Dr. Tayag

FIELD EPIDEMIOLOGY
TRAINING PROGRAM

Rabies Cases In San Lazaro Hospital
33rd Morbidity Week (August 13-19,1995)

FINDINGS: There were 52 rabies cases admitted to San Lazaro Hospital from January 1 to August 19, 1995. This is 33% higher compared to the same period last year. Ages of patients ranged from 2 to 78 years (median 28). Sixty-five percent were males. All of the cases died (case fatality ratio 100%). Thirty-five percent (18/52) of the cases came from NCR particularly Quezon City (7/18)[Fig.1].

DISCUSSION: Rabies is one of the oldest known and most feared of human diseases. It is primarily a disease of animals, but is occasionally transmitted to man by bites and produces encephalopathy which is always fatal. In most parts of the world, including the Philippines, domestic dogs account for most cases of human rabies. The incubation period is usually between 20 and 90 days but may vary from as short as 4 days to as long as 19 years. Symptoms of rabies (hyperactivity, disorientation, hallucination, or bizarre behavior) begin when the virus enters the central nervous system. Hydrophobia and aerophobia when present are pathognomonic.

Rabies has long been known to have a widespread occurrence in the Philippines. From 1991 to 1994, the National Epidemic Sentinel Surveillance System (NESSS) reported a total of 433 deaths from rabies. All cases were bitten by dogs. Most Filipinos have dogs as house pets with an estimated dog-to-human ratio of 1:10[1]. Frequent association with dogs and humans makes it necessary to have all dogs vaccinated against rabies.

Since rabies has a 100 percent case fatality rate, prevention is essential. Prevention would include the control of rabies in animals and the initiation of post exposure treatment (Table 1) before the onset of clinical symptoms. Immediately after a bite, scrub the wound with soap or detergent under running water for at least 5 minutes. Remove any remaining foreign material and irrigate the wound with antiseptic solutions like alcohol or povidone iodine. Each possible exposure to rabies should be evaluated by a physician. If possible, the dog's head should be brought to an appropriate laboratory for examination or the animal observed for 10-14 days.

RECOMMENDATIONS:

1. Nationwide public education on rabies transmission and prevention through the local health units and media.
2. Mass rabies vaccination of dogs in areas of high rabies incidence.

Reported by: Nicolas T. Catindig, MD
FETP Fellow

[1] Fishbein D. Rabies control in the Republic of the Philippines:benefits and costs of elimination. *Vaccine* Vol 9, Aug 1991, pp 581-587.

Figure 1. Rabies Cases by Place of Residence
San Lazaro Hospital, January 1 to August 19, 1995 (N=52)

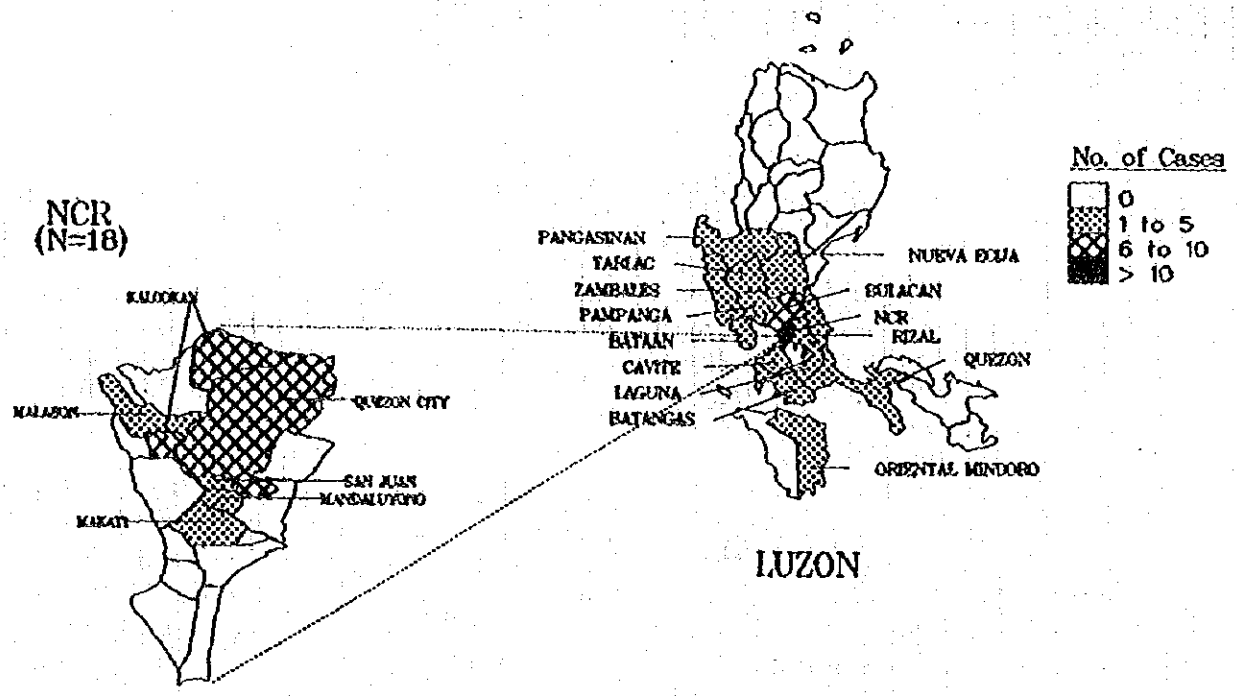


Table 1. National Rabies Control Program
Guidelines on Rabies Post-Exposure Prophylaxis

CONDITION	CATEGORY 1	CATEGORY 2		CATEGORY 3	
NATURE OF BITE OR EXPOSURE	Petting, feeding, licking of intact skin, no mucous membrane contact (Reliable History)	Category 1 with unreliable history, superficial scratch, licking of broken skin		Major bites (wounds on face, neck or finger); single, deep/multiple wounds; licking of mucous membrane	
ANIMAL CONDITION AT THE TIME OF BITE	unknown/sick/escaped/ proven rabid/ healthy animal	unknown sick escaped proven rabid	healthy animal	unknown sick escaped proven rabid	animal available for observation
MANAGEMENT	no immunization needed	vaccinate (G + V full course)	observe vaccinate (G + V full course) if animal gets sick during observation period (10 - 14 days)	vaccinate (G + V full course)	vaccinate (G + V) if animal remains healthy after observation period, discontinue V

G - globulin (passive immunization)
V - vaccine (active immunization)

SLH Sentinel Site Report
FEP, OPHS
Reporting Period: 01/01/95 to 08/19/95
As of 08/23/95

CITY / MUNICIPALITY	DIAGNOSIS						
	AFR	CHO	DEN	DIPH	HEP A	HEP B	MAL
KALOOKAN CITY	0	2	27	9	11	14	31
LAS PINAS	0	0	5	0	1	1	1
MAKATI CITY	0	1	4	3	2	2	1
MALABON	0	3	12	6	3	7	5
MANDALUYONG CITY	1	0	5	0	2	3	2
MANILA CITY	1	8	108	37	17	31	22
MARIKINA	0	0	1	1	1	2	1
MUNTINLUPA	0	0	4	0	0	1	0
NAVOTAS	0	4	9	8	1	2	12
PARANAQUE	0	2	11	1	2	2	6
PASAY CITY	0	3	4	4	1	0	1
PASIG	0	1	0	1	0	1	0
PATEROS	0	0	0	0	0	0	0
QUEZON CITY	0	5	13	11	3	9	30
SAN JUAN	0	0	2	0	0	0	0
TAGUIG	0	0	1	2	0	3	3
VALENZUELA	0	0	15	9	3	6	7
TOTAL	2	29	221	92	47	84	122

SLH Sentinel Site Report
FEP, OPHS
Reporting Period: 01/01/95 to 08/19/95
As of 08/23/95

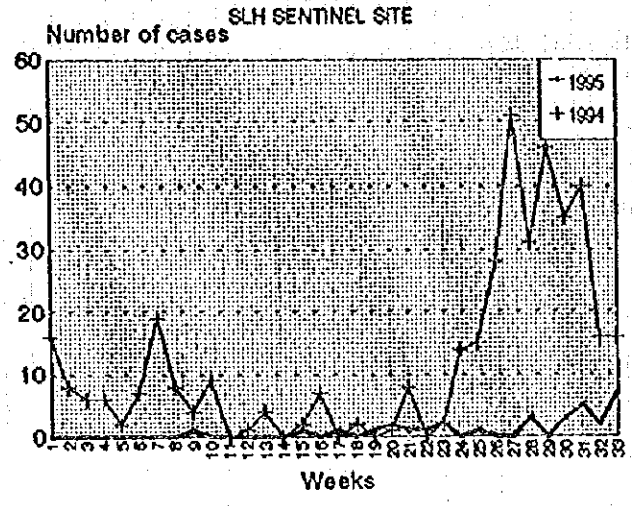
CITY / MUNICIPALITY	DIAGNOSIS						
	MEA	MEN	NEO	NON	RAB	TYP	TOTAL
KALOOKAN CITY	231	3	3	32	7	13	383
LAS PINAS	24	0	0	12	0	1	45
MAKATI CITY	15	1	0	8	1	3	41
MALABON	124	2	0	15	1	3	181
MANDALUYONG CITY	71	2	2	4	1	2	95
MANILA CITY	750	5	3	73	0	24	1079
MARIKINA	11	0	2	3	0	0	22
MUNTINLUPA	16	0	2	6	0	2	31
NAVOTAS	184	3	5	11	0	10	249
PARANAQUE	55	1	2	12	0	5	99
PASAY CITY	30	2	1	13	0	1	60
PASIG	26	0	0	6	0	1	36
PATEROS	1	0	0	2	0	0	3
QUEZON CITY	173	7	2	47	7	9	316
SAN JUAN	9	0	0	1	1	0	13
TAGUIG	32	1	1	6	0	0	49
VALENZUELA	57	0	2	17	0	3	119
TOTAL	1809	27	25	268	18	77	2821

SLH Sentinel Site Report
FEP - OPHS
Reporting Period: 01/01/95 to 08/19/95
As of 08/23/95

DIAGNOSIS	MORBIDITY WEEK 1994	1995				
	33rd Week	33rd Week	32nd Week	31st Week	30th Week	TOTAL
AFP	0	0	0	0	0	4
CHOLERA	16	7	2	5	3	32
DENGUE	34	15	8	3	11	267
DIPHTHERIA	2	3	5	0	5	119
HEPATITIS A	3	2	3	5	4	61
HEPATITIS B	0	1	0	10	5	100
MALARIA	0	2	2	1	6	262
MEASLES	27	22	23	31	18	1954
MENINGO.DIS.	2	3	0	0	3	39
NEONATAL TET.	2	1	1	1	1	30
NON-NEONATAL	11	17	26	17	14	535
PERTUSSIS	0	0	0	0	0	0
RABIES	2	0	0	0	1	52
TYPHOID	4	0	0	0	1	88
TOTAL	103	73	70	73	72	3543

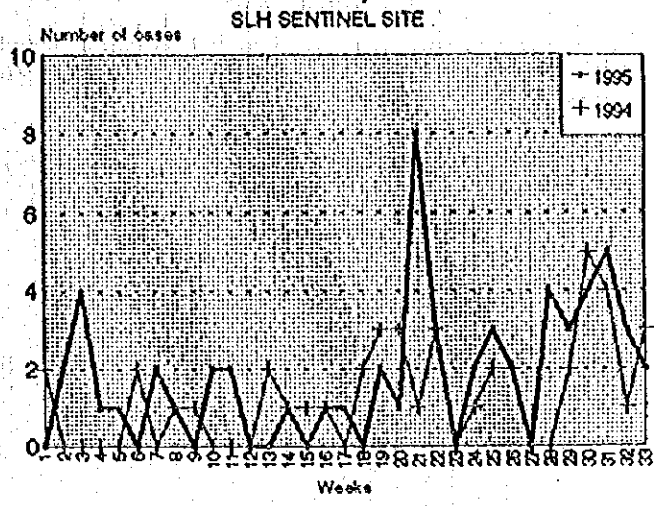
CHOLERA CASES, 1995 AND 1994

SLH SENTINEL SITE



HEPATITIS A CASES, 1995 AND 1994

SLH SENTINEL SITE



DENGUE CASES, 1995 AND 1994

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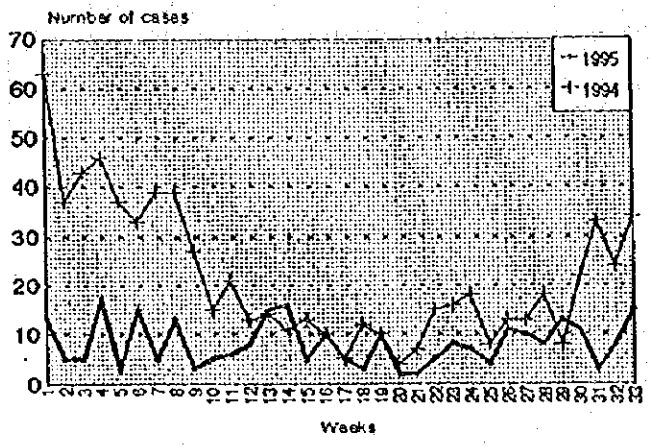

HEPATITIS B CASES, 1995 AND 1994

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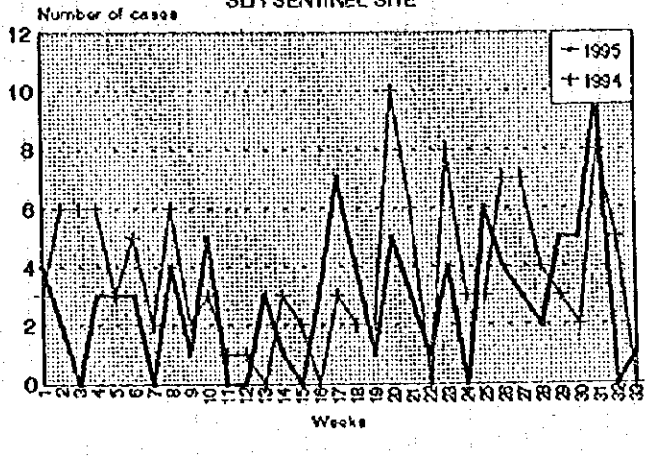

