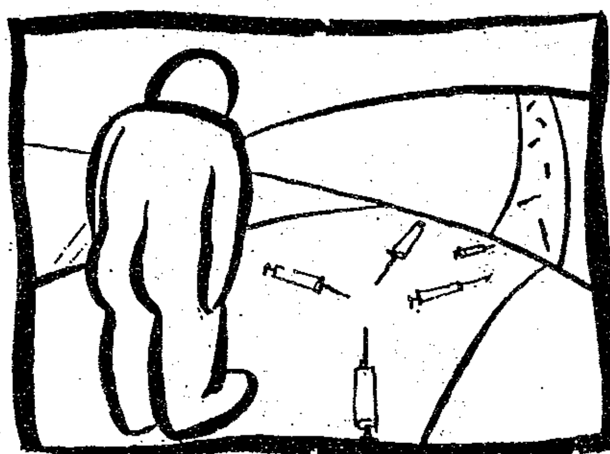
Filipinos are now HIV infected.

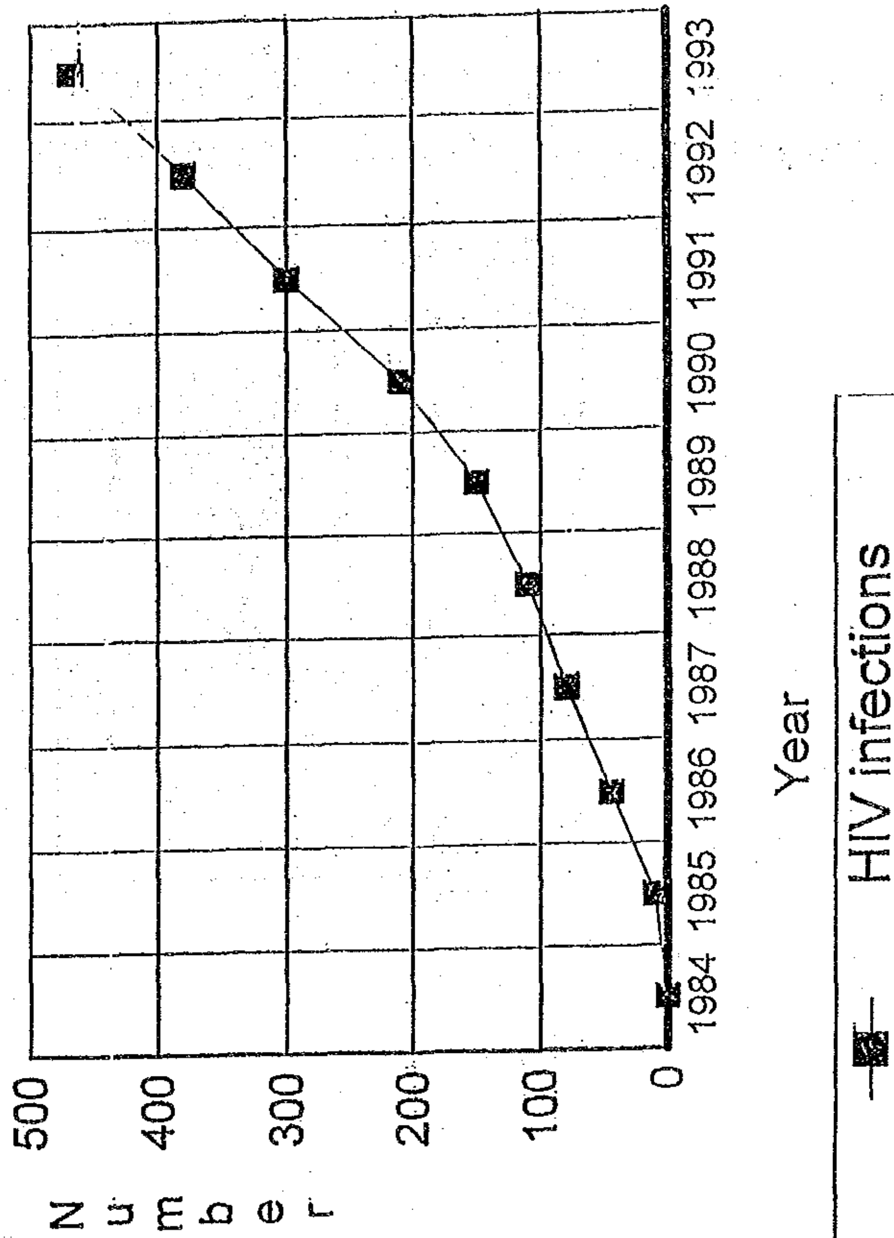
RED ALERT:

STOP AIDS !

86% of Filipinos are aware of AIDS, however many are still misinformed and believe that HIV can be transmitted through casual contact, kissing or saliva and mosquito bites.

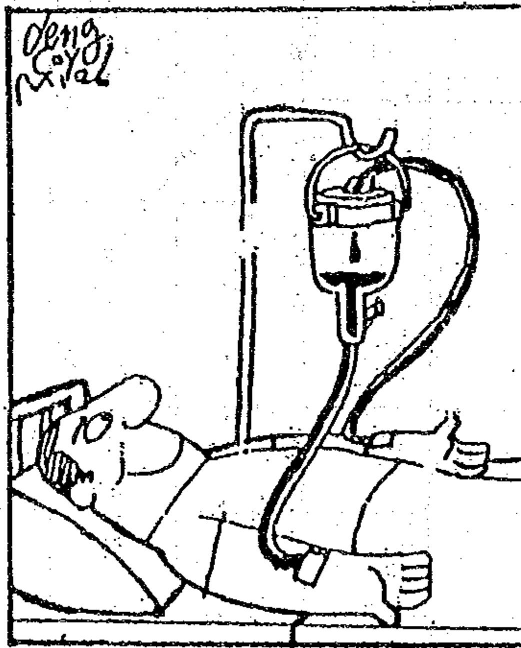
Injecting drug use now exist as a potential mode of transmission, as was found in a study conducted in Cebu City.





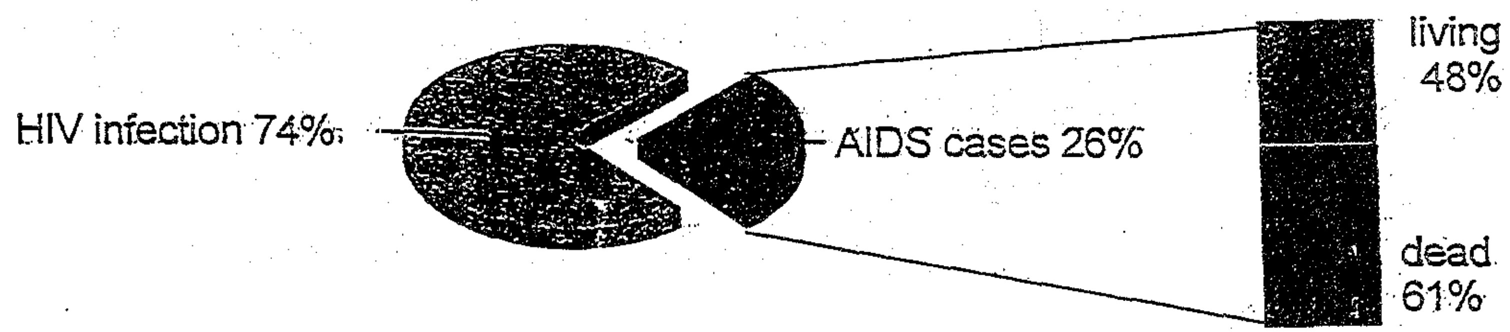
Cumulative HIV infections Reported
Philippines, as of December 1993
Number
500
400
300
200
100
0
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
Year
HIV infections

No documented case of blood transfusion among locally transfused individuals.



