BILATERAL

AGREEMENT BETWEEN THE REPUBLIC OF THE PHILIPPINES AND THE WORLD HEALTH ORGANIZATION ON THE FIRST ADDENDUM TO THE REVISED PLAN OF OPERATION FOR MALARIA ERADICATION PROGRAMME IN T...

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Note: The Agreement entered into force, October 15, 1969.

Reference: This Agreement is also published in VIII DFA TS No. 1, p.108.

THE GOVERNMENT OF THE REPUBLIC OF THE PHILIPPINES, hereinafter referred to as "GOVERNMENT," and the WORLD HEALTH ORGANIZATION, hereinafter referred to as "WHO" have agreed to the following FIRST ADDENDUM TO THE REVISED PLAN OF OPERATION signed by the Government on 14 March 1967 and by WHO on 10 February 1967.

The purpose of this Addendum is:

1. to record the achievements in 1967 and 1968;

2. to detail the plan of action for the years 1969 and 1970;

3. to record the commitments of the Government and of WHO for 1969 and 1970.

ACHIEVEMENT IN 1967 AND 1968

1. ORGANIZATION OF THE MALARIA ERADICATION SERVICE

The Malaria Law (Annex I) which was approved on 18 July 1966 recentralized the Malaria Organization previously under the eight Regional Health Offices into a Malaria Eradication Service (MES) directly under the Office of the Secretary of Health. Under this new arrangement, the MES is headed by a Project Director and assisted by a Deputy Project Director who shall act as Project Director in the absence of the regular incumbent to ensure the continuity of the service. The three new divisions created by law are: (1) Epidemiology, Research and Training, (2) Field Operations, and (3) Administration, in addition to the pre-existing Division of Malaria (Evalua-tion and Statistics), Annex II.

The country is divided into six Areas which are further subdivided into 39 Malaria Units (Annex III).

2. ADMINISTRATION AND FINANCE

The Project Director is vested by the Malaria Law with a direct line authority. A Planning Committee composed of the Project Director as chairman, the Deputy Project Director as vice-chairman, the Chief of Field Operations, Chief of Epidemiology, Research and Training, Chief of Administration, one area supervisor, and the Senior Advisers of the United States Agency for International Development/United States Public Health Service (AID/PHS) and WHO, as members, was created by the Secretary of Health for programme planning and evaluation. Results of malariometric surveys, spray-ing accomplishments, and epidemiological data are compiled

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and assessed by the Division of Malaria {evaluation and statistics) to inform and guide the Planning Committee. Work schedules for spraying operations and epidemiological activities are prepared by the malaria unit heads under the supervision of the area chief field malariologist supervisors. The Planning Committee reviews these schedules and upon approval, allocates the necessary manpower and financial support to carry out the plan of action. Supervi-sion is carried out from the following levels: (1) central, (2) area, (3) unit, (4) sector, and (5) squad.

Based on the degree of incidence, malarious areas are divided into "Early Attack" and "Late Attack." It is planned to undertake at least three spraying cycles before considering the eligibility of any area for consolidation.

There are three sources of local funds for the support of the Malaria Eradication Programme: the General Fund, the Foreign Assisted Project Peso Support Fund (FAPPSF), and the Sweepstakes Fund which came in only in 1968. The budgets of the Government for fiscal year 1967 and fiscal year 1968 were as follows:

FISCAL YEAR 1967

General
Funds

FAPPSF

Supplemental
Budget
RA4832

Total

Salaries .....

P4,372,010

.....

P73,944

P4,445,954

Wages.....

715,000

2,085,541

2,800,541

Travelling.....

460,000

210,000

308,850

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978,850

Supplies & Materials.....

241,600

90,000

250,000

581,600

Sundry.....

196,600

85,000

130,000

411,600

Fixed Expenditures.....

59,340

.....

6,665

76,005

Equipment.....

.....

.....

145,000

145,000

_____

_____

_____

_____

Total.....

P5,329,550

P 1,100,000

P3,000,000

P9,439,550

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FISCAL YEAR 1968

Regular
Funds

FAPPSF

Sweepstakes

Total

Salaries .....

P2,208,965

P.....

P91,034

P2,299,999

Training Allowance

20,000

.....

.....

20,000

Wages.....

4,522,985

715,000

.....

5,237,985

Salary adjustment .....

227,000

.....

.....

227,000

Travelling.....

768,850

210,000

50,000

1,028,850

FISCAL YEAR 1967

General
Funds

FAPPSF

Supplemental
Budget
RA4832

Total

Supplies & Materials.....