DIPHTHERIA CASES, 1995 AND 1994

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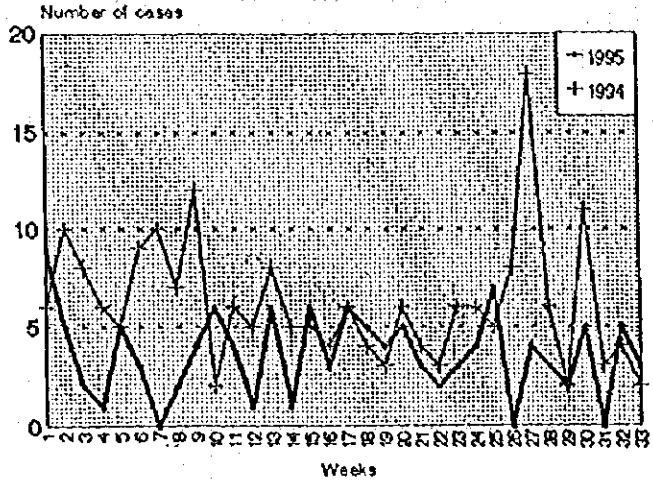

MALARIA CASES, 1995 AND 1994

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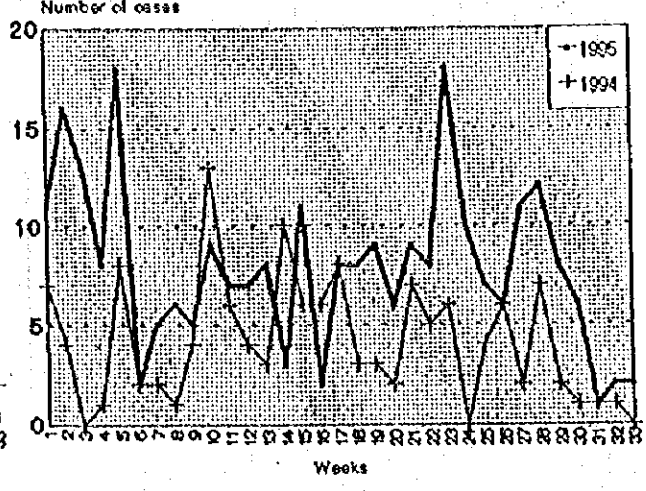

CHOLERA CASES, 1995 AND 1994

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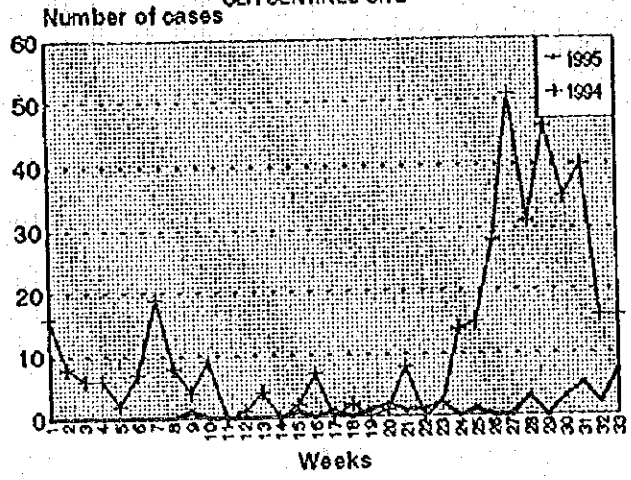

HEPATITIS A CASES, 1995 AND 1994

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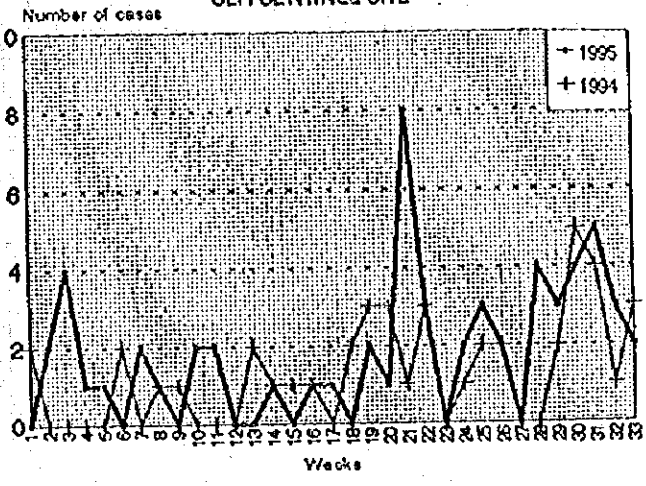

DENGUE CASES, 1995 AND 1994

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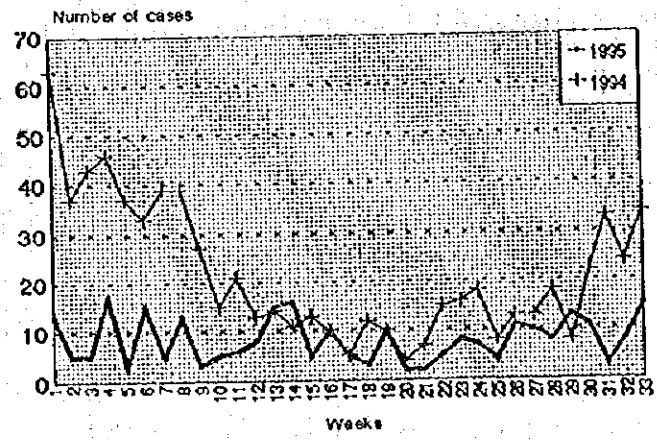

HEPATITIS B CASES, 1995 AND 1994

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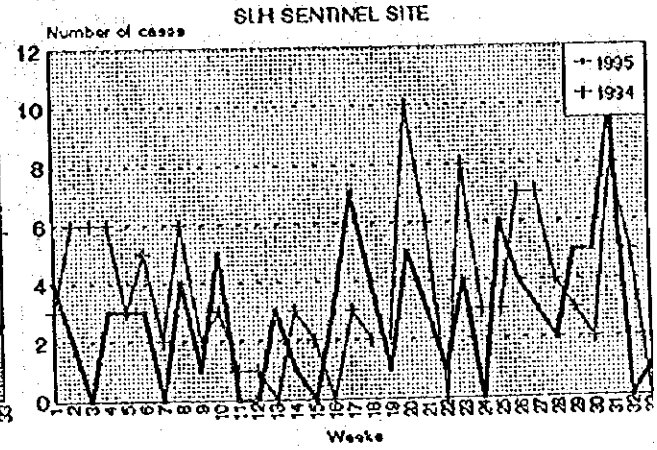

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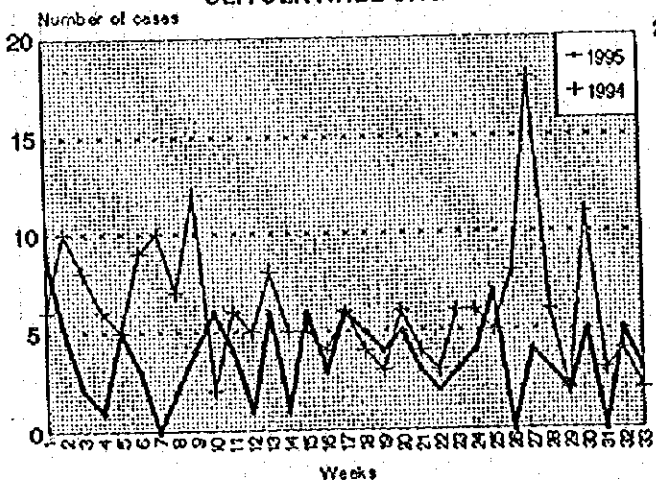

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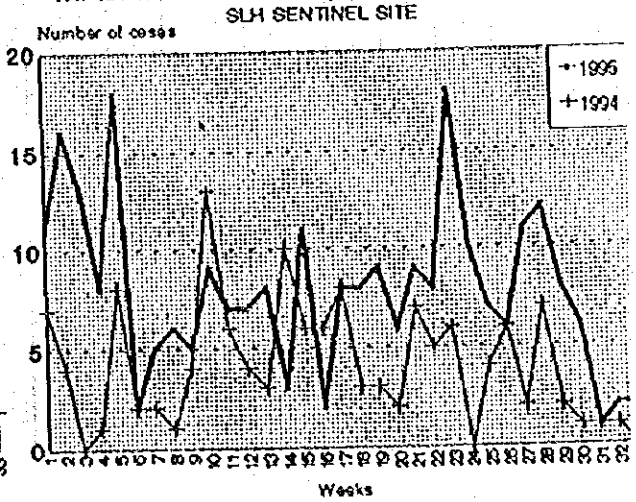


⑦ エイズ／ＳＴＤ課・1995/96 年度予算

COMPARATIVE BUDGETS FOR 1995-1996
Office for Public Health Services

NATIONAL AIDS/STD PREVENTION AND CONTROL PROGRAM

ITEM OF EXPENDITURE	1995	1996	% CHANGE	JUSTIFICATION
I. PERSONNEL	2,000,000.00	2,000,000.00		
SUBTOTAL	2,000,000.00	2,000,000.00		
II. NON				
A. DRUGS AND MEDICINES	14,000,000.00	14,000,000.00		
B. SUPPLIES AND MATLS.	3,250,000.00	3,250,000.00		
C. IEC	2,000,000.00	2,500,321.75	25	increased target groups
D. TRAINING	10,539,000.00	10,840,000.00	2.86	additional trng. for nabalarns, and. techs. & FHCN
E. MONITORING/EVALUATION	1,547,000.00	1,600,000.00	3.43	strengthen prog. mgt. and collaboration with LGUs
F. RESEARCH	1,700,000.00	3,358,438.00	97	capability building for research & dev't.
G. COMMUNICATION	250,000.00	250,000.00		
H. REPAIR OF FACILITIES	144,000.00	200,000.00	38	renovation of NAPCP office
I. REPAIR OF VEHICLES	100,000.00	100,000.00		
J. PRESS RELEASE	400,000.00	300,000.00	25	
K. TRANSPORTATION	100,000.00	150,000.00	5	
L. OTHERS	3,670,000.00	4,300,000.00	17	support for health initiatives (AIDS Unit as lead Health Hotel initiative)
SUBTOTAL	37,700,000.00	40,846,759.75	8.34	
III. CAPITAL OUTLAY	-	5,000,000.00		not enough service vehicles, computers, air-conditioning units and other equipments
SUBTOTAL	-	5,000,000.00		
TOTAL BUDGET	39,700,000.00	47,846,759.75	20.5	
PERCENTAGE BUDGET UTIL.				

biconbudget

Annex V

SPECIFIC COUNTRY PROJECT for the REPUBLIC OF THE PHILIPPINES

1 Country Background

1.1 Geography/demography/economy[1,2]

The Philippines is an archipelago of over 7 000 islands and islets lying some 960 km off the south east coast of Asia and with an area of land and sea of about 520 700 sq miles. It may be considered geographically as three main island groups. Luzon in the north is the largest island grouping and accounts for 47% of the land area, Mindanao in the south is the second largest grouping with 34%, and Visayas is a group of smaller islands between Luzon and Mindanao comprising the remaining 19% of land area.

The country is divided administratively into 16 Regions in turn divided into 76 provinces, 64 cities, 1 542 municipalities and 41 911 'barangays'.

The population (1994) is 68.6 million with an annual growth rate of 2.86% (1984-1994). 48.6% of the population is urban, an increase of 9.2 since 1984. The overall population density is 228.7 per sq km but the distribution is uneven with 13% occupying the National Capital Region which accounts for only 0.2% of the total land area. The National Capital, Southern Tagalog and Central Luzon Regions account for more than one third of the total population. The six least densely populated regions (Cordillera Administrative Region, Cagayan Valley, Eastern Visayas, Western Mindanao, Southern Mindanao and Bicol) are the least developed regions and have the poorest peace and order conditions.

The male to female ratio is 1.01:1

The country's wealth remains concentrated in the hands of a few families and the rural to urban migration is seen as a response to unbalanced development and perceived economic opportunities in urban centres. This migration exerts pressure on the urban resources and environment.

Economic growth has been continuous since the second World War with the exception of 1984 and 1985. Under martial law (1972-1980) it increased annually by an average of 6.2% and between 1986 and 1993 by 4% each year.

Social development is also inequitably distributed. Literacy, for example, is high at 93.5% (1990), but pockets of illiteracy exist in the remote barangays of nearly all provinces.

1.2 Health[3,4,5,6]

Health indicators show steady improvement with life expectancy rising from 58.4 years in 1975 to 64.6 in 1992, infant mortality falling from an average of 63 per 1 000 live births in 1977-86 to 57 in 1990 and the maternal mortality falling from 0.9 per 1000 live births in 1984 to 0.7 in 1994.

Communicable diseases are the major disease problem with the five leading causes of morbidity in 1991 being diarrhoea, bronchitis, influenza, pneumonia and tuberculosis. In the period 1981-1991 deaths from communicable disease have declined from 211.4 (34.8% of total mortality) to 126.6 (27%) per 1 000 population.

In 1992 there were 537 primary, secondary and tertiary care hospitals with 35 629 beds in the government sector and 1 095 hospitals with 36 736 beds in the private sector. Additionally there were 2 327 public health centres staffed by a doctor, nurses and midwives.

The number of medical practitioners in 1988 was 65 893.

The budget for health in 1995 is US$ 346 million (2.2% of the total government appropriation) representing US$ 5.0 per capita.

1.3 STD services[7,8]

The National STD programme

The National STD Programme was integrated into the National AIDS Programme in 1994. A second level manager has responsibility for STD and reports to the National AIDS/STD Control Programme (NASCP) manager. The STD programme until recently confined itself to organization and supervision of 130 'Social Hygiene Clinics' (SHC) which had responsibility for the mandatory periodic examination of hospitality women and entertainers for venereal disease. 83 of these are integrated into rural health units providing other health care services. The other 47 function exclusively as Social Hygiene Clinics.

Each region has an STD co-ordinator who usually has responsibilities for other health services. STD and AIDS coordination is sometimes combined. The duties of the STD co-ordinator include:

- organization and submission of SHC reports
- organization and facilitation of STD training
- monitoring of SHC activities (each clinic is to be visited at least monthly)
- liaison between the Department of Health and Local Government units

Since integration of the AIDS and STD programmes, progress has been made towards provision of routine STD care through basic health care services. With the support of WHO the national programme will train 1500 staff working in primary health care clinical services on case management of STD based on a syndromic approach.

A recently formed national STD technical committee meets regularly.