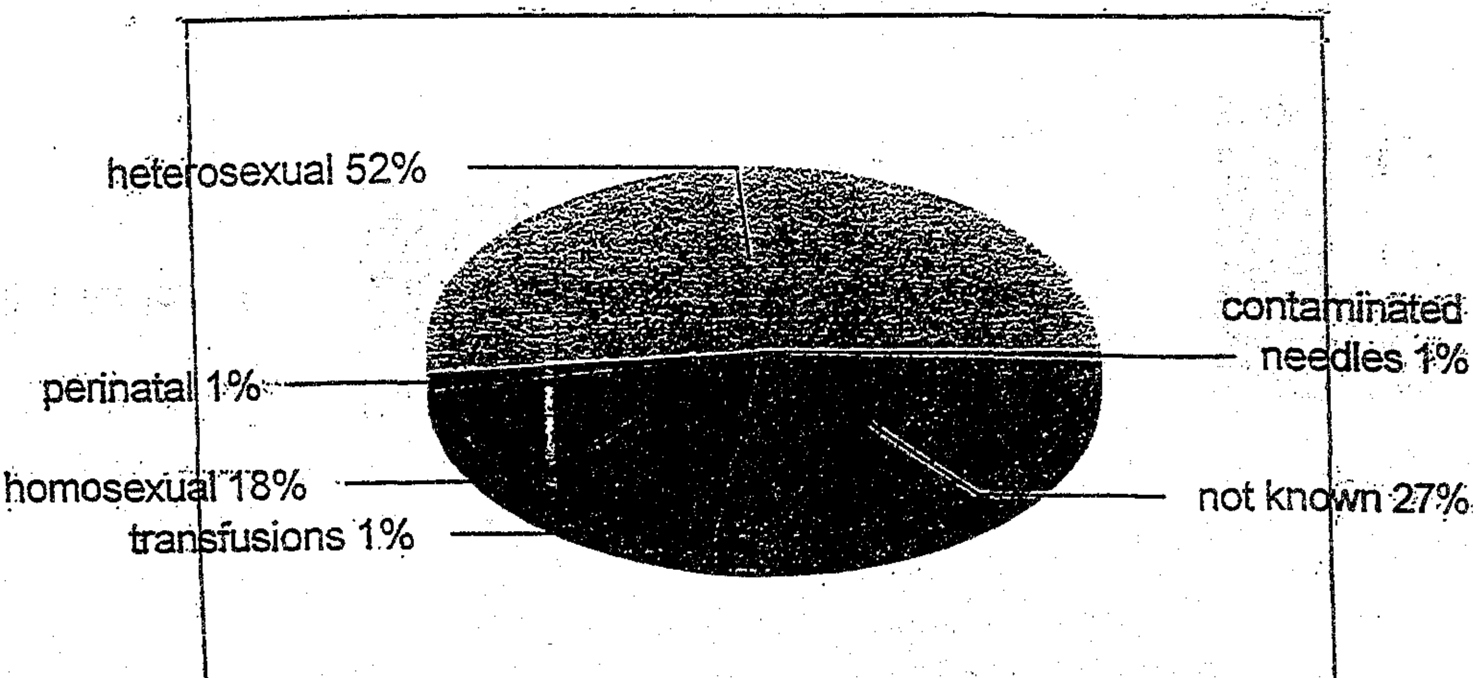
Reported HIV infections/AIDS and deaths

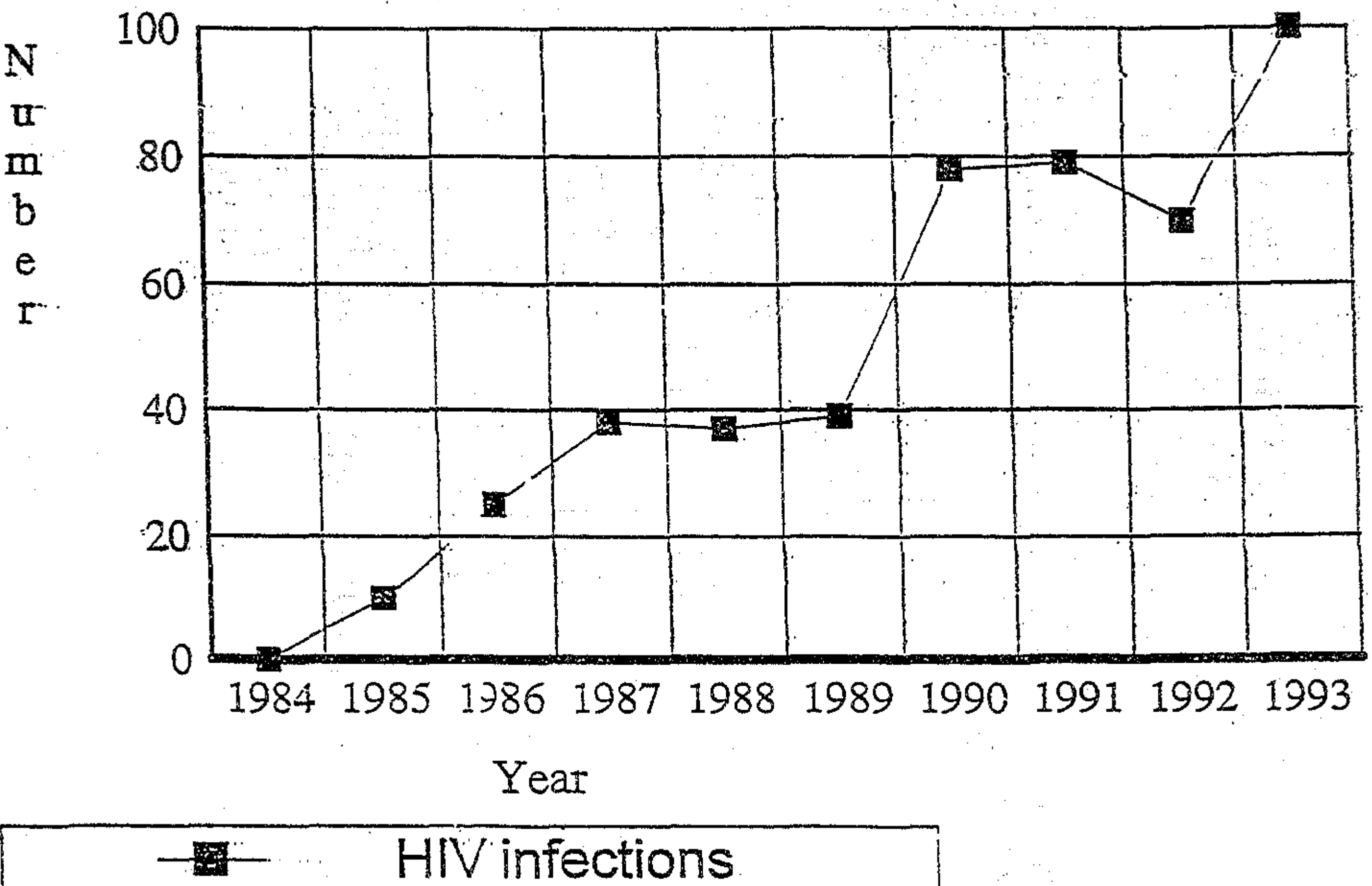
Philippines, as December 1993



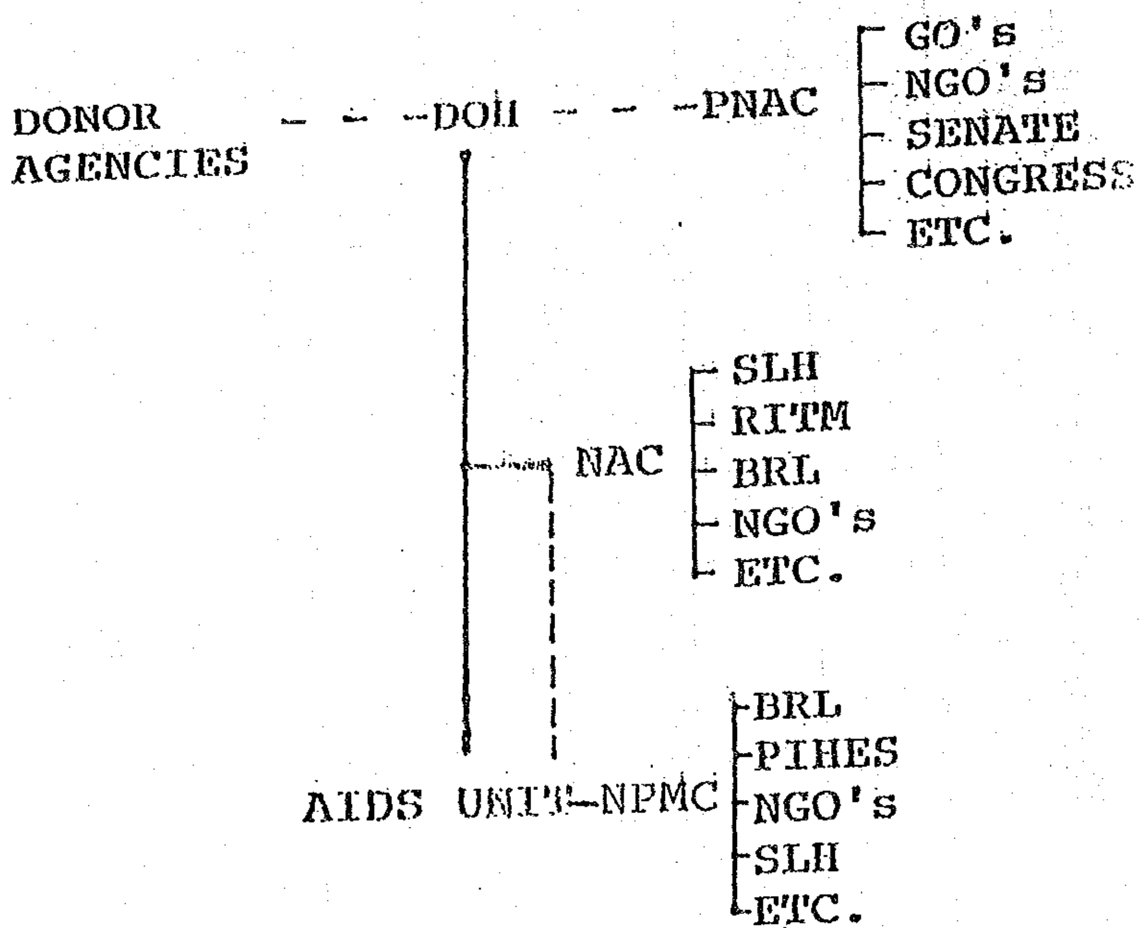
HIV infections by mode of transmission

Philippines, as of December 1993



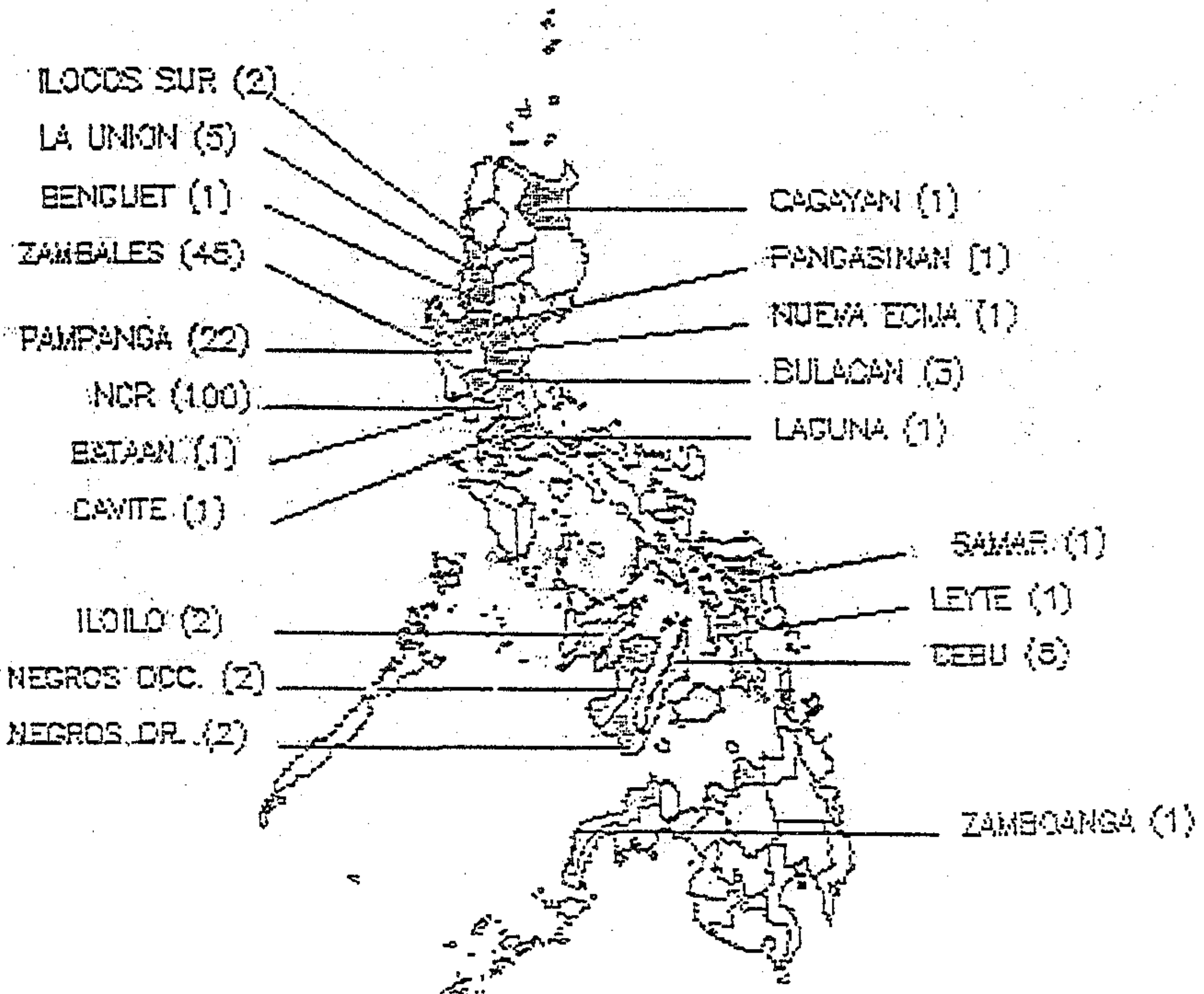

Reported HIV Infections by Year
Philippines, as of December 1993
Number
100
80
60
40
20
0
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
Year
HIV infections

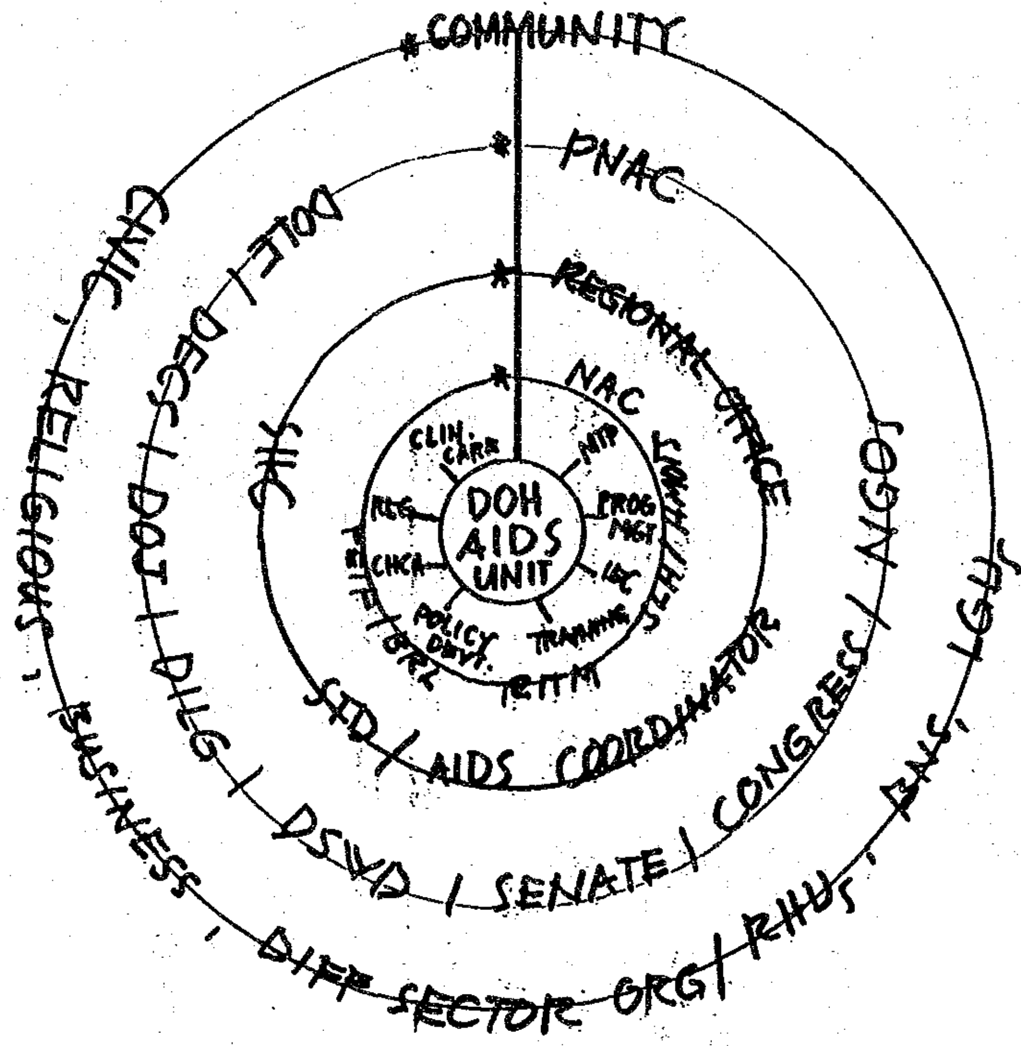
ORGANIZATIONAL STRUCTURE



Geographical Distribution of Reported HIV Infections

AIDS REGISTRY, 1984 – June 1992




*COMMUNITY
*PNAC
*REGIONAL OFFICE
*NAC
DOH AIDS UNIT
CLIN. CARE
PROG MGT
IEC
TRAINING
POLICY DEVT.
STD / AIDS COORDINATOR
DOLE / DECS / DOJ / DILG / DSWD / SENATE / CONGRESS / NGOS
