

フィリピン国
結核対策プロジェクト
運営指導調査団報告書

平成 10 年 9 月

国際協力事業団
医療協力部

序 文

フィリピン共和国政府は、結核対策を中心とする公衆衛生のモデルを構築するべく、プロジェクト方式技術協力をわが国に要請し、これを受けて国際協力事業団は1992年から5年間にわたり公衆衛生プロジェクトを実施しました。

同プロジェクトは1997年8月31日に終了しましたが、保健省が新たに策定した治療完了に重点を置く結核対策新指針の実施モデルを確立し、そこで得られた成果をもとに、結核対策新指針の全国展開を進めるため、実施エリアを拡大するのに必要な技術的支援を行う新たなプロジェクト方式技術協力を要請してきました。これを受けて国際協力事業団は、1997年9月1日から5年間の予定で、結核対策プロジェクトを開始しました。

当プロジェクトは、専門家の派遣、研修員受入れおよび機材供与を軸に、技術協力を実施してきました。今般これらの状況を踏まえ、プロジェクトの進捗状況と問題点を把握し、活動計画を参加型で策定するため、1998年8月3日から8月13日までの日程で、財団法人結核予防会結核研究所所長の森亨氏を団長とする運営指導調査団を派遣しました。本報告書は、同調査団が実施しました調査、協議およびその結果について取りまとめたものです。

ここに調査団員各位ならびに調査にご協力を賜りました関係各位に、深甚なる謝意を表しますとともに、プロジェクトの効果的な実施のために、今後ともご指導、ご鞭撻をお願い申し上げます。

1998年9月

国際協力事業団

医療協力部長 福原 毅文



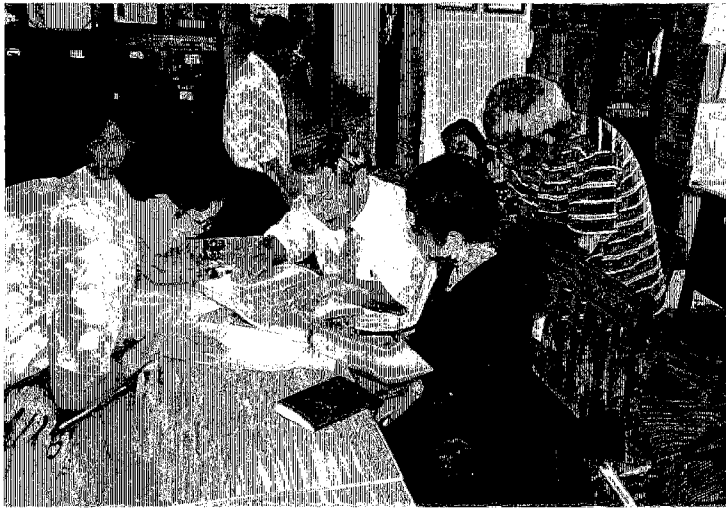
PCMワークショップ風景



同上



コレラRHU外観



コレラRIIUでの指導風景



サンボグBHS外観



同BHS内に設置されている
ミニラボラトリー



ピラRHU

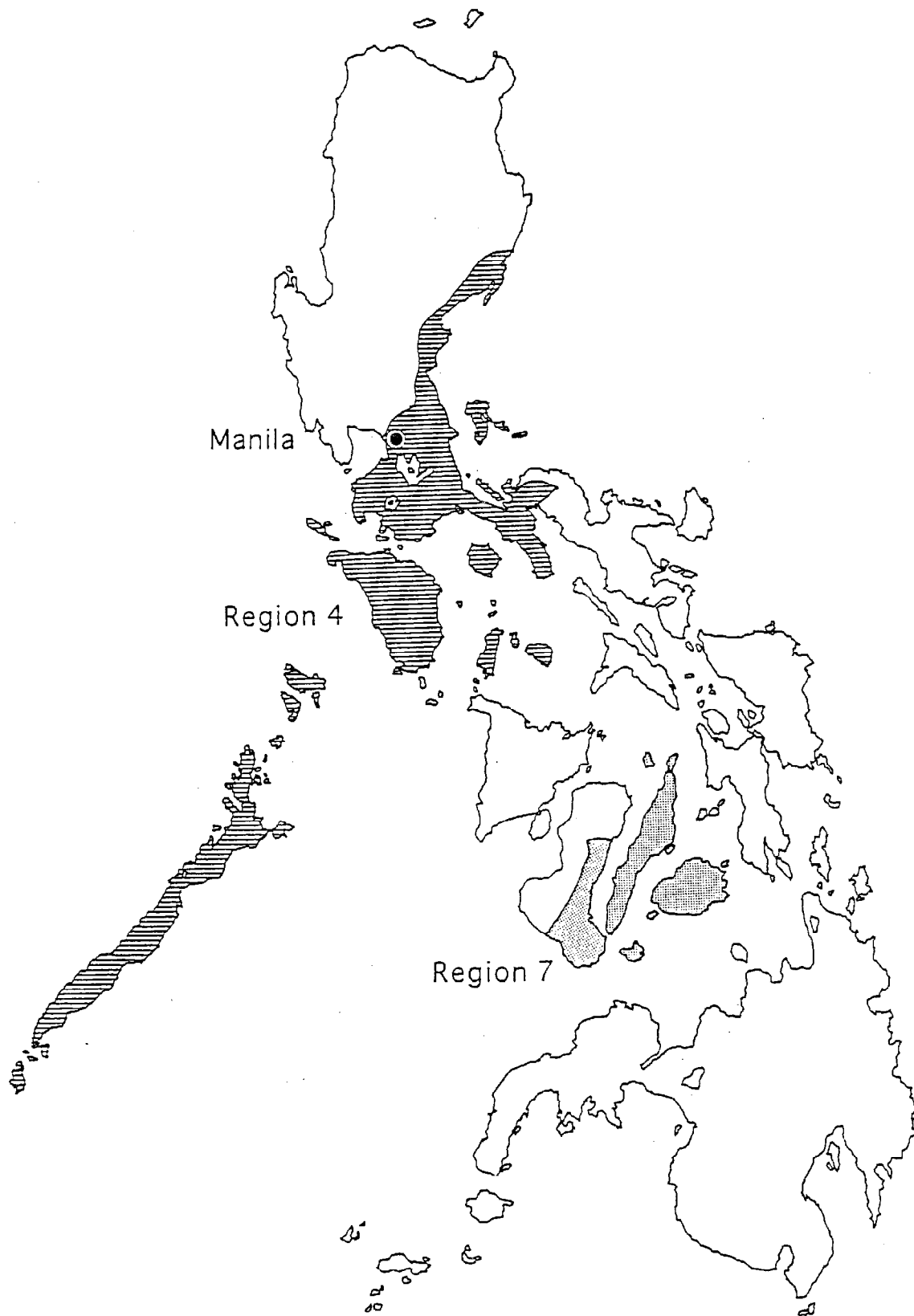


ピラBHS外観

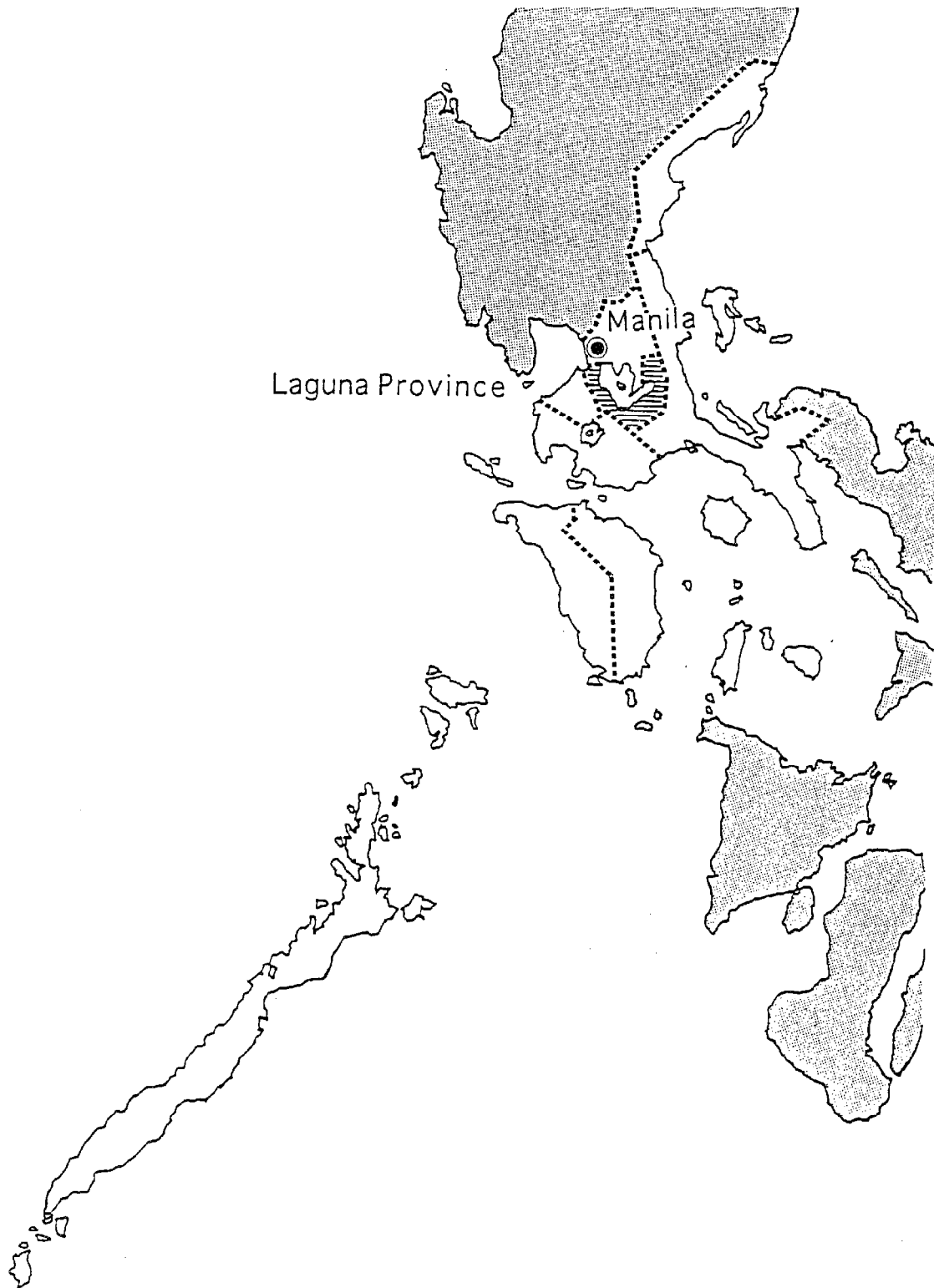


同BHSでの指導風景

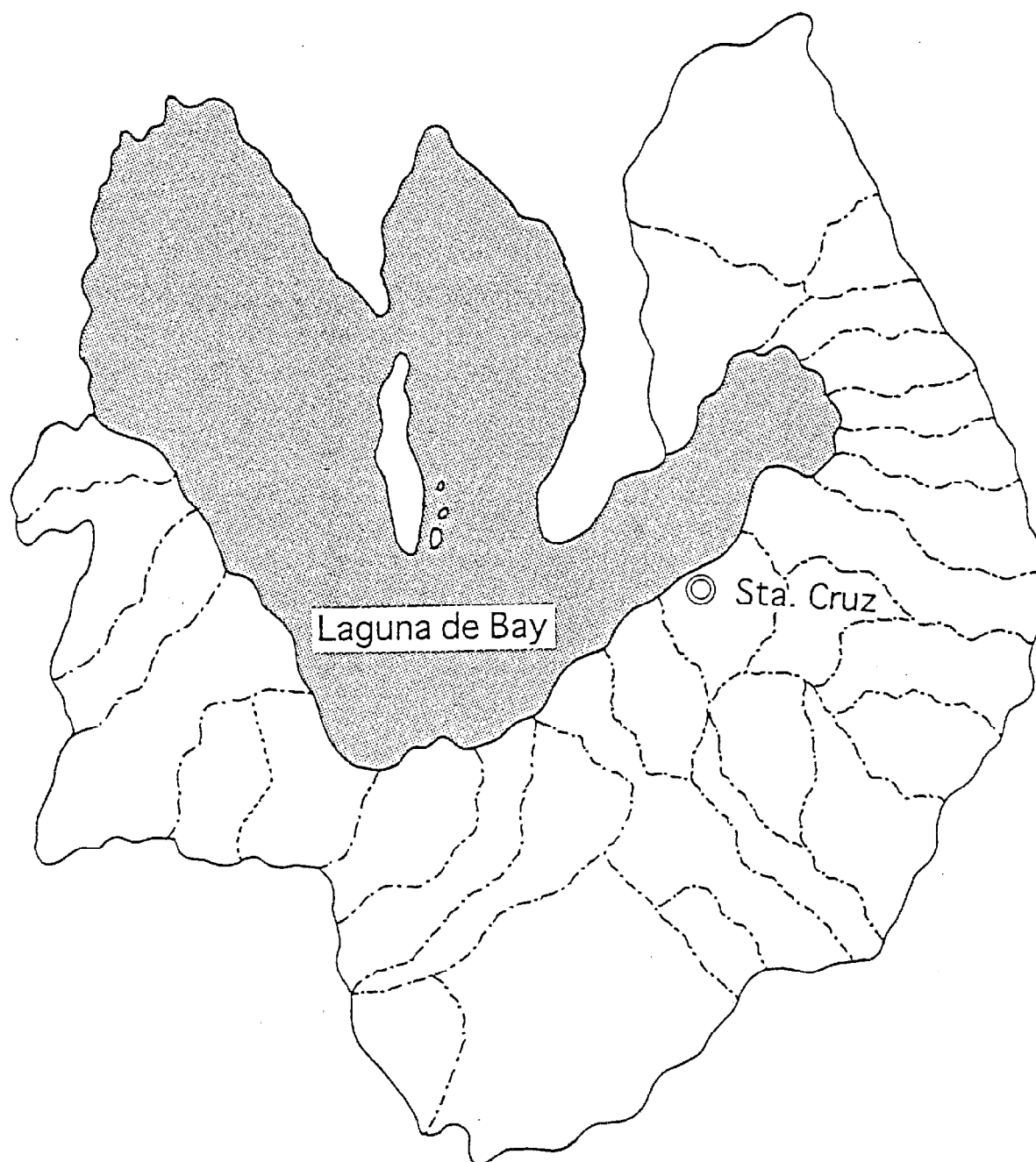
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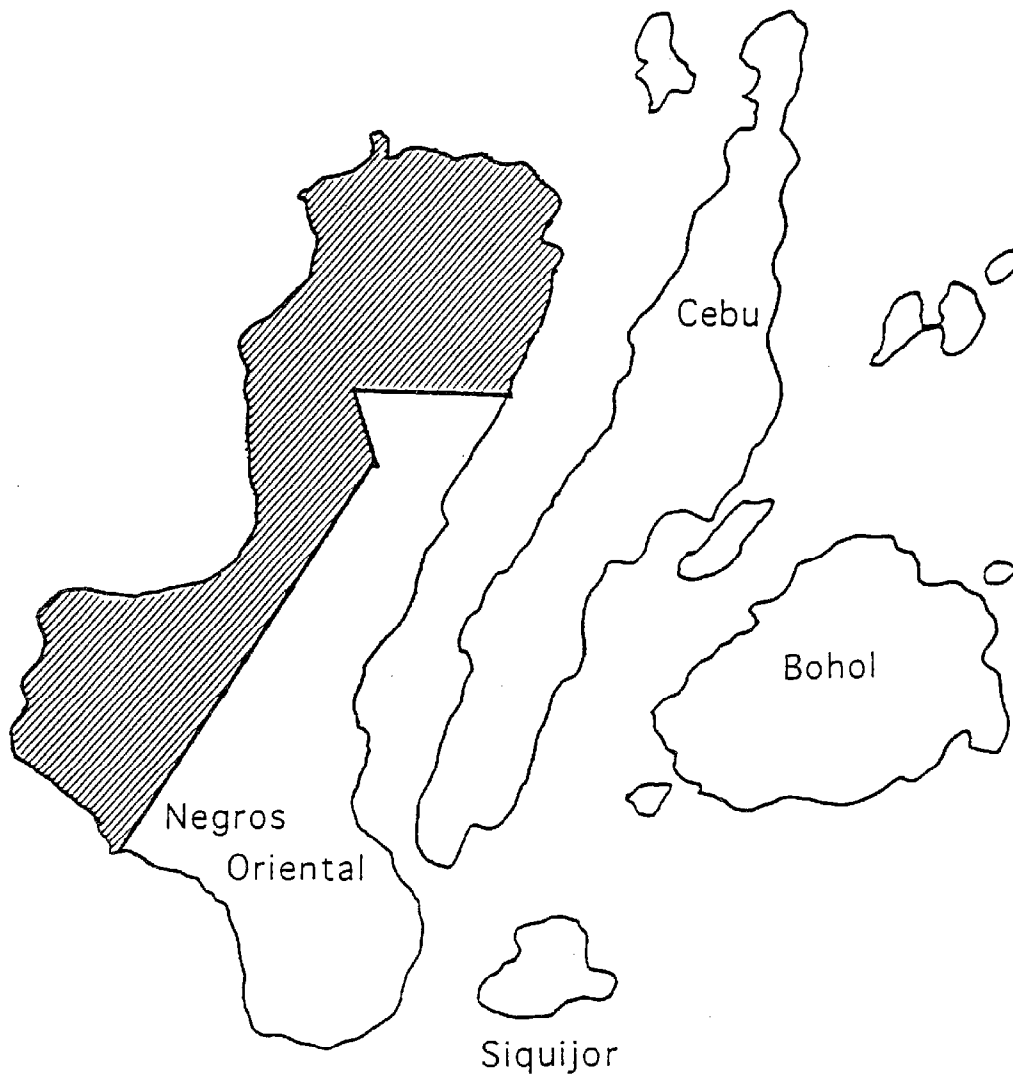
REGION 4



LAGUNA PROVINCE



REGION 7



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1 . 運営指導調査団派遣

1 - 1 調査団派遣の経緯と目的

わが国は1992年9月から5年間にわたり、結核対策を中心とする公衆衛生プロジェクトをセブ州をプロジェクト・サイトとして実施し、WHOとの連携を図り、保健省が新たに策定した治療完了に重点を置く結核対策新指針の実施モデルを確立した。フィリピン共和国（以下、フィリピン）政府は、そこで得られた成果をもとに、結核対策新指針の全国展開を進めるため、実施エリアを拡大するために必要な技術的支援を行う新たなプロジェクト方式技術協力を要請してきた。

これを受けてわが国は、1997年8月に事前調査団を派遣し、同月、討議議事録（R / D）を締結し、同年9月から5年間にわたりプロジェクト方式技術協力「結核対策プロジェクト」を実施することとした。

R / D締結時に詳細な活動計画を策定し先方と合意したが、問題点の把握・共有、今後の円滑なプロジェクト運営のためにプロジェクトサイクルマネジメント（PCM）手法による問題分析、目的分析を行うことが急務となっている。また、プロジェクト活動地域および拡大計画についても日比双方で十分な確認がなされておらず（ただし、R / Dのマスタープラン中の「成果」では言及されている）、先方が早急な拡大を企図しているところ、現時点で可能な限り明確に確定しておく必要がある。さらに、国立リファレンスラボラトリーの無償資金協力の要請があるものの、サイトについては先方の意向が割れているところ、先方の検討状況を把握する必要がある。あわせて、通貨危機に伴う先方のローカルコスト負担状況、ならびにプロジェクト開始時から現在までの活動状況の把握、今後の活動計画の策定のため今般運営指導調査団を派遣することとなった。

1 - 2 調査団の構成

担 当	氏 名	所 属
団長 総 括	森 亨	財団法人結核予防会結核研究所所長
団員 参加型計画手法	伊藤 毅	アイ・シー・ネット株式会社コンサルティング部研究員
団員 協力計画	伊藤 賢一	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	移動および業務
1	8 / 3	月	13:10 伊藤（毅）団員マニラ到着 16:00 J I C A事務所打合せ
2	8 / 4	火	8:00 プロジェクトチームとの打合せ 14:00 保健省結核課へのインタビュー
3	8 / 5	水	8:00 W H O表敬・協議 14:00 州保健局表敬・協議 16:00 マニラ市保健局調査
4	8 / 6	木	8:00 保健省結核課へのP C M手法に関するブリーフィング 13:10 森団長、伊藤（賢）団員マニラ到着 15:30 日本大使館表敬・打合せ 17:50 J I C A事務所表敬・打合せ
5	8 / 7	金	8:00 保健省口Pes次官表敬・協議 9:00 P C Mワークショップ（終日）
6	8 / 8	土	9:30 ボホール州へ移動
7	8 / 9	日	資料整理・団内打合せ
8	8 / 10	月	8:00 ボホール州保健局表敬・協議 8:40 コレラRural Health Unit（R H U）調査 10:00 サンボグBarangay Health Station（B H S）調査 11:00 ボホール州知事表敬 14:30 セブへ移動 17:45 マニラへ移動
9	8 / 11	火	6:00 ラグナ州へ移動 9:00 ラグナ州保健局表敬・協議 9:50 ラグナ州知事表敬 10:20 ピラR H U調査 11:20 ピラB H S調査 13:50 リージョン4保健局表敬・協議 17:50 保健省口Pes次官協議
10	8 / 12	水	8:00 保健省協議 14:00 国家経済開発庁（N E D A）表敬・協議 16:30 J I C A事務所報告
11	8 / 13	木	7:20 W H O表敬・協議 9:30 日本大使館報告 14:30 マニラ発

1 - 4 主要面談者

(1) フィリピン側関係者

保健省関連	次官	Dr. Antonio S. Lopez
	結核課長	Dr. Mariquinta J. Mantala
	結核対策官	Dr. Jaime Y. Lagahid
	検査試験課長	Dr. Veneracion D. Pacis-Munar
ボホール州知事		Mr. Rene L. Relampagos
ボホール州保健局		Dr. Franasco S. Kazalo
リージョン4保健局長		Dr. Conrado K. Galsim, Jr.
	副局長	Dr. Gerardo V. Bayugo
ラグナ州知事		Mr. Jose D. Lina, Jr.
ラグナ州保健局		Dr. Cirila D. Jorvina
国家経済開発庁 (NEDA) プロジェクトモニタリング課長		Mr. Rolando G. Tungpalan
WHO 西太平洋事務所結核担当官		Dr. Dongil Ahn

(2) 日本側関係者

日本大使館	福田 光	書記官
JICA フィリピン事務所	後藤 洋	所長
	黒柳 俊之	次長
	永井 真希	所員
プロジェクト	遠藤 昌一	チーフアドバイザー
	寺崎 義則	調整員
	大角 晃弘	専門家 (結核対策)

２．総 括

（１）PCMワークショップについて

８月７日、保健省検査試験局内の会議室で保健省、リージョン４、リージョン７等のプロジェクト関係者の参加を得てPCMワークショップを開催した。「フィリピンにおいて結核は深刻な問題である」を中心問題に据え、今一度結核対策およびプロジェクト活動を見直す観点から、参加者分析、問題分析、目的分析を行った。１日間という限られた時間であったためプロジェクトデザインマトリックス（PDM）の完成までには至らなかったが、参加者からは活発な議論がなされ、目的系図を作成することができた。今後、見落としている点や重複している点などを修正し、プロジェクト関係者で議論を重ね、プロジェクトの運営に資するようPCM手法が活用されることを期待する。

（２）各州の活動状況について

プロジェクト展開開始直前のボホール州と開始直後のラグナ州をフィールド調査したが、両者とも喀痰採取・検査・記録報告等において技術的に未熟であるものの、結核対策への取り組みの意欲は十二分にあり、研修を行いモニタリングやスーパービジョンを通じて管理を適切に行っていけば、うまく国家結核対策計画（NTP）が浸透していくものと思われる。人員・予算の配置等で先方の努力を引き続き促しながら、技術面でプロジェクト側が機能的に支援していくよう期待したい。

（３）国立リファレンスラボラトリーについて

本件については、無償資金協力の要請がなされている。正式なプロポーザルの提出手続きはNEDAが審査中であるが、現在はNEDAから保健省に対しコメントが付されており、保健省側が何らかのアクションをとるべき段階との由であった。早急な提出手続きを求めるとともに、特にラボラトリー建設予定地については結論を出すよう申し入れた。

（４）先方のローカルコスト負担状況、特に抗結核薬の確保について

おりからのアジア経済危機のあおりを受け、先方は予算が25%カットされるという深刻な状況にあり、特に抗結核薬の確保に大きな影響が出ている。見込まれる結核患者数に対し、抗結核薬を確保し得るのはそのうちの半数分であるとの由であった。先方も予算確保に努力していること、また当プロジェクト対象地区には優先的に供給するとの方針であることを確認したが、フィリピン全体の結核対策にとって非常に深刻な問題とし

て動きを引き続き注視する必要がある。

(5) 全体を通じて

いくつかの困難な状況はあるものの、中央レベルでも末端レベルでも結核対策に取り組む前向きな姿勢は共通するものであり、技術的支援を通じてNTPの実施・管理能力が十分向上するものと考えられ、今後のプロジェクトの取り組みにいっそう期待したい。大統領の掲げる優先施策である貧困者対策のなかで結核問題は重視されており、政府の関与も強まっている。また世界的な「結核再興」のなかで、現在のWHOのほか米国、カナダをはじめいくつかの政府・非政府機関がフィリピンの結核対策への国際協力に関心を示しており、今後は日本以外の援助国との効果的な協調関係のなかでプロジェクト活動を拡大していくことが必要になると考えられた。