Sources of STD care

<u>Public sector</u>

130 'social hygiene clinics'	- in excess of 90% of attendances are mandatory attendances by CSW	- poor premises, limited resources, large number of attendances, limited IEC - microscopy may be available but no quality control - Gc culture, chlamydia, etc unavailable - regular syphilis serology and HIV testing of CSW - clinics highly stigmatized - small charge to CSW - drugs not supplied

STD clinics attached to gyn/obs departments	- at least one teaching hospital has an STD clinic with open access	- good laboratory support - a charge may be made - drugs must be purchased
Other public sector health facilities	- no indication of whether patients attend with STD	- basic health care workers being trained in syndromic approach - effective STD drugs not available but patients can purchase at the pharmacy
Private sector		
Private STD clinics	- many in urban centres	- vary in the facilities available; a few have Gc culture & chlamydia identification
Private specialists	- dermatologists, gyn/obs, urologists see many STD	- laboratory support at best limited to microscopy, mostly treat on clinical grounds
Other practitioners	- probably some 48 000 all of whom see STD	- treatment usually based on clinical diagnosis
Pharmacists	- estimated that 70%+ of all STD patients first line of treatment is self medication from a pharmacist	- drugs effective for STD are readily available without prescription

STD incidence and prevalence[9,10]

Official STD statistics from the Department of Health are related to the 130 Social Hygiene Clinics. The total number of STD cases reported increased from 46 947 in 1989 to 72 318 in 1991. In 1992 3 757 cases of gonorrhoea were reported. If all clinics had reported consistently extrapolation suggested that the identified cases in the SHC would have been 11 704. Based on key informant interviews a qualitative estimate of 350 000 annual cases of gonorrhoea treated in all health care sources, other than by over the counter pharmacy treatment (rate = 51.5/1 000) was made. It is probable that some 70% of all STD are, in fact, self treated and the STD burden may thus be very large indeed.

A study by the Research Institute for Tropical Medicine, in 1991, showed the prevalence of STD in female sex workers to be 51.7% and in male sex workers, 10%[11]. Prevalence studies were performed on antenatal clinic attenders and registered and unregistered sex workers by AIDSCAP in 1994[12]. The results are shown in Tables 1-3.

TABLE 1
STD PREVALENCE IN ANC ATTENDERS AT PHILIPPINE GENERAL HOSPITAL, JULY/SEPTEMBER, 1994

Aetiology	positive (n)	prevalence
gonorrhoea	2 (203)	1%
chlamydial infection	10 (178)	5.6%
syphilis	1 (203)	0.5%
trichomoniasis	1 (103)	1%
bacterial vaginosis	23 (203)	11.3%
candidiasis	21 (203)	10.3%

TABLE 2
STD PREVALENCE IN CSW IN METRO MANILA, JULY/SEPT, 1994

	registered CSW		unregistered CSW		total	
aetiology	+ve (n)	prevalence	+ve (n)	prevalence	+ve (n)	prevalence
gonorrhoea	18(256)	7%	15(55)	27.3%	33(311)	10.6%
chlamydial inf	35(245)	14.2%	16(50)	32%	51(295)	17.3%
syphilis	4(256)	1.6%	4(55)	7.3%	8(311)	2.8%
trichomoniasis	8(256)	3.1%	13(55)	23.6%	21(311)	6.7%
bacterial vag	32(256)	12.5%	4(55)	7.3%	36(311)	11.6%
candidiasis	11(256)	4.3%	4(55)	7.3%	15(311)	4.8%

TABLE 3
STD PREVALENCE IN CSW IN CEBU, JULY/SEPT, 1994

	registered CSW		unregistered CSW		total	
aetiology	+ve (n)	prevalence	+ve (n)	prevalence	+ve (n)	prevalence
gonorrhoea	11(147)	7.5%	55(150)	36.7%	62(297)	22.2%
chlamydial inf	22(145)	15.2%	45(150)	30.0%	67(295)	22.7%
syphilis	6(147)	4.1%	14(150)	9.3%	20(297)	6.7%
trichomoniasis	30(148)	20.3%	62(150)	41.3%	92(298)	30.9%

The most recent round of HIV sentinel surveillance for HIV (1995) included reagin testing (VDRL) for syphilis. The results are shown in table 4.

TABLE 4
VDRL POSITIVITY AMONGST HIV SURVEILLANCE GROUPS

Surveillance Groups	SENTINEL SITES					
	Quezon City	Pasay City	Cebu City	Angeles City	Iloilo City	Davao City
Sex Workers:						
registered female	0.33	-	0.33	9.0	1.0	1.0
freelance female	4.0	4.0	9.0	15.0	5.0	12.0
male	1.0	-	3.0	3.0	-	-
Male STD patients	-	5.0	1.0	-	5.0	0.04
MSM*	3.0	6.0	5.0	11.0	12.0	5.0
Male IDU†	1.0	2.0	5.0	-	-	-

* Men who have sex with men
† Injecting drug users
\- Indicates testing not performed

In 1990 in the National Capital Region, 1.38% of 329 894 blood donors were sero positive for syphilis. A subsection of 22 700 donations from private blood banks had 4 403 positives (19%). Private banks use many paid donors who may have particular risk factors.

Chancroid and herpes genitalis are reportedly uncommon.

Antimicrobial resistance patterns

Various studies have shown up to 75% of beta lactamase[13] producing penicillin resistant gonococci and up to 52% chromosomal resistance in non beta lactamase producers[14].

A study by AIDSCAP in 1994 in two major cities showed some reduced susceptibility of *Neisseria gonorrhoea* to ciprofloxacin in 33% of isolates and significantly reduced susceptibility (MIC > 1.0mg/ml) in 13%.

HIV situation

At 30 November 1995 the transmission categories for HIV infections were: 51.3% heterosexual, 17.8% homosexual, 0.5% injecting drug use, 1.3% blood or blood products and 1.4% by the materno foetal rate. 27.6% of the reported infections remained unclassified.

TABLE 5
HIV PREVALENCE 1988-94 - PHILIPPINES

YEAR	1988	1989	1990	1991	1992	1993	1994 (Nov 30)	Cumulative total
reported positives by year of diagnosis	35	39	68	79	69	100	88	557
HIV Incidence/ 100,000	0.06	0.06	0.11	0.13	0.11	0.15	0.13	N/A

Case management of patients with STD

The National STD Technical Advisory Committee has made recommendations on drugs and is developing case management guidelines for all levels of health care workers. A manual of procedures is in existence but is most suitable as reference document.

In the SHC is made largely on a clinical (guess made on experience and acumen) basis assisted in some places by microscopy. Education is provided and condoms are supplied.

Basic health care workers are being trained in syndromic diagnosis.

Other health care workers in private or public sectors are likely to treat clinically and case management is likely to be confined to treatment.

Drugs must be purchased and a wide selection of effective ones are available. Drugs are expensive but it would appear that most people will find resources to obtain them if necessary.

Laboratory support to STD services

Laboratory support is limited in both the public and private sector. The expertise is available in many regional laboratories but equipment, consumables and reagents are often unavailable. Screening tests for syphilis (reagin) are usually available in the public sector and readily available in the private sector. Antenatal screening for syphilis is inconsistently performed.

A few private clinics, mostly in the National Capital Region, are very well equipped and may include chlamydia identification.

The Regional Institute of Tropical Medicine has a full capability for routine STD laboratory investigations, including chlamydia identification by elisa methods, and has undertaken considerable operations research.

Non governmental STD activities

Family Health International through its sub contractor, AIDSCAP, has undertaken considerable operations research and needs assessment amongst sex workers in several cities, some of which is described above. It is presently considering its further activities.

AusAID has supported a 'Project for Model Community Health/STD Facilities in Commercial Sex Areas in the Philippines' with US$ 656 000, over two years from mid 1995, to be implemented by the NASCP with the technical support of WHO. This Project will upgrade three SHC and provide a comprehensive health care service for sex workers including reproductive health.

JICA is considering financial support to a similar project with the addition of a strong STD laboratory support component.

With encouragement from the NASCP the Philippine Society of Venereologists Incorporated was formed in 1993 and has played a major role in training and in facilitating operational research.

1.4 Socio cultural context[15,16]

Prostitution is illegal in the Philippines but tacitly acknowledged to exist by the requirement for workers in the entertainment industry to be examined for sexually transmitted disease. Sex work is common with some 43 000 registered prostitutes (1989). The number of unregistered sex workers is unknown but generally accepted as being significantly greater than that of registered. Sex workers are usually from a lower socio-economic class and many have migrated from rural to urban areas in search of a livelihood.

The requirement for women to remain celibate until marriage, the 'macho' image projected by men and the expectation that they will be sexually experienced, provides fertile ground for sex work. Twenty six percent of women, however, will have had sexual experience by the age of twenty. The equivalent figure for men is 54%.

The number of clients that a sex worker will have over a certain period seems to be considerably less than in, for instance, Thailand.

There appears to be a considerable degree of non commercial sexual networking and there are many well patronised short time hotels and lodging houses.

The strong social disapproval of homosexuality is probably lessening. Sex between men is very common. The 'bakhla' or effeminate homosexual seems to be tolerated and is not uncommonly seen at many levels of society. Bisexual behaviour or 'silahis' is certainly common in urban areas. Sex within ongoing relationships between silahis seem to be very much less common than casual sexual encounters for which there are many opportunities in parks, open spaces, rest rooms and cinemas.

In Metro Manila, at least, male sex workers are available in clubs and would classify themselves are purely heterosexual in their out of work interests.

Much commercial and non commercial sex takes place without use of condoms. Whilst one study showed that men believe condoms to be of the utmost importance when engaging in commercial sex, 72% of respondents in the same study had never used a condom with their extra marital partner[17]. Female sex workers understandably would prefer to use condoms in their work. Many use them regularly but may not if the client refuses or if the client is a regular.

Men who have sex with men have a high level of awareness of the importance of condom use but few use them consistently in a proper manner.

Many sex workers take antibiotics purchased over the counter, either prophylactically, for signs or symptoms, presumed to indicate infection, or prior to a mandatory visit to the SHC to ensure that their working card is stamped. Douching before examination is also common. The registered sex workers, who normally work from an establishment, may be required by the management to undergo an examination at a private clinic or by a doctor, retained by the establishment, after going with a client. This almost invariably leads to antibiotic treatment.

Accredited medical care is valued and readily sought in the Philippines. Consultations are not expensive - usually in the region of P 1-200 (US$ 2-4). There is an exceedingly strong sense of family in the Philippines and when in need a very wide extended family is available. This may not be so pertinent for migrant workers who are a great distance from their original birthplace.

An estimated two to three million Filipinos are employed officially or unofficially as overseas contract workers[18] and the Philippines provides in excess of 60% of the personnel for the worlds shipping industry.

Although pockets of injecting drug use have been shown in urban areas in different parts of the country it is not presently seen as a major problem.

Clearly the socio cultural environment provides a potential for rapid HIV spread. It is interesting that the Philippines remains a low HIV prevalence country as shown by the low annual reported incidence - see Table 5. Factors in explanation may include:

- a low incidence of infective genital ulceration, ie chancroid, herpes genitalis and primary syphilis
- universal male circumcision which in itself may be protective for HIV acquisition and may also protect against infective genital ulceration
- few injecting drug users
- low numbers of clients per sex worker

2.0 Project

2.1 Overall Project

The project for the Philippines follows the overall Project outline having the same objectives and outputs.

A programme already exists and programme management is to be further supported by the European Community. The areas identified as requiring support are the delivery of routine STD case management through the general health system, services for target groups particularly sex workers and surveillance. Operational research to support these components will be necessary.

2.2 Preliminary workplan and indicative budget

WORKPLAN AND BUDGET

Component	Area	Activity	Estimate	Subtotal	Comment
2.2.1 National programme development					A functioning STD programme management is in existence & is integrated with the AIDS programme. Assistance in strategy development has been provided by Ausaid and support to STD management is planned by the European Community.
	Project support staff	- expatriate medical officer for first two years only P4	220 000		The project staff will be working directly with the Nat STD Prog.
		- national project officer	24 000		The medical officer will establish the project & support the national counterpart who will take over completely in the third year. The national project officer may usefully be the national STD programme manager (Rabin ??)
		- internal travel by project staff	30 000		
	Training in programme management	- 4 staff to attend STD programme managers course	see intercountry budget		Intercountry programme manager's course to be held in Manila - see separate intercountry activity budget
	Resource allocation		40 000		Support to the project costs. Support to meetings. Support to training workshops.

	STD technical advisory group/ committee				This committee is already in existence, meeting regularly & is to receive additional support from the European Commission.
	National case management guidelines				Already under preparation by the Nat Tech Adv Comm who will also periodically review.
		- preparation of different versions of guidelines	5 000		There will be a need to adapt the guidelines for different grades of Health care worker.
		- translation into Tagalog/ local languages	2 000		Basic health care workers will benefit from local language versions - at least 4 languages.
		- publication & distribution of guidelines	15 000		Support to wide distribution of appropriate versions is important.
Subtotal for 2.2.1: National programme development				336 00	

2.2.2 Strengthening of primary health care facilities	Structural upgrading	- 12 selected primary health care facilities	36 000		Support to the development of suitable facilities for provision of primary health care services. Minimal alterations to permit patients to be seen in privacy for PHC including STD. 4 existing primary health care facilities at Barangay level will be selected in 3 sites - 1 in Metro Manila and 2 in the provinces. Selected facilities may include MCH/FPC
	Supplies & equipment	- furnishings	24 000		Sufficient to allow services to be provided eg, desks, chairs, tables, cupboards, filing cabinets, screens, etc. Couch, sterilizer, small instruments, etc.
		- clinical equipment	12 000		
		- consumables	48 000		Gloves, syringes, needles
	Drugs	- support to essential drugs programme particularly in STD	240 000		A vertical supply of the STD drugs recommended in the nat case management guidelines will be supported. Consideration will be given to establishing a revolving drug fund in accordance with MOH policy.
	Training	- workshops for training of basic providers (3)	15 000		The Nat Prog will have already completed training of many basic health workers. The trainers trained & used by them will run the 3 day Project workshops.
		travel/per diem			
		trainers fees			
		- refresher workshops (9)	18 000		A one day refresher workshop will be held in each of the 3 sites in years 2-4.
		- workshops for private health care workers (4-6)	12 000		Training for the private sector, which provides a substantial proportion of STD care, is appropriate.
		trainers fees etc			
Subtotal for 2.2.2: Strengthening of primary health care facilities				405 000	