CIVIC, RELIGIOUS, BUSINESS, DIFF SECTOR ORG / RHUS, BNS, LGUS

PREVENTION AND CONTROL PROGRAM

LONG TERM OBJECTIVES:

1. Reduce transmission of HIV (human immunodeficiency virus) and STDs (sexually transmitted disease).
2. Prevent development of STD complications.
3. Reduce impact of HIV infection, AIDS (acquired immunodeficiency disease syndrome) and STDs on the individual, family, community and society.

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STRATEGIES:

1. Prevention of transmission of HIV and STDs thru sex, blood and perinatal routes.
2. Reduction of the impact of HIV infection and STDs on individuals, family, community, and society.

PROGRAM STRATEGIES

a. PREVENTION OF SEXUAL TRANSMISSION

- Research based * modify sexual behavior

b. PREVENTION OF TRANSMISSION THROUGH BLOOD

- Mandatory screening of all blood products

- Training and supervision of health workers

c. PREVENTION OF TRANSMISSION THROUGH INJECTIONS & SKIN PIERCING INSTRUMENTS

- Promote risks of needle sharing

14

- Guidelines for appropriate sterilization and safe handling

- Promotion of the use of disposable syringes/needles

D. PREVENTION OF PERINATAL TRANSMISSION

- Health Education (ante/post natal)

- HIV (+) - counselled against conception

E. REDUCTION OF IMPACT ON INDIVIDUALS AND SOCIETY

- Extensive counselling skills and educ. campaigns

- Tapping NGO for social support

PROGRAM/OPERATIONAL SUPPORT

1. SURVEILLANCE

   - Assessment of the current status
   - Monitoring trend of infection

2. INFORMATION, EDUCATION AND COMMUNICATION

   - Effectiveness through proper training
   - Establishment of Info. center, Hotline, Newsletter, Leaflets, etc.