３．PCMワークショップ

３－１ PCMワークショップの概要

日時：1998年 8 月 7 日 9 時～16時30分

場所：保健省研究実験局会議室

３－２ ワークショップの事前準備

ワークショップの参加者分析のための情報収集として、日本人専門家、フィリピン側カウンターパート、WHOの結核担当者からの聞き取りを行うとともに、マニラ市の市保健局と市立保健センター（City Health Center）を視察し、情報を取りまとめた。

３－３ ワークショップの結果

（１）参加者分析

事前の聞き取りなどにより収集した情報をもとに参加者表の試案を作成し、その結果について参加者とともに議論を行った。結果は別添３のとおりである。この表は行政レベル別（Central、Region、Province、Municipality、その他）にまとめてあるが、プロジェクト実施の機能別に見てみると以下のような特徴が指摘できる。

意思決定機能の分散

地方分権化（devolution）により、県と市の保健担当機関は保健省の管轄下にならない。結核対策は全国プログラムであるが、実際の活動は県と市の保健職員が行い、そのための人事権や必要な予算措置に関する権限は県と市にある。

監督・指導機能の重複

現場レベルの活動主体はRHUを管轄する市だが、県以上の行政レベルがこれを監督あるいは技術指導する。しかし、少なくとも今回のワークショップと個別のインタビューからは、これに関しての県、州、中央の役割分担は明確に確認できなかった。おそらく、人材と資金の事情などによりそれぞれの行政レベルが柔軟に対応しており、明確な役割分担は決まっていないのではないと思われる。

ワークショップでは議論されなかったが、地方分権化により「District」の機能がほぼ完全に欠如したために、県が全域のRHUを監督・指導する体制となり、県の負担が過剰になっているという指摘もあった。

治療薬調達の不安定さ

治療薬は一義的には必要量が中央から配布されることとなっているが、近年の経済状況の悪化などにより十分な量が調達されていない。中央では不足分を地方行政府

が補完することを期待している。各地方行政府がどの程度の量を補完する必要があるのかがわかるのは、中央での予算の決定および各地方行政府への配分が決まってからと考えられるが、地方行政府の予算策定と時期的に合致するか疑問である。この問題は、全体的な薬剤補給体制の不備とも関連している。

協力者との関係の不明確さ

現在、WHO、ワールドビジョンなどの国際NGO、さらに現地NGOも結核対策を進めているが、これらとプロジェクトとの関係は構築されていない。

(2) 問題分析

ワークショップで作成された問題系図は図3-1のとおりである。系図中のカッコ付き番号はプロジェクト対象地における重要問題を示し、それぞれカッコ内に書かれているリージョンにおいて重要であることを意味する。

1) 問題構造

問題系図に示される問題構造を簡潔にまとめると以下ようになる。

中心問題：

「フィリピンにおいて結核の問題がきわめて深刻である」

(モデレーターによる提示)

直接原因：

「多くの未診断の患者が多く存在する」「治療が十分完了しない」「感染リスクが高い」。最重要課題は「治療を適切に行うこと(適切なケース・ホールディング)」。感染リスクの問題については詳細な分析を行わなかった。

診断の問題：

顕微鏡などの機材の不足と検査の質の低さ(診断業務の問題)、患者に対する教育の不足などにより患者が診断を受けないこと(受け手の問題)、RHUに対する信頼性が低いために診断を受けないこと(提供側の問題)の3つの問題群。

治療の問題：

結核対策に従事する人材の不足、治療薬の不足、既存のヘルスワーカーの質の低さ、記録・報告システムの不備、治療方法不統一による副作用、RHUの利用率の低さ(診断の に同じ)の6問題群。

2) 対象地域における問題

問題分析において、本プロジェクトの現在の対象地であるリージョン4とリージョン7について重要な問題の特定を行った。ただし、時間の不足により具体的な内容の確認や全体での議論は行っていない。

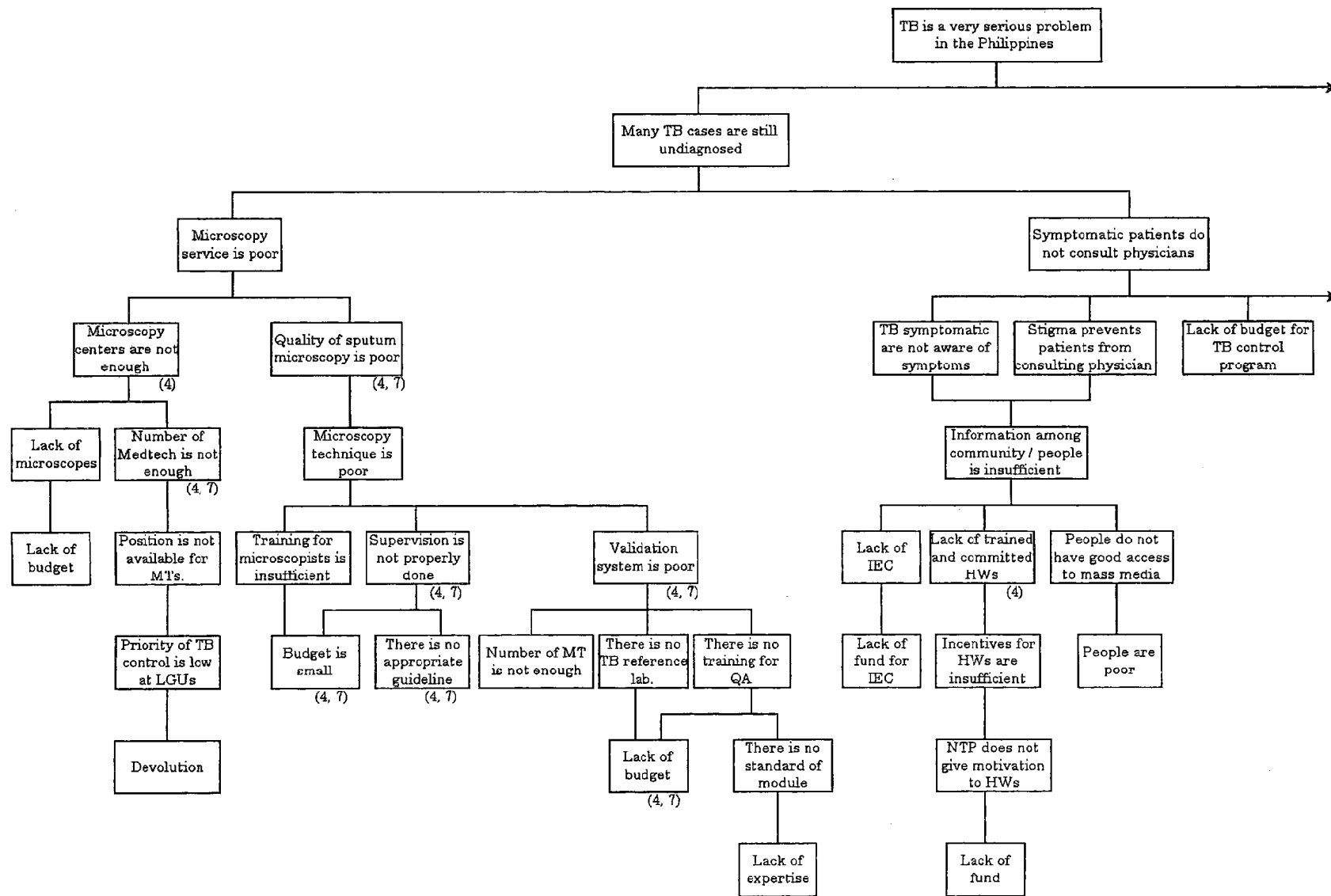


图 3-1 Problems Tree (1)

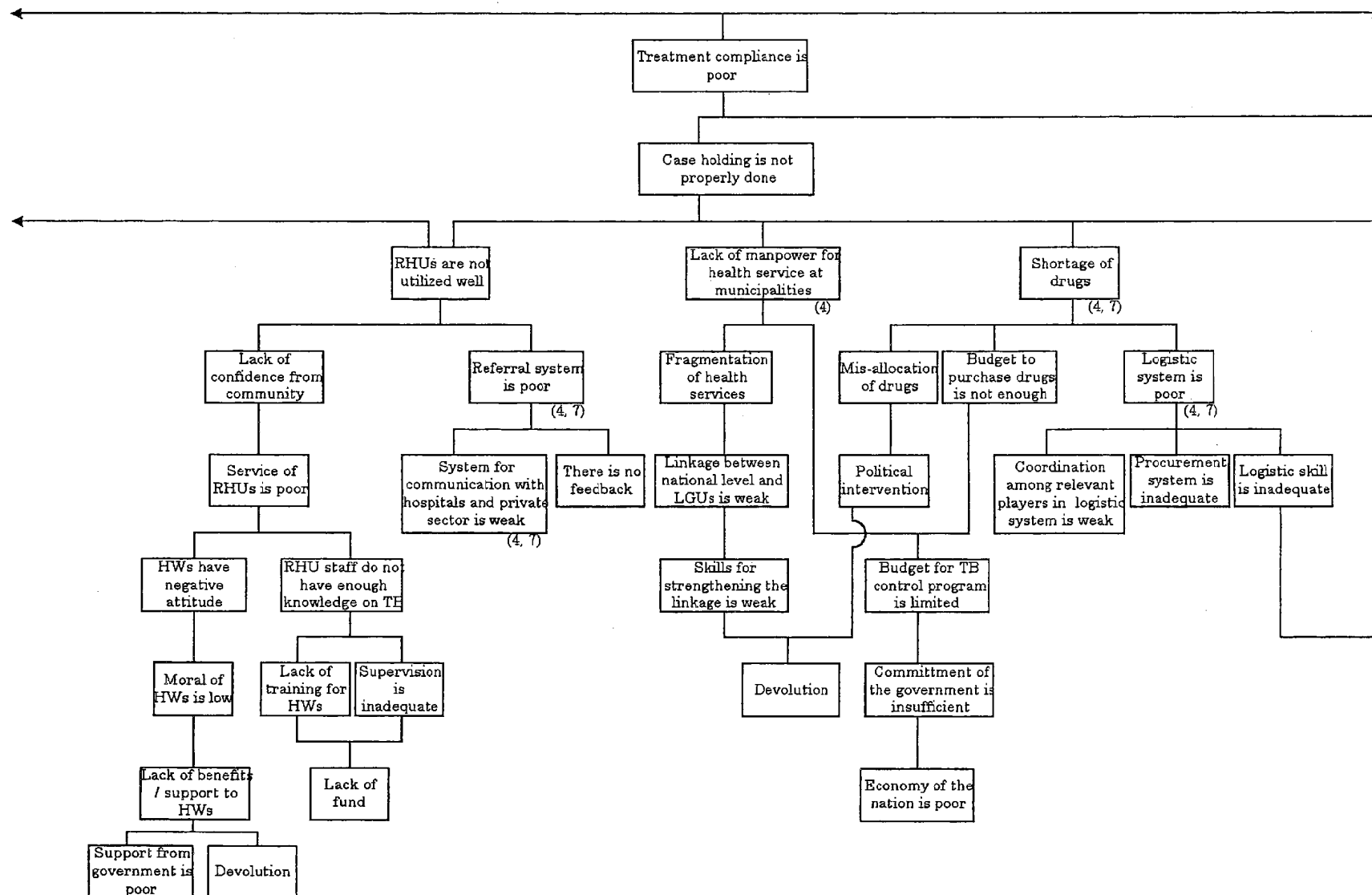


图 3-1 Problems Tree (2)

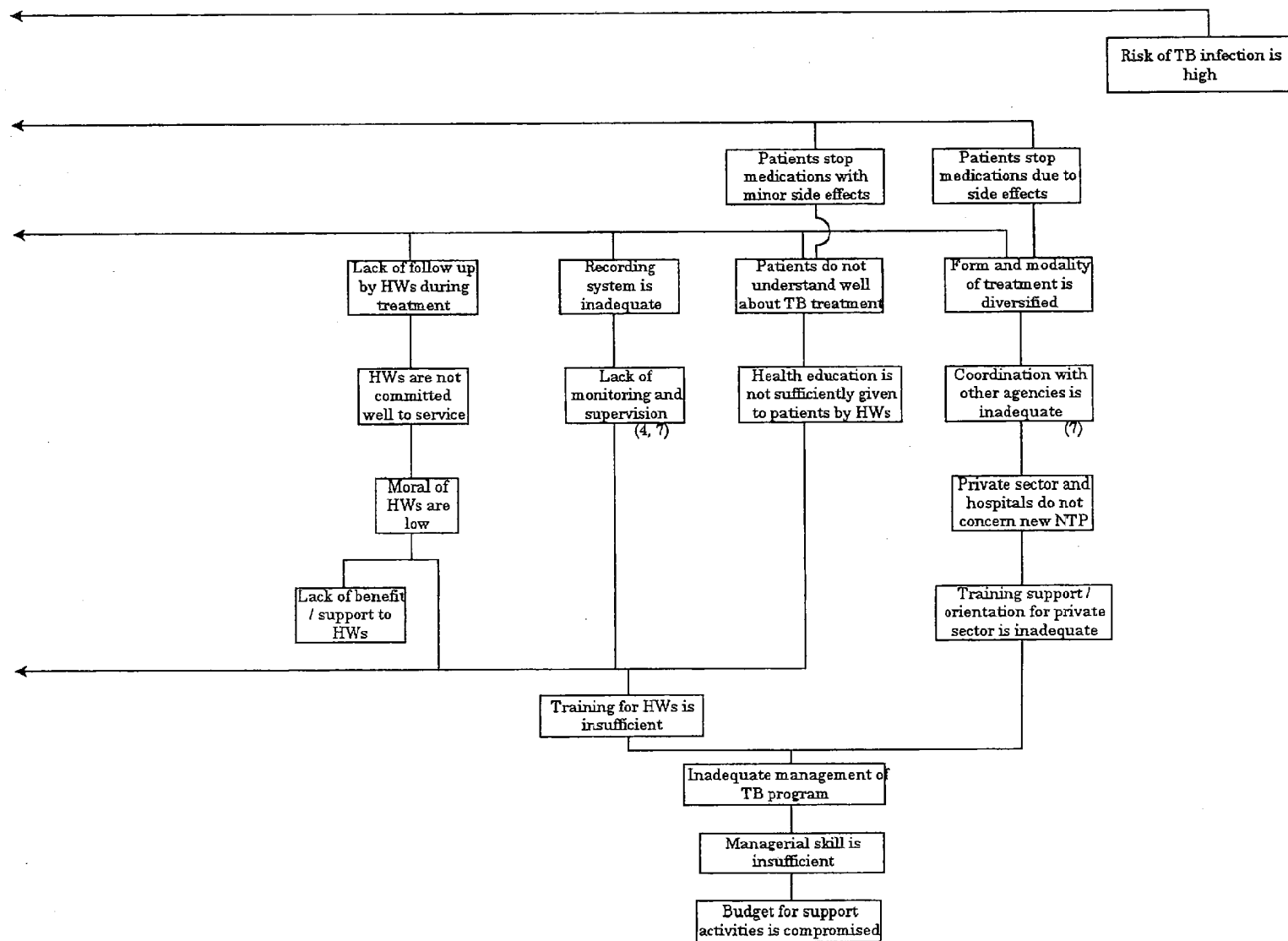


图 3-1 Problems Tree (3)

リージョン４とリージョン７共通：「顕微鏡検査を行う検査官の不足」「顕微鏡検査の監督制度の未整備」「検査制度（validation）の未整備」「民間・病院とのリファレルシステムの未整備」「治療薬の不足」「不適切な薬剤調達制度」「治療記録のモニタリング・監督制度の未整備」。

リージョン４：「訓練されたヘルスワーカーの不足」。

リージョン７：「民間などとの治療方法の不統一」。

（３）目的分析

ワークショップで作成された目的系図は図３－２に示すとおりである。系図中の丸番号は同レベルの手段のなかでの優先度を示す（例：「結核の診断の改善」のためには「顕微鏡検査の質的向上」が「患者が診断を受けに来るようになる」より優先課題である）。点線で囲まれた部分が本プロジェクトの範囲を表す。また、カッコ内のアルファベットは責任機関を示し、以下の凡例に従う。

C: Central R: Regional P: Province M: Municipality
Hu: R H U B: B H S Ho: Hospitals Pr: Private clinics
J: J I C A

１）優先課題

上位目的達成のためにいくつかのアプローチが確認されたが、そのなかで以下の分野は特に優先度が高いとされた。

「治療薬の充足」

中央のみでなく、地方行政府も予算を確保することが必要。また、調達・輸送などの補給体制の改善のため、特に管理分野の人材育成が必要。

「ヘルスワーカーによる患者治療のモニタリングとフォローアップ」

つまり適切な直接監視下短期化学療法（DOTS）の実施に同じ。このために、ヘルスワーカーに対するインセンティブの付与と監督・モニタリング制度の整備が必要である。

「全体的な結核対策プログラムのための人材の調達」

量的向上を意味し、地方行政府による採用の増加と各行政レベル間の協調的な人材の活用が必要。

「顕微鏡センターの設立」

「顕微鏡検査の質的向上」

検査技師の訓練と検査体制（validation system）の構築を並行して行うことが必要。

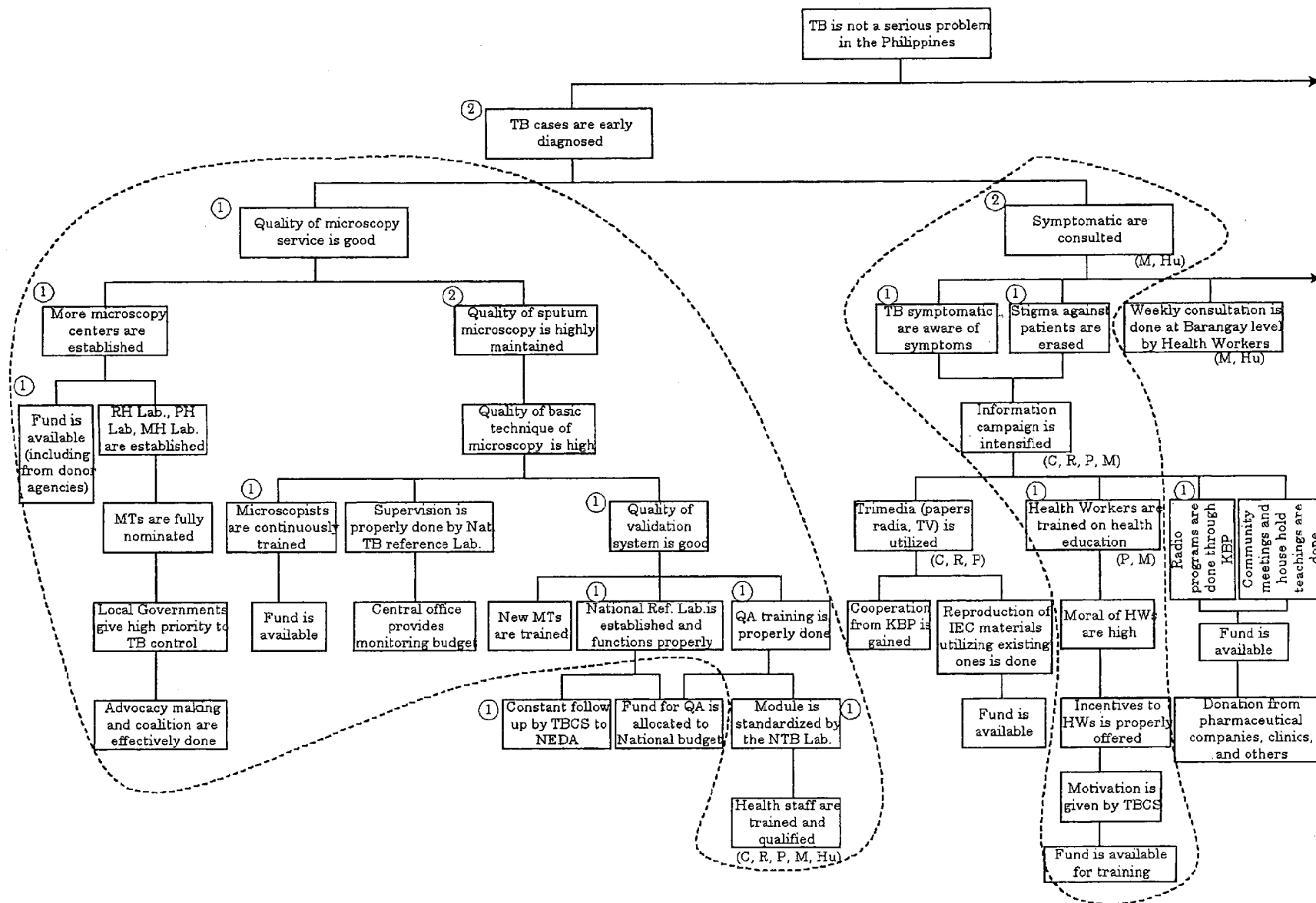


图 3-2 Objectives Tree (1)

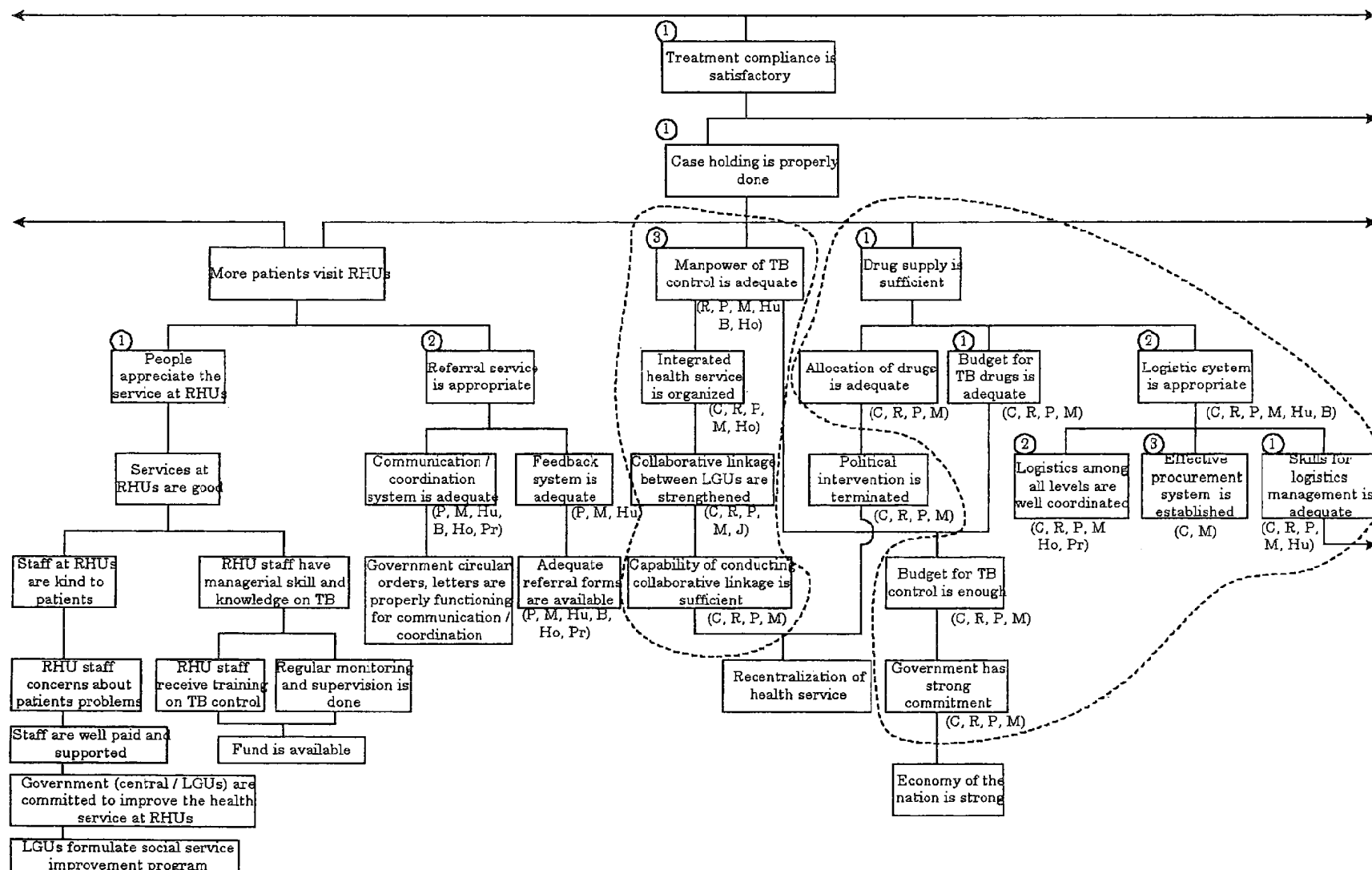


图 3-2 Objectives Tree (2)