491,600

90,000

53,000

634,600

Sundry.....

326,600

85,000

45,000

456,600

Fixed Expenditures.....

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100,000

.....

.....

100,000

Equipment.....

.....

.....

45,000

45,000

Capital Outlay.....

120,000

.....

.....

120,000

Continuing Appropriation.....

429,642

.....

.....

429,642

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Total.....

P9,215,642

P1,100,000

P284,034

P10,599,676

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The AID and the WHO committed:

Fiscal Year 1967

Fiscal Year 1968

AID

$1,521,000

$1,153,000

WHO

115,000

3. OPERATIONS

a. Delimitation studies

During the second half of 1967 and early 1968 a re-delimitation of the malarious areas was undertaken in all potentially malarious areas and some of the non-malarious areas where malaria cases had recently been reported or were suspected. This was done by carrying out some rounds of active case detection (ACD), passive case detection (PCD), and school surveys in selected localities, and the subsequent investigation of confirmed cases. These studies covered a population of around 4 million.

b. Geographical reconnaissance

Geographical reconnaissance was undertaken in the entire attack phase area, and showed the following upon completion:

_____

_____

Total attack phase area

Number of

Houses

Number of Localities

Number of Population

Before rcdelimitation

1.2 million

27,372

6.2 million

After redelimitation

1.8 million*

38,023

9.5 million*

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c. Development of locality cards

Locality cards containing vital operational and epidemiological informa-tion were prepared for each locality under operational coverage.

d. Spraying operations

The above activities replaced the second regular spraying cycle in 1967, which was limited to indicator districts and highly malarious areas. Similarly, the first cycle 1968 was not started before April 1968 due to some delay in completing the extensive redelimitation studies and geographic reconnais-sance operations. As a result of the late start of the first cycle in 1968, the second cycle did not start until the latter part of October 1968.

Spraying operations during 1967 and 1968 may be summarized as follows:

YEAR

FIRST CYCLE

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SECOND CYCLE

Target number of houses

Percentage coverage

Target number of houses

Percentage coverage

1967

1.2 million

86.2

0.7 million

75.7

1968

1.6 million

84.8

0.20 million

75.0

e. Epidemiological operations and assessment

During 1967 epidemiological evaluation of the operations was based on results obtained in indicator districts. To this end 23 indicator districts were established in early 1967, covering 0.37 million inhabitants. These indicator districts were increased later on in number and size to include 0.75 million people. The following results were recorded:

1967

Number of Slides

Projected
ABER %

ACD

PCD

Others

API %

1st Semester

35,219

1,820

3,794

19.8

30.6

2nd Semester

41,871

4,708

157

12.5

15.7

During the redelimitation studies the following data were collected:

Number of Slides

AREA

ACD

PCD

Others

Total
Positive

Potentially malarious
(3.1 million)

113,893

7,684

.....

3,276

Non-malarious
(0.9 million)

32,821

5,534

.....

1,410

Malarious
(6.2 million)

56,555

7,002

7,675

6,522

During 1968 no ACD was carried out, except for some rounds in areas adjoining the attack phase area. With a view to assessing the current malaria load in all units, a mass survey was conducted in 670 localities, with a population of 264,000 representing the most malarious localities of each unit. The examination results of 76,658

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blood slides have been reported, showing 1,505 positives, i.e., and average parasite rate of 2.0% (range 0 — 12.5%). It was also shown that 50% of the positive localities had blood indices below 2% — an indication that surveillance has to be established.

Entomological observations were carried out regularly, including suscep-tibility tests. No signs of resistance of the local vectors have been observed.

f. Participation of general health services

Involvement of hospitals, rural health units and other health establish-ments in case detection activities received continuous attention in indicator districts, during the delimitation studies, and in the evaluation of the 1968 operations.

During the delimitation studies, a total of 20,220 blood smears were col-lected from various sources, 7362 by rural health units (total number in the country is 1435), 7277 by malaria field laboratories, 4273 by volunteers and 1308 by hospitals and private practitioners.