3. TRAINING OF PERSONNEL

   - Staff of STD Clinics, hosp., and RHU in counselling clinical care and lab. skills

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4. LABORATORY FACILITIES

- Hospital

- STD clinics

5. STRENGTHENING OF STD PROGRAM

- Decrease the incidence of HIV

6. STRENGTHENING OF RESEARCH CAPABILITY

- Clinical Research

- Behavioural Research

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PROGRAM THRUSTS FOR '94
(HEALTH FOR MORE IN '94)

1. Training of all public health workers (physicians, nurses, dentists, med.tech., MSW) especially about basic STD/AIDS Education, epidemiology, prevention and control.

2. Focus the communication campaign strategy to identified groups practicing risky behaviors like sex workers, intravenous drug users, homosexuals. At the same time reaching the general population through tri-media.

3. Develop a comprehensive plan for STD Control including among others provision of drugs and medicines, improving the diagnostic capabilities of Social Hygiene Clinics (SHC), and changing the image of SHC into a family service-oriented clinics.

3.1 Finalization/Printing/ Distribution of STD manual of procedure

3.2 Development/Improvement of STD Reporting System

3.3 Improve/Make functional existing Social Hygiene Clinics (130 SHCs all over the country

3.4 Staff Development

3.5 Provisionb of drugs/ laboratory reports

4. Nationwide implementation of AIDS Education integration in all school levels. and in the workplace

5. Passing a bill for non-mandatory testing, non discrimination and protection of workers found to be HIV (+).

6. Develop a set-up of a community-based social support system for PWAs and PHIVs nationwide.

7. Frequent consultation with different sectors like the Philippine National AIDS Council (PNAC), AIDS Prevention and Control Committee (APCC), STD/AIDS Coordinators, NGOs, to "feel the pulse" regarding the implementation of the STD/AIDS program.

8. Promotion of condom use.

VISION FOR THE PHIL. AIDS PROGRAM

- Suitable hospital facilities and equipment for care and diagnosis
- Center of information exchange, Training and Research
- Capabilities of Regional Medical Centers to handle AIDS case
- Removal of discrimination and stigma through Mass Media Awareness
- Strengthened collaboration with different GO's and NGO's and concerned sectors.

CURRENT PROBLEMS

1. No Center for Information Research & Training

2. Inadequacy of Funds for Program Management

   * Training

   * IEC Development

   * Support Activities

3. No adequate facilities for National, Regional Testing Capabilities

4. No Appropriate Hospital for National/Regional Networking

MATRIX OF ACTIVITIES

STD/AIDS UNIT

ACTIVITY \ GROUP & BUDGET	RITM 5.6M	HMDTS 3.6M	SLH 5.1M	HIS	FETP 4.9M	PIHES .4M	AIDS 8M	OSC	HOMS/ BLR	DIRFO .7M	HOSPITAL	BRL	HERD ZONE	PNAC
...opment of Materials	X	X	X			X	X (circled)			X	X			
...ase Notification				X (circled)	X					X				
...ation, Public	X		X			X (circled)	X	X		X (circled)	X			
		X (circled)												
...nsing & Regulation									X HOSP (circled)			X LAB (circled)		
...ent Care	X		X (circled)							X	X (circled)			
...cy Development					X		X	X (circled)	X			X		X (circled)
...ram Dev't/Management		X					X (circled)	X		X	X		X (circled)	
...ity Assurance	X (circled)											X		
...earch	X (circled)		X (circled)	X	X							X		
...ial Services	X		X					X (circled)		X				
...veillance	X				X (circled)					X		X		
...ting	X									X	X (circled)	X		
...ining, Health Sector	X	X	X		X	X				X (circled)	X	X		
...SP. POLICY DEVT.									X (circled)					

4．熱帯医学研究所におけるエイズ関連活動

4－1　エイズ関連活動リスト
4－2　エイズ研修グループ概要
4－3　第三国研修概要
4－4　HIV検査プロフィシエンシー

4－1　エイズ関連活動リスト

SUMMARY
OF
AIDS-RELATED ACTIVITIES OF THE
DOH-RESEARCH INSTITUTE FOR TROPICAL MEDICINE (RITM)

I. Surveillance

POPULATION	DATE	STATUS
A. Male and female sex workers in Metro Manila (Manila, Quezon City, Makati, Mandaluyong)	1985-1992	Manila completed
B. Returning Overseas Workers (With AIDS registrar)	1989	Completed
C. Blood donors (with Philippine NationalRed Cross)	1990	Completed
D. Prenatal patients (with Fabella Hospital)	1991	Completed

II. Care/Follow-up of HIV Infected/ AIDS Patients

Complete examinations upon diagnosis: regular follow-up and counselling; prophylactic and therapeutic treatment during AIDS stage	1986 to present	Ongoing

III. Laboratory

A. Serves as the National Reference Center for HIV Testing - Confirms "positive" tests from private laboratories	1987 to present	Ongoing
B. Evaluates HIV Test kits prior to licence for distribution by the Bureau of Food and Drugs	1988 to present	Ongoing
C. Performs special HIV tests such as p24 antigen, CD counts, viral serology, etc.	1987 to present	Ongoing
D. Conducts proficiency workshops for Medical Technologists for accreditation of private laboratories prior to performing HIV antibody testing	1988 to present	Ongoing
E. Performed studies to determine cost-effectivity of using	1990	Completed

(1) Pooled sera and
(2) Filter paper collected blood for HIV testing

F. Evaluated testing practices of laboratories in Metro Manila	1991-1992	Completed
G. Participates in International Quality Assessment programs	1988 to present	Ongoing

IV. Educational Activities

A. Lectures, talks at international, national and local meetings averaging 200/year	1985 to present	Ongoing
B. Health Education/Intervention Program on AIDS/STDs among male and female commercial sex workers (CSW) in Metro Manila	1989-1990	Completed
C. Health Education strategy for health workers in Metro Manila	1990	Completed
D. AIDS Education for High School Students (Pasay, Paranaque, Makati and Las Piñas)	1992-1993	To be completed
E. Health Education for Overseas Workers - Seminars for departing workers (15 agencies) and workshop for management	1993	Completed report pending
F. Development of Model AIDS/STD Counselling and Education among CSWs in Mandaluyong	1993-1994	Ongoing
G. separate Courses (2-1/2 to 5 days) for Physicians, Nurses, Social Workers and Counsellors	1991 to present twice yearly	Ongoing
H. Participation in talk shows on T.V., radio and press conferences locally and international	1985 to present	Ongoing

V. Economic

The Medical Economic Impact of AIDS in the Philippines	1993	Ongoing

VI. Assistance in Livelihood Project for HIV infected patients	1991 to present	Ongoing

SIGNIFICANT OUTPUT OF RITM AIDS PROJECTS

I. Surveillance

1. HIV Seroprevalence of 1 per 1000 among CSWs found during the period of study

2. Collection of behavioral information among CSWs

3. Surveillance of overseas workers in 1989 revealed an infection rate of 1 per 1000

4. No infection was detected among other population groups

II. Care and Management

1. Continuous follow-up and appropriate treatment of infected patients from time of diagnosis

2. Determination of the laboratory and clinical picture of AIDS among Filipinos

3. Demonstration of pathology seen in AIDS patients on post mortem examinations

4. **Demonstration that tuberculosis is the most common serious infection among Filipinos with AIDS**

5. Development of protocol for managing AIDS patients

6. Counselling of HIV infected patient, family and friends

III. Laboratory

1. Confirms "reactive" sera referred by private laboratories

2. Evaluates HIV test kits

3. Performs special HIV tests

4. Trains private laboratory Medical Technologists

5. Has developed a quality assessment program for national use

6. Has shown that using pooled sera for HIV tests is very economical (75% savings). Data was used by WHO in drafting guidelines on the use of pooled sera.