2.2.3 Development/ strengthening of selected facilities for target groups	Structural upgrading	- 6 selected social hygiene clinics	24 000	Two 'social hygiene clinics' will be upgraded in Metro Manila and two in each of the Provinces selected for PHC strengthening. The facilities will be developed to offer a comprehensive health care service which will include STD case management. Structural changes will need to be quite considerable to improve the image of the clinics.
	Supplies & equipment	- furnishings	6 000	Sufficient to allow services to be provided eg. desks, chairs, tables, cupboards, filing cabinets, screens, etc.
		- clinical equipment	10 000	Couch, sterilizer, small instruments, etc.
		- consumables	60 000	Gloves, syringes, needles etc
	Drugs	- support to essential drugs programme particularly in STD	200 000	A vertical supply of the STD drugs recommended in the nat case management guidelines will be supported. Consideration will be given to establishing a revolving drug fund in accordance with MOH policy which would allow some cost recovery on subsidized drugs
	Training	- workshops on STD case management (3)	15 000	A 3 day workshop will be held for the staff of each of the facilities on STD case management
		- workshops on counselling etc (3)	15 000	Another workshop (3-4 days) for each facility will develop the approach to these special groups, the role of outreach & peer workers
		- refresher workshops (9)	18 000	A one day refresher workshop will be held in each facility in years 2, 3 & 4
	Outreach	- contract with NGO to identify, train and supervise peer workers for outreach	60 000	An international NGO with experience in the field will recruit and train representatives of the identified target groups as peer workers to educate, encourage the use of the facility and promote appropriate health care seeking behaviour. a curriculum for their training will be developed with consultant technical support. There will be refresher training each year and continuous supervision by the NGO. A close liaison with the facility staff will be essential.
	Technical support	- two consultant months	26 000	Technical support will be provided in training and in working with target groups
Subtotal for 2.2.3: Development of selected facilities for target groups			434 000	

2.2.4 Essential operational research	Laboratory requirements	- equipment - consumables/reagents	20 000 5 000		Much epidemiological & clinical information has been obtained by the AIDSCAP project. It will be necessary to verify that data is consistent with the situation in each site & to repeat some studies at periodic intervals. Some laboratory strengthening will be necessary in each of the three sites
	Staff training	- laboratory staff - clinical staff	5 000 3 000		If necessary training will be arranged at the Research Inst for Tropical Med in workshops. Quality control will be arranged through this Inst.
	Protocol development	- national and consultant technical support			
	Studies	- antimicrobial susceptibility - prevalence in clinic attenders groups - proportion of specific STD in syndromes	20 000		A provisional sum is set aside for operations research studies
	Data analysis	- computer support - consultant technical support	1 000		
		- publishing & distribution of results	1 000		
	Technical support	- 2 months over the Project period	26 000		
Subtotal for 2.2.4: Essential operational research				81 000	

2.2.5 Reporting and surveillance	Reporting system	- development of a sentinel site reporting protocol with consultant tech support - development & procurement of reporting forms etc - reporting expenses	 2 000 4 000		Presently STD reports come only from the social hygiene clinics. A system of sentinel reporting from representative sites in the public & private sector will be developed. It will be piloted in the straightened facilities together with other facilities with Ausaid STD activities. Support will be given to the Nat Prog in setting up the reporting system
	Studies	- periodic etiologic surveys in some of the selected facilities - staff training - support to laboratory - support to prevalence & antimicrobial susceptibility studies (see 2.2.4)	20 000		
	Technical support	- one consultant month over the Project	13 000		
Subtotal for 2.2.5: Reporting and surveillance				39 000	
2.3 Monitoring & evaluation	Development of a monitoring system	- identification of indicators - setting of targets - development of monitoring protocol			This will be undertaken by the Project staff
	Implementation of monitoring	- continuous monitoring process	12 000		
	Evaluation	- annual internal review	4 000		The responsibility of the Project officer
Subtotal for 2.3: Monitoring & evaluation				16 000	

2.4 Miscellaneous expenses	Transport	- project vehicle	20 000		
		- maintenance & running costs	20 000		
	Attendance by Project staff at international symposia	- travel			Within the Region as far as possible
		- per diem	10 000		
	Contingency	10% of total	136 100		
Subtotal for 2.4: Miscellaneous expenses				186 100	
WHO Programme support costs - 13%				194 600	
TOTAL ESTIMATED COSTS FOR PROJECT OVER 4 YEARS (calculated at 1995 costs)					1 691 700

2.3 Contribution by the Government of the Republic of the Philippines

It is assumed that the Government of the Philippines will provide the following resources for this project:

- furnished office accommodation with public utilities for the project staff
- secretarial assistance to the project staff
- suitable accommodation and utilities for workshops and other training activities
- suitable health facilities and public utilities for the primary health care component
- medical nursing and support staff for the primary health care component
- suitable health facilities and public utilities for the target group component
- medical, nursing and support staff for the target group component
- laboratory facilities and utilities for the operational research component
- technical and support staff for the operational research component
- suitable staff to support the reporting and surveillance component

3.0 Other factors

1.0 Sustainability

The Philippines has a well established National AIDS and STD Programme. It has undertaken a broad training project for STD physicians. There is an understanding of the public health importance of STD and a commitment within the Ministry of Health to develop the STD programme and services. This project encourages delivery of services through the general health care system in order to facilitate access to effective and acceptable STD care. Syndromic case management will be promoted as a low cost, realistic alternative to expensive and impractical aetiological, laboratory based, diagnosis. It is, therefore, very much in keeping with the overall STD/HIV strategy of the Philippines and it is reasonable to expect that there will be a long term, sustainable outcome.

This project should provide an example of best practice which can be extended to other parts of the country.

2.0 Social appraisal

2.1 Economic status of beneficiaries of the project.

It is the poor who have the greatest problems coping with the effects of STD and the catastrophic impact of AIDS. This project will deliver benefits to many individuals, at all levels of society, but will particularly focus efforts towards those disadvantaged groups particularly vulnerable to STD, including HIV.

2.2 Gender issues

STD have greater potential for causing suffering in women because symptoms frequently present later in them than in men. Complications and permanent sequelae are very much more common in women. In addition low priority is given to their health and their economic abilities are limited. Thus STD services may be expected to be of particularly benefit to women.

One of the areas for strengthening will be STD services for sex workers which will also particularly benefit women.

2.3 Environmental issues

There are no significant environmental implications.

4.0 Risks and assumptions

REFERENCES

[1] Gaccad EG, Cruz M. The Philippines. In: Monograph on STD in Asia & the Pacific. East West Centre for Population Studies, Hawaii. In press

[2] The Philippines Country Profile, Internal Planning Service, Department of Health of the Philippines, June 1995

[3] The Philippines Country Profile, Internal Planning Service, Department of Health of the Philippines, June 1995

[4] Philippine Health Situationer, Health Intelligence Service, 1994

[5] Current Trends in Health Human Resources Development, Southeast Asian Information Centre, TRF Survey Findings, 1993

[6] SEAMIC Health Statistics, International Foundation of Japan. 1990

[7] Gaccad EG, Cruz M. The Philippines. In: Monograph on STD in Asia & the Pacific. East West Centre for Population Studies, Hawaii. In press

[8] Gallwey J, unpublished mission report, Republic of the Philippines, WHO/GPA Western Pacific Regional office, 1993

[9] Gaccad EG, Cruz M. The Philippines. In: Monograph on STD in Asia & the Pacific. East West Centre for Population Studies, Hawaii. In press

[10] Gallwey J, unpublished mission report, Republic of the Philippines, WHO/GPA Western Pacific Regional office, 1993

[11] OT Monzon, RT Santana et al; The Prevalence of Sexually Transmitted Diseases and Human Immunodeficiency Virus among Filipino Sex Workers. J Phil Microbiol Infect Dis 1991. 20 (2): 41-44

[12] Wi TE; AIDSCAP Resident Adviser in the Philippines, Personal Communication: May 1995

[13] Wi TE; AIDSCAP Resident Adviser in the Philippines, Personal Communication: May 1995

[14] Clendennen III TE et al. In Vitro Antibiotic Susceptibilities of *N gonorrhoeae* Isolates in the Philippines. Antimicrobial Chemother, 1992

[15] Gallwey J, unpublished mission report, Republic of the Philippines, WHO/GPA Western Pacific Regional office, 1993

[16] Gaccad EG, Cruz M. The Philippines. In: Monograph on STD in Asia & the Pacific. East West Centre for Population Studies, Hawaii. In press

[17] D'Aknes L, Aquino C. Sexual Practices and Partners of Urban Filipino Males: Implications for Intervention Programmes. 1995

[18] Manthey G, Technical Officer, National STD/AIDS Programme, Republic of the Philippines. Personal communication.

⑨ USAID・エイズサーベイランス及び教育プロジェクト（ASEP）

AIDS Surveillance and Education Project (ASEP)

The AIDS Surveillance and Education Project (A.I.D. Project No. 492-0473) was authorized on July 20, 1992. The five-year bilateral project will extend from 1992 to 1997. USAID/Manila will provide $10 million in Development Assistance grant funds, and the Government of the Philippines (GOP) will contribute the Peso equivalent of $2.3 million over the life-of-project. The GOP Department of Health (DOH) is the lead implementing agency.

The goal of ASEP is to control HIV/AIDS transmission within the Philippine population. The project purpose is to institutionalize public and private sector mechanisms for monitoring HIV prevalence, and encourage behaviors which reduce individual risk for contracting or transmitting HIV. The goal and purpose of ASEP support the objectives of the first and second Medium Term Plans (MTP1, MTP2) of the National AIDS Prevention and Control Program for the Philippines (NAPCP).

A sentinel surveillance system for monitoring HIV sero-prevalence in the Philippines is being implemented under the surveillance component of ASEP. Mass media, and information, education and communication (IEC) programs which help reduce HIV transmission among individuals at risk are being implemented under the education component of the project.

The AIDS Surveillance and Education Project (ASEP) supports key components of overall Philippine strategy:

National HIV Sentinel Serologic Surveillance
ASEP is establishing the National HIV Sentinel Surveillance System at strategically located geographic sites throughout the country to monitor groups likely to practice high-risk behaviors, including male and female CSWs, male STD patients, men who have sex with men and intravenous drug users.

Technical Assistance to AIDS/STD Prevention Programs
The Program for Appropriate Technology in Health (PATH) through the Education component of the ASEP, has continued to strengthen the capacity of the DOH to develop and oversee implementation of a primary Prevention AIDS information, education and communication (IEC) Strategy. Operations plans for implementation of strategy activities were developed and initial target groups and geographic areas for HIV education have been selected.

Educational Outreach Projects by NGOs.
USAID supports NGO subprojects in Metro-Manila, Angeles City, Cebu and Davao, which provide HIV outreach education, behavior change communications and other HIV prevention activities.

Multimedia Campaign
John Hopkins is implementing a ten-month campaign directed at the entire Filipino population with particular emphasis on sexually active adults and teenagers. This strategy combines mass media and public relations activities to achieve dissemination of accurate information on AIDS, publicize the efforts of the DOH, local government units (LGUs) and NGOs to prevent and control HIV/AIDS in the Philippines, and to strengthen the participation of NGOs and other concerned groups in the national effort to prevent and control the spread of HIV/AIDS.

Support for an All Voluntary Blood Banking Program
As a result of a USAID-funded field survey undertaken from September 1993 to January 1994, which confirmed that potentially infective blood is circulating within the blood transfusion system, activities of the Philippine Department of Health to develop and implement a safe blood banking program are being supported.

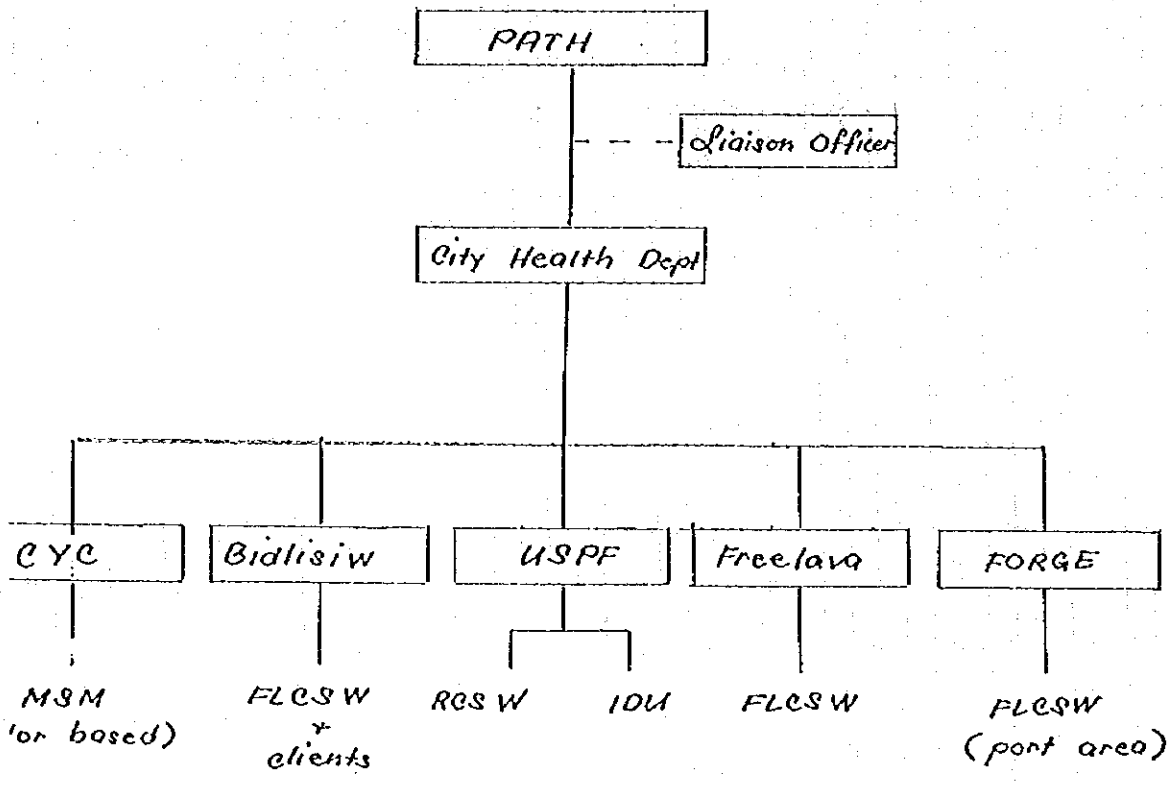
AIDS Phil-Thai Technical Exchange Program.
USAID is providing assistance for study tours to Thailand by member of the Philippine AIDS Council (PNAC) and the DOH/LGU/NGO HIV/AIDS Surveillance teams to participate in learning experiences on Thai HIV/AIDS prevention and control strategies.