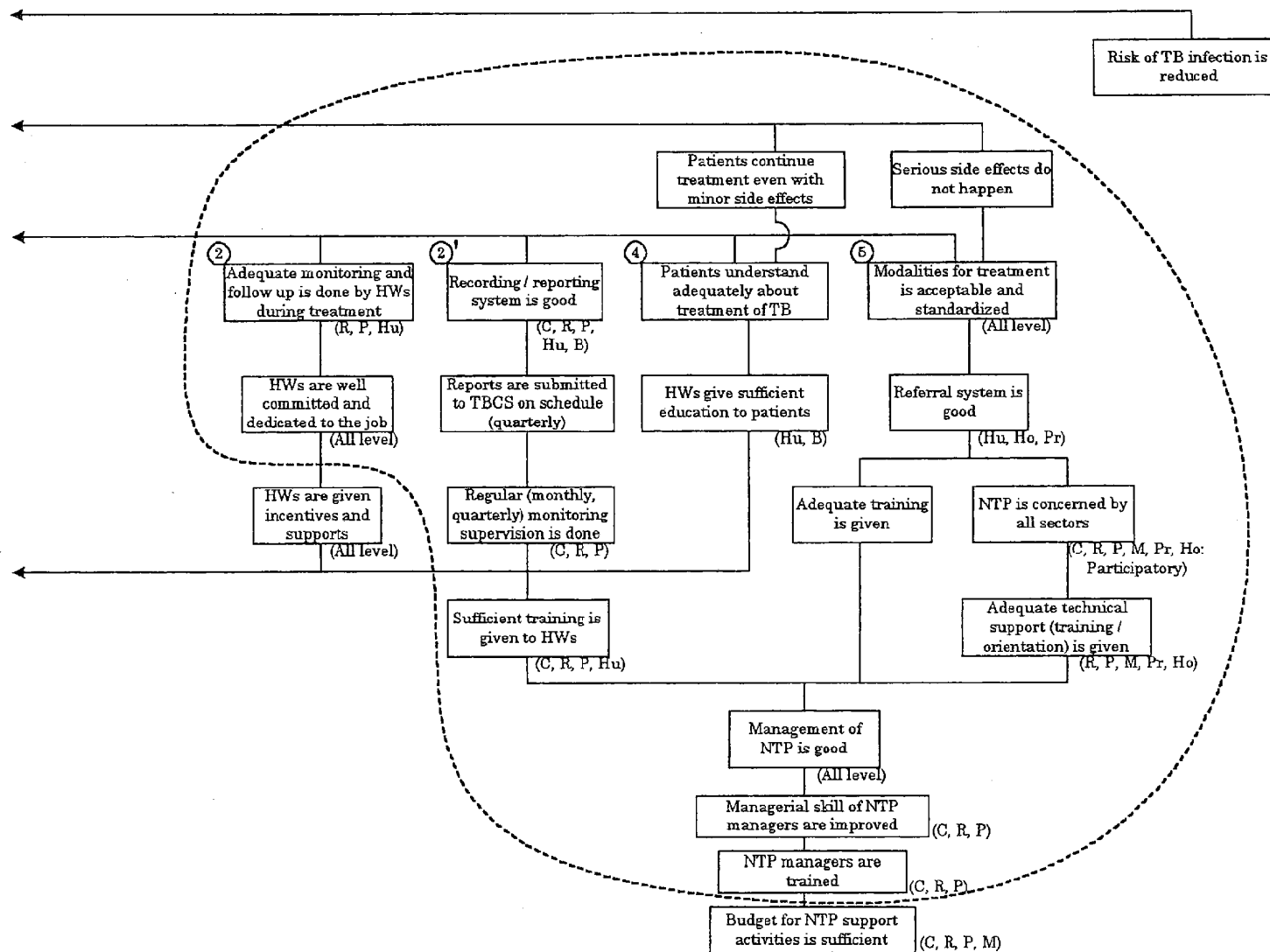


图 3-2 Objectives Tree (3)

2) 技術向上の必要な分野

上位目的達成のためのアプローチを技術向上の必要な分野（技術協力の必要な分野）という横断的な視点からみると、「検査技師育成」「検査技術訓練講師育成」「監督官（supervisor）育成」「検査の質管理に関する訓練」「ヘルスワーカーへの保健教育に関する訓練」「ヘルスワーカーへのDOTSに関する訓練」「リファレルシステムに関する訓練」「薬剤調達・配送に関する技術の訓練」「管理者レベルのプログラム管理に関する訓練」の9分野にまとめられる。

3) 組織・制度・運営上の改善が必要な分野

また、それぞれのアプローチを実現していくうえで組織・制度などの面で改善が必要な分野は「国立リファレルラボラトリーの設置」「検査の質管理のためのvalidationの標準化」「民間・病院との連携体制の確立」「各行政レベルでの協調体制の確立」「薬剤ロジスティックス・システムの確立」「DOTS活動の定期モニタリング・指導体制の確立」の6分野である。

4) その他

多くの局面で「結核対策の（政策における）優先度が高まる」という状況が必要になっており、そのための啓蒙活動やプロジェクトの成果の公表などによる宣伝活動の必要性がうかがえる。

5) プロジェクトの範囲

ワークショップの参加者により、本プロジェクトが検討されたアプローチの大半をカバーしていると認識された。ただし、この範囲内での各項目の具体的な活動内容と役割分担については確認できなかった。プロジェクトの範囲外とされた部分は、「メディアによる啓蒙活動」「住民への直接的な啓蒙・教育活動」「RHUの全般的な改善」「リファレルシステムの構築（民間・病院との連携体制の確立）」「ヘルスワーカーに対するインセンティブの供与」「感染リスク軽減のための活動」である。

3 - 4 改訂版系図の作成

現地ワークショップにおいて、フィリピンにおける結核対策に関する問題構造と目的構造を大局的に把握することができたが、ワークショップの時間的な制約から、詳細については議論が不十分と思われる部分もあった。このため、ワークショップの事前に行った関係者からの情報収集、問題分析の前に行った参加者分析での検討の結果などをもとに、ワークショップで作成された系図への加筆修正を行い、改訂版系図を作成した。それぞれの系図の修正点は以下のとおりである。

(1) 問題系図の改訂

上述のように、調査期間中に収集された情報をもとに問題系図の修正を行った。改訂版問題系図（図3 - 3）の中の角の丸い枠にかかれた「問題」が修正・追加を行った箇所であり、その説明は以下のとおり。

「顕微鏡の不足」の原因として、「新規購入予算の不足」に「既存の機材の維持・管理が不適切」を追加した。

「Medtechの不足」について、県レベルで用意する分と市レベルで用意する分があり、この点を明記した。

「検査技師（microscopist）に対する研修の不足」の原因として、「予算の不足」に「研修講師の不足」「講師研修の不足」を追加した。

「顕微鏡検査の監督（supervision）が不十分」と「確認検査（validation）が不十分」という問題は、オリジナルでは「顕微鏡検査の基本的技術が不足」の原因となっていたが、これらを「顕微鏡検査の質監理の不足」としてまとめ、「顕微鏡検査の質が悪い」という問題の原因とした。

「顕微鏡検査の監督が不十分」の原因に「監督官の不足」とそれにつながる原因群を追加した。

一般に対する情報提供の問題で、「訓練を受け、積極的に従事する職員の不足」の原因として、職員に対するインセンティブの問題に「職員に対する訓練の不足」を追加した。

2 ページ目、「R H U のサービスが十分でない」問題に関して、「R H U 職員が結核対策に関する十分な知識をもっていない」という問題の原因に「R H U に多くのプロジェクトが任されている」ために「結核対策に関する活動に集中できない」という問題を追加した。

リファレルシステムに関して、オリジナルの「病院・民間とのコミュニケーションが弱い」という問題をさらに、R H U 間のコミュニケーションに関する問題にも広げた。

「病院・民間とのコミュニケーションの問題」の原因に「N T P の管理者レベルの臨床経験が少ない」ために「臨床面に関する信頼性が強くない」という問題を追加した。

「病院・民間がN T P に十分関与していない」問題の原因として「病院・民間の結核対策に対する優先度が低い」とことと「病院の公衆衛生に関する機能が不十分である」ことをあげた。

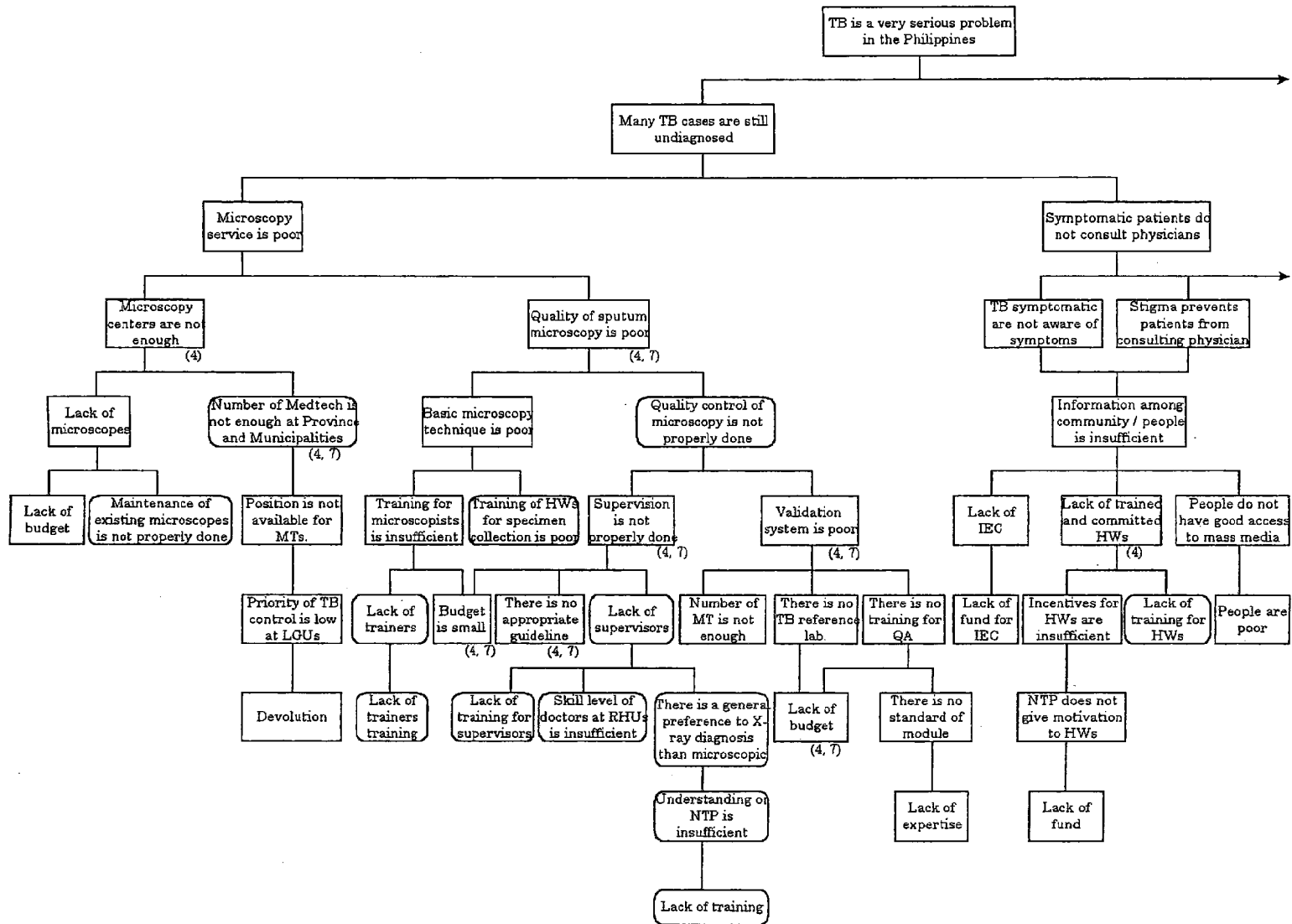


圖 3-3 改訂版問題系圖 (1) Problems Tree-Revised (1)

圖 3-3 改訂版問題系圖 (2) Problems Tree-Revised (2)

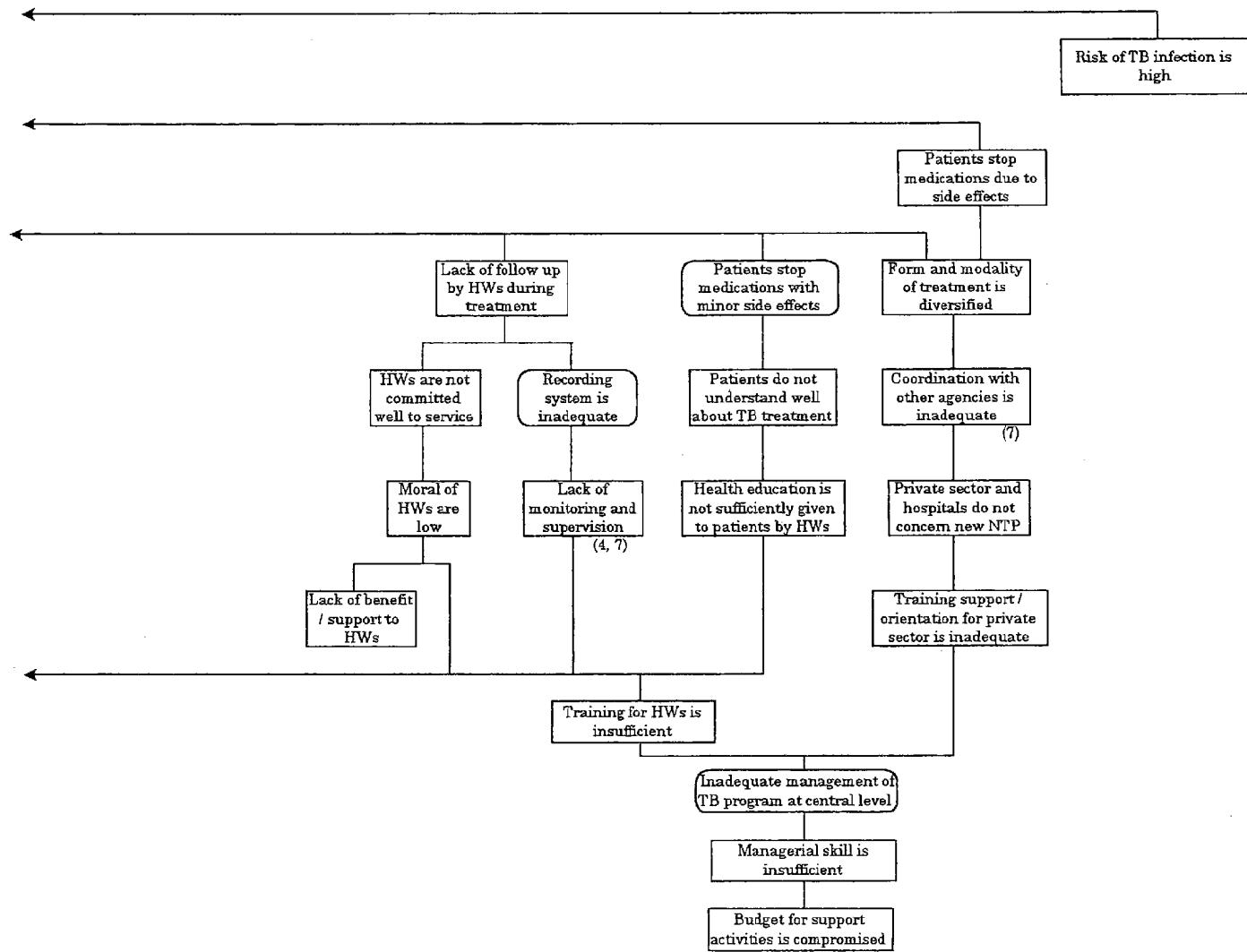


図 3-3 改訂版問題系図 (3) Problems Tree-Revised (3)

「R H Uが十分活用されていない」という問題は、オリジナルでは「継続治療（case holding）が適切に行われていない」ことの直接原因となっていたが、直接原因として「移転患者が適切にフォローされていない」を加え、その原因として「リファレルシステムが不十分である」という問題につなげた。

「継続治療が適切に行われていない（Case holding is not properly done）をより明確にするため、「D O T Sが適切に実施されていない（DOTS is not properly practiced）」に変更した。

「市レベルにおける保健・医療サービス職員の不足（lack of manpower）」を、治療分野との関連をより明確にするため「D O T Sを実施するための職員の不足」とした。

「結核治療薬の不足」の原因の「分配が適正でない」問題の原因に「菌陰性かつX線陽性の患者に投薬されている」に関する問題群を追加した。

「治療薬購入のための予算の不足」の原因を「中央レベルでの予算の不足」と「地方政府レベルでの補完的予算の不足」の2つに分類した。

3 ページ目、「記録システムが不適切」を「ヘルスワーカーが適切に患者をフォローしていない」問題の原因とした。

「患者が、治療薬による軽微な副作用で治療を中断してしまう」という問題は「治療完了率が低い（Treatment compliance is low）」の直接原因であったが、「D O T Sが適切に実施されていない」の原因とした。

「結核対策プログラムが適切に管理されていない」という問題の主体が実施部隊の地方行政ではなく中央にあることを明確にした。

（２）目的系図の改訂

上記の問題系図の修正点をもとに目的系図の改訂を行った。改訂版目的系図中（図３ - ４）の、角の丸い枠の「手段」が追加・修正箇所である。その他の凡例は目的系図のものと同一である。またこの改訂に伴い、プロジェクトの範囲の再確認を日本側専門家に対して行った。この段階で特に行った修正は以下のとおりである。

住民啓蒙、ラジオ放送はtrimediaに包括。

プライオリティ１「ラジオ放送」は「trimedia」に移動。

マンパワー調達につながる手段としての「保健セクターの再度の中央集権化」は非現実的なので削除。

「治療薬の分配適正化」の手段「政治的介入の排除」の手段の「中央集権化」も削除。

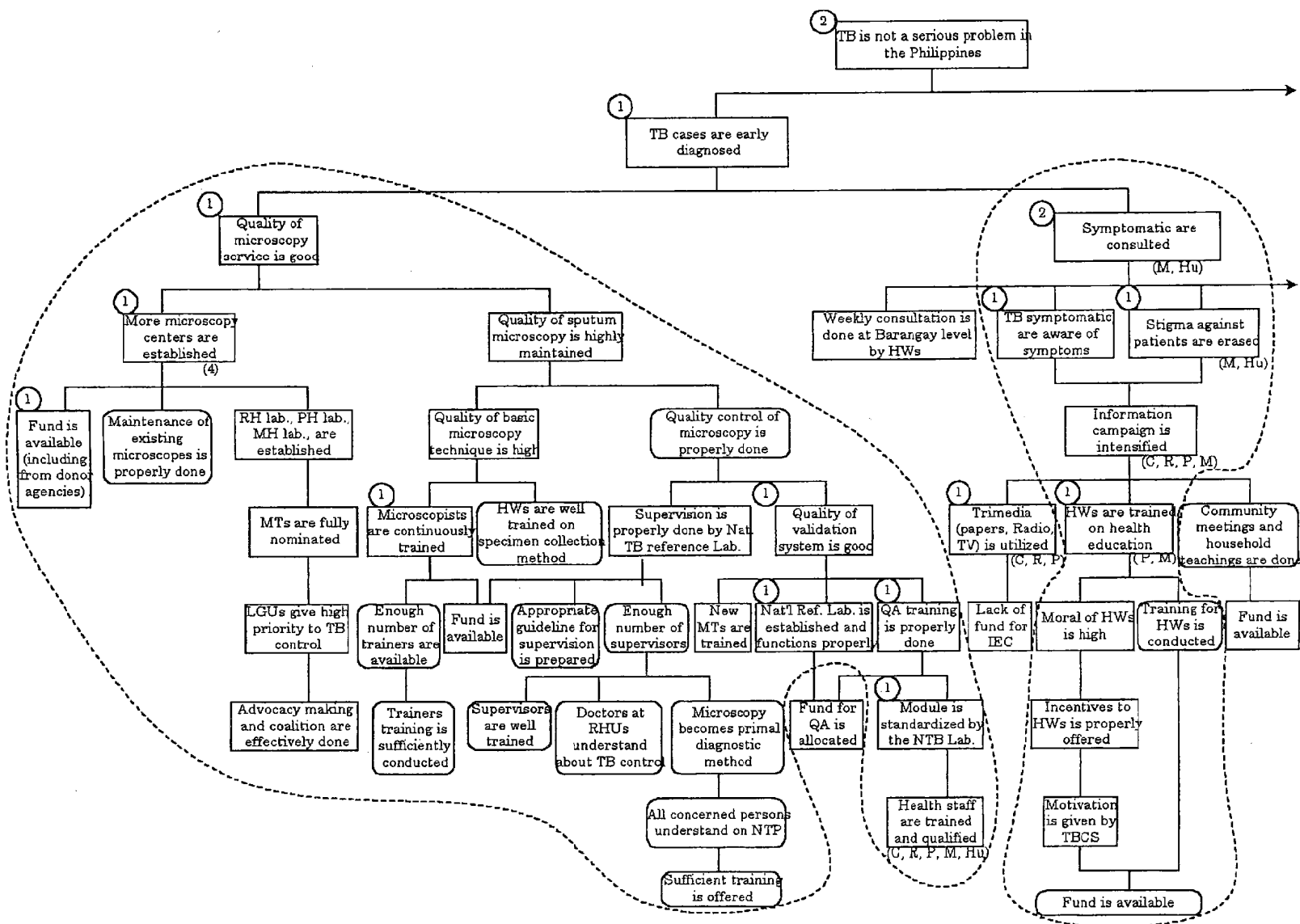


图 3-4 改訂版目的系图 (1) Objectives Tree-Revised (1)

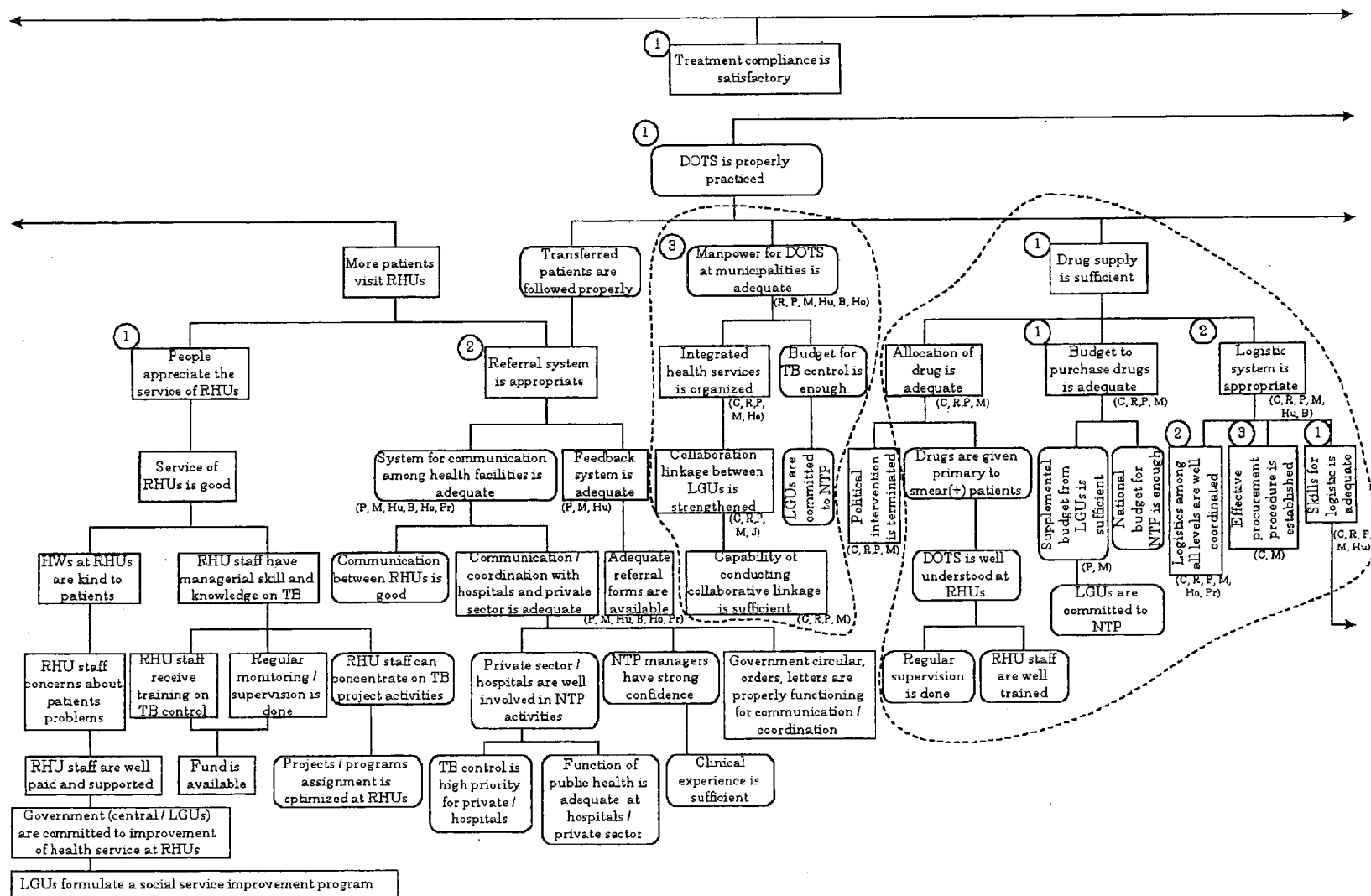


图 3-4 改訂版目的系图 (2) Objectives Tree-Revised (2)