7. Has shown that filter paper collected blood can be used for HIV test and is practical for remote areas in the Philippines

IV. Health Education

1. Health Education (HE) program for CSWs showed that AIDS knowledge and awareness improved and condom use increased. However, a high prevalence of sexually transmitted diseases (STDs) was seen prior to HE. Inconsistent condom use however led to continuing STDs indicating HE should be a continuing process. This led to the formulation of the peer education strategy.

2. HE program for CSWs also showed that the N. gonorrhea isolated from CSWs is highly resistant to penicillin (70% prevalence of resistance).

3. The HE program showed that private STD clinic practices need to be improved.

4. HE program for health workers resulted in improvement of knowledge, attitudes and practices. The latter was not sustained indicating the need for a continuing program.

5. The HE program for overseas workers revealed unanimous acceptance with enthusiasm by all subjects and excellent support by almost all recruiting agencies.

6. The remaining HE economic programs/study are either under analysis or still in the data collection phase.

4 － 2　エイズ研修グループ概要

AIDS RESEARCH GROUP ACTIVITIES

NATIONAL AIDS PREVENTION AND CONTROL PROGRAM OBJECTIVES

To reduce the incidence of HIV infection, and to reduce the impact of HIV and AIDS within the family, the community and the society.

PROGRAM COMPONENTS

1. Surveillance
2. Clinical Management and Care
3. Laboratory Services
4. Communications and Health Education

THE NATIONAL REFERENCE CENTER FOR HIV TESTING

FUNCTIONS:

1. Confirms HIV seroreactive samples from primary HIV screening laboratories

2. Evaluates HIV diagnostic kits for initial registration with BFAD

3. Involved in epidemiologic surveillance of HIV infection among population groups at risk

4. Work-up of HIV infected/AIDS cases

5. Conducts laboratory-based research activities

6. Provides training for laboratory professionals on HIV testing and other tests utilized in the work-up of HIV infected cases

I. SURVEILLANCE:

A. Sex Workers

B. Overseas Workers

C. Blood Donors

II. CLINICAL MANAGEMENT AND CARE

A. Management of HIV-infected/AIDS individuals

B. Co-factors for HIV Disease Progression

C. Alternative Livelihood Project

D. Economic Implications of HIV infection/AIDS

III LABORATORY SERVICES:

A. National Reference Laboratory

B. Cost-Effective Methods for HIV Testing

  1. Use of Pooled Sera

  2. Filter Paper Collected Samples

C. Proficiency Workshops for HIV Testing

IV. COMMUNICATIONS AND HEALTH EDUCATION

A. Commercial Sex Workers

B. Overseas Contract Workers

C. Health Care Workers

D. Adolescents: Students

E. Govt./Private Groups and Organizations

A. COMMERCIAL SEX WORKERS

1. Focus Group Discussions
2. Seminars
3. IEC Materials
4. STD Management
5. Condom Distribution
6. Peer Education/Counselling

B. OVERSEAS CONTRACT WORKERS:

1. Seminars
2. Role Plays
3. Dilemma Situation
4. Headbands Simulation
5. Traveller's Kit
6. Video Film
7. IEC Materials

C. HEALTH CARE WORKERS

1. HIV Testing Proficiency Workshops (MT)
2. Case Management Conferences (w/ SLH)
3. Structured Courses for MDs, RNs, Social Workers
   * Lectures
   * Role Plays
   * IEC Materials
   * HIV/AIDS Computer Tutorial Session

D. Adolescents: High School Students

1. Teacher's Guide Manual
2. Flip Charts
3. Audiotapes
4. Teacher's Training

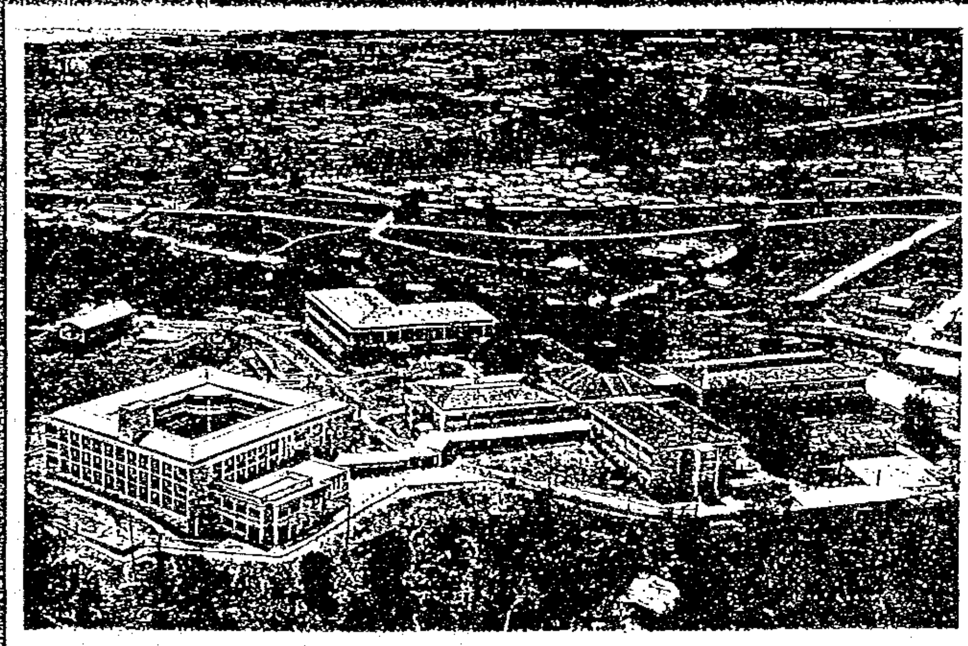
C. HEALTH CARE WORKERS :

1. HIV Testing Proficiency Workshops (MT)
2. Case Management Conferences (w/ SLH)
3. Structured Courses for MDs, RNs, Social Workers
   * Lectures
   * Role Plays
   * IEC Materials
   * HIV/AIDS Computer Tutorial Session
4. TCTP - HIV Testing Workshop

4 － 3　第三国研修概要

THIRD COUNTRY TRAINING PROGRAMME
in the
FIELD OF TROPICAL MEDICINE

GENERAL INFORMATION ON THE
GROUP TRAINING COURSES
ENTITLED
"WORKSHOP ON THE LABORATORY DIAGNOSIS
AND RESEARCH TECHNIQUES IN
ACUTE RESPIRATORY INFECTIONS (ARI),
DIARRHEAL DISEASES (DD) AND
HUMAN IMMUNODEFICIENCY VIRUS (HIV)
INFECTION"



THE GOVERNMENT OF THE REPUBLIC
OF THE PHILIPPINES
WITH THE TECHNICAL COOPERATION OF THE
GOVERNMENT OF JAPAN

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INTRODUCTION

In view of recent advances in medical laboratory technology, group training courses entitled "Workshop on Laboratory Techniques in Acute Respiratory Infections, Diarrheal Diseases and Human Immunodeficiency Virus, (hereinafter referred to as the "Workshops") are being offered by the Research Institute for Tropical Medicine (RITM), Department of Health, Republic of the Philippines, in cooperation with Japan International Cooperation Agency (JICA).