⑩ PATHのセブにおける組織図

STD-HIV/AIDS PREVENTION AN EDUCATION PROGRAM

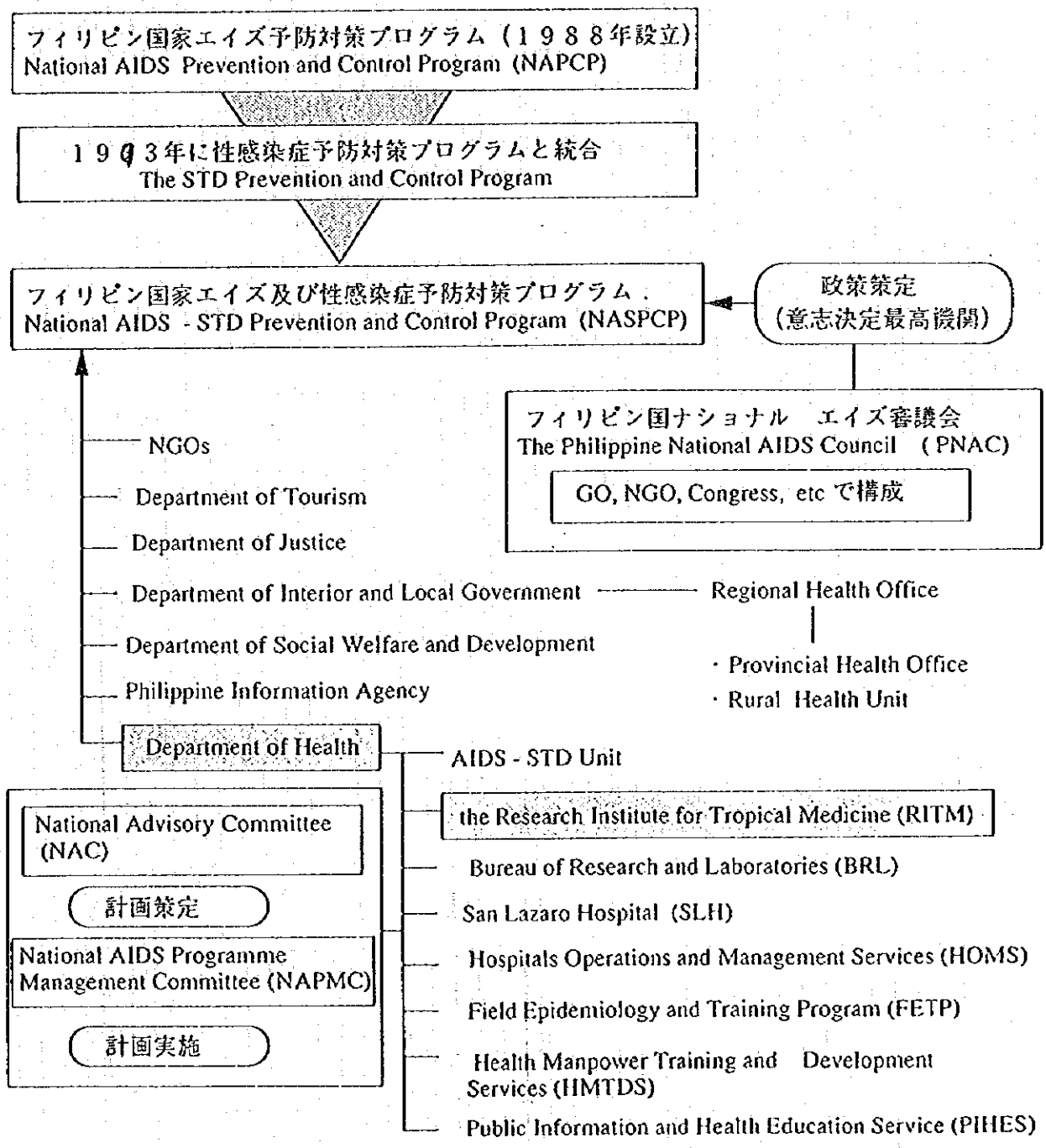
JECT : Aids Surveillance & Education Project

NOR : Program for Appropriate Technology in Health

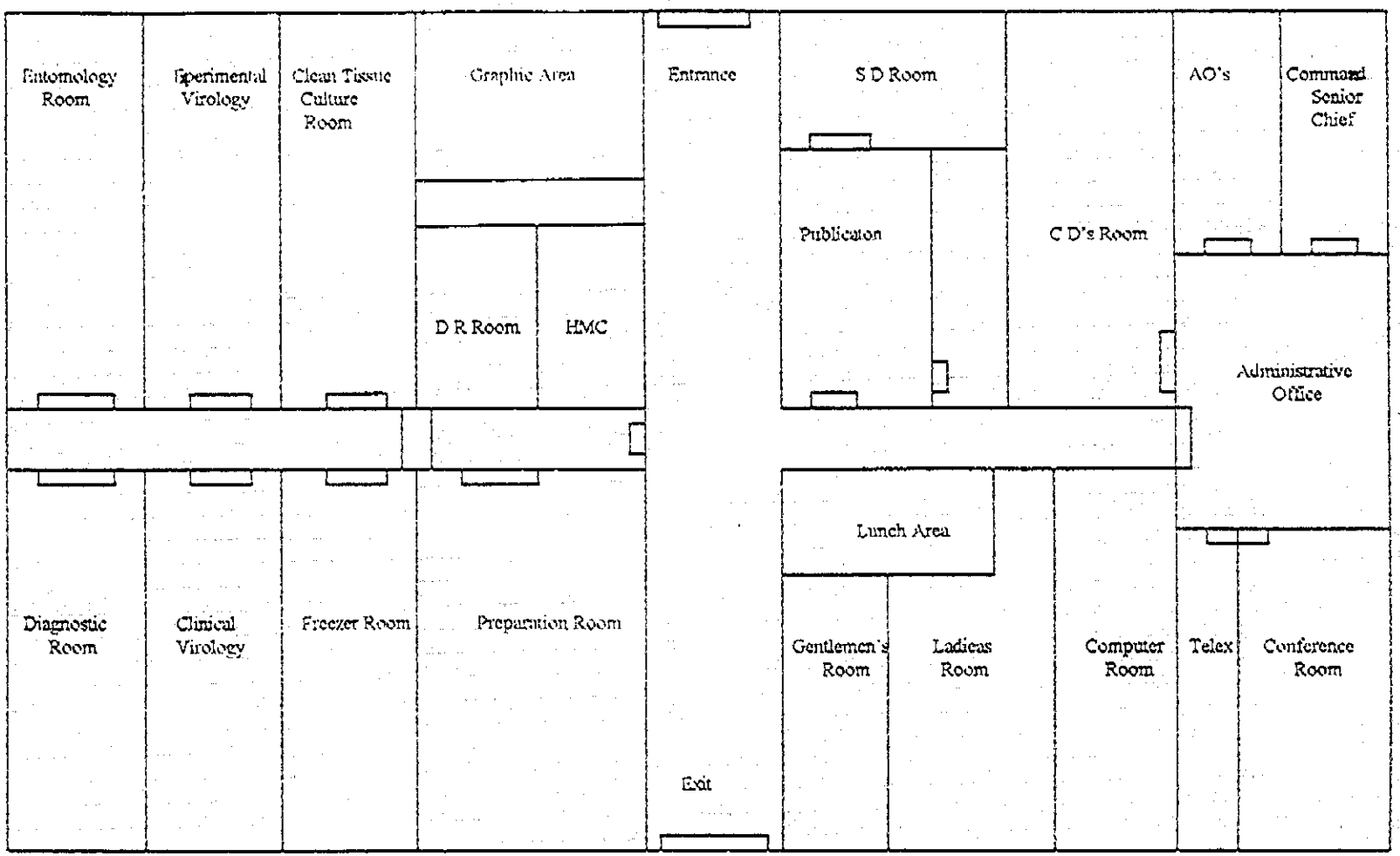


⑪ フィリピン国エイズ等性感染症対策実施体制

フィリピン国　エイズ等性感染症対策実施体制

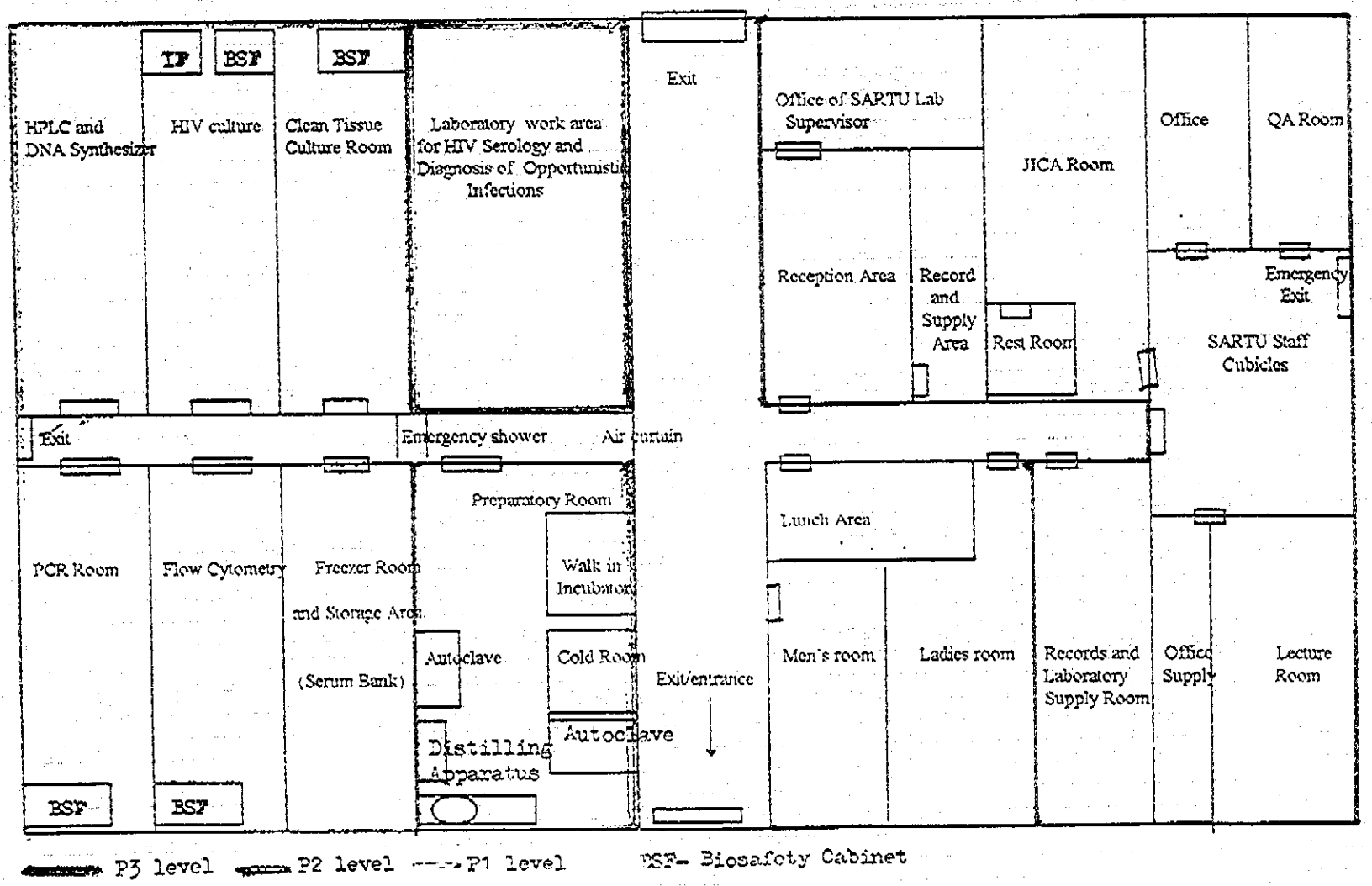


旧 NAMRU ラボラトリー現在の平面図



旧 NAMRU ラボラトリー改修案

PROPOSED SARTU PHYSICAL PLAN



BACKGROUND: STD Control Program

- under the Communicable Disease Control Service
- integrated into the NAPCP in 1993

STD SERVICE INFRASTRUCTURE

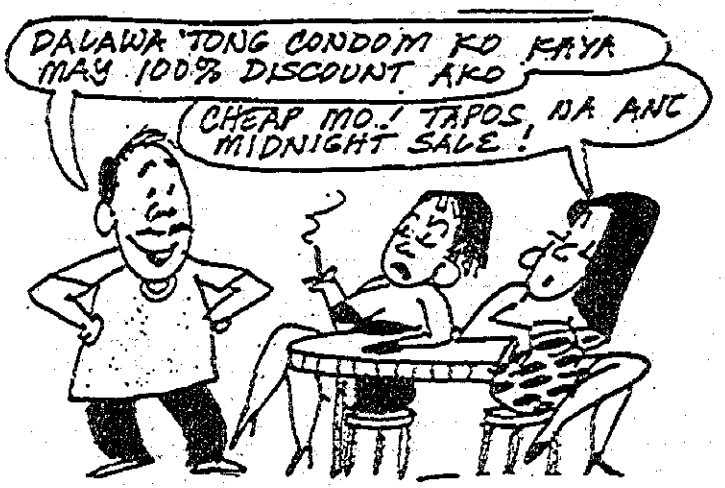
- Social Hygiene Clinics
- Government Hospitals
- Non-government Organizations
- Private Practitioners
  - General Practitioners
  - Specialists: OB/Gynecologists, Internists, Urologists, Dermatologists
- Rural Health Units
- Pharmacists/Drugstore Clerks

Support services

- National STD Management Guidelines
- Laboratory Support
  - Model
  - Standard
- Drug Supply
- Condom Supply

IEC

- mass media activities
- information centers
- National AIDS newsletter
- AIDS hotline service
- training of health workers