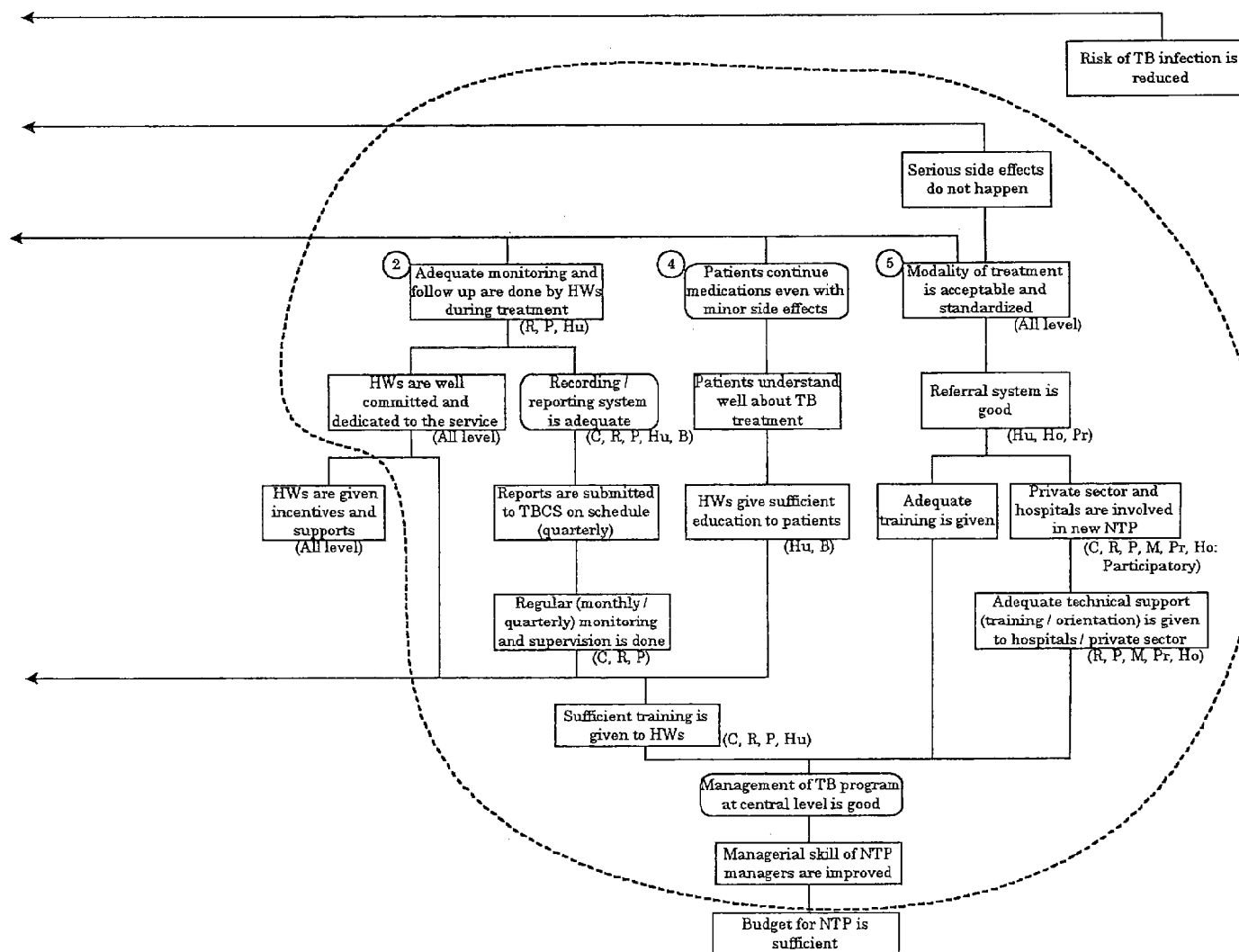


图 3-4 改訂版目的系图 (3) Objectives Tree-Revised (3)

3 - 5 分析結果に関する留意点と今後の検討課題

(1) 参加者分析

本プロジェクトの参加者分析における最大の問題は、プロジェクトの直接的な実施者の範囲が不明確なことである。この問題の原因として地方分権化があげられる。結核対策の国家レベルでの管理は中央の政府機関である保健省結核対策課（Tuberculosis Control Service；TBCS）によって行われているが、現場での活動は県と市によって実施されている。しかし、地方分権化により、TBCSは県と市の保健担当部局に対して直接的な権限をもたない。このため、「ワークショップの結果」の「参加者分析」の項でも述べたように、人事権などの意思決定機能が分散したり、プロジェクト実施の指導・監督機能の役割分担が不明確になっている。この問題をPCMの観点からみると、後に述べるPDMの活動や成果の達成責任の所在が不明確になる、あるいはプロジェクトの内部要因と外部条件の区別が不明確になるという問題が起こる。これがプロジェクトの進捗そのものに直接大きな影響を及ぼす可能性は高くないと予想するが、プロジェクトのモニタリング・評価の際には大きな問題となり得る。今後、本プロジェクトのカウンターパートと日本人専門家の間でこの点についての整理が必要である。

(2) 問題分析

改訂作業を行った後でも大きな問題構造はオリジナルの系図と変わらないが、今後さらに以下の点について確認が必要である。

リージョン4、リージョン7での重要問題の詳細について。

問題をもつ主体の特定（誰にとっての問題かが明確でないものが多い。また同じ問題でも主体が異なることで問題の性質も異なることがあり得る）。

(3) 目的分析

目的分析についても、改訂後のアプローチの構造の大きな変化はない。ただし、下位の手段（系図の下部）について選択肢（あるいは必要手段）が増えているので、これらの部分についてはPDMの作成に向けてその現実性と効率性を検討する必要がある。その他、以下の点について確認が必要と思われる。

microscopy center とregional、provincial、municipal laboratoryの違い（同じであれば用語を統一する。異なるものであればその役割分担を明確にする）。

優先課題について再度コンセンサスを確認する必要がある。

主な手段の責任機関を明記したが、ワークショップでは2つのグループで作業基準が統一されなかったとみられるため、再度全体の見直しをするとともに、複数の機関が

責任を共有あるいは分担している場合はその内容を明確にする。

3 - 6 P D M試案の作成

(1) アプローチのまとめ

上記の改訂版目的系図をもとにプロジェクトが対象とするアプローチを整理したものが表 3 - 1 である。1 ページ目が診断分野、2 ページ目が治療分野となっているが、レベル 1 は共通の上位目的であり、レベル 2 以下は並列していると考ええる。またレベル 7 は内容が活動レベルのものをまとめた。アプローチによっては、手段の分岐が少ないため中間のレベルがない形になっているものもある。

(2) P D M試案の作成

上記のプロジェクトの対象分野のアプローチの整理表、改訂版目的系図、さらに N T P に示される結核対策プログラムの目標達成指標などから、P D M試案を作成した(表 3 - 2)。

1) 「プロジェクトの概要 (Narrative Summary)」

「プロジェクトの概要」は、単なる表 3 - 1 の内容の転記ではなく、「成果」「活動」の内容から、プロジェクト実施上 1 つの「成果」あるいは 1 つにまとめた「活動」とした方がよいものなどを検討し再編成したものである。

「プロジェクト目標 (Project Purpose)」と「成果 (Output)」は原則としてプロジェクト対象地におけるそれぞれの達成を意味する。「成果」と「活動 (Activity)」は、上記のアプローチ概要表をもとに作成した。上記の表の下線部が「上位目標」、太イタリック文字が「プロジェクト目標」、太字が「成果」に対応する。ただし、「プロジェクト目標」と「上位目標」については 2 つの案を提示している。プロジェクト期間中にプロジェクトが達成できるという範囲からどちらが適切かを決定する必要がある。A 案 (上位目標 A とプロジェクト目標 A の組み合わせ) では「プロジェクト目標」と「成果」が近すぎ (成果の総体が目標そのものといえる)、「プロジェクト目標」の指標の設定が困難である。B 案 (それぞれの B の組み合わせ) はプロジェクト対象地域での目標達成が全国レベルに影響を及ぼす程度になるかどうか疑問である。

その他の主な変更点は以下のとおりである。

「監督・指導 (supervision)」は診断分野と治療分野を統合して 1 つの成果とした。

治療分野の「適切な治療モニタリング・追跡がヘルスワーカーによって行われる (Adequate monitoring and follow up are done by HWs.)」は、D O T S の実

表 3 - 1 アプローチ概要表：診断分野

Level 1	<u>TB is not a serious problem in the Philippines.</u>				
Level 2	<i>TB cases are early diagnosed.</i>				
Level 3	Quality of microscopy service is good.				Symptomatic are consulted.
Level 4	More microscopy centers are established.	Quality of sputum microscopy is highly maintained.			TB symptomatic are aware of symptoms and not affected by stigma.
Level 5		Quality of basic microscopy technique is high.	Quality control of microscopy is properly done.		Information campaign is intensified.
Level 6			Supervision is properly done by Nat l. TB Ref. Lab.,	Quality of validation system is good.	HWs are trained on health education.
Level 7	<ul style="list-style-type: none"> -Maintenance of existing microscopes is properly done. -Advocacy making and coalition are effectively done. -MTs are fully nominated. -Establishment of RH/PH/MH labs. 	<ul style="list-style-type: none"> -Trainers training is sufficiently conducted. -Microscopists are continuously trained. -HWs are well trained on specimen collection. 	<ul style="list-style-type: none"> -Appropriate guidelines for supervision is prepared. -Sufficient training on NTP is offered. -Doctors at RHUs understand about TB control. -Training for supervisors are done. 	<ul style="list-style-type: none"> -New MTs are trained. -Nat l. Ref. Lab. Is established. -Health staff are trained. -Module is standardized. -QA training is properly done. 	<ul style="list-style-type: none"> -Training for HWs is conducted. -Incentives to HWs is properly offered.

表 3 - 1 アプローチ概要表 (続き) : 治療分野

Level 1	TB is not a serious problem in the Philippines.											
Level 2	Treatment compliance is satisfactory											
Level 3	DOTS is properly practiced.											
Level 4	Manpower for DOTS at Municipality level is adequate.	Drug supply is sufficient.						Adequate monitoring and follow up are done by HWs during treatment.		Patients continue medication even with minor side effects.		Modality of treatment is acceptable and standardized.
Level 5	Integrated health service is organized.	Allocation of drug is adequate.	Budget to purchase drugs is adequate.		Logistic system is appropriate.			HWs are well committed; dedicated to service.	Recording / reporting system is adequate.	Patients understand well about TB treatment.		Referral system is good
Level 6	Collaboration linkage between LGUs is strengthened.	Drugs are given primarily to smear(+) patients.	National budget for NTP is adequate.	Supplemental budget from LGUs is sufficient.	Logistics among all levels are well coordinated.	Effective procurement system is established.	Skills for logistic is adequate.					Privates / hospitals are committed to NTP
Level 7		-RHU staff are well trained. Regular supervision is done.						-HWs are well trained.	-Training is given to HWs. -Regular monitoring / supervision is done.	-HWs give sufficient education to patients. -HWs are given training.	-Adequate training is given to RHUs.	-Adequate technical support (training / orientation) is given to privates / hospitals.

表 3 - 2 P D M 試案

Project title: DOH-JICA Tuberculosis Control Project

Target: TB patients

Duration: 1997

Area: Region VII (Cebu Prov., Negros Oriental Prov., Bohol Prov.); Region IV (Laguna Prov.)

Date: 1998/8/30

Narrative Summary	Verifiable Indicator	Means of verification	Important Assumption
Overall Goal: A. TB problem is reduced in the target areas. B. TB problem is reduced in the Philippines.	A. Rate of new smear (+) per pop. by age in the target areas. B. Rate of new smear (+) per pop. by age in the nation.		1. Minimum sufficient activities for TB control are sustained.
Project Purpose: A. Diagnosis and treatment of TB is properly done. B. TB problem is reduced in the target areas.	A. B. Rate of new smear (+) per pop. by age in the target areas.		2A. Risk of TB infection does not become higher. 2B. TB reduction in the target areas have enough impact at national level.
Output: 1. Sufficient number of microscopic centers are established. 2. Quality of basic technique of microscopy is improved. 3. Quality validation system is established. 4. Manpower for DOTS at Municipality is adequate. 5. DOTS method is followed by RHUs and BHCs. 6. Drugs supply is improved. 7. Modality of treatment is standardized among private sector and hospitals. 8. Appropriate supervision for diagnosis and treatment is conducted. 9. Patients are well informed about TB. 10. Project implementation framework is established.	1. No. of centers with at least one MT and one workable microscope at Reg. / Prov. / Mun. 2. Positive rate. 3-1. Nat'l Ref. Lab. is established by year ... 3-2. 4. 5-1. Sputum negative conversion rate at 2 nd and 3 rd month of treatment. 5-2. % of new pulmonary smear (+) lost. 6. % of treated patients per diagnosed. 7. 8. No. of supervisory visit per mo. 9. % of symptomatic per pop. 10. Demarcation of all activities are documented.		3B. Risk of TB infection does not become higher. 4. RH / PH / MH laboratories are properly managed. 5. Trained personnel stay in the project. 6. RHUs/BHCs are fairly trusted.

<p>Activity:</p> <p>1-1. Technical support for maintenance of existing microscopes (R, P, M, Hu).</p> <p>1-2. Supervision of maintenance of existing microscopes (R, P, M).</p> <p>1-3. Advocacy activities to Provinces and Municipalities for assignment of MTs (P, M).</p> <p>1-4. Establishment of RH/PH/MH labs (R, P, M).</p> <p>2-1. Trainers training for microscopy (T, R, P, M).</p> <p>2-2. Training of MTs on microscopy (Hu).</p> <p>2-3. Training of HWs on specimen collection (Hu, B)</p> <p>3-1. Advocacy activities to Provinces and Municipalities for assignment of validators (P, M).</p> <p>3-2. Training for validators (R, P, M).</p> <p>3-3. Establishment of National Reference Lab (T).</p> <p>3-4. Standardization of validation module (N).</p> <p>3-5. Training on QA to NTP coordinators (R, P, M)</p> <p>4-1. Initiation of collaborative linkage among LGUs.</p> <p>4-2. Advocacy activities to Provinces and Municipalities creation of integrated health service (P, M).</p> <p>5-1. Establishment of recording and monitoring system for DOTS (R, P, M, Hu, B).</p> <p>5-2. Training on treatment recording / reporting (DOTS) (Hu, B).</p>		<p>7. Actual support from LGUs can be obtained (assignment of MTs and validators, budget allocation for drugs).</p> <p>8. Trained personnel stay in the project.</p> <p>9. National Reference Lab. is properly managed.</p> <p>10. HWs at RHUs and BHU are well motivated.</p> <p>11. Transferred patients are properly followed (referral system among RHUs and between private sectors and hospitals is appropriate).</p> <p>12. Health staff at LGUs can allocate sufficient time and effort for TB control program (duty is not overload).</p> <p>13. Sufficient drugs are available.</p>
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<p>6-1. Training of RHU staff on DOTS/NTP to optimize drug distribution to patients (Hu, B).</p> <p>6-2. Advocacy activity for budget allocation for drugs (T, P, M).</p> <p>6-3. Improvement of procurement procedure (T, M).</p> <p>6-4. Training on logistics (T, R, P, M, Hu).</p> <p>6-5. Establishment of coordination system for logistics (T, R, P, M. Hu, Pr).</p> <p>7-1. Orientation seminars and training on NTP for private sector and hospitals (T, R, P, M, Hu, Pr, Ho: participatory approach).</p> <p>8-1. Formulation of a guideline of microscopy and treatment supervision (N).</p> <p>8-2. Training on NTP (R, P, M, Hu).</p> <p>8-3. Training of supervisors on diagnosis, DOTS, drug allocation (R, P, M).</p> <p>9-1. Training on health education (Hu, B).</p> <p>9-2. Health education to patients (Hu, B).</p> <p>9-3. Information campaign (N).</p> <p>10-1. Clarification of responsibilities of above activities and outputs.</p> <p>10-2. Establishment of a coordination system among implementing agencies.</p> <p>10-3. Establishment of project implementation monitoring mechanism.</p>		<p>14. Transportation system for drug distribution is appropriate.</p> <p>15. Private sector and hospitals follow NTP / DOTS.</p> <p>16. Operational budget for supervision activities is available at LGUs.</p> <p>Precondition:</p>
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施とその監督の両方が含まれているため、監督の部分を上記の「監督・指導」の活動にまとめ、DOTSの実施に関する部分を独立させた。

患者に対する啓蒙・情報提供活動についても診断分野と治療分野を統合して1つの成果とした。

治療薬の供給の問題では、「薬品の適正配分」「治療薬購入予算の確保」「薬剤補充システムの確立」は通常であればいずれも「成果」レベルの内容であるが、これらのための活動内容が比較的乏しく、外部条件と思われる要因が多いと考えられたため、「治療薬の供給状況が改善する」という1つの「成果」にまとめた。

各「成果」「活動」の役割と責任の分担が必ずしも明確でないと思われたため、「プロジェクト実施体制が確立する」という「成果」を追加した。

「活動」のカッコ内はそれぞれの活動の対象を示し、以下の凡例に従う（「N:全国」以外はプロジェクト対象地内を前提とする）。ただし、「3 - 5 分析結果に関する留意点と今後の検討課題」の項でも述べたように、それぞれの活動の主体は一義的にはTBCSだが、必ずしも明確にはなっていない。

T: TBCS R: Region P: Province M: Municipality
Hu: RHU B: BHS Ho: Hospitals Pr: Private clinics
N: 全国

2) 「外部条件 (Important Assumption) 」

外部条件とは、プロジェクトの実施に重大な影響を及ぼす可能性のある外部の（プロジェクトでコントロールできない）条件のうち、それが満たされるかどうか現時点で不明なもの、満たされない可能性が懸念する程度ありモニタリングが必要なもののことである。それぞれ1段階上に進むために必要な条件である（例：「活動」と同じレベルにある外部条件は、活動実施中あるいは実施後の時点で「成果」を達成するために必要な外部の条件）。番号にAあるいはBとあるものは「プロジェクト目標」のAあるいはB案に特有の条件である。

この試案では、地方行政府に権限のある検査技師の採用などはプロジェクトの外部であるとし、外部条件に入れた（外部条件7）。

3) 「指標 (Verifiable Indicator) 」

「指標」はプロジェクトから入手した、すでに活用している指標のリストを参考に記入した。AあるいはBとあるものは、AあるいはB案に特有の指標である。「成果」の指標の番号は「成果」の番号と対応している（例：「指標」5 - 1と5 - 2は「成果」5のための指標である）。試案作成時に適切な指標がみつからなかったものは空欄のまま

ま残してある。

3 - 7 P C M手法の適用に関する今後の進め方

今後、本プロジェクトにP C M手法を適用するために、以下の順序で作業を進めていく必要がある。

(1) 最終版P D Mの作成

1) 「プロジェクト目標」「上位目標」の決定。

現在2つ示されている試案から適切な方を選択する。

2) 「成果」「活動」の決定

「成果」と「活動」を見直し、必要があれば削除・追加・修正する。また、ワークショップでの議論などをもとに、対象地域別に特に重要な「成果」と「活動」を明らかにする。さらに、それぞれの「成果」と「活動」について、責任者(機関)を明確にする。複数の責任者(機関)が関与するものについては、責任者(機関)ごとの役割と責任の分担を明確にする。

3) 「外部条件」の決定

現在示されているものについてそれぞれ、プロジェクト実施にとっての重要性、条件の満たされる可能性について再度検討し、重要性の低いもの、可能性の高いものを削除する。また、キラーアサンプション(満たされる可能性がない、あるいはきわめて低く、それによってプロジェクトの活動、成果、目標などの達成が阻害されることが予想されるもの)がないかを確認する。キラーアサンプションと思われるものがある場合は、その条件に影響されないように活動、成果、目標などを変更する必要がある。これについても対象地によって外部条件が異なる可能性がある。

4) 「指標」「指標データ入手手段(Means of Verification)」の決定

現在示されている指標についてそれぞれ適性を検討する。また、空白で残されている部分について適切な指標項目を設定する。さらに各指標について、対象地別に達成すべき具体的な目標値と達成すべき時期を明記する。次に、それぞれの指標についてそのデータの入手先を明らかにし、「指標データ入手手段」に記入する。

(2) 最終版P D Mの合意

上記のP D Mの作成は、フィリピン側と日本側双方による共同作業によって行うこととしたい。ただし、完成後はフィリピン側関係者と内容について十分検討し、相互理解を図る必要があり、関係者間で試行的に使用してみて、使いづらい点があれば現場の状況にあわせてP D Mを見直していくように弾力的に運用していくことが重要である。

別添1 ワークショップ参加者リスト

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Dr. Mariquita J. Mantala	Director III, Tuberculosis Control Services (TBCS), Department of Health (DOH)
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伊藤 賢一	国際協力事業団医療協力部医療協力第一課（調査団員）

別添2 ワークショップ実施スケジュール

1. Opening
2. Briefing on PCM
3. Participation Analysis
 - Presentation by Ito
 - Discussion on stakeholders, functions, problems
4. Problems Analysis (1)
 - Discussion on problems relevant to tuberculosis control
 - Group discussion
5. Lunch
6. Problems Analysis (2)
 - Continuation of group discussion
 - Presentation of the results from each group
7. Objectives Analysis
 - Discussion on the ideal situation (group discussion)
 - Discussion on responsibility of approaches
 - Discussion on the coverage of the Project
8. Closing

別添 3 参加者分析結果

1. Central level

Category	Institution	Function	Problems
Decision maker	Congress	Allocation of budget.	
Decision maker	DOH Secretary of Health Undersecretary of Health	Decision-making on NTP. Negotiation with Congress.	
Implementing agency of the cooperation project	TBCS Directors and staff	Overall planning Oversees Project. Coordination with LGUs. Monitoring and evaluation. Drug supply. Trainers training Training for higher level coordinators. Technical support to Provinces, and RHUs.	Budget shortage (cut by parliament), 70% of the budget is for drug (other activities are limited), and money allocation is delayed. Communication with Regions and LGUs are weak (long-distance lines). Delay of drug distribution. Drug shortage. No technical development (especially clinical experience). Competition with private sectors. Lack of confidence. No specialized laboratory.
Decision maker	JICA	Decision-making on Japanese activities. Funding.	Inflexible fund usage. Different stand point about expansion of NTP activities in the project.
Implementing staff of the cooperation project	JICA experts	Technical advice (management of NTP; technical aspect of NTP).	Training method is different from ones done by other agencies.
	FACS		
	Bureau of Research and Laboratories		
	NEDA		

2. Regional / Provincial level

Category	Institution	Function	Problems
Responsible of NTP; of the cooperation project at target area	<u>Regional Health Office</u>		Too many duties (operationally, technically). Bureaucracy (in terms of relationship with DOH). No supplemental budget allocation (especially for drug). Insufficient monitoring/reporting. Lack of practical experience, and confidence. Insufficient communication with hospitals.
	Regional Health Officer	Coordination among JICA, TBCS and LGUs. Monitoring, supervision and evaluation. Technical support to Province and RHUs. Information management (quarterly monitoring, annual reporting).	
	Regional Medical Co.		
	Regional Nurse Co.		
Collaborator; Decision maker at Provincial level	Governor	Decision making at Provincial level. Supplemental budget allocation.	
Responsible for NTP; the cooperation project at target area	<u>Provincial Health Office</u>		Shortage of budget (especially for drug). Too many duties. Lack of clinical experience, and confidence.
	Provincial Health Officer	Process decision-making. Supplemental financial support.	
	Provincial Medical Co.	Technical supervision.	
	Provincial Nurse Co.	Technical supervision.	
	Provincial Medtech	Validation of examination.	Lack of human power.
	Chest Center		
	Provincial/District Hospital	Case finding; case holding Referral to other health facilities	Public Health function is weak, and referral function is insufficient. Possess own policy for TB control, and is not necessarily committed to NTP.

3. Municipal level, and others

Category	Institution	Function	Problems
Collaborator; Decision maker at Municipal level	Mayor	Prioritize projects in Municipality. Supplemental budget allocation.	Sometimes difficult to have commitment.
Responsible person of NTP; of the cooperation project at target area	Municipal Health Officer	Activity planning. Data management. Supervision of RHUs activities.	
Implementing body of NTP activities	<u>RHU:</u>		Too many duties. Lack of budget (for drug, operation, training for midwives / volunteers). Lack of equipment for TB control. Insufficient quality of microscopy (medtech).Lack of manpower (especially medtech). Insufficient level of skill of doctors. Case holding is improper. Preference is X-ray oriented than microscopy.
	Public Health Nurse	NTP field activities (case finding; case holding).	
	Rural Health Midwife		
	RHU Medtech		
Collaborator	Barangay Health Worker (Volunteer)	Partner (DOTS promotion, follow-up of defaulters). Communication with patients.	Lack of motivation (some are given financial and non-financial incentives). Shortage of number. Educational background is not sufficient.
Collaborator	NGOs		
Collaborator	Other cooperation agencies (WHO, WB, others)		
Collaborator	Private clinics		Case holding is improper. Preference is X-ray oriented than microscopy. Send positive patients to RHUs for treatment. Improper referral.
Beneficiary	Patients		

別添 4 モニタリングシステム概要表（記入例）

プロジェクトの要約	指標	目標値	データ入手方法			データ集積方法			意思決定方法	
			担当者	時期	方法・記録	担当者	時期	方法	責任者	時期
プロジェクト目標 B. TB problem is reduced in the target areas.	Rate of new smear (+) per pop. by age.	X% by year Y.	RHUs	annual						
成果 1 Sufficient number of microscopic centers are established.	No. of centers with at least one MT and one workable microscope.	X in Y Prov. by year O. Z in W Prov. by year O.								
成果 2 Quality of basic technique of microscopy is improved.	Positive rate.	X% by year Y in A Prov.								
成果 3 Quality of validation system is established.	Nat'l Ref. Lab. is established.	Established by year O.								
成果 4 Manpower for DOTS at Municipality level is adequate.										
成果 5 DOTS method is followed by RHUs and BHCs.	1. Sputum negative conversion rate at 2 nd and 3 rd month. 2. % of new pulmonary smear (+) lost.	1.X% in Y Prov. by year O; Z% in W Prov. by year O; 2. A% in Y Prov. by year O; B% in Z Prov. by year O;								
成果 6 Drugs supply is improved.	% of treated patients per diagnosed.	% of symptomatic per pop.								
成果 7 Modality of treatment is standardized among private sector and hospitals.										
成果 8 Appropriate supervision for diagnosis and treatment is conducted.	No. of supervisory visits per month.									
成果 9 Patients are well informed about TB.	% of symptomatic per population.									
成果 10 Project implementation framework is established.	Demarcation of activities are documented.									