RITM, the research arm for infectious diseases of the Department of Health, was established in 1981 with a grant-in-aid from the Government of Japan. The Institute was supported by the Technical Cooperation Project which was implemented through JICA. The plan for the Workshops was formalized in the Record of Discussions between the Japanese Consultation Team and the RITM Advisory Committee on 31 October 1986. This agreement called for a 5-year annual programme which consisted of workshops on ARI and DD given at yearly intervals alternately from 1987 to 1991. In July 24, 1992, the Government of Japan granted a 5-year extension of the program from 1992-1996. This year (_____), the workshop will be conducted on _______________.

A. INFORMATION ON TRAINING COURSES

A-1. RATIONALE

The epidemiology and clinical features of infectious diseases vary among regions and countries according to their particular environments. Precise information on diseases is essential to proper health care. This entails having adequate and reliable means of confirming disease by laboratory diagnostic procedures. The Workshops aim to serve the needs of developing countries in this part of the world. They focus on the application of modern medical laboratory technology in ARI and DD, which are among the leading causes of morbidity and mortality in the region. In addition, in view of the increasing public health importance of HIV infection in the region, the extended program will now include training on HIV testing.

A-2. PURPOSE

The purpose of the Workshops is to provide the opportunity for updating knowledge and improving skills in the diagnosis of ARI, DD and HIV.

A-3. OBJECTIVES

At the end of the Workshops, the participants are expected to be able to:

a) perform laboratory procedures for the isolation and identification of causative organisms,
b) perform rapid antigen detection of etiologic agents directly from clinical specimens by means of reliable and specific technology,
c) perform antibody detection for diagnosis by using appropriate technology,
d) perform drug susceptibility tests,
e) analyze contaminated food samples (for DD workshop only),
f.) do bacteriological test for water potability (for DD workshop only),

g) perform HIV testing reliably and accurately,
h) to be able to apply cost-effective approaches in the detection of HIV infection, and
i) act as trainors to impart skills and knowledge to others working with them.

A-4. DURATION

The Workshop on ______________________ will be held from ____________________ to________________________. The Workshop on HIV will be from ____________________ to____________________.

A-5. VENUE

The Workshop will be held at the:
Research Institute for Tropical Medicine
Department of Health Compound
Alabang, Muntinlupa, Metro Manila
Philippines

A-6. LANGUAGE OF INSTRUCTION

The Workshop will be conducted in English.

A-7. CURRICULUM

The curricula of the Workshops are presented in Appendices I A-C. They consist of twenty-five (25) percent lectures and seventy five (75) per cent bench work.

A-8. WORKSHOP ACTIVITIES AND SCHEDULE

The schedule of activities of the Workshop is presented in Appendix II.

A-9. PARTICIPATING COUNTRIES

The countries invited to nominate candidates are as follows:
Brunei, Cambodia, Fiji, Hongkong, Indonesia, Laos, Malaysia, Papua New Guinea, People's Republic of China, Republic of Korea, Singapore, Solomon Island, Sri Lanka, Thailand, Tonga, Western Samoa, Vanuatu, Vietnam and the Philippines.

A-10. NUMBER OF PARTICIPANTS

Each country is requested to nominate three (3) candidates indicating their priority status for consideration by a duly designated Selection Committee at RITM. *The total number of participants from the above-mentioned countries shall be twelve (12).*

A-11. CERTIFICATE OF TRAINING

Participants who successfully complete the Workshop on ARI/DD/HIV will be awarded a Certificate of Training.

B. ADMISSION REQUIREMENTS

B-1. QUALIFICATIONS OF APPLICANTS

To be eligible for admission, the applicants should:

a) be nominated by their respective governments in accordance with the procedures as specified in B 2, below,
b) have at least a B.S. degree in Medical Technology or its equivalent, M.D. or related profession,
c) have work experience of more than two (2) years in a bacteriology and /or virology laboratory,
d) be involved in health research, training, or diagnostic services,
e) be under forty (40) years of age as a general rule,
f) have a good command of English,
g) be in good physical and mental health, and
h) not be in the 8th - 9th month of pregnancy.

B-2. PROCEDURES FOR APPLICATION

a) Governments wishing to participate in the Workshop on ARI/DD/HIV shall forward five (5) copies of the Application Form A. 2-3 (Colombo Plan for Technical Cooperation) for each nominee to the government of the Republic of the Philippines through diplomatic channels not later than three months before the commencement of the workshop.

b) The government of the Republic of the Philippines will inform the nominating countries whether or not applicants are accepted to the Workshop not later than one month before the commencement of the Workshop.

C. PRESENTATION OF COUNTRY REPORTS

Participants are required to prepare a report on the epidemiological and microbiological aspects of ARI/DD/HIV in their respective countries for presentation in the Workshop. A suggested outline of the contents of the country report is provided in Appendix II.

The report must be about five (5) pages long. Manuscripts, typewritten and double-spaced, must be submitted to RITM for printing on the first week of the Workshop. Participants are requested to supplement their presentations with audio-visual aids (maps, projection slides, tables, graphs, etc.).

D. ALLOWANCES AND EXPENSES

The Government of Japan will bear the following expenses:

1) Economy class round-trip ticket between the international airport designated by JICA and the Ninoy Aquino International Airport (for foreign participants),
2) Domestic travel costs during observation tours,
3) Living allowance equivalent to P500 for board and other daily incidental expenses of foreign participants,
4) Lodging accommodation for foreign participants to be paid directly to RITM, and
5) Medical insurance for foreign participants during the workshop.

E. ACCOMMODATIONS

Participants to the Workshop will stay at:

THE RESIDENCE HALL
Research Institute for Tropical Medicine
Department of Health Compound
Alabang, Muntinlupa, Metro Manila
Tel. Nos. 842-2245
842-2828
842-2079
FAX NO. (632) 842-2245

F. REGULATIONS

Participants are advised:

1) to follow the course curriculum and schedule,
2) not to extend the training period,
3) not to bring any dependent or member of their family
4) to return to their home country on completion of the course according to the schedule set by JICA
5) to carry out such instructions and abide by such conditions as may be stipulated by both the nominating government and the Republic of the Philippines regarding the training
6) to observe the rules and regulations of the training institution or establishments in which participants will undertake study or training
7) to refrain from engaging in political activities, or any form of employment for profit or gain, or any improper act
8) to discontinue the course should they become seriously ill and be considered unable to continue the training course.

G. OTHER INFORMATION

G-1. VISA

Before leaving their countries of origin, participants should obtain visa for entry to the Philippines in their respective countries.

G-2. AIRPLANE TICKET

Participants are requested to arrive in and leave the Philippines on the dates designated by JICA. The dates will be indicated in their airline tickets.

G-3. OTHER TRAVEL EXPENSES

Participants shall assume responsibility for all other expenses incurred during the travel between their home countries and Manila.