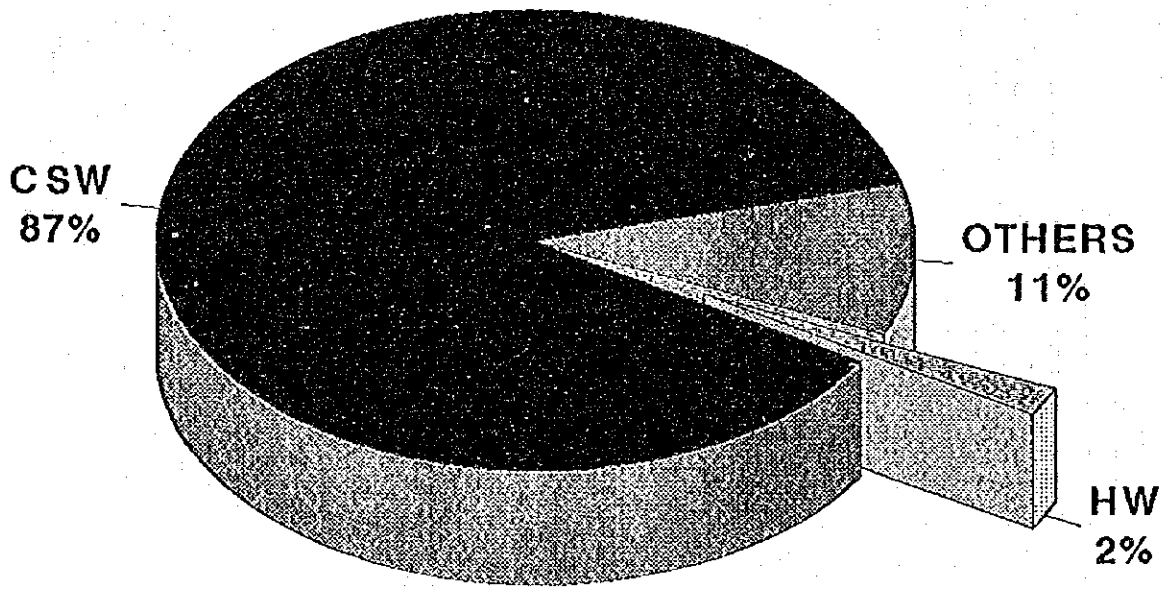
Laboratory Services

- initial screening: gov't. and private labs accredited by Bureau of Research and Laboratories
- confirmatory testing:
    a) Bureau of Research and Laboratories
    b) Research Institute for Tropical Medicine

Clinical Care and Management

- HIV/AIDS Core Teams created in all government hospitals
- syndromic approach to STD management promoted
- research capabilities strengthened:
    a) improve diagnostic acumen
    b) appropriate drug prescription
    c) behavioral aspect of service delivery

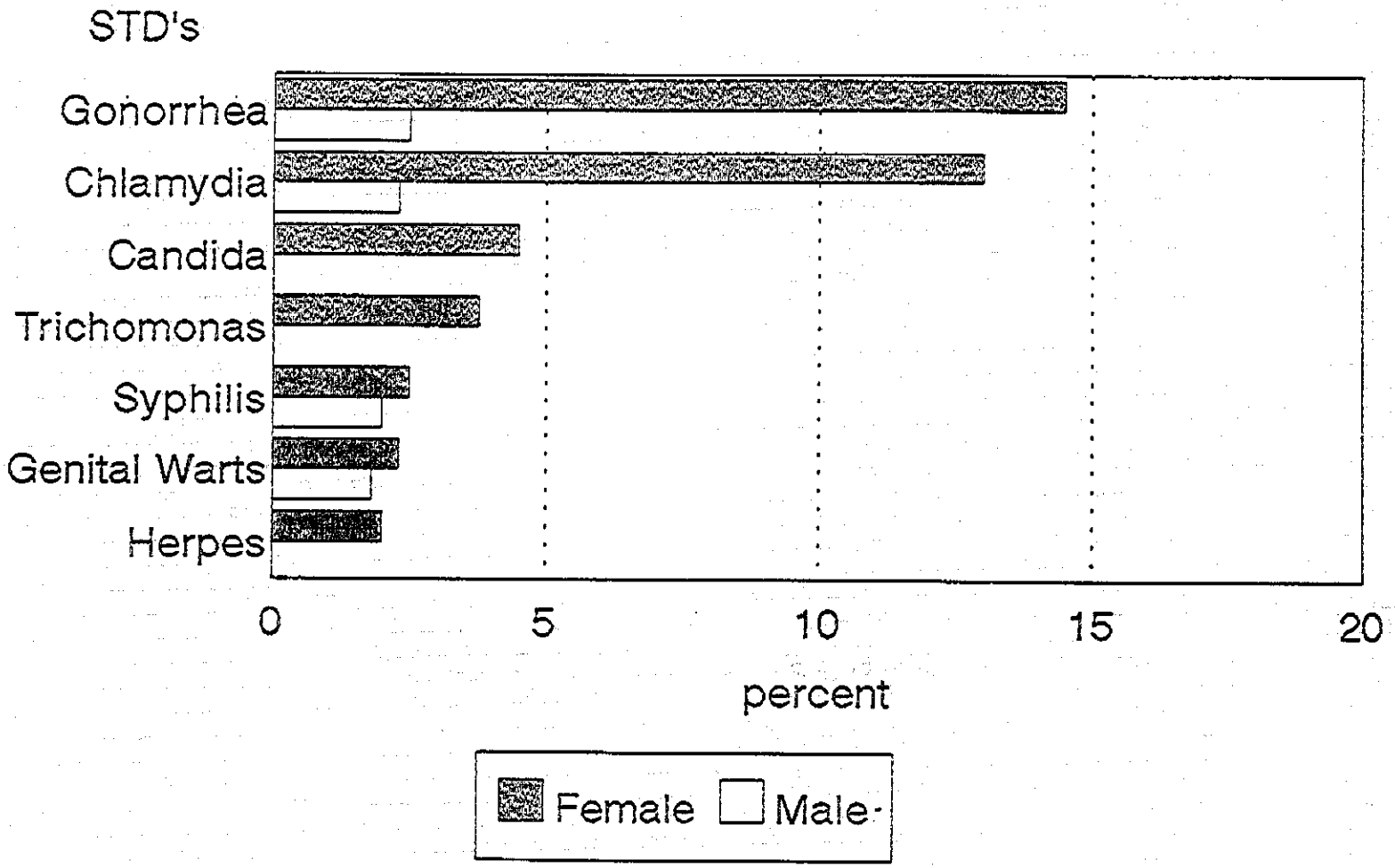
DISTRIBUTION OF SHC ATTENDEES
PHILIPPINES 1993



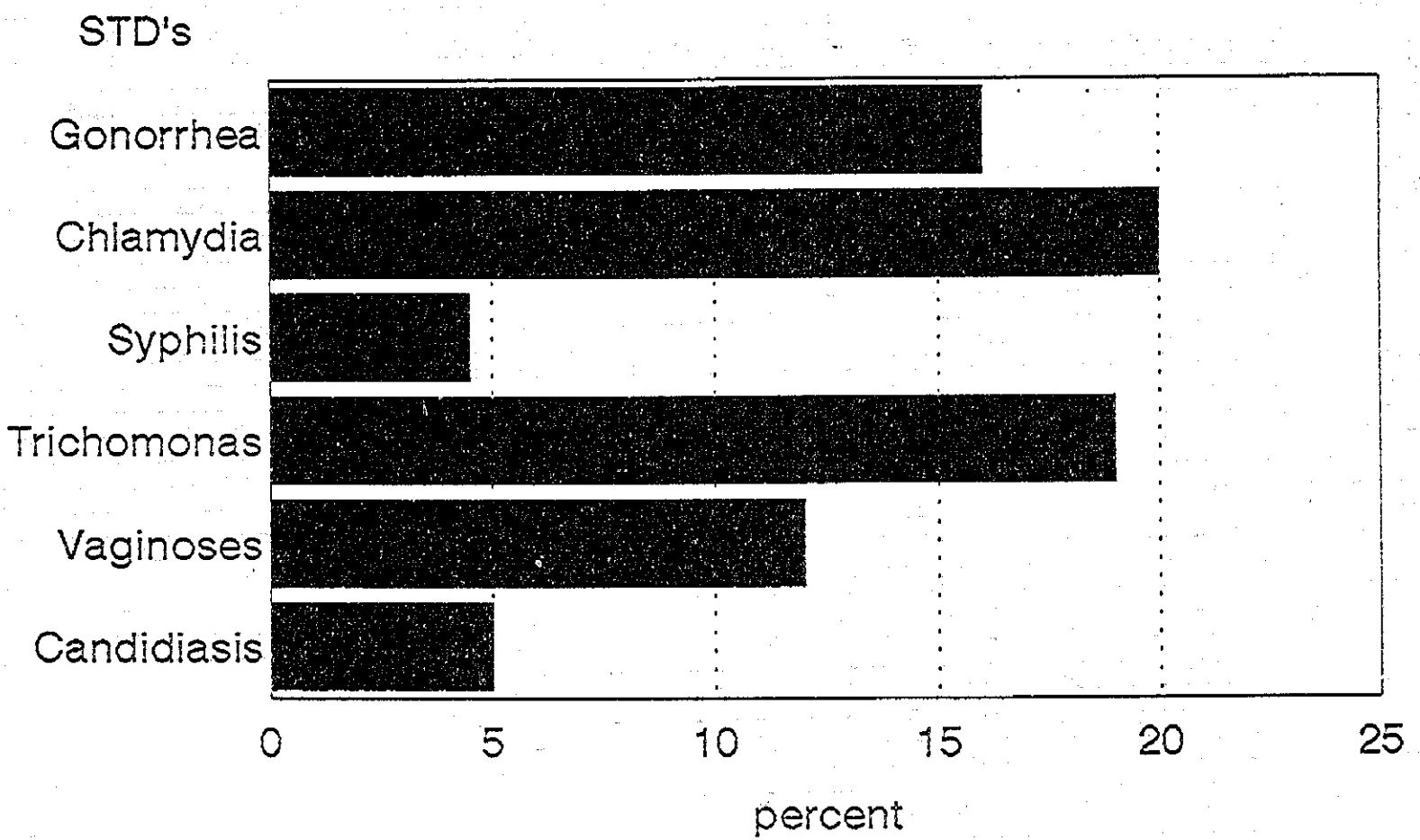
REGISTERED COMMERCIAL SEX WORKERS

REGION	NUMBER
I	2.001
II	768
III	3,654
IV	1,640
V	667
VI	1,756
VII	4,784
VIII	1,270
IX	465
X	870
XI	2,739
XII	343
CAR	512
NCR	22.008
TOTAL	43,477

STD Prevalence among Female and Male Sex Workers, 1990



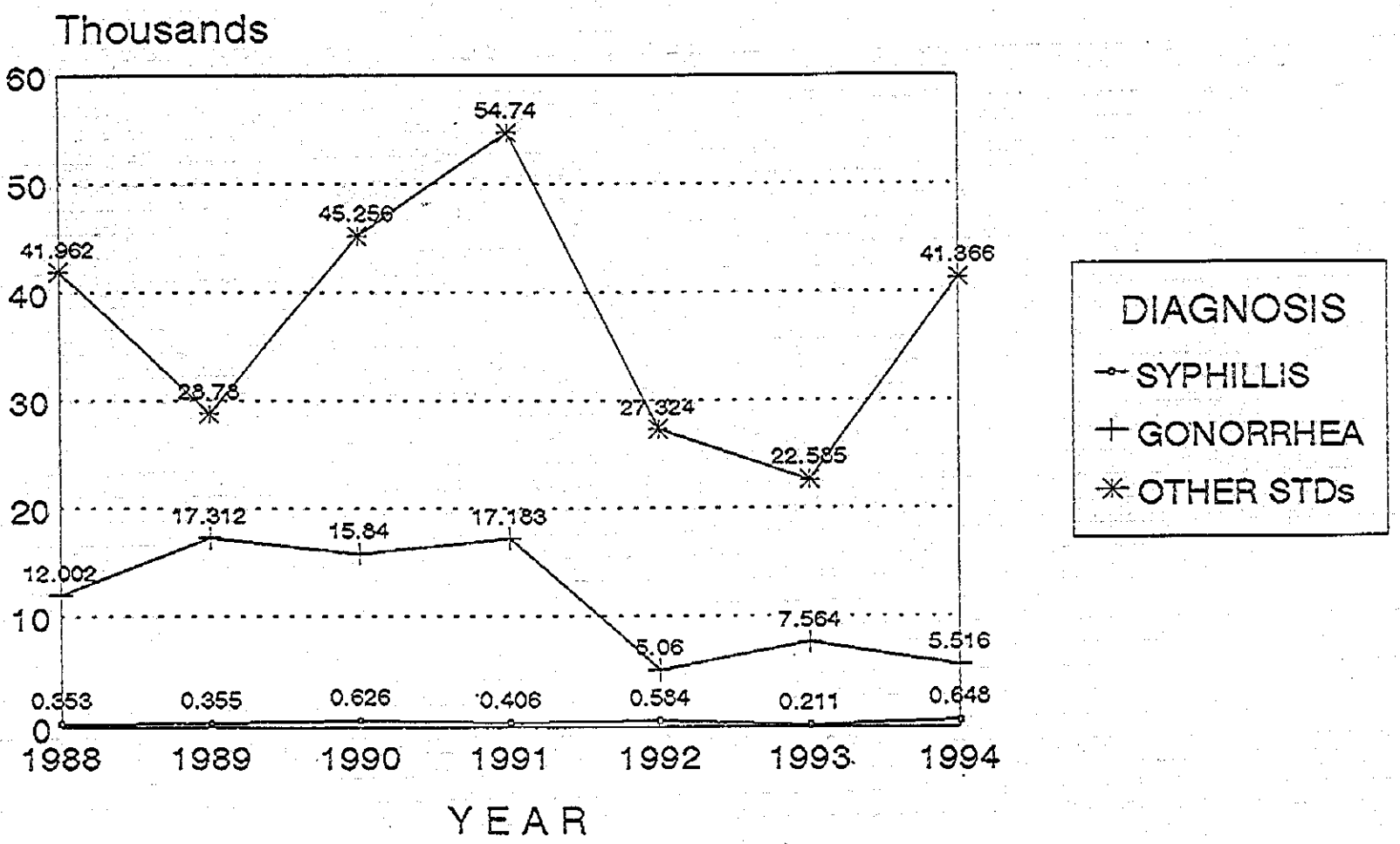
STD Prevalence among Sex Workers Cebu City, 1994