4 . 協議結果

8月3日から13日まで先方政府および関係機関との協議およびフィールド調査を行い、右結果を踏まえ協議議事録（ミニッツ）を先方ロペス保健省次官とわが方森団長との間で締結する予定としていたが、ロペス次官が急用により調査団訪比中に署名できなくなったところ、森団長のサインを残し、後日ロペス次官がサインを行った。右確認事項の概要は以下のとおりである。

（１）総論

本プロジェクトは結核対策新指針の拡大を行うためのマネジメント能力向上を図る目的で1997年9月1日に開始された。1997年8月14日に締結されたR / Dに基づき、JICAは3人の長期専門家を派遣し、3人の研修員を受け入れ、必要な機材を供与した。今回、現在までの活動を振り返り、現状を踏まえ今後の計画について協議を行った。

（２）協議結果

１）PCM手法の導入について

プロジェクトの円滑な運営のためPCM手法を導入することとした。調査団訪比中に開催されたPCMワークショップでは、参加者分析、問題分析、目的分析を行った。ワークショップの結果、暫定的に作成された系図はミニッツ付表１のとおりである。ワークショップの結果を踏まえ、さらに議論を重ねてPDMを完成させることとする。

２）プロジェクト対象地域について

R / Dに記載のあるとおり、下記のようにプロジェクト活動を進める。

- リージョン７：セブ州で結核対策新指針を実施して得られた成果を他の３州に広げ、リージョン全体をカバーする。
- ラグナ州：新指針のデモンストレーションエリアとして今年はフェーズ１の地域で展開し、次の年に残りの地域をフェーズ２として実施する。さらなる拡大についてはデモンストレーションの成果に基づいて議論を行う。
- 検査部門の向上：菌検査分野では、開始当初から国全体を対象としている。

３）国立リファレンスラボラトリーについて

フィリピン側は正式要請を提出するべく必要な行動をとる。

（３）これまでの実績

1998年7月末までの活動の実績はミニッツ付表２のとおりである。

（４）今後の活動計画

現状を踏まえ、両者はミニッツ付表３のとおり今後の活動計画を策定した。

附 属 資 料

ミニッツ

1997年度年間概要報告

1998年度第1四半期概要報告

1998年度第1回合同調整委員会議事録

R / D、T S I (1997年8月14日署名)

① ミニッツ

MINUTES OF DISCUSSIONS
BETWEEN THE JAPANESE CONSULTATION TEAM
AND THE AUTHORITIES CONCERNED OF THE GOVERNMENT OF
THE REPUBLIC OF THE PHILIPPINES
ON THE JAPANESE TECHNICAL COOPERATION
FOR THE TUBERCULOSIS CONTROL PROJECT

The Japanese Consultation Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Dr. Toru Mori visited the Republic of the Philippines for the purpose of reviewing the activities of the Tuberculosis Control Project (hereinafter referred to as "the Project"), and discussing the future implementation plan for the Project.

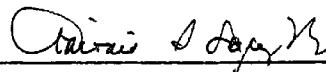
During its stay, the Team exchanged views and had a series of discussions with the Philippine authorities concerned about the implementation of the Project.

As a result of the discussions, both sides agreed upon the matters referred to in the document attached hereto.

Manila, August 12, 1998



Dr. Toru Mori
Leader
Consultation Team
Japan



Dr. Antonio Lopez
Undersecretary for Public Health Services
Department of Health
The Republic of the Philippines

ATTACHED DOCUMENT

1. GENERAL REVIEW

The Project started on September 1, 1997, for the purpose of improving management of National Tuberculosis Program (hereinafter referred to as "NTP") with regards to expansion of the implementation of the new NTP policies and strategies.

In accordance with the Record of Discussions (hereinafter referred to as "R/D") signed on August 14, 1997 by both sides, JICA has dispatched 3 long-term experts to the Philippines and accepted 3 counterpart personnel as trainees in Japan and also provided equipment to activate the implementation of the Project.

Both sides reviewed the activities in regard to the implementation of the Project. Based on the common understanding of the present situation of the Project, both sides discussed the future implementation plan of the Project.

2. SUMMARY OF DISCUSSIONS

Both sides agreed upon the following matters:

(1) The introduction of the Project Cycle Management (hereinafter referred to as 'PCM') Method

The Project Cycle Management (PCM) method is introduced for the better management of the Project. In the PCM workshop held during the Team's stay, participation analysis, problems analysis and objectives analysis were done by the participants. Results of the workshop are shown in ANNEX I. Based on the result, Project Design Matrix will be completed through further discussions.

(2) The project site and tentative plan of the expansion

As is described in the R/D, the Project will implement its activities in the Provinces as follows:

- Region VII: The achievement in implementing the New National Tuberculosis Control Guidelines in the Cebu Province is being expanded to the remaining three provinces, thus covering the entire



area of Region VII

- Laguna Province: The implementation of the demonstration program of the New Guidelines has been launched early this year in the Phase I area, which will be expanded to the remaining area in the Phase II in the coming year. Further expansion will be discussed based on the achievement of the demonstration program.

- Improvement of the laboratory services: For the component of bacteriological examination services, the Project covers the whole country from the start, considering the urgent need for it.

(3) Establishment of the National Tuberculosis Reference Laboratory

The Philippine side will take necessary action so that the official proposal be submitted to the Government of Japan as soon as possible.

3. ACHIEVEMENT OF TENTATIVE SCHEDULE OF IMPLEMENTATION

The technical cooperation activities under the Project which have been carried out by the end of July 1998 are presented in ANNEX II.

4. TENTATIVE SCHEDULE OF IMPLEMENTATION

According to the present situation of progress of the Project, both sides jointly formulated the Implementation Plan of the Project. The timetable of the Implementation of the Project is presented in ANNEX III.

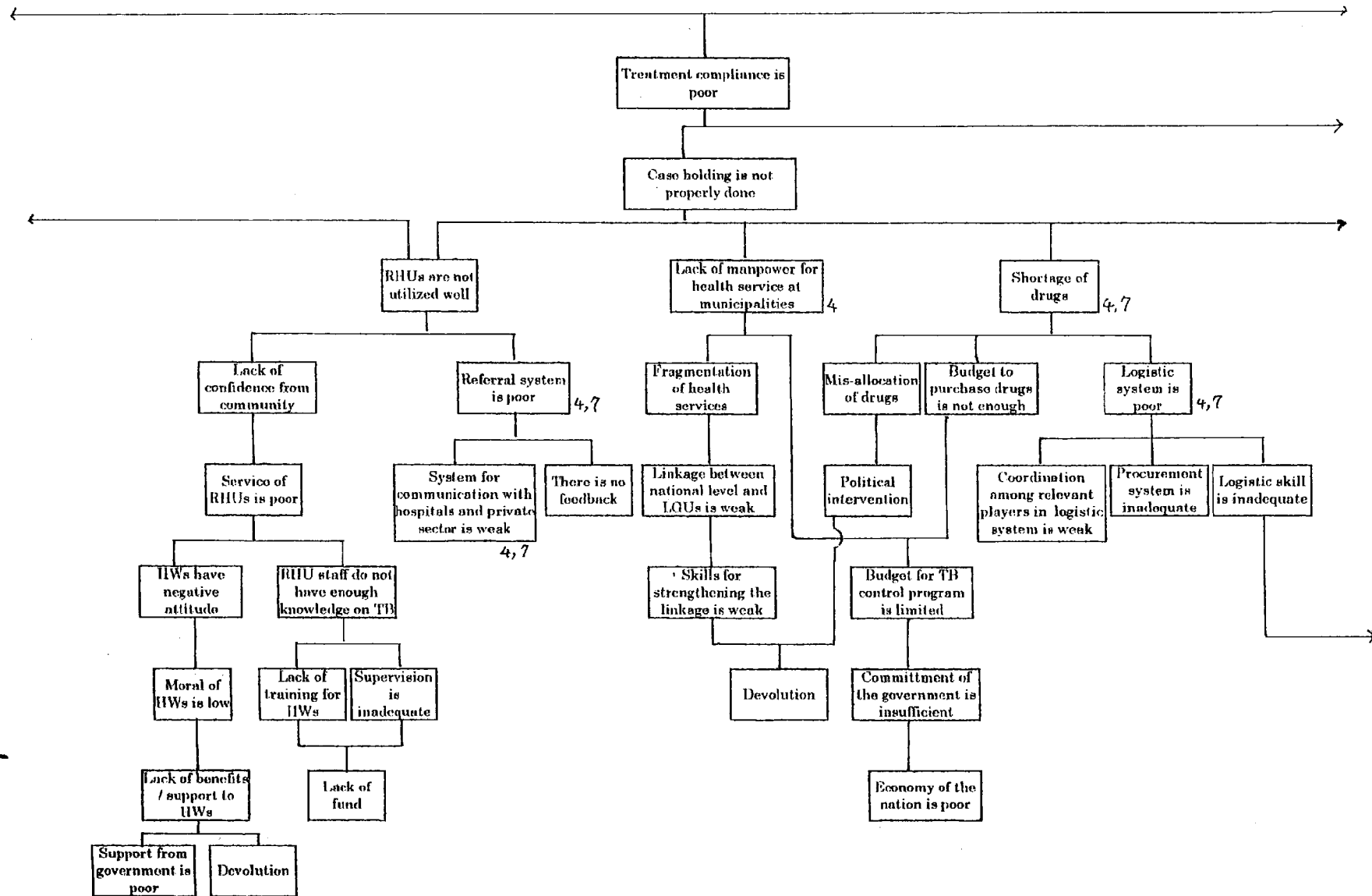
T.M.

✓

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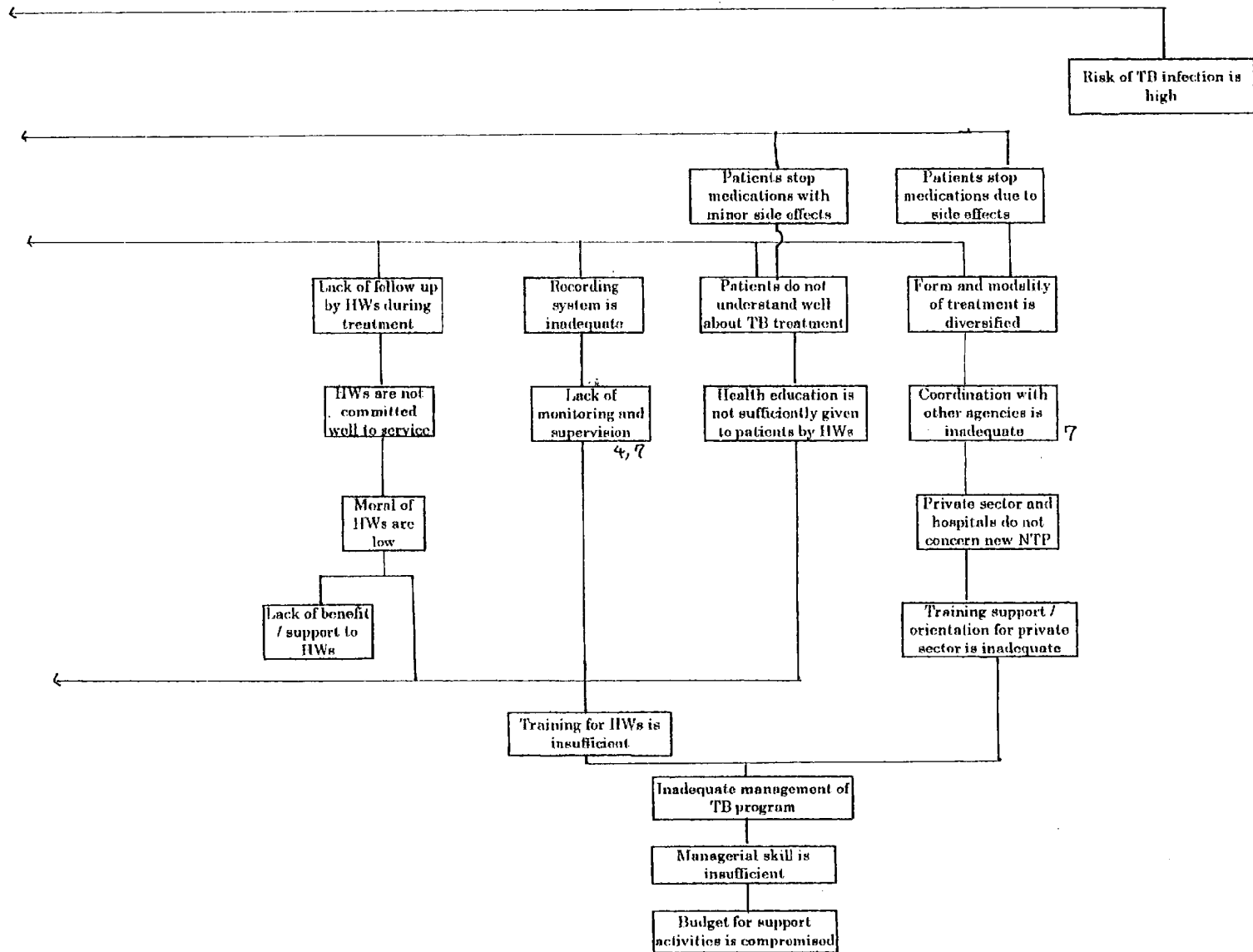


Problems Tree (2)



7.4.4.

Problems Tree (3)



Objectives Tree (1)

T.M.

TB is not a serious problem in the Philippines

②

TB cases are early diagnosed

①

Quality of microscopy service is good

①

More microscopy centers are established

①

Fund is available (including from donor agencies)

RH Lab., PH Lab., MH Lab. are established

MTs are fully nominated

Local Governments give high priority to TB control

Advocacy making and coalition are effectively done

②

Quality of sputum microscopy is highly maintained

Quality of basic technique of microscopy is high

①

Quality of validation system is good

①

New MTs are trained

Constant follow up by TBCT to NEDA

Fund for QA is allocated to National budget

Module is standardized by the NTB Lab.

Health staff are trained and qualified

②

Symptomatic are consulted

①

TB symptomatic are aware of symptoms

①

Stigma against patients are erased

Information campaign is intensified

Print media (papers, radio, TV) is utilized

Cooperation from KBP is gained

Reproduction of IEC materials utilizing existing ones is done

Fund is available

Incentives to IHWs are properly offered

Motivation is given by TBCT

Fund is available for training

M Hu

Weekly consultation is done at Barangay level by Health Workers

M Hu

C R P M

Health Workers are trained on health education

P M

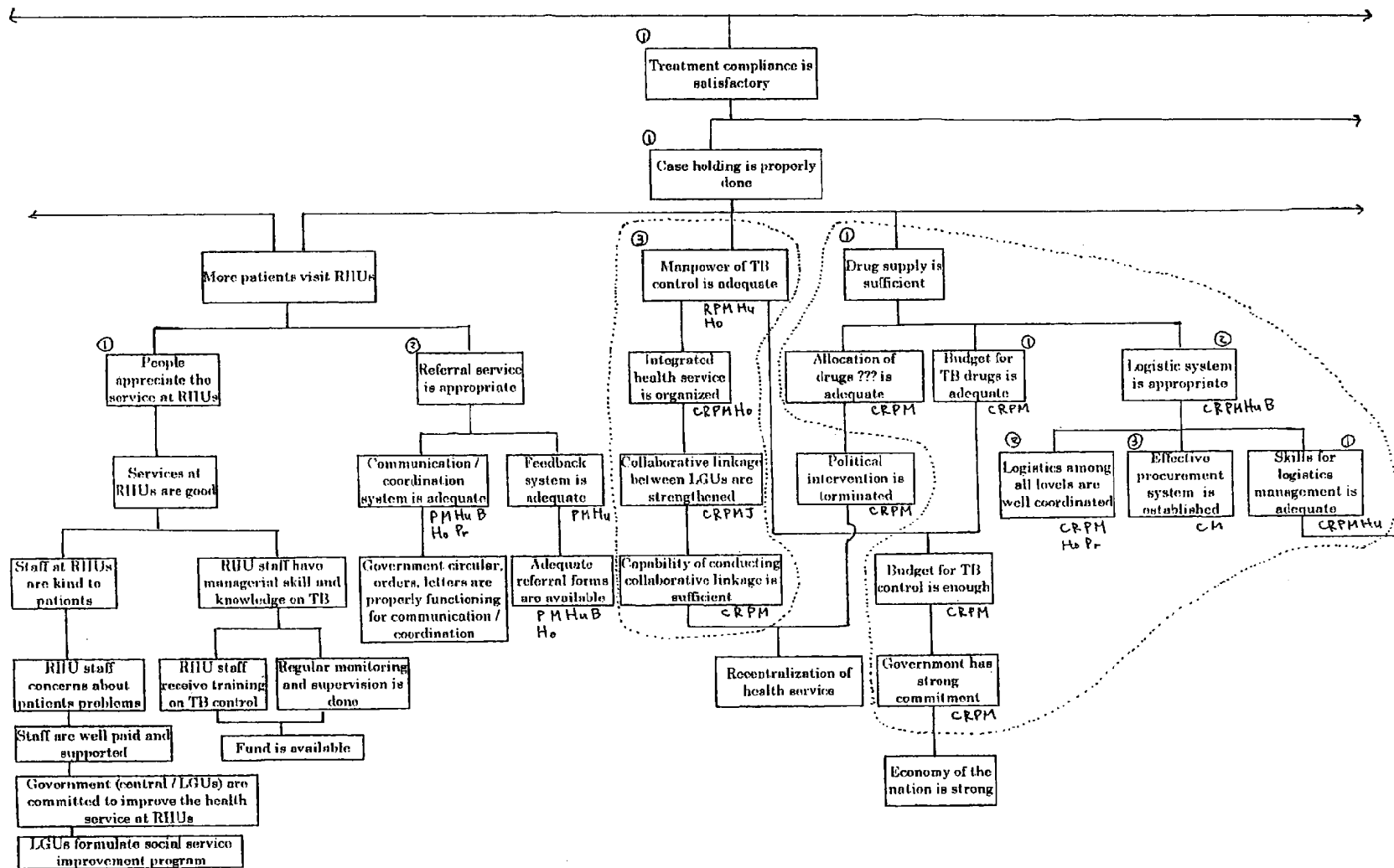
Radio programs are done through KBP Community meetings and house hold teachings are done

Fund is available

Donation from pharmaceutical companies, clinics, and others

4

Objectives Tree (2)



7/2.



1. Note on the Problems Tree and Objectives Tree

- (1) In the Problems Tree, if a problem is accompanied with number(s) 4 and/or 7, it means that this particular problem is especially important in Region 4 and/or 7.
- (2) In the Objectives Tree, letters noted under means show responsible agency(ies) for the means, and they refer to the following.
 - C: Central institutions (DOH, TBSCS)
 - R: Regional office
 - P: Provincial government
 - M: Municipality
 - Hu: Rural Health Units
 - B: Barangay Health Stations
 - Ho: Public Hospitals
 - Pr: Private clinics
 - J: JICA or Japanese government
- (3) In the Objectives Tree, circled numbers show priority among the same level of the means.
- (4) In the Objectives Tree, areas within the dotted line are the coverage of the DOH-JICA TB Control Project.

2. Brief explanation on the results

- (1) Core problem: "TB is a very serious problem in the Philippines".
- (2) Direct causes: "Many TB cases are still undiagnosed" (diagnostic problem).
 - "Treatment compliance is poor" (treatment problem).
 - "Prevalence of TB infection is high" (infectious problem).
- (3) The diagnostic problem has three dimensions including microscopy technique, service supply, and patient side.
- (4) The treatment problem has six dimensions including service supply, manpower, drug, follow up/supervision, patients understanding, and modality of treatment among health facilities.
- (5) The infection problem was not discussed in the workshop.
- (6) Region 4 and Region 7 share the following problem as important problems. Microscopy technique, insufficient number of MTs, supervision of MT, validation system, referral system with other health sectors, shortage of drug.
- (7) Region 4 has other important problem such as lack of manpower at municipal level and lack of trained and committed health workers.
- (8) The DOH-JICA project covers most of the objectives tree sharing responsibility between DOH and JICA.
- (9) The higher priority was given to treatment compliance, and critical issue was identified as sufficient drug supply. Second priority was given to monitoring and supervision of case holding.
- (10) In the case finding issue, establishment of more microscopy center was given the highest priority, followed by training for microscopists and improvement of validation system.
- (11) Due to the time limitation, the result of the workshop needs further discussion to complete the analysis. JICA mission, team will have further investigation on the results in Japan, and finalize the trees. Based on the finalized trees, a tentative PDM will be formulated. DOH-JICA Project will discuss on the contents of the tentative PDM to finalize it.

ANNEX II.

ACHIEVEMENT OF TENTATIVE SCHEDULE OF IMPLEMENTATION

TABLE I. Dispatch of Japanese Experts

EXPERT	DESIGNATION	DURATION
LONG TERM		
1. Dr. Shoichi Endo	Chief Adviser	September 1, 1997 -
2. Mr. Yoshinori Terasaki	Coordinator	September 1, 1997 -
3. Dr. Akihiro Okado	TB Control	April 10, 1998 -
SHORT TERM		
1. Dr. Masashi Suchi	TB Control	November 19 - December 17, 1997
2. Dr. Akihiro Okado	TB Control	February 16 - March 13, 1998
3. Ms. Akiko Fujiki	Bacteriology	April 1 - April 29, 1998

TABLE 2. Counterpart Training in Japan

NAME	COURSE TITLE	DURATION
1. Ms. Lucy Aguiman	Laboratory Works for Tuberculosis Control	September 29, 1997 to February 15, 1998
2. Dr. Ma. Vicenta Vasquez	Tuberculosis Control Program Management	May 5, 1998 - June 21, 1998
3. Dr. Mary Angeles Piñero	Tuberculosis Control	June 15, 1998 - October 18, 1998

TABLE 3. Provision of Equipment from the Japanese Government Fiscal Year 1997

	ITEM	QTY	DESCRIPTION	ALLOCATION
1	Microscope	100	Binocular, lights/miller	Microscopy Centers in the province of Negros Oriental; Laguna; Siquijor and Bohol
2	Vehicle	2	Toyota Hi-ace	TBCS and Laguna PHO
		3	Toyota Hi-lux 4x4	Negros Oriental PHO, Siquijor PHO and Bohol PHO
3	Computer	3	with Printer, AVR & UPS	Project Office (2) and TBCS
4	Copier	2	with Sorter	Project Office and Laguna PHO

TABLE 4.1. Training activities for the implementation of the new NTP Policies and Guidelines in the expansion areas.