G-4. PERSONAL EXPENSES

Participants shall make their own arrangements for any financial matter of a personal nature not provided for by JICA as in airport tax, excess baggage charge, etc.

G-5. PHOTOGRAPHS

For administrative purposes, participants are requested to bring five (5) copies of a recent photograph (passport size).

G-6. ARRIVAL PROCEDURES

Upon arrival at the Ninoy Aquino International Airport in Manila, participants are requested to observe the following arrival procedures:

a) When quarantine, immigration and customs clearance procedures have been completed, participants should proceed to the lounge leading to Gate No. 1.

b) A representative holding a placard marked with your name and "RITM" will be waiting for you. Please stay in the lounge until you find the representative of RITM.

G-7 CLIMATE IN MANILA

Monthly mean temperature and rainfall in Manila

Month	Jan.	Feb.	Mar.	Apr.	May	Jun.	
Temperature °C	26.0	26.4	27.7	29.1	29.6	28.7	
Rainfall mm	13.3	6.3	10.1	21.3	122.9	286.9	
No. of Rainy days	4	3	4	4	9	16	
Month	**Jul.**	**Aug.**	**Sept.**	**Oct.**	**Nov.**	**Dec.**	**Year**
Temperature °C	28.0	27.5	27.5	27.8	27.2	26.3	27.6
Rainfall mm	354.3	479.9	401.0	181.9	114.2	58.1	2050.2
No. of Rainy days	22	22	22	17	12	9	132

G-8. CORRESPONDENCE:

Further information concerning the Workshops is available at the following address:

The Secretariat
Third Country Training Program
Research Institute for Tropical Medicine
Department of Health Compound
Alabang, Muntinlupa, Metro Manila
Philippines
Tel. No. 842-2828
842-2245
842-2079
842-2194
FAX No. (632) 842-2245

APPENDIX I-A
COURSE CURRICULUM FOR ACUTE RESPIRATORY INFECTIONS (ARI)
YEAR _______________

SUBJECT	COVERAGE
Overview of Acute Respiratory Infections (ARI)	Magnitude of the ARI problem worldwide and various respiratory pathogens involved in ARI
Etiology of ARI and Laboratory Procedures for the Diagnosis of ARI	
1) Bacteriology	a) Culture isolation/identification of *S. pneumoniae, H. influenzae, S. aureus* and other respiratory pathogens
	b) Rapid techniques for antigen detection: Counter immunoelectrophoresis (CIE), latex agglutination (LAT), and enzymeimmunoassay (EAI)
	c) Antibiotic Susceptibility Testing

2) Virology

a) Detection of important respiratory viruses like respiratory syncytial virus (RSV), adenovirus, influenza virus types A & B, parainfluenza virus types 1, 2 and 3 by the following:
   1) Cell culture techniques
   2) Rapid antigen detection by immunofluorescence (IF) & enzyme-linked immunosorbent assay (ELISA)

b) Serologic diagnosis of ARI by EIA and other conventional methods

3) Other Important Respiratory Pathogens

a) Chlamydia pneumoniae
   1. Isolation by cell culture technique
   2. Identification by immunoflourescence

b) Mycoplasma pneumoniae
   1. Isolation and cultures
   2. Serology

c) Special staining procedures for Pneumocystis carinii

d) Legionella
   1. Culture isolation
   2. Serology

4). Important Vaccine Preventable Diseases

a) Epidemiology and clinical features of diphtheria, pertussis and measles.

b) Laboratory procedures including
   1. Isolation and identification
   2. Pertussis serology by EIA
   2. Measles serology

APPENDIX 1-B
COURSE CURRICULUM FOR
DIARRHEAL DISEASES (DD)
YEAR _______________

SUBJECT	COVERAGE
Epidemiology of Diarrheal Diseases Etiology of Diarrheal Diseases	Morbidity and mortality: global and regional perspectives; determinants of risks, nutritional sequelae & control measures
Laboratory Diagnosis of Diarrheal Diseases	
1) Bacteriology	Isolation & identification: ETEC, EPEC, EIEC, EAEC, EHEC, Salmonella, Shigella, vibrios, Campylobacter, Aeromonas, Yersinia enterocolitica
2) Virology	General diagnostic methods in virology Rotavirus detection - latex agglutination and ELISA for antigen detection & serotyping; electron microscopy; genomic RNA analysis Adenovirus detection - latex agglutination, immunofluorescence (IF) methods
3) Parasitology	Primary stool analysis: collection, concentration methods, special staining techniques, microscopic examination, stool culture, morphology/identification of the different parasitic agents of diarrhea (E. histolytica, G. intestinalis and Cryptosporidium) Serodiagnostic tests in parasitology - IFAT, IHAT, AGD, ELISA Isoenzyme analysis for invasive amoebiasis
4) Rapid Diagnostic Methods	Special laboratory techniques: RPLA for ETEC-LT, ELISA for ETEC-ST and EIEC
5) Other Capabilities	Coverage: Storage of isolates; antimicrobial susceptibility testing; bacteriologic water analysis; Investigations of foodborne bacterial diseases, culture and toxin detection of C. difficile

APPENDIX I-C
COURSE CURRICULUM FOR
HUMAN IMMUNODEFICIENCY VIRUS (HIV)
YEAR ____________

SUBJECT	COVERAGE
Nature of HIV infection	Biology of HIV, pathogenesis, and clinical picture
Epidemiology	Global & regional occurrence
Counselling	Pre-test, post-test; HIV/AIDS prevention
AIDS-related issues	Confidentiality, social, ethical and medio-legal aspects
Laboratory methods	
1) Screening tests	Enzymeimmunoassays, agglutination tests and rapid tests
2) Supplemental tests	Western Blot, Lineimmunoassay, & immunoflourescence test
Cost-effective approaches	Serum pooling Use of filter paper collected blood
	Other alternative strategies
Infection control	Laboratory safety and precautions

APPENDIX II
SUGGESTED OUTLINE OF COUNTRY REPORTS

TITLE: Epidemiological and microbiological aspects of ARI/DD/HIV in (Name of Country)

The presentation should include:

I. Background information on the country
   a. *General information on the country*
   b. Population and demographic characteristics
   c. National Health Plan
   d. Health statistics in the past three (3) years to include leading causes of *morbidity and mortality*
   e. Health care delivery system
      1. Organizational aspects
      2. Manpower resources
      3. Research and training programmes
      4. Disease and control
      5. Institutional linkages
   f. System and activities of medical or public health laboratories
      1. Kinds of examination done
      2. Number of specimens
      3. Results of examinations in a year

II. Epidemiological aspects of ________________________
   a. Morbidity and mortality rates for _______________ disease,
   b. Age and sex distribution
   c. Seasonality
   d. Country-specific risk factors

III. Microbiological aspects of _________________ disease
   a. *Most common etiologic agents of* _______________ *including most* common specific types if special typing procedures are performed
   b. General patterns of antimicrobial susceptibility of most common bacterial pathogens

IV. Problems and recommendations
(Biodata of presentor or participant and publications, annual reports if any should also be presented. Use audio-visual aids (maps, projection slides, graphs, tables, etc.)