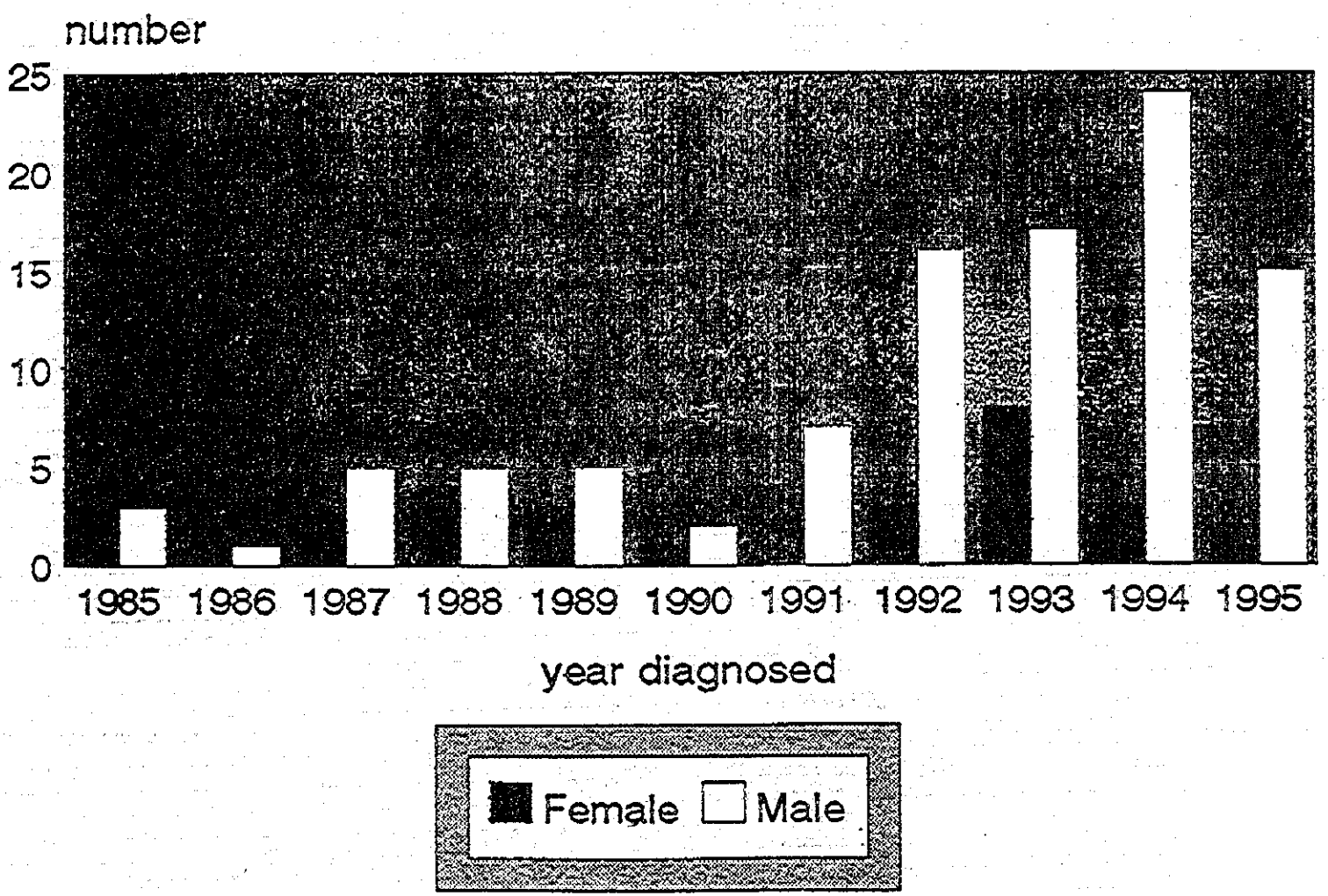
PERCENTAGE OF STDs AMONG SHC ATTENDEES PHILIPPINES, 1991 - 1994

STDs	1991 N=72550	1992 N=27178	1993 N=30360	1994 N=47530
1. NGU	69	69	57	69
2. GONORRHEA	24	19	25	17
3. CANDIDIASIS	3	5	5	4
4. TRICHOMONIASIS	2	4	9	5
5. GENITAL WART	1	1	0.6	0.1
6. SYPHILIS	0.6	2	0.7	1.9
7. HEPATITIS B	0.3	-	1.7	0.3
8. SCABIES	0.2	0.3	0.3	1.5
9. GEN. HERPES	0.1	0.4	0.2	0.5
10. PED. PUBIS	0.1	0.04	0.2	0.06

STDs AMONG SHC ATTENDEES
PHILIPPINES, 1988 - 1994



Number of HIV and AIDS Cases Reporting to have worked or stayed overseas by Gender for Year of Diagnosis, 1985-1995



Number of HIV and AIDS Cases Reporting to have Worked or Stayed Overseas by Gender for Year of Diagnosis, 1985-Aug. 1995

YEAR	FEMALE	MALE
1985	0	3
1986	0	1
1987	3	5
1988	4	5
1989	3	5
1990	1	2
1991	0	7
1992	3	16
1993	8	17
1994	3	24
1995	2	15
TOTAL	27	100

STD STATISTICS PER REGION

JANUARY - JUNE 1995

REGION	NGU	GC	TV	CAN	HB	HPV	SY	SB	PP	HSV	OTHERS	TOTAL
I*	103	31	6	15	0	1	2	6	6	6		176
II	77	351	0	14	0	[illegible]	0	0	0	0		442
III	972	355	59	9	0	[illegible]	69	0	0	0	2	1479
IV												
V												
VI	894	209	3	16	0	-	18	0	0	0		2240
VII	667	78	17	314	0	[illegible]	14	0	0	0	6	1381
VIII	301	54	0	10	0	-	0	0	0	0	0	365
IX	325	159	31	0	0	-	3	0	0	0		521
X	153	14	0	0	0	-	0	2	0	0		174
XI	636	369	252	402	0	1	35	11	0	1		2116
XII	455	110	99	3	0	5	82	13	0	0	5	1618
NCR	0	349	0	0	0	-	1	0	0	0	36	4019
CAR	12	96	80	93	0	[illegible]	26	0	0	0		313
ARMM												
TOTAL												

LEGEND

NGU - NON-GONOCOCCAL URETHR
GC - GONORRHEA
TV - TRICHOMONAS VAGINALIS
CAN - CANDIASIS
HPV - HUMAPAPELLO VIRUS
SY - SYPHI
SB - SCABI
PP - PEDICOSIS PUBIS
HSV - HERPESGENITALIS
HB - HEPATIS B

SOURCE SOCIAL HYGIENE CLINIC

* JAN - MAR

実施協議調査団報告書

1．実施協議調査団の派遣

1－1　調査団派遣の経緯と目的

フィリピン共和国（以下、フィリピンと略す）政府の発表によると、同国のＨＩＶ感染率は0.1%未満と、現時点では低位だが、都市圏や観光地での活発な風俗産業を背景に性感染症（ＳＴＤ）罹患率が高いことや、海外出稼ぎ労働者におけるＨＩＶ感染の広がり、麻薬の流通等、適切な対策を早急に講じなければ、今後急速にエイズ感染が拡大する可能性が懸念される状況にある。

このような状況下、同国保健省は積極的にエイズ対策に取り組むべく、現在エイズ／ＳＴＤ対策第2次中期計画を実施中である。この計画では、エイズの感染状況を正確に把握するための検査・サーベイランス体制を確立することや、主要な感染経路への対策を強化することなどに重点が置かれている。

このため、同国は我が国に対し、① エイズ中央ラボラトリーとそれに連なるリファラルシステムの確立、及び② 保健所（Social Hygiene Clinic；SHC）におけるエイズ感染予防活動の支援を要請してきた。前者により、感染実態を把握するためのエイズに関する検査・サーベイランス体制の整備・確立を図り、後者により、感染予防活動に取り組む公衆衛生従事者の能力向上と検査設備の改善を図ろうとするものである。

本調査団は、本プロジェクトの最終的な協力内容、協力方法、協力対象地域等の特定と、協力実施計画の策定を行い、討議議事録（Ｒ／Ｄ）及び暫定実施計画書（ＴＳＩ）の署名・交換を行うことを目的として、平成8年3月17日から同年3月26日までの日程で派遣された。

1－2　調査団の構成

	担　当	氏　名	所　属
団長	総括	大谷　明	国立予防衛生研究所名誉所員
団員	ウイルス学	栗村　敬	大阪大学微生物病研究所教授
団員	エイズ検査	吉原なみ子	国立予防衛生研究所エイズ検査室長
団員	衛生行政	柏樹悦郎	厚生省大臣官房政策課長補佐
団員	協力計画	鳥居　久	国際協力事業団医療協力部医療協力第一課職員

1－3　調査日程

日順	月日	曜日	移動及び業務	
			大谷団長、吉原団員、柏樹団員、鳥居団員	栗村団員
第1日	3月17日	日	9:55　成田発（JL742） 13:35　マニラ着 16:50	10:45　関空発（TG621） 13:55　マニラ着
2日	3月18日	月	9:30　ＪＩＣＡフィリピン事務所打合せ 11:00　日本大使館表敬 15:00　保健省第1回協議	
3日	3月19日	火	9:00　保健省第2回協議 14:00　ＵＳＡＩＤ 16:00　WHO西太平洋地域事務所	
4日	3月20日	水	午 前　エイズ関連ＮＧＯ訪問 15:00　ケソン市衛生部 16:30　マカティ市衛生部	
5日	3月21日	木	午 前　バコロド市へ移動（空路） 午 後　バコロド市衛生部、保健所、赤十字血液センター、地域病院、 エイズ関連ＮＧＯ	
6日	3月22日	金	午 前　イロイロ市へ移動（海路） 11:00　イロイロ市長表敬 午 後　衛生部、保健所、地域病院 夜　エイズ関連ＮＧＯ活動視察	
7日	3月23日	土	午 前　保健所 午 後　資料整理	
8日	3月24日	日	午 後　マニラへ移動（空路）	
9日	3月25日	月	9:00　保健省最終協議 14:00　ＪＩＣＡ事務所報告 16:00　日本大使館報告 夕 刻　団長主催レセプション（R／D署名・交換）	
10日	3月26日	火	14:45　マニラ発（JL742） 19:40　成田着	9:00　マニラ発（PR428） 13:00　関空着

1－4　主要面談者

(1)　フィリピン側

保健省

Carmencita N. Reodica, M. D.	次官（公衆衛生担当）
Antonio S. Lopez, M. D.	次官補（公衆衛生担当）
Evelyn Grace B. Gacad, M. D.	エイズ／ＳＴＤ課長
Manuel M. Dyrit, M. D.	検査試験課長
Virgilio L. Gonzales , M.D.	サンラザロ病院長
Remigio Olveda, M. D.	熱帯医学研究所長

イロイロ市

Urminico M. Baronda, M. D.	衛生部長

ＵＳＡＩＤ

Carol E. Carpenter-Yaman, MPH, PHD	保健部長

ＷＨＯ

尾身　茂	ＥＰＩ担当部長

ＨＯＰＥ（ＮＧＯ）

Gloria A. Melocoton	代表

(2)　日本側

在フィリピン日本国大使館

桂　誠　総領事

依田紀彦　一等書記官

ＪＩＣＡフィリピン事務所

橋本明彦　所長

力石寿郎　次長

岩崎英二　所員

2．総括

平成8年3月17日から3月26日まで、フィリピンにおけるエイズ対策プロジェクト内容の最終的協議を行う目的をもって同国を訪問した。今回の主要面談者は、フィリピン保健省のレオディカ次官、ロペス次官補を始め同省エイズ／性感染症（ＳＴＤ）課ガカット課長、検査試験課（ＢＲＬ）ダイリット課長、サンラザロ病院ゴンザレス院長、熱帯医学研究所（ＲＩＴＭ）オルベダ所長始め各部局担当官及び日本大使館、ＪＩＣＡ事務所各位であった。既に過去2回の調査結果から明らかなように、フィリピンにおけるエイズウイルス感染の現況は小規模にとどまっているが、70%以上が売血に依存している輸血体制、増加しつつあるＳＴＤは、近くエイズウイルス感染の爆発的急増を推定させる危険要因となっている。このような状況下で、日本に望まれる協力の在り方としては、① 安全な血液供給体制確立、② エイズ・ＳＴＤに対する信頼度の高いサーベイランス体制の整備、③ エイズウイルス感染防止への草の根的啓蒙運動への技術的援助であると考えられる。血液問題については、日本では日本赤十字連盟がこの援助の担い手として最も優れていると判断されるので、この問題に関する協力は同連盟に要請するのが至当であり、現時点ではＪＩＣＡは残る2つの問題に焦点を合わせた援助を考えるべきであろう。

今回の調査訪問において、上記の基本的見解についてフィリピン、日本関係者間で了解が得られたので、更に具体的事項について関係部署の担当者と協議の結果、下記の項目について協力を開始することでＪＩＣＡ、フィリピンが合意し、3月25日に双方でR／D文書の署名、交換を行った。

(1) エイズ中央ラボラトリーの確立

ＢＲＬ、サンラザロ病院、ＲＩＴＭの三者が協力して運営するフィリピン最初のＰ3施設を含む実験室の整備を行い、フィリピンにおける信頼の高いエイズサーベイランスの実施に協力する。

(2) 地方保健衛生施設（ＳＨＣ）の強化とＮＧＯ支援を通じたエイズ予防教育への協力

このプロジェクト実施のために、適時専門家の派遣、研修員の受入れ、機材供与を行う。

なお、このプロジェクトの協力期間は5年とする。

3．協議概要

協議は日本側R／D案を項目ごとに検討する形式で進められた。上潟口専門家が調査団派遣に先立ちフィリピン側と調整をしていたため、協議はスムーズに進んだ。この中、特に議論が集中した点に関し、協議結果を以下に記述する。

(1) エイズ中央ラボラトリーの整備・確立について

本プロジェクトでは、エイズ中央ラボラトリーを整備・確立し、エイズ等にかかる検査・診断機能や研修実施体制、サーベイランス体制を確立する計画である。また、本ラボラトリーと各地の地域ラボラトリー等との間にリファラルシステムを確立し、本ラボラトリーをフィリピンにおけるエイズ／性感染症（ＳＴＤ）分野のナショナル・リファラルラボラトリーとして機能させる計画である。本計画のフィリピン側推進者は、保健省公衆衛生局長（総責任）、エイズ／ＳＴＤ課、サンラザロ病院、検査試験課（ＢＲＬ）、熱帯医学研究所（ＲＩＴＭ）である。

本ラボラトリーを整備・確立するに当たり、建物はメトロマニラ・サンタクルズ市内にある保健省敷地内の旧米海軍医科学研究所（ＮＡＭＲＵ）が提供される。本施設（平屋、550平米）は築後10年以上経過しているが、堅牢な基礎構造の建築物であり、部分的補修により長期間の利用が可能である。補修工事の内容としては、内外壁塗装や、床・天井・屋根の小規模修理等が予想される。建物補修にかかる費用は、フィリピン側の財政が逼迫していることから、日本側が帰国後、検討する。

リファラル機能の確立については、エイズ以外のＳＴＤについては本ラボラトリーがリファラルセンターとして機能することで問題ないが、エイズについては組織機構上、ＲＩＴＭがその機能を果たすこととなっている、との説明がフィリピン側からあった。これに対し、日本側は、本ラボラトリーの検査・診断機能の確立後は、本ラボラトリーがエイズについても同様の機能を担うことを提案した。フィリピン側は、日本側提案について態度を保留したが、調査団の所見では、ＲＩＴＭの現状を考えると、本ラボラトリーの整備・確立後は、業務分掌が再考される可能性が高いと予想される（特に、本ラボラトリーにはフィリピン初のＰ３実験室を設置する計画であり、これによりＨＩＶウイルスの分離等が可能になると、エイズ研究の中心は同研究所から本ラボラトリーに移る可能性が高いと思料される）。