PROVINCE/ CATEGORY	DURATION	BATCH	DATE	PARTICI- PANTS
LAGUNA				704
SUPERVISORS	4 days	1	October 1997	13
MHOs, PHNs, MTs	3 days	2	February/March 1998	69
RHMs	2 days	4	March 1998	169
BHWs	1 day	15	March/April 1998	453
NEGROS ORIENTAL				1,098
SUPERVISORS	5 days	1	January 1998	17
MHOs, PHNs, MTs	3 days	4	February/March 1998	143
RHMs	2 days	6	February to April 1998	344
BHWs	1 day	21	February to April 1998	594
SIQUIJOR				195
MHOs, PHNs, MTs	3 days	1	November 1997	24
RHMs	2 days	1	November 1997	37
BHWs	1 day	4	November 1997	134

TABLE 4.2. Training of Microscopists on Direct Smear Examination

CATEGORY	DURATION	BATCH	DATE	PARTICI- PANTS
MTs in Dist. Hosp. and RHUs in Cebu Prov.	5 days	3	September and October 1997	24
MTs in Negros, Cebu and Laguna Province	5 days	4	February to April 1998	33
MTs in Negros Oriental	5 days	4	February to April 1998	36
Microscopists in Laguna	8 days	1	May 25 to June 3, 1998	7
Microscopists in Laguna (Basic)	8 days	1	July 27 to August 5, 1998	8

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TABLE 4.3. Training of Senior Medical Technologists on Quality Control in Microscopy

CATEGORY	DURATION	BATCH	DATE	PARTICI-PANTS
MTs in Siquijor Province	10 days	2	October and November 1997	2

TABLE 4.4. Quality Control on Direct Smear Examination for Validators

CATEGORY	DURATION	BATCH	DATE	PARTICI-PANTS
MTs in Negros Oriental, Mandaue and Cebu Cities	5 days	1	22 - 26 June 1997	4

TABLE 4.5. Refresher Training Course on the New NTP Guidelines (Cebu, Danao and Toledo Cities)

CATEGORY	DURATION	BATCH	DATE	PARTICI-PANTS
MHOs PHNs, MTs	1 day	3	13, 14 & 17 . October 1997	114

TABLE 4.6. Orientation Seminar for Medical Doctors, Nurses and Medical Technologists of VSMMC Involved in the Management of TB Cases

CATEGORY	DURATION	BATCH	DATE	PARTICI-PANTS
MHOs, PHNs, MTs	1 day	2	18 & 19 October 1997	26

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TABLE 5. Implementation of the New NTP Guidelines

	Laguna	Siquijor	Negros Or.	Bohol
Launching Activities	September 19, 1997	September 15, 1997	January 16, 1998	
Baseline Survey	24-28 November to 3 December 1998	October 7, 1998	January 20-23 to February 3-4, 1998	2-3, 7-10, 14-17 July 1998
Start of Implementation	24 July, 1998	April 1998	May 1998	

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TENTATIVE SCHEDULE OF IMPLEMENTATION FOR JAPANESE FISCAL YEAR 1998-99 (APRIL '98 to MARCH '99)

TUBERCULOSIS CONTROL PROJECT

ITEM		4	5	6	7	8	9	10	11	12	1	2	3						
ACTIVITIES	1) Implementation of New NTP Guidelines				Establishment of demonstration area in Laguna Province Expansion within Negros Oriental, Siquijor, Bohol Province														
	2) Strengthening of Bacteriological Laboratory Service					Quality control of smear examinations													
	3) Establishment of Surveillance System					Intensify the recording/reporting system at RHU level													
	4) Conducting operational Research						Implementation of DOTS												
	5) Enhancing IEC Activity						Establish suitable motivating system in community level												
	6) Implementation of Training						Training for MIOs, PHNs, Med.tech. & RBMs												
							Training for BIN on DOTS												
							Training for Med.tech. on microscopy												
MISSIONS	CONSULTATION SURVEY TEAM																		
DISPATCH OF JAPANESE EXPERTS	L O N E G M	1) DR. SHOICHI ENDO (CHIEF ADVISOR)																	
		2) DR. AKIHIRO OKADO (TB CONTROL)																	
		3) MR. YOSHINORI TERASAKI (COORDINATOR)																	
		4)																	
		5)																	
	S H O R T M	1) BACTERIOLOGY (1)																	
		2) BACTERIOLOGY (2)																	
		3) TUBERCULOSIS CONTROL (1)																	
		4) TUBERCULOSIS CONTROL (2)																	
		5)																	
		6)																	
		7)																	
COUNTERPART TRAINING IN JAPAN	1) TB CONTROL PROGRAM MANAGEMENT																		
	2) TUBERCULOSIS CONTROL																		
	3) LABORATORY WORKS FOR TB CONTROL																		
	4)																		
EQUIPMENT												←Submitting A-4 form							Receiving equipment →

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② 1997年度年間概要報告

DOH JICA Tuberculosis Control Project

Annual Report on the Project Performance particularly Case-Finding Service in 1997 and Report on the Treatment Outcome of the Patients Registered during the last quarter 1996

Introduction

This is the first annual report on the Project Performance on the case-finding service covering the whole Project area since the 3rd Intensive Service Area started the new NTP policies and strategies in the last quarter 1996. This is also the first report on the treatment outcome of the patients registered for treatment in the whole Project area.

A. Case-Finding Activities

1. Symptomatics Examined

As shown in the Table 1, a total of 17,231 symptomatics were sputum examined. The most number of symptomatics examined by quarter was 4,912 in the 1st quarter of 1997. The least was 3,783 in the 2nd quarter. The least is 76.6 % of the most. This difference may be within the random fluctuation.

2. Collection of 3 sputum specimens

92.5 % of the symptomatics were collected 3 sputum specimens. The lowest number of symptomatics who submitted 3 sputum specimens by quarter was 88.8 % in the 4th quarter. Collection of 3 specimens below 80 % was observed only in 3 RHUs out of 67 RHUs/City HCs. This is considered a satisfactory performance.

Table 1 Case-Finding Activity (Laboratory Register) 1997

	1st qtr	2nd qtr	3rd qtr	4th qtr	Total
No. Symptomatics					
Examined	4,912	3,783	4,651	3,885	17,231
Rate 3 Specimens					
Collection (%)	94.0	95.0	92.1	88.8	92.5
No. of Sputum					
Positive Cases	713	624	754	618	2,709
Positive Rate (%)	14.5	16.5	16.2	15.9	15.7
Positive Cases Per					
100,000 Population	24.4	21.4	25.8	21.2	92.7

2,709 sputum positive patients were discovered.

3. The positive rate (the rate for sputum positive cases discovered per symptomatics examined) was 15.7 %. The highest rate by quarter was 16.5 % in the 2nd quarter and the lowest was 14.5 in the first quarter. The lowest rate was 87.9 % of the highest. The fluctuation by quarter is small. Therefore the technique of microscopy is considered constant throughout the year. However the difference among RHUs is quite large as stated later.

4. The positive patients discovered in 1997 per 100,000 population is 92.7. The highest rate by quarter is 25.8 and the lowest is 21.2, which is 82.2 % of the highest. From this fact it may be considered that the number of sputum smear positive cases discovered throughout the year 1997 is constant.

5. Proportion of Smear Positive Cases Among The Cases Registered for Treatment were as follows.

	1st qtr	2nd qtr	3rd qtr	4th qtr	Total 1997
(%)	38.9	56.6	66.0	69.2	54.6

The proportion of smear positive cases discovered among the cases registered for treatment has gradually increased from 38.9 % in 1st quarter to 69.2 % in the 4th quarter and the average is 54.6 %. The reason for this increase may be attributed to the TBCS' instruction given in the 2nd quarter to give high priority on the use of drugs to the smear positive cases due to the shortage of drugs .

This instruction should be observed in the future too since the shortage of drugs is expected to continue for some time. In order to minimize treatment of x-ray positive and smear negative cases, effort should be made to improve the quality of the x-ray diagnosis.

6. Doubtful Diagnosis

One positive among the examination of 3 sputum specimens is defined as doubtful diagnosis.

The 129 doubtful diagnosis are reported in 1997 which is 0.7 % of the total number of symptomatics examined. This number is very small, hence the technique applied for smear examination in the Cebu Project is considered constant and well standardized. However more than 1.0 % of the doubtful diagnosis was observed in Cebu City, Balamban District and Daan Bantayan District. The rate is extremely high 8.9% in Daan Bantayan. The smear examination technique of the microscopists in these districts should be reviewed.

7. Analysis of the case finding performance by district.

There is a considerable difference in case finding performance by district such as

positive rate, smear positive cases per population and symptomatics per population as shown in Table 2.

The correlations between these figures are shown in Fig. 1, 2 and 3.

Fig. 1 shows that there is no apparent correlation between positive rate and the discovery of smear positive patients per population. All districts seem to have similar status in terms of microscopy examination (positive rate) and case discovery per population except for 2 districts Malabuyoc and Daan Bantayan. This means that the quality of sputum microscopy and case discovery are uniform. The case discovery per population of 165.41 is exceptionally high in Malabuyoc. The higher prevalence of tuberculosis in Malabuyoc is unlikely. The reason for the high discovery rate is likely due to false positive. The exceptionally high positive rate was observed in Daan Bantayan. The reason was found to be due to the poor quality of microscopy service because of the absence of trained microscopist.

There seems to be negative correlation between the positive rate and the symptomatics examined per population shown as shown in Fig. 2. This means that more symptomatics are examined, the lower the positive rate. In Argao and Badian districts, the criteria for the examination of symptomatics seems loose. Stricter application of the criteria in the selection of symptomatic for microscopic examination is suggested because the examination with low positive rate (too many slides to be examined with low yield) may lead to false negative.

Fig.3 shows the correlation between smear positive cases discovered per population and symptomatics examined per population. In this figure there are 2 exceptions, Malabuyoc and Daan Bantayan. After these two are excluded, Argao and Badian are slightly apart from others. The problems are already discussed above.

B. Treatment Outcome

The treatment outcome for the smear positive cases registered during the 4th quarter 1996 was shown in the Table 3. This is the 1st figure covering the whole Cebu Project Area.

Overall cure rate is 77.4 %. The rate for those in the districts from the 1st Intensive Service Area is 81.4 %. This is satisfactory. The rate for Cebu City is as low as 72.3 %. This is below the expectation. The rate for lost and transfer out cases are as high as 11.5 % and 7.3 %. In order to improve treatment outcome, these figures should be reduced through the intensification of DOTS and the development of efficient referral system. The rate for the 3rd ISA is as low as 73.9 % and the rate for the treatment completed cases without follow up sputum examination is as high as 11.4 %. The rate for the treatment completed cases is particularly high in Daan Bantayan

- 66.7 %, Carcar - 24.1 % and Minglanilla - 12.4 %. As mentioned above, no trained microscopist was available in Daan Bantayan. Good microscopy service should be developed in those area.

The rate for the treatment completed cases among smear negative cases registered in the whole project area is 85.8 %.

The cure rate for relapse cases and failure cases are 50.0 % and 60.0 % respectively. Due to the small number of the cases, further analysis is not possible. However further effort should be made to improve the treatment outcomes of relapse and failure cases because this is the last chance for them to cure.

Table 2. CASE-FINDING ACTIVITIES

	POPULATION	SMEAR (+) CASES	POSITIVE RATE	POSITIVE CASES PER 100,000 POP.	SYMPTOMATICS	SYMPTOMATICS PER 100,000
DISTRICTS						
Argao	148,768	141	8.8	94.78	1,599	1,075
Badian	78,006	66	9.3	84.61	711	911
Balamban	83,338	71	14.3	85.20	495	594
Bantayan	110,486	93	21.8	84.17	426	386
Barili	108,811	94	13.5	86.39	697	641
Bogo	137,806	110	20.5	79.82	536	389
Camotes	81,181	54	12.5	66.52	431	531
Carcar	153,323	128	13.0	83.48	988	644
Daan Bantayan	64,845	37	27.4	57.06	135	208
Danao	109,829	90	18.9	81.95	477	434
Lapu-Lapu	75,818	76	15.4	100.24	493	650
Malabuyoc	75,569	126	19.6	166.74	642	850
Minglanilla	295,834	255	15.7	86.20	1,627	550
Sogod	100,588	69	12.1	68.60	570	567
Tuburan	64,754	51	13.0	78.76	391	604
CITIES						
Lapu-Lapu	173,744	178	14.3	102.45	1,246	717
Mandaue	194,745	180	13.6	92.43	1,325	680
Cebu	662,299	705	20.2	106.45	3,484	526
Danao	79,932	56	18.7	70.06	300	375
Toledo	121,469	129	19.6	106.20	658	542
TOTAL	2,921,145	2,709	15.7	92.74	17,231	590

Figure 1. Correlation Between Positive Rate of Smear Examination and Smear Positive Cases Per Population

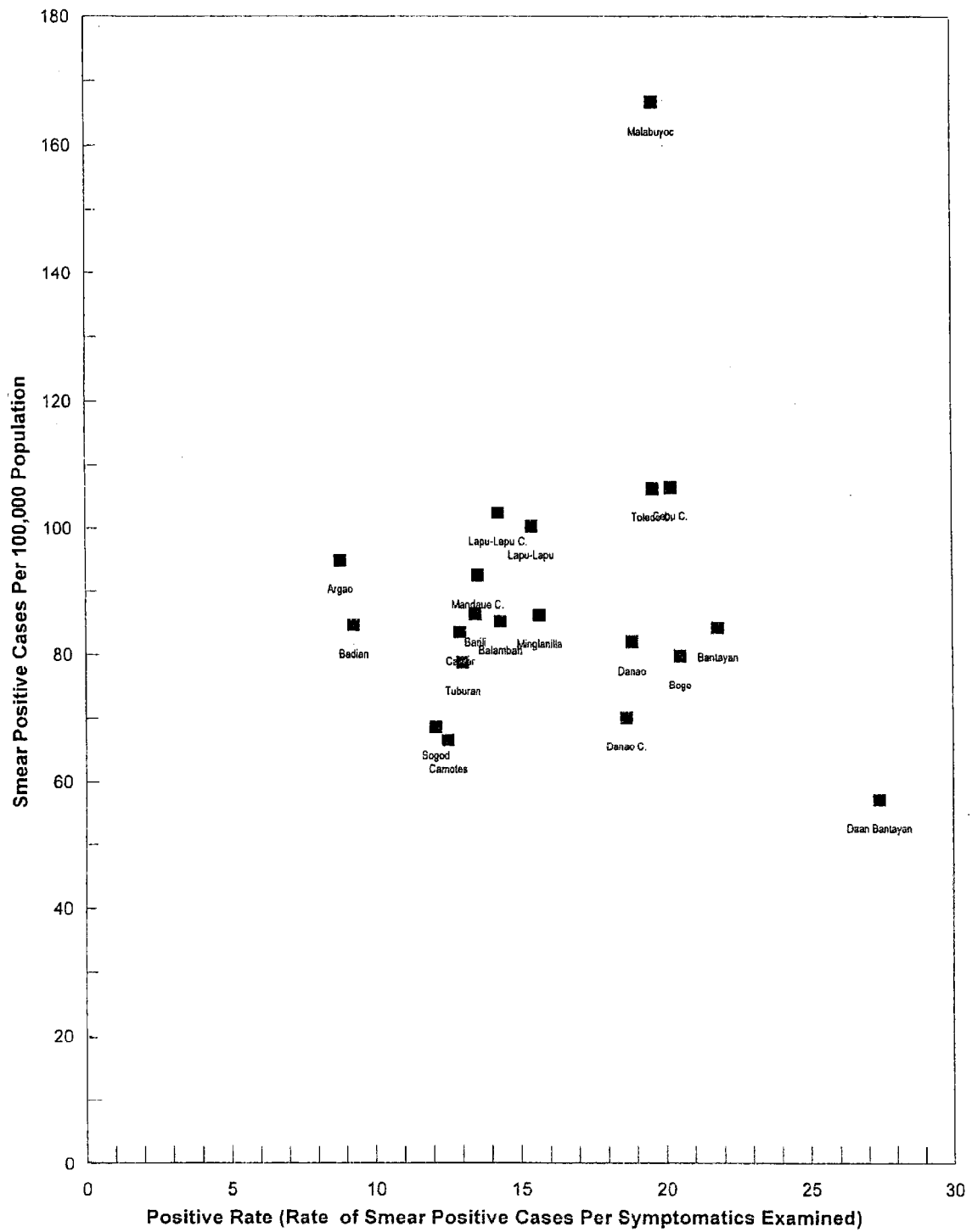


Figure 2. Correlation Between Positive Rate of Smear Examination and Symptomatics Per Population

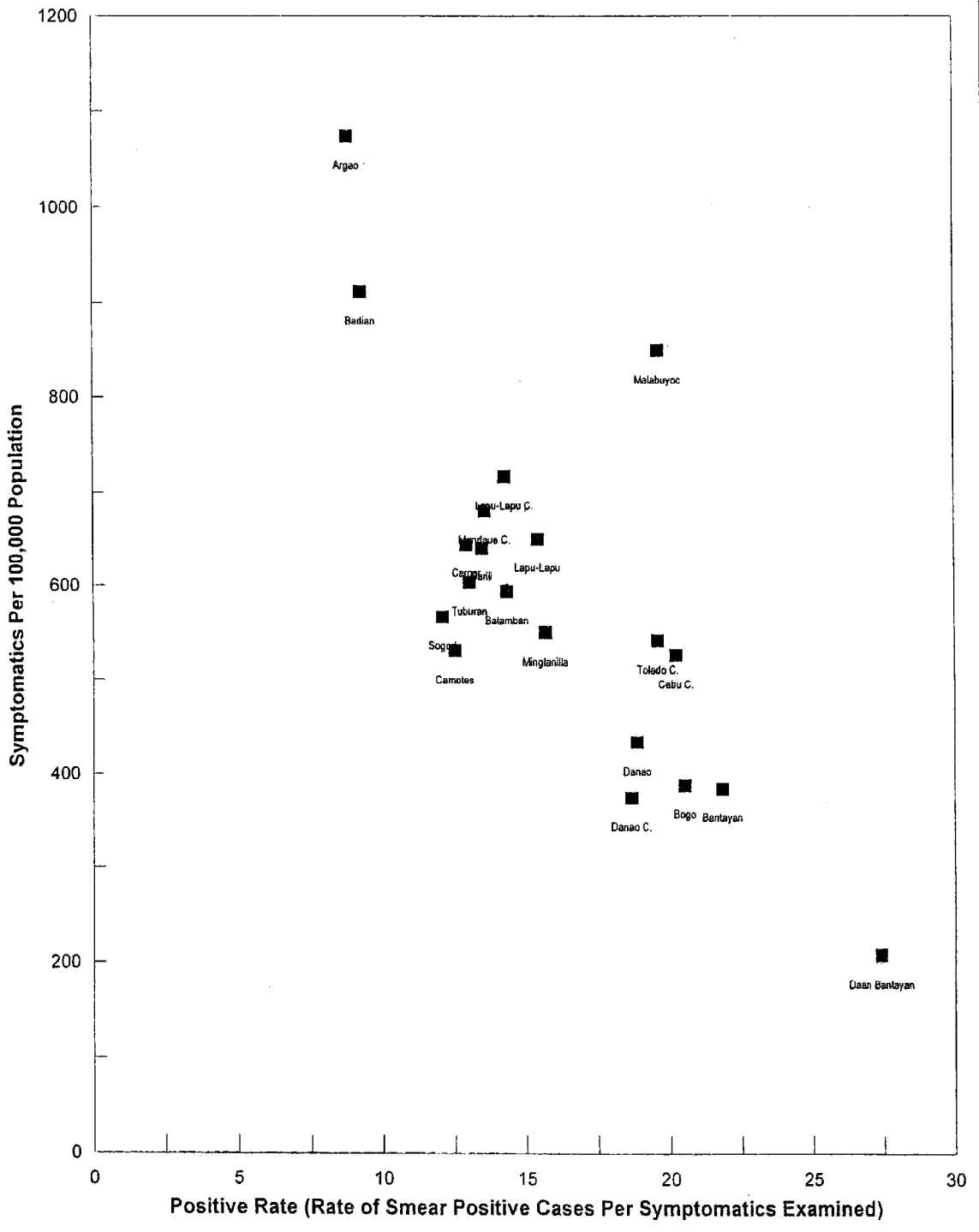


Figure 3. Correlation Between Smear Positive Cases and Symptomatics Per Population

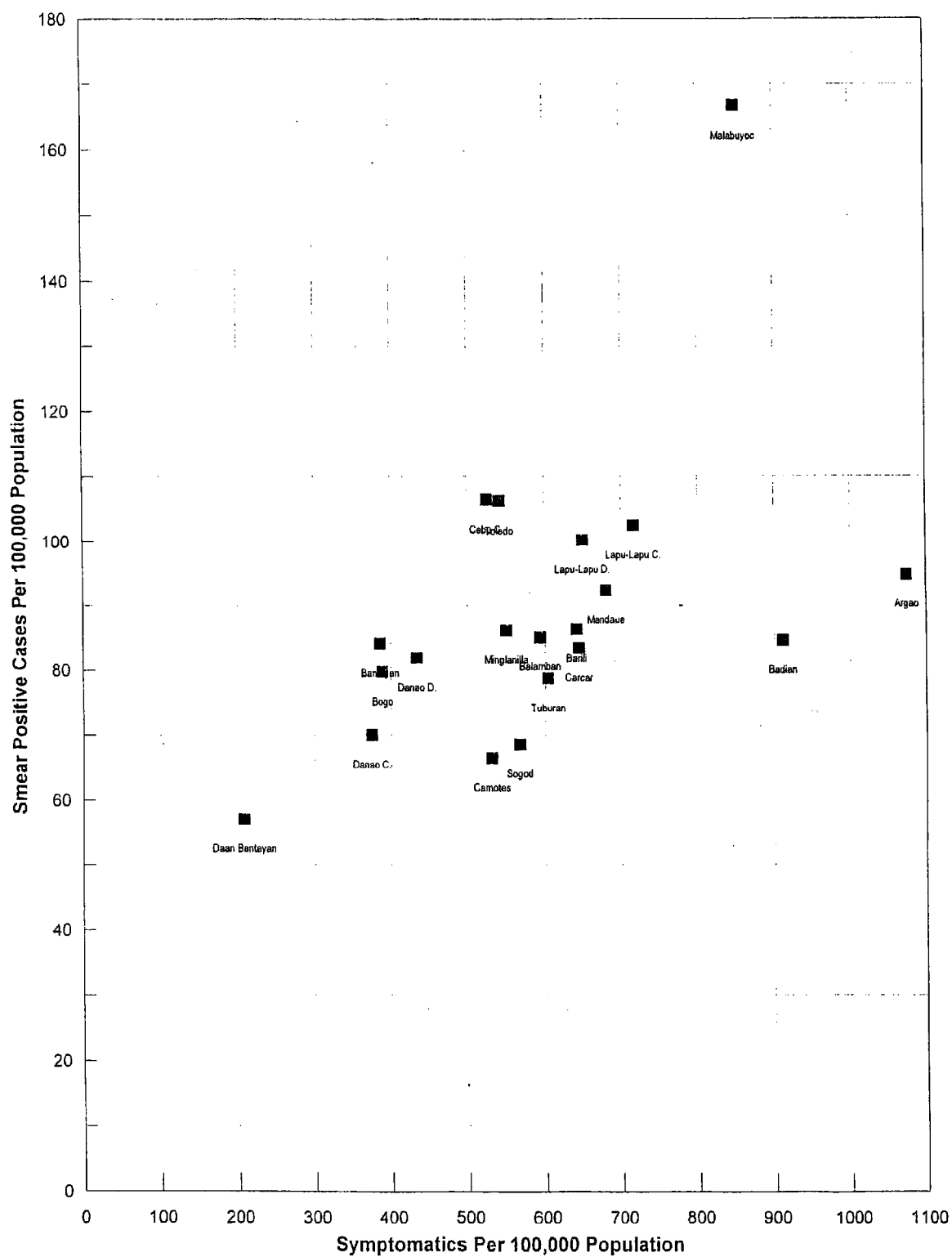


TABLE 3.1
COHORT REPORT ON THE RESULTS OF PULMONARY TB CASES
October - December 1996
NEW SMEAR POSITIVE CASES

	No. Registered	%	Cured	%	Completed	%	Died	%	Failure	%	Lost	%	Tranferred	%
Argao	25	100.00%	23	92.0%	0	0.0%	1	4.0%	0	0.0%	0	0.0%	1	4.0%
Badian	12	100.00%	10	83.3%	0	0.0%	1	8.3%	0	0.0%	1	8.3%	0	0.0%
Barili	18	100.00%	12	66.7%	0	0.0%	3	16.7%	1	5.6%	0	0.0%	2	11.1%
Bogo	42	100.00%	34	81.0%	0	0.0%	2	4.8%	1	2.4%	2	4.8%	3	7.1%
Danao	29	100.00%	22	75.9%	1	3.4%	0	0.0%	1	3.4%	4	13.8%	1	3.4%
Sogod	19	100.00%	17	89.5%	0	0.0%	1	5.3%	0	0.0%	1	5.3%	0	0.0%
SUBTOTAL 1st ISA	145	100.00%	118	81.4%	1	0.7%	8	5.5%	3	2.1%	8	5.5%	7	4.8%
Minglanilla	60	100.00%	49	81.7%	7	11.7%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Carcar	29	100.00%	16	55.2%	7	24.1%	1	3.4%	0	0.0%	2	6.9%	3	10.3%
Malabuyoc	22	100.00%	18	81.8%	0	0.0%	0	0.0%	0	0.0%	3	13.6%	1	4.5%
Lapu-lapu	17	100.00%	13	76.5%	0	0.0%	0	0.0%	1	5.9%	1	5.9%	2	11.8%
Tuburan	6	100.00%	4	66.7%	0	0.0%	0	0.0%	0	0.0%	2	33.3%	1	16.7%
Balamban	16	100.00%	13	81.3%	0	0.0%	0	0.0%	1	6.3%	2	12.5%	0	0.0%
Daan Bantayan	9	100.00%	0	0.0%	6	66.7%	1	11.1%	0	0.0%	2	22.2%	0	0.0%
Camotes	17	100.00%	14	82.4%	1	5.9%	1	5.9%	0	0.0%	1	5.9%	0	0.0%
Bantayan	38	100.00%	29	76.3%	3	7.9%	0	0.0%	0	0.0%	5	13.2%	1	2.6%
SUBTOTAL 2nd ISA	214	100.00%	156	72.9%	24	11.2%	3	1.4%	2	0.9%	18	8.4%	8	3.7%
DISTRICT TOTAL	359	100.00%	274	76.3%	25	7.0%	11	3.1%	5	1.4%	26	7.2%	15	4.2%
Cebu City	191	100.00%	138	72.3%	4	2.1%	4	2.1%	9	4.7%	22	11.5%	14	7.3%
Danao City	16	100.00%	16	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lapu-Lapu City	48	100.00%	41	85.4%	2	4.2%	0	0.0%	1	2.1%	2	4.2%	2	4.2%
Mandaue	47	100.00%	43	91.5%	0	0.0%	0	0.0%	0	0.0%	2	4.3%	2	4.3%
Toledo city	31	100.00%	21	67.7%	2	6.5%	0	0.0%	6	19.4%	1	3.2%	1	3.2%
CITY TOTAL	333	100.00%	259	83.4%	8	2.5%	4	0.4%	16	5.2%	27	4.6%	19	3.8%
GRAND TOTAL	692	100.00%	533	77.0%	33	4.8%	15	2.2%	21	3.0%	53	7.7%	34	4.9%

TABLE 3.2
COHORT REPORT ON THE RESULTS OF PULMONARY TB CASES
October - December 1996
NEW SMEAR NEGATIVE CASES

	No.	%	Completed	%	Died	%	Failure	%	Lost	%	Tranferred	%
	Registered											
Argao	20	100.00%	16	80.0%	2	10.0%	0	0.0%	2	10.0%	0	0.0%
Badian	19	100.00%	16	84.2%	2	10.5%	0	0.0%	1	5.3%	0	0.0%
Barili	28	100.00%	23	82.1%	0	0.0%	0	0.0%	0	0.0%	5	17.9%
Bogo	23	100.00%	20	87.0%	2	8.7%	0	0.0%	1	4.3%	0	0.0%
Danao	12	100.00%	11	91.7%	0	0.0%	0	0.0%	1	8.3%	0	0.0%
Sogod	13	100.00%	13	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
SUBTOTAL 1st ISA	115	100.00%	99	86.1%	6	5.2%	0	0.0%	5	4.3%	5	4.3%
Minglanilla	85	100.00%	76	89.4%	1	1.2%	0	0.0%	6	7.1%	2	2.4%
Carcar	43	100.00%	34	79.1%	3	7.0%	0	0.0%	6	14.0%	0	0.0%
Malabuyoc	6	100.00%	6	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lapu-lapu	29	100.00%	25	86.2%	0	0.0%	0	0.0%	3	10.3%	1	3.4%
Tuburan	12	100.00%	10	83.3%	0	0.0%	0	0.0%	1	8.3%	1	8.3%
Balamban	16	100.00%	13	81.3%	0	0.0%	0	0.0%	3	18.8%	0	0.0%
Daan Bantayan	2	100.00%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	1	50.0%
Camotes	12	100.00%	10	83.3%	0	0.0%	2	16.7%	0	0.0%	0	0.0%
Bantayan	13	100.00%	7	53.8%	0	0.0%	0	0.0%	3	23.1%	0	0.0%
SUBTOTAL 2nd ISA	218	100.00%	182	83.5%	4	1.8%	2	0.9%	22	10.1%	5	2.3%
DISTRICT TOTAL	333	100.00%	281	84.4%	10	3.0%	2	0.6%	27	8.1%	10	3.0%
Cebu City	244	100.00%	209	85.7%	4	1.6%	1	0.4%	16	6.6%	14	5.7%
Danao City	16	100.00%	16	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lapu-Lapu City	88	100.00%	73	83.0%	7	8.0%	1	1.1%	4	4.5%	3	3.4%
Mandaue	83	100.00%	74	89.2%	1	1.2%	0	0.0%	3	3.6%	5	6.0%
Toledo city	21	100.00%	18	85.7%	0	0.0%	2	9.5%	0	0.0%	1	4.8%
CITY TOTAL	452	100.00%	390	86.3%	12	2.7%	4	0.9%	23	5.1%	23	5.1%
GRAND TOTAL	785	100.00%	671	85.5%	22	2.8%	6	0.8%	50	6.4%	33	4.2%

TABLE 3.3
COHORT REPORT ON THE RESULTS OF PULMONARY TB CASES
October - December 1996
RELAPSE CASES

	No.	%	Cured	%	Completed	%	Died	%	Failure	%	Lost	%	Tranferred	%
	Registered													
Argao	2	100.00%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%
Badian	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Barili	1	100.00%	0	0.0%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%
Bogo	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Danao	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Sogod	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
SUBTOTAL 1st ISA	3	100.00%	1	33.3%	0	0.0%	0	0.0%	1	33.3%	1	33.3%	0	0.0%
Minglanilla	7	100.00%	4	57.1%	1	14.3%	1	14.3%	0	0.0%	1	14.3%	0	0.0%
Carcar	2	100.00%	0	0.0%	0	0.0%	1	50.0%	1	50.0%	0	0.0%	0	0.0%
Malabuyoc	4	100.00%	4	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lapu-lapu	1	100.00%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Tuburan	1	100.00%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Balamban	1	100.00%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Daan Bantayan	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Camotes	1	100.00%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Bantayan	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
SUBTOTAL 2nd ISA	17	100.00%	10	58.8%	2	11.8%	3	17.6%	1	5.9%	1	5.9%	0	0.0%
DISTRICT TOTAL	20	100.00%	11	55.0%	2	10.0%	3	15.0%	2	10.0%	2	10.0%	0	0.0%
Cebu City	10	100.00%	5	50.0%	1	10.0%	0	0.0%	1	10.0%	0	0.0%	3	30.0%
Danao City	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lapu-Lapu City	2	100.00%	1	50.0%	0	0.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%
Mandaue	1	100.00%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
CITY TOTAL	13	100.00%	7	53.8%	1	7.7%	0	0.0%	1	7.7%	1	7.7%	3	23.1%
GRAND TOTAL	33	100.00%	18	54.5%	3	9.1%	3	9.1%	3	9.1%	3	9.1%	3	9.1%

TABLE 3.4
COHORT REPORT ON THE RESULTS OF PULMONARY TB CASES
October - December 1996
FAILURE CASES

	No.	%	Cured	%	Completed	%	Died	%	Failure	%	Lost	%	Tranferred	%
	Registered													
Argao	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Badian	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Barili	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Bogo	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Danao	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Sogod	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
SUBTOTAL 1st ISA	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Minglanilla	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Carcar	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Malabuyoc	1	100.00%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lapu-lapu	1	100.00%	0	0.0%	0	0.0%	1	100.0%	0	0.0%	0	0.0%	0	0.0%
Tuburan	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Balamban	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Daan Bantayan	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Camotes	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Bantayan	2	100.00%	1	50.0%	0	0.0%	0	0.0%	1	50.0%	0	0.0%	0	0.0%
SUBTOTAL 2nd ISA	4	100.00%	2	50.0%	0	0.0%	1	25.0%	1	25.0%	0	0.0%	0	0.0%
DISTRICT TOTAL	4	100.00%	2	50.0%	0	0.0%	1	25.0%	1	25.0%	0	0.0%	0	0.0%
Cebu City	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Danao City	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Lapu-Lapu City	0	0.00%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Mandaue	1	100.00%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
CITY TOTAL	1	100.00%	1	100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
GRAND TOTAL	5	100.00%	3	60.0%	0	0.0%	1	20.0%	1	20.0%	0	0.0%	0	0.0%

③ 1998年度第1四半期概要報告

DOH-JICA Tuberculosis Control Project

Quarterly Report on the Project Performance during the Period of April to June 1998

I Progress of the Project Activities

1.1. The First Joint Coordinating Committee Meeting of the Project was held on April 6 1998 at the training room of the Bureau of Research and Laboratory under the chairmanship of Dr A Lopez, Undersecretary for Public Health. 15 members and 11 observers and 2 secretaries were present. The project activities, which had been performed since the inception of the project in September 1997, were reported and the plan of activities for the Japanese fiscal year 1998 (April 1998 to March 1999) were discussed and approved. Recognizing the seriousness of the tuberculosis problem in the country, the possibility of fast-tracking the project implementation in the country was discussed.

1.2. Ms A Fujiki, JICA Expert on Laboratory Service, visited the Project April 1-29. She visited Siquijor, Negros Oriental and Laguna where the implementation of the new NTP just started or were just going to start now and advised on the provision of senior medical technologists, equipment and facilities which are required for quality control of the field microscopy. She also gave her advice on the improvement of laboratory service in Siquijor.

The follow-up visit by the Regional Coordinator and JICA staff verified that the Province of Negros Oriental followed her advice properly and the preparations were going smoothly.

1.3. The Training of Microscopist for the expansion of implementation of the new NTP in the Province of Laguna was conducted with 7 participants at the Research Institute of Tropical Medicine (first 5 days) and the DOH-JICA AIDS Project (second 3 days) during the period of May 25 to June 3. The duration of the training of this kind was extended from 5 to 8 days, because the performance of the trained microscopists showed they needed another 3 days training.

1.4. The Training of Senior Technicians in Quality Control of Field Microscopy was conducted at the Reference Laboratory Cebu, during the period of July 22 to 26. 4 senior technicians from Cebu City, Mandaue City and the Province of Negros Oriental attended.

1.5 Monitoring Visits were made by the Regional and Provincial Coordinators accompanied by JICA staff to 25 RHUs in Cebu Province and 10 RHUs/City HC and 4 RHUs in the Province of Negros Oriental and Siquijor respectively.

1.6. The Meetings of Technical Working Groups were held in the Project area of Cebu and Negros Oriental. Strategy of efficient monitoring were discussed. The Cebu group

decided to carry out 4 visits a month. The Negros Oriental group is suffering from shortage of gasoline. The group agreed to make an efficient plan for conducting monitoring visit so that the outcome can be maximized with the limited frequency of visits. The group also decided to form a tuberculosis board to pursue community participation. The proposed members were representatives of the medical society, the local governments and NGOs, PHO, Regional and Provincial TB Coordinators and JICA staff.

II Achievement

2.1. Negros Oriental started the implementation of the new NTP in May. The monitoring visits conducted June 16-18 found out that the start of the implementation was smooth.

2.2 The preparation for the implementation of the new NTP in Laguna is going smoothly. Implementation will start as soon as additional medical technologists are recruited.

2.3 The performance of the tuberculosis services in the Cebu Project area in 1997 was tabulated. 17,231 symptomatics were sputum examined and 2,709 smear positive cases were discovered. The discovery rate was 92.7/100,000 population. There is no significant difference in discovery rate per population by districts except for the 2 districts. Hence, the case finding service reached the satisfactory level except for the 2 district. The low performance may be due to the absence of microscopist for some time in one district. An abnormally high discovery rate was observed in another district. The microscopy service has to be investigated. The development of a system which can identify problems in performance can be considered a good improvement in program evaluation.

III Problems

3.1. The first report on the treatment outcome was obtained covering the patients registered in the whole Cebu Project area. This includes the patients registered during the last quarter of 1996. The report showed that the cure rates in Cebu City and in the 3rd Intensive Area were 72.3 and 73.9 % respectively. These are significantly lower than the 81.4 % rate in the 1st ISA and 85.2 % rate average in the other 5 cities. The low cure rate in Cebu City was attributed to the high rate of Lost and Transfer out cases. Regional Coordinator and JICA Expert discussed with Dr Tomas Fernandez, City Health Officer of Cebu City, the improvement of treatment service through intensifying of DOTS and the development of an effective referral system for the transferred out patient to the new RHU. The reason for the low cure rate in the 3rd ISA was incomplete follow-up sputum examination which is due to the frequent absence/turn over of RHU staff. Two MHOs of Daan Bantayan were recommended to undergo the training in the new NTP which will be held in Bohol in August. The Provincial Coordinator will discuss with the Barili Municipality about the recruitment of a new microscopist.

3.2. Actual monitoring had been performed mainly by the Provincial Coordinator and JICA Technical Assistants. The Provincial Nurse Supervisors and District Nurse Coordinators did not actively participate in this activity. It seems that they are not confident in what and how to monitor. Training of these staff in monitoring is considered necessary.

3.3 The proper use of the vehicles provided by JICA often calls attention. The vehicles were provided for Bohol, Siquijor, Negros Oriental, Laguna and TBCS from the budget of the Japanese fiscal year 1997. This matter, including allocation, was discussed with the Regional Director 7. The Resident Representative of JICA Philippines Office will write to those concerned to call their attention.

3.4. The austerity drive due to the Asian economy crisis cut the travel expenses, including per diem and gasoline. Hence the supervisors were facing difficulty in carrying out monitoring visits. Tuberculosis is the most serious problem in this country. The new NTP just started recently and the monitoring of field activities are crucial in the success of the program particularly at the beginning of implementation. The authorities are requested to allocate travel fund to tuberculosis control activities with highest priority.

IV Special Issues

Dr A Ookado the long term expert arrived in the Philippines on the 10th of April accompanied by his wife and child. Dr S Endo, together with his wife, went to Japan for home leave for the period of April 20 to June 3. Mr Y Terasaki, together with his wife and son, went to Japan also for home leave for the period of June 15 to July 31.

V Future Plan of Activities

- 5.1. Workshop for Project Cycle Management July 30 to August 5
- 5.2. Visit of Mission for the Project Planning August 6 to 14
- 5.3. Training in the new NTP for the expansion of the implementation to Bohol
 August 17 to October
- 5.4. Training of the newly recruited microscopists of Laguna Province
- 5.5. Launching of the field tuberculosis services in Laguna Provinces
- 5.6 Intensive monitoring in the Laguna Province
- 5.7. Training of supervisors in monitoring

MINUTES OF THE FIRST
JOINT COORDINATING COMMITTEE MEETING

DOH-JICA TUBERCULOSIS CONTROL PROJECT

DATE: 6 April 1998
VENUE: Bureau of Research and Laboratories
Training Room
TIME: 2:00 p.m.- 5:00 p.m.

CHAIRPERSON:

Dr. Antonio S. Lopez
Undersecretary, OPHS

MEMBERS PRESENT:

A. Philippine Government

Dr. Mariquita J. Mantala
Director, DOH - TBCS

Dr. Felicitas S.V. Ureta
Director, DOH - FACS

Dr. Jazmin Chipeco
Chief, Technical Division, RFO IV
(Regional Representative)

Dr. Ramon Maceren
Chief, Technical Division, RFO VII
(Regional Representative)

Dr. Cirila D. Jorvina
PHO II, Laguna Province

Dr. Jesus Fernandez
PHO II, Cebu Province

Dr. Filemon Flores
PHO II, Negros Oriental

Dr. Francisco Razalo
PHO II, Bohol

Ms. Zenaida Leonardo
NEDA - PMS Representative

Ms. Malou Eudela
NEDA - PMS Representative

Dr. Criselda Abesamis
Officer-In-Charge, DOH-BRL

B. Japanese Government

Mr. Hiroshi Goto
JICA Resident Representative

Dr. Shoichi Endo
Chief Adviser
DOH-JICA TB Control Project

Mr. Yoshinori Terasaki
Coordinator
DOH-JICA TB Control Project

C. Other Agencies

Ms. Maki Nagai
JICA Asst. Resident Representative

Ms. Saeda Makimoto
Staff, First Medical Cooperation Division
JICA Headquarters

Dr. Hikaru Fukuda
Representative
Embassy of Japan

Dr. Leopold Blanc
Representative
WHO - WPRO

OTHER OBSERVERS:

Dr. Elaine R. Teleron
Regional NTP Medical Coordinator
Region VII

Ms. Mila F. Marzo
Regional NTP Nurse Coordinator
Region IV

Dr. Rosalind G. Vianzon
Medical Specialist III, DOH - TBCS

Dr. Vivian S. Lofranco
Medical Specialist IV, DOH - TBCS

Ms. Maita Alcampado
Liaison Officer
JICA Philippine Office

Ms. Melia-Ellen Castillo
BRL Bacteriology Section Representative

Ms. Maricel L. Trono
Technical Assistant
DOH-JICA TB Control Project

Ms. Nyree Dawn V. Canete
Technical Assistant
DOH-JICA TB Control Project

Ms. Fannie Grace E. Borja
Technical Assistant
DOH-JICA TB Control Project

The meeting was opened by the Joint Coordinating Committee Chairperson, Dr. Antonio S. Lopez. The participants gave a brief personal introduction.

I. PROGRESS OF THE PROJECT

Dr. Rosalind G. Vianzon, Medical Specialist III - TBCS, presented the report on the progress of the project activities.

1.1 LAUNCHING and ADVOCACY CEREMONIES

Launching and Advocacy Ceremonies were held in the provinces of Siquijor on September 15, 1997, Laguna on September 19, 1997, and Negros Oriental on January 16, 1998. Officials and Representatives of various agencies participated and showed their support to the Revised National Tuberculosis Program.

1.2 TRAINING ACTIVITIES

A grand total of 2,160 different health personnel have already been trained on NTP since the inception of the project. These included Municipal Health Officers, Public Health Nurses, Rural Health Midwives, Medical Technologists, Hospital Staff and Barangay Health Workers.

A. Revised NTP Guidelines

13 supervisors from Laguna participated in the Training of Trainers during the last quarter of 1997. Furthermore, 69 MHOs/ PHNs/ MTs, 169 RHMs and 453 BHWs were trained during the 1st quarter of 1998.

In Negros Oriental, 17 supervisors, 143 MHOs/ PHNs/ MTs, 327 RHMs and 575 BHWs were trained during the 1st quarter of 1998. While in Siquijor, 24 MHOs/ PHNs/ MTs, 37 RHMs and 134 BHWs participated in the same kind of training during the last quarter of 1997.

B. Microscopy

24 medical technologists in the district hospitals and RHUs of Cebu province and 33 medical technologists in Negros Oriental, Cebu and Laguna were trained on microscopy during the 4th quarter of 1997 up to the 1st quarter of 1998. On the other hand, 2 senior medical technologists in Siquijor participated in the two-week training on Quality Control in Microscopy during the 4th quarter of 1997.

C. Refresher Training and Orientation Seminar

114 MHOs/ PHNs/ MTs from Cebu, Danao and Toledo cities participated in the one-day Refresher Training Course during the last quarter of 1997. Also, 26 hospital staff from the Vicente Sotto Memorial Medical Center participated in the one-day Orientation Seminar for health personnel involved in Tuberculosis Control Service during the same period.

1.3 COUNTERPART TRAINING IN JAPAN

Dr. Rosalind Vianzon, Medical Officer, DOH TBCS completed the basic course on tuberculosis control at Research Institute of Tuberculosis, Japan and was assigned as a coordinator for JICA Tuberculosis Control Project.

Ms. Lucy Aguiman, Medical Technologist, Cebu Reference Laboratory completed the tuberculosis bacteriology course at RIT, Japan.

1.4 SHORT TERM EXPERTS

Dr. Masashi Suchi visited the Project from November 19 to December 17, 1997. He conducted the baseline survey and took part in the workshop for planning of the implementation of the Project in Laguna.

Dr. Akihiro Okado visited the Project from February 15 to March 13 and assisted the training in Negros Oriental.

1.5 PROVISION OF EQUIPMENT FOR THE JAPANESE FISCAL YEAR 1997

All equipment will arrive by the end of April 1998. (*See Table 8 for the items*)

1.6 NATIONAL REFERENCE LABORATORY

DOH made a request to the Japanese Government for the establishment of National Reference Laboratory. The request is now under consideration by the Japanese Government.

II. ACCOMPLISHMENTS

Accomplishments of the project were narrated by Dr. Vianzon. She reported the project's attainments in case finding, treatment and DOTS. She also featured the expansion of the Project to the provinces of Siquijor, Laguna and Negros Oriental. Also mentioned in the report were some of the problems encountered in the Cebu Project.

2.1 CEBU PROJECT

2.1.1 Case-finding

1. From the 4th quarter of 1996 to the 3rd quarter of 1997, a total number of 17,692 symptomatics were examined.
2. The rate of three (3) specimen collection steadily increased from 92.6% in the 4th quarter of 1996 to 94.6% in the 2nd quarter of 1997. However, there has been a slight decrease to 92.7 % during the 3rd quarter of 1997.
3. The number of new sputum positive cases totaled to 2,847 during the said period with a positivity rate of 16.1%.
5. The case detection rate for sputum positive cases was averaging 97.5 per 100,000 population during the 4th quarter of 1996 up to the 3rd quarter of 1997.

2.1.2 Treatment

1. Out of the total number of pulmonary cases discovered during the 4th quarter of 1996 up to the 1st quarter of 1997, more than 50% of those registered for treatment were smear negative. Nevertheless, the proportion of smear positive cases increased to as high as 68.2% during the 3rd quarter of 1997.
2. During the 1st quarter of 1996, a cure rate of 83.4% was achieved. However, it decreased to 74.1% in the second quarter but reverted back to 81.2% in the 3rd quarter of 1996.
3. Completion rate steadily decreased from 3.2% in the 1st quarter to 1.9 % in the 3rd quarter of 1996.
4. Death Rate became as low as 2.3% in the 3rd quarter of 1996.

5. Failure Rate of 1.1% in the 1st quarter increased to 2.3% in the 2nd quarter then decreased to 1.9% in the 3rd quarter of 1996.

6. Lost cases continued to increase in the 2nd and 3rd quarter of 1996.

7. Transferred out rate is relatively constant except for a slight increase during the 2nd quarter of 1996.

2.1.3 Introduction of DOTS

DOTS was introduced to the whole project area. However, the health workers at 58 Health Centers of Cebu City have yet to be trained in DOTS particularly on patient education and recording system.

2.1.4 Summary

The Tuberculosis Control Program has been maintained at a satisfactory level in the Cebu Project area. The NTP diagnosed nearly 3,000 new smear positive cases in 1997 and has cured more than 80% new smear positive cases diagnosed from the 1st quarter to the 3rd quarter of 1996.

2.1.5 Problems Encountered in the Cebu Project

a. Wide Variation of Positivity Rate by RHU

There were 18 RHUs which reported a positive rate of less than 10% during the 3rd quarter of 1997. Effort is being made to intensify the quality control of smear examination carried out at the field laboratory.

b. Large Number of Patients Lost During Treatment (particularly in the cities)

Effort is being exerted in the improvement of the referral system and the reinforcement of the patient-health worker relationship through DOTS.

c. The employment of 2 casual Medical Technologists were terminated.

Therefore, there is a vacuum in the microscopy service in Lapu-Lapu City.

d. Temporary Increase in the Proportion of Smear Positive Patients Among the Registered Cases for Treatment

There may be a possibility that the constant increase in the proportion of smear positive patients among the registered cases for treatment might be just temporary due to the instruction to place priority in the treatment of smear positive cases because of the recent shortage of drugs. In order to provide x-ray positive, smear negative patients with proper diagnosis and treatment, it is advisable to organize a committee to evaluate the diagnosis of such patients.

2.2 EXPANSION OF THE NTP TO THREE (3) NEW PROVINCES

The Project has expanded to the provinces of Laguna (Region IV) and Siquijor and Negros Oriental (Region VII). Launching ceremonies were conducted, training activities were implemented and cooperation among concerned agencies was established in the new Project sites.

III. PLAN OF PROJECT ACTIVITIES FOR THE FISCAL YEAR 1998

3.1 EXPERTS

Three (3) long term experts- Chief Advisor, Medical Officer, Project Coordinator- will be dispatched for the Project. Two (2) short term experts will also be dispatched - one (1) medical officer will be dispatched for 4 weeks (3 times) and one (1) bacteriologist will be dispatched for 4 weeks (2 times).

The Project employs four (4) Technical Assistants and one (1) Secretary.

3.2 PROVISION OF EQUIPMENT

The following equipment will be provided by the Project: four (4) teaching microscopes; four (4) computers with printer, AVR and UPS; four (4) copiers with 20-bin sorter; four (4) overhead projectors (portable type); four (4) portable screens; four (4) sound systems; and four (4) slide projectors.

3.3 COUNTERPART TRAINING IN JAPAN

The Project will offer three (3) training courses in Japan.

- (1) Management of NTP
- (1) Group Training on Tuberculosis Control
- (1) Bacteriological Examination of Tuberculosis

3.4 EXPANSION OF THE IMPLEMENTATION OF THE NEW NTP AND MAINTENANCE OF THE PROJECT ACTIVITIES IN CEBU

1. Monitoring of the implementation of the new NTP in Cebu, Laguna, Negros Oriental and Siquijor
2. Expansion of the Project implementation and training activities to the 2nd half of the Laguna province and Bohol province.
3. Operational research on the improvement of quality control of smear examination and x-ray diagnosis

IV. DISCUSSION

4.1 TREATMENT OUTCOME

Dr. Mariquita Mantala, Director-TBCS, inquired as to the substantial decrease of cure rate in the 2nd quarter of 1996 from 83.4% to 74.1% and its subsequent increase to 81.2% in the 3rd quarter of 1996.

The Cohort Report of the 1st quarter 1996 included only one-third of cases registered for treatment in Cebu City because they started the implementation only in March 1996, as explained by Dr. Shoichi Endo, Project Chief Adviser. Furthermore, he said that the

decrease in the 2nd quarter was attributed to the considerable number of transient patients/residents of Cebu City who do not notify the treatment center of their transfer of domicile or work area. Nevertheless, the subsequent increase in the 3rd quarter was due to the implementation of DOTS.

Dr. Elaine Teleron, Regional NTP Medical Coordinator - Region VII, added that the implementation of the new guidelines covered the whole of Cebu last quarter of 1996. During the first quarter of 1996, there were only six (6) participating districts and the implementation in Cebu City started only in March 1996. She informed the body that Cebu City had a problem with case-holding. Moreover, the second phase of the project started in the 1st quarter of 1996 and the third phase on the last quarter of 1996. This does not mean that DOTS was also expanded that way. DOTS was first field tested in some areas in Cebu. The increase in cure rate in the 3rd quarter of 1996 may be attributed to DOTS.