本ラボラトリーの名称は、関係各機関（サンラザロ病院、ＢＲＬ、ＲＩＴＭ）の積極的関与と連携が必要であることを確認する意味合いからも、Cooperativeという言葉を入れ、STD/AIDS Central Cooperative Laboratory（略称：SACCL）とすることで合意した。また、本ラボラトリーに対して1998年までに保健省から独自の予算措置がなされることを確認した。

組織図上は、国家エイズ／ＳＴＤ対策計画の一機関として位置づけられる。

(2) Social Hygiene Clinic（SHC）のモデルづくりについて

ＳＨＣのモデルづくりについては、プロジェクト開始後にベースライン調査を実施し、現状把握・分析を行った上で、モデルの在り方、サイトの選定等を具体的に検討することとする。

なお、フィリピン側から、ＳＨＣにおけるシンドロミックアプローチ（症状に基づく治療）への支援を要望されたが、日本側としては、治療薬の供与は対応が予算上困難なこと等を説明し、見送ることで合意した。

(3) 今後の日本側スケジュールについて

早急に国内委員会を設置する。専門家派遣については、リーダーは年内、その他専門家はできる限り早期に実現する方向で調整をする。

4．プロジェクト実施上の留意点

エイズ中央ラボラトリー（ＳＡＣＣＬ）及びリファラルシステムの確立

ＳＡＣＣＬの設置は日米協調の点からも意義がある。アメリカはシンドロミックアプローチの手法を使って、性感染症（ＳＴＤ）及び診断の指導を行っているが、症状のでない感染者はラボラトリーでの検査が必要である。また、世界銀行、アジア銀行、ＥＵなど他のプロジェクトは、地方、地域のエイズを含めたリプロダクティブヘルスについての援助計画がある。日本のモデルサイトは大都市であるので、これらの援助とは重複しない。他のプロジェクトと協調しながらＳＴＤ／エイズの予防活動をしていくことになり、他のプロジェクトでもＳＡＣＣＬは必要な施設である。そのような背景からＳＡＣＣＬの設置は良いタイミングである。また、リファラルシステムの確立はＳＡＣＣＬの活動内容を更に高めるものとなる。

4－1　エイズ中央ラボラトリーの概要と留意点

ＳＡＣＣＬはエイズ、日和見感染症及びＳＴＤなどに関わる実験室診断、研修、研究、サーベイランスを行うために必要な施設である。保健省の敷地内のサンラザロ病院の向かい側に旧米国海軍研究所（旧ＮＡＭＲＵ-2）がある。この施設はＮＡＭＲＵ時代はＨＩＶ／エイズに関する血清学検査を始めウイルス培養、臨床診断、研究を行っていた。フィリピンに返還後はサンラザロ病院、検査試験課（ＢＲＬ）及び熱帯医学研究所（ＲＩＴＭ）の３者が共同利用する施設となっている。現在はサンラザロ病院がＮＡＭＲＵが置いていったフローサイトメーターを使ってＣＤ４／ＣＤ８を検査したり、実験室の一部で細菌検査を行っている。この施設を修理し、Ｐ３を新設して、Ｐ２以下のラボラトリーを整備すれば実験室として使用可能である。更に管理部門も加えればＳＡＣＣＬとしての機能を持つ施設になる。サンラザロ病院はエイズの臨床面のリファレンスセンターであり、エイズ病棟には常に数人のエイズ患者が入院している。他の病院の医療従事者にもエイズに関する教育、研修を行っており、フィリピンのエイズ患者治療の中心的病院である。

現在は施設の管理をサンラザロ病院が行っているが、ＳＡＣＣＬの使用についてはサンラザロ病院、ＢＲＬ、ＲＩＴＭの３者が共同で利用できるルール作りが必要である。

まず、建物を整備するとともにＳＡＣＣＬの組織を確立する。ラボラトリーは細菌、ウイルス、血清、免疫などの部門を設置し、ＨＩＶ抗体確認検査、ＨＩＶのウイルス分離などＨＩＶ病原体に関する検査、エイズの日和見感染症に関わる病原体検査及び診断、ＳＴＤの検査を行う。ＨＩＶを始めカリニ肺炎や結核など日和見感染症に関する病原体、クラミジア、ヘルペス、ヒトパピロマウイルス、サイトメガロウイルス、Ｂ型肝炎、トキソプラズマ、淋菌、梅毒、カンジダその他の真菌などを扱えるようにし、検査機能の向上を図る。

更にＨＩＶ検査及び日和見感染症に関する検査のクオリティーコントロール及びクオリティーアシュアランスを行う。

正確なサーベイランスを実施するには地域病院及び地域保健所のエイズ／ＳＴＤ対策行政官及び現場の技術者に対して教育が必要であり、彼らに対して研修及び実習を行えるようにする。

フィリピンは人員や予算を当面３者から持ち回りで提供する予定であるが、来年度からはＳＡＣＣＬの人員の予算を要求している。将来は専任の研究者の確保が望ましい。

4－2　リファラルシステムの確立とモデル検査所の選択

ＳＡＣＣＬと地方を結ぶリファラルシステムの確立するためには各州がエイズ／ＳＴＤ課のコーディネーターにより参画するとともに、モデルとなる地方検査所を選ぶ必要がある。フィリピンのＨＩＶセンチネルサーベイランスは年に２回、６対象群（登録売春婦、未登録売春婦、売春夫、男性ＳＴＤ患者、女性ＳＴＤ患者、男性同性愛者、麻薬静注者）に対して行っている。２サイトずつ増やして、現在10サイト（ケソン市、パサイ市、セブ市、ダバオ市、アンヘレス市、イロイロ市、カガヤンデオロ市、ジェネラルサントス市、バギオ市、ザンボアンガ市）である。ＨＩＶ抗体と梅毒を地域病院ラボラトリーなどで検査している。モデル検査所は病院内のラボラトリー及び保健所（ＳＨＣ）を活用し、ＨＩＶ及びＳＴＤのスクリーニング検査ができるようにする。サーベイランスサイトの選択はフィリピンとＵＳＡＩＤとの協調である。地方検査所を選定する場合は、これらの地域から選ぶ方が良い。その理由としては、これらのサイトは本省のエイズ／ＳＴＤ課からサーベイランスについての指導を受けているので、ＨＩＶ検査などの実施が容易であること、またこのプロジェクトは日米協調であることなどによる。

また、初年度はモデル検査所は2～3カ所が適当と考える。その基準は地方衛生部及びＳＨＣの協力が得られること、ＮＧＯ活動が活発なこと、ＨＩＶ感染者がいるかまたは将来感染が予想される地域、専門家が指導のための交通が容易に確保できることなどである。対象地域検査所の特徴を表4-1にまとめた。

以上のことから鑑みて、モデル検査所は初めはパサイ市とアンヘレス市を対象にし、余裕があったらセブ市を加える。これらの地域は行政サイドが協力的であり、予防活動も積極的であるとともに、既にエイズ患者がみつかっていて感染が広がる恐れがある地域である。また、マニラからのアクセスも比較的容易である。一方、ジェネラルサントス市はこれから発展する地域であり、現在、人の流入が激しく、海外からの渡航者も増えている。ＳＴＤ感染率が高いことなど、一旦ＨＩＶが侵入すれば感染の拡大は目にみえる地域である。また日米協調からも対象としては適当と考えられるが、現在のところ交通の便が悪いため、新空港ができ上がる次年度以降が良いであろう。その場合はダバオ市と一緒のサイトにするのも一考と考えられる。

表4－1　Social Hygiene Clinic(SHC)の特徴

City	行政の協力	NGOの活動	登録CSW	フリーCSW	男性STD患者	マニラからの交通	地域の特徴
QUEZON	○*1	○				車で0.5～1時間	マニラの歓楽街を閉めた後客が移動。感染者あり。
PASAY	○	◎	1,460	3	2	車で0.5～1時間	マニラの歓楽街を閉めた後客が移動。感染者あり。
MAKATI	◎	◎				車で0.5～1時間	マニラの歓楽街を閉めた後客が移動。感染者あり。
CEBU	◎*2	○	2,350	50	30	飛行機で40分	最初の感染者、麻薬常用者がいる。工業投資が活発。人の移動が多い。観光地。
DAVAO	○	○	1,165	13	3	飛行機で1時間	工業開発、人の流入が激しい。
ANGELES	○	○				車で1.5時間	クラーク空軍基地跡の歓楽街。新国際空港および工業団地の投資。
ILOILO	○	今から設置	1,000+	100+	30-90	飛行機で1時間	港町
CAGAYAN DE ORO	○	○	300	30-50	3	飛行機で1時間	港町
GENERAL SANTOS	◎	△*3				DAVAOから車で6時間*4	アメリカとの協調地域。保健分野での協力要請。STDの陽性率が高い。工業投資で人の流入が激しい。
BAGIO	○	△	1,580	0	15-20	飛行機30分／車10時間	観光地
ZAMBOANGA	(未調査)	(未調査)	2,320	72	5	飛行機2時間	港町。インドネシア、マレイシアとの往来が多い。

*1　○協力的
*2　◎非常に協力的
*3　△あまり活発ではない
*4　今年中にマニラから１時間の新空港ができる予定

来院者数（登録CSW、フリーCSW、男性STD患者）は、１ヵ月あたりの平均数。

5．提言

1996年3月21日の保健省（DOH）発表の資料によると、同月現在までに報告のあったＨＩＶ感染者は732名であり、うちエイズ患者は249例となっている。過去1カ月間に発見されたエイズ症例の大部分は性交による感染であるが、1名は外国における針刺し事故による看護婦の例であった。

このようにフィリピンは7,000万人を超える人口の割にＨＩＶ／エイズは少ない。しかし、社会経済的に低い層では性感染症（ＳＴＤ）の蔓延もみられ、一方、海外出稼ぎ労働者のＨＩＶ／エイズに占める比率は18%の高率となっている（主として船員）。この点よりみて、国境を他国と共有しない利点を生かして独自のエイズ対策を確立することがフィリピンにおけるエイズ流行の素地をなくし、現在の良好な状態を維持することになろう。

(1) 当プロジェクトの留意すべき点

フィリピンにおける経済状況は良い方向に向かっており、5カ年計画を立てるに当たっては5年後の状況を予測したものでなければならない。単純にＮＧＯに援助をするＵＳＡＩＤ、ＡｕｓＡＩＤ方式は将来において厳しい評価を受けると思われる。ラモス大統領も（新聞によると）「社会福祉事業の一環として貧困問題をとらえる時期は終わり、教育や職業訓練、医療分野における援助により貧困層の自立促進に対する協力が必要」と述べている。その中での医療協力プロジェクトは当然、これまでと異なるものを求められるに違いない。

正確な情報を適正に評価するシステムの確立とそれの裏づけとなる信頼できる検査技術、教育手段の移転を中心とする5年後をみたプログラムが望まれる。

(2) 満たされるべき条件

① 検査、臨床、社会と幅広いプロジェクトを調和させること（チームリーダーの選択の条件）。

② 熱帯医学研究所（ＲＩＴＭ）、検査試験課（ＢＲＬ）、サンラザロ病院の3機関が協調する体制を作り上げること。

③ 単純な援助でなく5年後をみたものであること。具体的には患者情報（ＳＴＤ／エイズ）を正確に遅れることなく集めるシステムをＤＯＨを中心に行うこと。そのためにモデル保健所（ＳＨＣ）を中心にブロックごとにＳＨＣ群を作り、集めた情報をコンピューターでＤＯＨに送ること。更に定期的にまとめた情報を末端に還元すること。

④ モデルＳＨＣの選択

ＳＨＣのレベルの差は予想以上に大きく、そのためどのレベルのＳＨＣをモデルとするかは極めて重要なポイントになる。今回訪問したケソン市、バコロド市、イロイロ市のＳＨＣを比較しても歴然たる差があり、高い視点から目的をはっきりさせてモデルＳＨＣを選択することにより、プログラムの将来での評価は高まるであろう。

⑤ 研修員の選択

単に論功行賞や年功序列によらぬよう限られた人材を徹底的に教育し、それらを中心に将来のＳＴＤ／エイズ対策を行えるようにする必要がある。また、過去にＪＩＣＡなどによる研修を経験した人材のリフレッシュも重要である。

(3) 国際機関

1) 現状

① UDP

・フィリピンに1名のエイズ担当官

② UNAIDS

・フィリピンにUNAIDS直轄の担当官を置く。

・Theme Groupを置く。これは6名（UNAIDSを構成する国連6機関より各1名）を置き1年交代で議長を置く（1年目はWHOより）。

③ WHO

・ジュネーブにAIDS/STD Division（ASD）を置きDorothy Blakeを長とする。

・一部、選んだ国にCountry Program Advisor（CPA）を置く。フィリピンはその1つの国となる。

・図形　Western Pacific Region担当として次の3人を置く。

Regional Advisor on STD

WPROの予算で補う

Public Health Scientist/Epidemiologist

厚生省予算で雇う

UNAIDS-seconded Post for Training and Education of CSW & HCW

UNAIDSが雇う

④ Country's Representative of WHO

・Dr. Alberto Romualdesを置く。

このような体制は複雑極まりなく、うまく機能させ有効なエイズ対策をとるには十分な意思の疎通が必要であろう。

ただ、WHOはフィリピンのNGOに対応して直接20万ドル（年間）を支出する予定である。

(4) 各国のODAとフィリピンNGO

日本を除いてはUSAIDがPATHを中心に活躍しているが、本国よりの予算が不安定であることと、単純にNGOの意向に従って資金を提供しているようにみえる。AusAIDについても同様の傾向がある。EUも一部NGOに協力している。

NGOの行動は全国的視野を欠いているので、有効なエイズ対策というより急場しのぎの感がある。Reach Out（ケソン市）、Kabalikat Drop-in Center（ケソン市）、H. O. P. E Volunteer Foundation（パコロド市）のようなNGOはよく動いてはいるが限度があり、これをDOHがどのように活用していくのかが、今後の大切な点である。

国連機関の混乱状態（エイズ対策に関して）も見受けられる状況下ではJICA、日本大使館が中心となり、年に1～2回、DOHを含めて十分な報告会を開き、すべてのプロジェクトの調和を図ることができることが望まれる。