4.2 FAST-TRACKING OF PROJECT IMPLEMENTATION

Dr. Elaine Teleron narrated that the Project started in September 1992 and the Cebu Reference Laboratory was established in 1994 in response to the inquiry of Dr. Antonio Lopez on the background of the Project. The series of training covered six districts or 23 municipalities which composed the 1st Intensive Service Area. Project implementation was done also on a step-wise manner.

As observed by Dr. Mantala, the first five years of the project was a little bit slow, in terms of implementation. Nevertheless, when all the system was stabilized in its second phase, expansion was made possible. She then inquired about the possibility of fast-tracking the expansion to cover more provinces nationwide. Dr. Antonio Lopez agreed with Dr. Mantala's suggestion and at least cover 10-15 provinces within the five-year project period. Dr. Shoichi Endo, Chief Adviser, explained that the Record of Discussion signed prior to the current project, limited the expansion to Region VII and Laguna Province, then to ten (10) other provinces. Furthermore, he remarked that ample time should be allotted to planning and developing strategies, in case of fast-tracking, so that the quality of the existing project will not be compromised.

4.2.1 Constraints

The committee identified several constraints in the fast-tracking of implementation. Among them are: (1) lengthy time required to train all concerned health personnel, (2) inadequacy of resources to effectively monitor and supervise the newly trained health workers to assess the degree of their knowledge and practice of the new NTP policies and guidelines, (3) inadequacy of trainers and the fast turnover of personnel in the Regional and Provincial level; and (4) temporary shortage of TB drugs.

4.2.2 Recommendations

1. Dr. Lopez suggested that the number of facilitators to be trained should be increased so that more resource persons can be developed for the planned project expansion.
2. Dr. Mantala suggested that the already trained and experienced personnel should extend their expertise to other provinces / expansion areas.

3. Meanwhile, Dr. Chipeco shared the "Adopt A Province" approach being implemented in the Regional Field Office IV. In this strategy, a manager is assigned to handle the technical and administrative support requirements of a specific program. Moreover, she also suggested that in order to maximize the limited resources, monitoring activities should also cover other DOH programs.

4. Ms. Zenaida Leonardo, representative of the NEDA-PMS, suggested that the NGOs be involved and trained on NTP. Dr. Razalo, Dr. Ureta and Dr. Lopez were united in the suggestion to train and include private practitioners in the Program since a large percentage of TB patients consult with them.

5. Dr. Antonio Lopez suggested that the resources and assistance from various agencies for expansion should be consolidated. Dr. Endo emphasized that the cooperation of the LGUs is also necessary for the success of the project.

6. Ms. Zenaida Leonardo suggested that the task force set targets on how many should be trained. With this, Dr. Endo remarked that the planning is done by province and the target set is that all government health personnel in the province should be trained. He added that already trained health personnel in existing project areas can be tapped for the expansion of the implementation to other provinces.

V. ADJOURNMENT

The meeting adjourned at 4:00 p.m.

Approved by:



DR. MARIQUITA J. MANTALA

Director III

DOH - Tuberculosis Control Service

TABLE 1. Training activities for the implementation of the new NTP policies and strategies in the expansion areas are shown below.

PROVINCE/ CATEGORY	DURATION	BATCH	DATE	PARTICI- PANTS
LAGUNA				704
SUPERVISORS	4 days	1	October 1997	13
MHOs, PHNs, MTs	3 days	2	February/March 1998	69
RHMs	2 days	4	March 1998	169
BHWs	1 day	15	March/April 1998	453
NEGROS ORIENTAL				1,062
SUPERVISORS	5 days	1	January 1998	17
MHOs, PHNs, MTs	3 days	4	February/March 1998	143
RHMs	2 days	6	February to April 1998	327
BHWs	1 day	21	February to April 1998	575
SIQUIJOR				195
MHOs, PHNs, MTs	3 days	1	November 1997	24
RHMs	2 days	1	November 1997	37
BHWs	1 day	4	November 1997	134

TABLE 2. Training of Medical Technologists on Microscopy

CATEGORY	DURATION	BATCH	DATE	PARTICI- PANTS
MTs in Dist. Hosp. and RHUs in Cebu Prov.	5 days	3	September and October 1997	24
MTs in Negros, Cebu and Laguna Province	5 days	4	February to April 1998	33

TABLE 3. Training of Senior Medical Technologist on Quality Control in Microscopy

CATEGORY	DURATION	BATCH	DATE	PARTICIPANTS
MTs in Siquijor Province	10 days	2	October and November 1997	2

TABLE 4. Refresher Training Course (Cebu, Danao and Toledo Cities)

CATEGORY	DURATION	BATCH	DATE	PARTICIPANTS
MHOs PHNs, MTs	1 day	3	13, 14 & 17 October 1997	114

TABLE 5. Orientation Seminar for Medical Doctors, Nurses and Medical Technologists of VSMMC involved in the management of TB cases

CATEGORY	DURATION	BATCH	DATE	PARTICIPANTS
MHOs PHNs, MTs	1 day	2	18 & 19 October 1997	26

TABLE 6. Case-finding

INDICATORS	4th Qtr. 96	1st Qtr. 97	2nd Qtr. 97	3rd Qtr. 97	TOTAL
No. Symptomatics Examined	4,349	4,910	3,782	4,651	17,692
Rate 3 Specimen Collection	92.6	93.8	94.6	92.7	93.4
No. of Smear Positive Cases	755	718	624	750	2,847
Positive Rate (%)	17.2	14.6	16.5	16.1	16.1
Smear Positive Population (100,000)	25.8	24.6	21.4	25.7	97.5

Proportion of Smear Positive Cases Registered for Treatment

INDICATORS	4th Qtr. 96	1st Qtr. 97	2nd Qtr. 97	3rd Qtr. 97
% Smear (+) New and Relapse / Registered Patients	47.9	41.1	58.8	68.2

TABLE 7. Treatment

Treatment Outcome of Smear Positive Patients Registered for Treatment

TREATMENT OUTCOME	1st Qtr. 96 %	2nd Qtr.96 %	3rd Qtr.96 %
Cured	83.4	74.1	81.2
Completed	3.2	2.1	1.9
Died	3.2	3.2	2.3
Failure	1.1	2.3	1.9
Lost	5.3	11.8	9.4
Transferred Out	3.7	6.5	3.4

TABLE 8. Provision of Equipment from the Japanese Government Fiscal Year 1997

	ITEM	QTY	DESCRIPTION	ALLOCATION
1	Microscope	100	Binocular, lights/miller	Microscopy Centers in the province of Negros Oriental; Laguna; Siquijor and Bohol
2	Vehicle	2	Toyota Hi-ace	TBCS and Laguna PHO
		3	Toyota Hi-lux 4x4	Negros Oriental PHO, Siquijor PHO and Bohol PHO
3	Computer	3	with Printer, AVR & UPS	Project Office (2) and TBCS
4	Copier	2	with Sorter	Project Office and Laguna PHO

TABLE 9. Provision of Equipment from the Japanese Government Fiscal Year 1998

	ITEM	QTY	DESCRIPTION	ALLOCATION
1	Teaching Microscope	4	Binocular with one sided viewer attachment	Bohol PHO; Siquijor PHO; Laguna PHO and Negros Oriental PHO
2	Computer	5	with Printer, AVR & UPS	Cebu Project Office; Regional Office IV; Bohol PHO; Negros Oriental PHO and Laguna PHO
3	Copier	4	with 20 bin sorter	Cebu Project Office; Regional Office IV; Bohol PHO and Negros Oriental PHO
4	Overhead Projector	4	Portable	Bohol PHO; Siquijor PHO; Laguna PHO and Negros Oriental PHO
5	Screen	4	Portable	Bohol PHO; Siquijor PHO; Laguna PHO and Negros Oriental PHO
6	Sound System	4		Bohol PHO; Siquijor PHO; Laguna PHO and Negros Oriental PHO
7	Slide Projector	4		Bohol PHO; Siquijor PHO; Laguna PHO and Negros Oriental PHO

TENTATIVE SCHEDULE OF IMPLEMENTATION FOR JAPANESE FISCAL YEAR 1998-99 (APRIL '98 to MARCH '99)

TUBERCULOSIS CONTROL PROJEC

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RECORD OF DISCUSSIONS
ON THE JAPANESE TECHNICAL COOPERATION
FOR
TUBERCULOSIS CONTROL PROJECT

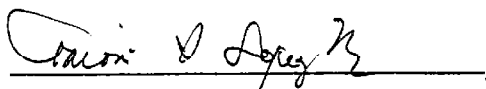
With regard to the Japanese technical cooperation for Tuberculosis Control Project in the Republic of the Philippines, Mr. Hiroshi Goto, Resident Representative of Philippine Office, Japan International Cooperation Agency, held a series of discussions with the Philippine authorities concerned. The discussions were in accordance with the results of the Japanese Preliminary Study Team conducted in the Republic of Philippines from May 29 to June 7, 1997.

As a result of the discussions, both sides agreed to recommend to their respective Governments the matters referred to in the document attached hereto.

Manila, August 14, 1997


HIROSHI GOTO

Resident Representative
Philippines Office
Japan International Cooperation
Agency


ANTONIO LOPEZ, MD., M.P.H. *mm*

Assistant Secretary and Officer in
Charge, Office for Public Health
Services, Department of Health
Republic of the Philippines

ATTACHED DOCUMENT

I. COOPERATION BETWEEN BOTH GOVERNMENTS

1. The Government of the Republic of the Philippines will implement the Tuberculosis Control Project (hereinafter referred to as "the Project") in cooperation with the Government of Japan.
2. The Project will be implemented in accordance with the Master Plan which is given in Annex I.

II. MEASURES TO BE TAKEN BY THE GOVERNMENT OF JAPAN

In accordance with the laws and regulations in force in Japan, the Government of Japan will take, at its own expense, the following measures through Japan International Cooperation Agency (hereinafter referred to as "JICA"), , according to normal procedures under the Colombo Plan Technical Cooperation Scheme.

1. DISPATCH OF JAPANESE EXPERTS
The Government of Japan will provide the services of the Japanese experts as listed in Annex II.
2. PROVISION OF MACHINERY AND EQUIPMENT
The Government of Japan will provide such machinery, equipment and other materials (hereinafter referred to as "the Equipment") necessary for the implementation of the Project as listed in Annex III. The Equipment will become the property of The Government of the Republic of the Philippines upon delivery C.I.F. to the Philippine authorities concerned at the ports and /or airports of disembarkation.
3. TRAINING OF PHILIPPINE PERSONNEL IN JAPAN
The Government of Japan will receive Philippine personnel connected with the Project for technical training in Japan.
4. SPECIAL MEASURES TO BE TAKEN BY THE GOVERNMENT OF JAPAN
To ensure the smooth implementation of the Project, the Government of Japan will take, in accordance with the laws and regulations in force in Japan, special measures through JICA for supplementing a portion

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of the local cost expenditures necessary for the execution of the middle level trainees training program.

III. MEASURES TO BE TAKEN BY THE GOVERNMENT OF THE PHILIPPINES

1. The Government of the Philippines will take necessary measures to ensure self-reliant operation of the Project during and after the period of Japanese technical cooperation, through the full and active involvement in the Project of by all related authorities, beneficiary groups and institutions.
2. The Government of the Philippines will ensure that the technologies and knowledge acquired by the Philippine nationals as a result of Japanese technical cooperation will contribute to the economic and social development of the Philippines.
3. The Government of the Philippines will grant, in the Philippines, privileges, exemptions and benefits to the Japanese expert referred to in II-1 above and their families, which are no less favorable than those accorded to experts of third countries working in the Philippines under the Colombo Plan Technical Cooperation Scheme.
4. The Government of the Philippines will ensure that the Equipment referred to in II-2 above will be utilized effectively for the implementation of the Project in consultation with the Japanese experts referred to in Annex II.
5. The Government of the Philippines will take necessary measures to ensure that the knowledge and experience acquired by the Philippine personnel from technical training in Japan will be utilized effectively in the implementation of the Project.
6. In accordance with the laws and regulations in force in the Philippines the Government of the Philippines will take necessary measures to provide at its own expense for the Project:
 - (1) Services of the Philippines counterpart personnel and administrative personnel as listed in Annex IV;
 - (2) Land, buildings and facilities as listed in Annex V;
 - (3) Supply or replacement of machinery, equipment, instruments, vehicles, tools, spare parts and other materials necessary for

- implementation of the Project other than the Equipment provided through JICA under II-2 above;
- (4) Means of transport and travel allowances for the Japanese experts for official travel within the Philippines; and
 - (5) Assistance to find suitably furnished accommodations for the Japanese experts and their families.
7. In accordance with the laws and regulations in force in the Philippines the Government of the Philippines will take necessary measures to meet:
- (1) Expenses necessary for transportation within the Philippines of the Equipment referred to in II-2 above as well as for the installation, operation and maintenance thereof;
 - (2) Customs duties, internal taxes and any other charges imposed in the Philippines on the Equipment referred to in II-2 above; and
 - (3) Running expenses necessary for the implementation of the Project.
8. The Government of the Philippines will provide anti-tuberculosis drugs and laboratory supplies necessary for implementation of the Project.

IV. ADMINISTRATION OF THE PROJECT


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1. Undersecretary for Public Health Services, Department of Health, as the Project Director, will bear overall responsibility for administration and implementation of the Project.
 2. Director, the Tuberculosis Control Services, Department of Health, as the Project Manager, will be responsible for the managerial and technical matters of the Project.
 3. Director, Regional Health Office, Region IV and VII, will be responsible for administrative and managerial matters of the Project in his/her area and for advising on technical matters to the Local Government Units.
 4. The Provincial Health Officer will be responsible for administrative and technical matters of the Project in his/her province under the Project.
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5. The Local Government Units will be responsible for implementation of the tuberculosis services activities in their area under the Project.
6. The Japanese Chief Advisor will provide necessary recommendations and advice to the Project Director and Project Manager on any matters pertaining to the implementation of the Project.
7. The Japanese experts will provide necessary technical guidance and advice to the Philippine counterpart personnel on technical matters pertaining to the implementation of the Project.
8. For the effective and successful implementation of technical cooperation for the Project, a Joint Coordinating Committee and a Technical Working Group will be established whose functions and composition are described in Annex VII.

V. JOINT EVALUATION


Evaluation of the Project will be conducted jointly by the two Governments through JICA and the Philippine authorities concerned, at the middle and during the last six months of the cooperation term in order to examine the level of achievement.

VI. CLAIMS AGAINST JAPANESE EXPERTS

 The Government of the Philippines shall bear claims, if any arises, against the Japanese experts engaged in technical cooperation for the Project resulting from, occurring in the course of, or otherwise connected with the discharge of their official functions in the Republic of the Philippines except for those arising from the willful misconduct or gross negligence of the Japanese experts.

VII. MUTUAL CONSULTATION

There will be mutual consultation between the two Governments on any major issues arising from, or in connection with, this Attached Document.



VIII. MEASURES TO PROMOTE UNDERSTANDING OF AND SUPPORT FOR THE PROJECT

For the purpose of promoting support for the Project among the people of the Philippines, the Government of the Philippines will take appropriate measures to make the Project widely known to the people of the Philippines.

IX. TERM OF COOPERATION

The duration of the technical cooperation for the Project under the Attached Document will be five(5) years from September 1, 1997.

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ANNEX

I MASTER PLAN

1 Overall Goal

To reduce tuberculosis problem in the Philippines

2 Project Purpose

To improve management of National Tuberculosis Program (hereinafter referred to as "NTP") with regards to expansion of the implementation of the new NTP policies and strategies

3. Output of the Project


- (1) National Tuberculosis Reference Laboratory is established.
- (2) Implementation of the model of new NTP policies and strategies is maintained in Cebu Province and is expanded to three other provinces in Region VII.
- (3) NTP national demonstration site is established in Laguna Province, Region IV.
- (4) Implementation of the new NTP policies and strategies is expanded to some other provinces.

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4. Activities of the Project

- (1) Technical advice to the Tuberculosis Control Service - Department of Health with regards to expansion of the implementation of the new NTP policies and strategies
- (2) Improvement of tuberculosis service such as case-finding and treatment integrated into general health services, mobilization of primary health care services to implement Directly Observed Treatment, Short Course, and strengthening of bacteriological laboratory service. For this purpose a demonstration area will be developed.



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- (3) Implementation of simple, efficient and effective recording and reporting system for management of tuberculosis service at the health facilities and supervision, monitoring and evaluation
 - (4) Strengthening IEC activities for tuberculosis control and related activities
 - (5) Establishing a surveillance system for management of NTP, monitoring of epidemiological impact of NTP and evaluation of the Project
 - (6) Establishing a laboratory service network with reference laboratory for ensuring the quality of bacteriological service
 - (7) Conducting operational research in defined areas to identify a better model of program implementation
 - (8) Holding various meeting such as seminars and workshops to motivate decision makers, health professionals of NGOs and private sectors for better cooperation in the implementation of new NTP policies and strategies
 - (9) Training program in order to improve and maintain the technical level of health personnel
 - (10) Others mutually agreed upon as needed

II LIST OF JAPANESE EXPERTS



- 1. Long-term experts
 - (1) Chief Advisor (This Expert might also serve concurrently as the expert on tuberculosis control)
 - (2) Coordinator
 - (3) Experts in the following fields
 - (a) Tuberculosis control
 - (b) Other related fields mutually agreed upon as necessary
 - 2. Short-term experts in the following fields
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- (1) Tuberculosis control
- (2) Bacteriology
- (3) Epidemiology
- (4) Radiology
- (5) Other related fields mutually agreed upon as necessary

III LIST OF MACHINERY AND EQUIPMENT

1. Machinery and equipment for:
 - (1) transportation and communication
 - (2) survey, monitoring and evaluation activities
 - (3) the improvement of NTP activities
 - (4) IEC
2. Machinery and equipment in other related fields mutually agreed upon as necessary

IV LIST OF PHILIPPINE COUNTERPART AND ADMINISTRATIVE PERSONNEL

1. Project Director
 2. Project Manager
 3. Counterpart personnel in the following fields.
 - (1) Tuberculosis control
 - (2) Bacteriology
 - (3) Epidemiology
 - (4) Radiology
 - (5) Others mutually agreed upon as necessary
 4. Administrative personnel
 - (1) Coordinator
 - (a) Project coordinator of Tuberculosis Control Services, Department of Health
 - (b) Regional NTP coordinators
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- (c) Provincial/Chartered City NTP coordinators
- (d) Rural health Units or District Health Office Representatives
- (2) Secretary
- (3) Drivers
- (4) Other supporting staff mutually agreed upon as necessary

V LIST OF LAND, BUILDINGS AND FACILITIES

1. Sufficient space for implementation of the Project
2. Offices and necessary facilities for the Japanese experts
3. Facilities such as electricity, gas, water, sewerage system, telephones and furniture necessary for Project activities and operational expenses for utilities
4. Other facilities mutually agree upon as necessary

VI JOINT COORDINATING COMMITTEE AND TECHNICAL WORKING GROUP

1. Joint Coordinating Committee
 - (1) Functions

The Joint Coordinating Committee will meet at least once a year and whenever necessity arises, and work :

 - (a) To review and authorize the an Annual Work Plan of the Project under the framework of the Record of Discussions
 - (b) To review overall progress of the Project
 - (c) To discuss other major issue reverent to the Project
 - (2) Composition
 - (a) Chairperson:

Undersecretary for Public Health Services, Department of Health
 - (b) Members:

Philippine Side:

 - 1) Director, Tuberculosis Control Services, Department of Health
 - 2) Director, Regional Health Office, Region VII

- 3) Director, Regional Health Office, Region IV
- 4) Director, Foreign Assistance Coordinating Services, Department of Health
- 5) Representative of National Economic Development Agency
- 6) Representative of Local Government Units

Japanese Side:

- 1) Chief Advisor
- 2) Coordinator
- 3) Other Experts
- 4) Resident Representative of JICA in the Philippines
- 5) Other personnel to be dispatched by JICA, as necessary

Note: A representative of WHO/WPRO will be invited to be a member of Joint Coordinating Committee for the better coordination with WHO Program.

Official(s) of the Embassy of Japan may attend the Joint Coordinating Committee meeting as observer(s).

2. Technical Working Group

(1) Functions

The Technical Working Group will meet at least quarterly and whenever necessity, and work :

- (a) To monitor the implementation of the Project;
- (b) To submit to Joint Coordinating Committee and participating agencies quarterly report;
- (c) To formulate and propose to Joint Coordinating Committee the Annual Work Plan of the Project;
- (d) To coordinate with Local Government Units; and
- (e) To make decisions on operational matters.

(2) Composition

Philippine Side:

- (a) Project coordinator of Tuberculosis Control Services, Department of Health
- (b) Regional NTP coordinators
- (c) Provincial/Chartered City NTP coordinators
- (d) Rural health Units or District Health Office Representatives

Japanese Side:

- (a) Chief Advisor
- (b) Coordinator
- (c) Other Experts

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TENTATIVE SCHEDULE OF IMPLEMENTATION
FOR
TUBERCULOSIS CONTROL PROJECT IN THE PHILIPPINES

Mr. Hiroshi Goto, Resident Representative of the Japan International Cooperation Agency (hereinafter referred to as "JICA") in the Republic of the Philippines and Philippine authorities concerned have jointly formulated the Tentative Schedule of Implementation for Tuberculosis Control Project in the Philippines (hereinafter referred to as "the Project") as attached hereto.

The schedule has been formulated in connection with the attached document of the Record of Discussion signed between JICA and the Philippine authorities concerned for the Project, on condition that the necessary budget be allocated for the implementation of the Project and that the schedule is subject to change within the framework of the Record of Discussion when necessity arises in the course of implementation of the Project.

Manila, August 14 , 1997



HIROSHI GOTO
Resident Representative in the
Republic of the Philippines
Japan International Cooperation
Agency



ANTONIO LOPEZ, MD., M.P.H.
Assistant Secretary and Officer in
Charge, Office for Public Health
Services , Department of Health

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TENTATIVE SCHEDULE OF IMPLEMENTATION OF THE PROJECT: ACTIVITIES

1. ACTIVITIES FOR THE OUTPUT OF THE PROJECT	Year 1 Sept. 1997 - Aug. 1998	Year 2 Sept. 1998 - Aug. 1999	Year 3 Sept. 1999 - Aug. 2000	Year 4 Sept. 2000 - Aug. 2001	Year 5 Sept. 2001 - Aug. 2002
1. Establishment of National Tuberculosis Reference Laboratory	=====	=====	=====	=====	=====
2. Maintenance of implementation of new NTP policies and strategies in Cebu Province and expansion of implementation of new NTP policies and strategies to three other provinces in Region VII	=====	=====	=====		
3. Establishment of NTP national demonstration site in Laguna Province, Region IV	=====	=====	=====		
4. Assistance in expansion of the implementation of the new NTP policies and strategies to cover some other provinces			=====	=====	=====
NOTE: This schedule is subject to change within the framework of the Record of Discussion when the necessity arises during the course of the Project implementation					

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TENTATIVE SCHEDULE OF IMPLEMENTATION OF THE PROJECT: INPUTS

II. INPUTS BY JICA	Year 1 Sept. 1997 - Aug. 1998	Year 2 Sept. 1998 - Aug. 1999	Year 3 Sept. 1999 - Aug. 2000	Year 4 Sept. 2000 - Aug. 2001	Year 5 Sept. 2001 - Aug. 2002
1. Dispatch of Japanese Experts in the Philippines					
1.1 Long Term					
a. Chief Advisor	=====	=====	=====	=====	=====
b. Coordinator	=====	=====	=====	=====	=====
c. Tuberculosis Control	=====	=====	=====	=====	=====
d. Bacteriology	=====	=====	=====	=====	=====
e. Other related fields mutually agreed upon as necessary					
1.2 Short Term					
a. Tuberculosis Control	== ==	== == ==	== == ==	== == ==	== == ==
b. Epidemiology	==	==	==	==	==
c. Bacteriology		== == ==	== == ==	== == ==	== == ==
d. Other related fields mutually agreed upon as necessary					
2. Counterpart Training in Japan					
a. Tuberculosis Control	=====	=====	=====	=====	=====
b. Laboratory Works for Tuberculosis Program Management	=====	=====	=====	=====	=====
c. National Tuberculosis Program management	==	==	==	==	==
3. Provision of Equipment	==	==	==	==	==
4. JICA study mission	Consultation Team		Advisory Team		Evaluation Team
III. INPUTS BY THE PHILIPPINE SIDE	Year 1 Sept. 1997 - Aug. 1998	Year 2 Sept. 1998 - Aug. 1999	Year 3 Sept. 1999 - Aug. 2000	Year 4 Sept. 2000 - Aug. 2001	Year 5 Sept. 2001 - Aug. 2002
1. Assignment of counterpart personnel	=====	=====	=====	=====	=====
2. Provision of office space for Japanese experts					
DOH - Central Office	=====	=====	=====	=====	=====
DOH - Regional Office	=====	=====	=====	=====	=====
3. Provision of anti-tuberculosis drugs and laboratory supplies	=====	=====	=====	=====	=====
4. Meeting of Coordinating Committees					
Joint Coordinating Committee	==	==	==	==	==
Technical Working Group	==	==	==	==	==
* The Committee may meet more often as the need arises					
5. Submit annual activity report	==	==	==	==	==