During the ensuing 1968 spraying operations, a total of 32,302 blood smears with 4469 positives, were collected through PCD in the attack phase area. In addition, 4307 with 171 positives were collected in the adjacent non-malarious areas.

g. Health education

A health educator from the general public health service has been detailed to the MES to motivate arid co-ordinate the health education activities of the malaria eradication programme. Malaria posters have been developed for distribution in malarious areas. In each malaria unit, a malaria technician has been designated as health educator.

h. Development of operational manuals

The following operational manuals were completed in fiscal year 1967 and updated in fiscal year 1968:

1. Administration
2. Geographical Reconnaissance and Spraying
3. Epidemiology
4. Entomology
5. Health Education and Training
6. Records and Data Transmission
7. Transport

i. Training activities

A training section has been created with qualified full-time staff. A WHO training adviser was assigned to this activity. The malaria field laboratory at Tala has been converted into a national malaria training centre for in-service and pre-service training of malaria personnel. Senior members of the MES were called from time to time for refresher courses at the Malaria Eradication Training Centre (METC). In fiscal year 1967, seven malariologists and two engineers took up a pre-service training in Tala. At the METC, six malariologists, three engineers, four technicians, and seven administrative personnelundertook in-service training. In fiscal year 1968, five professional and sixty-two sub-professional personnel were trained in Tala. At the METC, the following MES personnel were trained in Tala. At the METC, the following MES personnel undertook in-service training

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on:

General Course for Instructors — 2 engineers

Public Health Administration — 1 administrator

General Course for Professional Personnel — 12 physicians and

7 engineers

Special Course for Senior Instructors — 2 physicians

PLAN OF ACTION FOR FISCAL YEAR 1969 AND FISCAL YEAR 1970

1. ORGANIZATION OF THE MALARIA ERADICATION SERVICE

There is no change in the organization structure (Annex II) of the MES and neither is a change contemplated for fiscal year 1970.

2. ADMINISTRATION AND FINANCE

The appropriation for malaria eradication is broken down as follows:

FISCAL YEAR 1969

Funds
Regular

FAPPSF

Sweepstakes

Total

Personal Services:

Salaries.....

P2,205,541

.....

P83,736

P2,289,277

Wages.....

4,523,409

500,000

.....

5,023,409

Training Allowance.....

20,000

.....

.....

20,000

Travelling Expenses .....

768,850

250,000

40,000

1,058,850

Supplies & Materials.....

491,600

250,000

93,122

834,722

Sundry.....

326,600

100,000

40,000

466,600

Fixed Expenditures.....

69,000

.....

7,955

76,955

Equipment.....

.....

.....

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18,000

18,000

Continuing Appropriation

429,642

.....

.....

429,642

Total.....

P8,834,642

P1,100,000

P282,813

P10,217,455

The budget under consideration for fiscal year 1970 in Congress is essen-tially the same as that of fiscal year 1969.

3. OPERATIONS

a. Attack operations and geographical reconnaissance

The plan is to spray every human habitation, schoolhouse, and church in malarious areas with the dose of 2 grams of technical DDT, per square meter of sprayable surface, twice a year at an interval of six months.

It is estimated that attack measures will be applied to cover the following:

POPULATION

Under Attack

Under Risk Spraying Pre-Consolidation Consolidation

CY 1969 9.87 million 6.73 million 3.14 million 0 million

CY 1970 10.26 million 6.25 million 1.59 million 2.4 million

Spraying is conducted simultaneously in the different sectors. From the geographical reconnaissance maps

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brought along, squad leaders pinpoint the houses and other structures to be sprayed by the spraymen. In the course of spraying, squad leaders update the locality maps for use in the next spraying season. Mop-up spray teams follow the regular spray crews to spray pending structures.

b. Establishment of surveillance

Mass drug administration to all fever cases and suspects at intervals of four weeks is conducted in attack areas with approximately 300,000 population where malaria transmission is persistently high, such as Palawan in Area "D," whole Area "B," and Mindoro of Area "C" to reduce the reservoir of infection.

Active Case Detection is conducted in communities projected for con-solidation.

1. Parasitological examination

Each of the thirty-nine malaria units is provided with microscopists who examine blood smears collected within their respective jurisdic-tions. A national reference laboratory is set up to re-examine all positive blood films and 10% of the negatives from each unit.

2. Chemotherapy

Presumptive treatment will be administered to fever cases and malaria suspects and radical treatment will be given to confirmed cases. A

schedule of treatment is prepared by the MES. All canvassers and PCD posts are provided with this schedule for their guidance in the treatment of cases.

3. Epidemiological investigations

Whenever a confirmed case is reported in localities outside the attack areas, an epidemiological investigation is conducted.

4. Remedial measure

Upon verification by the area supervisor that the case is indigenous, focal or general spraying is ordered, depending upon the extent of foci of infection.

5. Entomology

Each area has an entomological team composed of a research entomologist, one technician, and two to six entomological aides (one of which is a driver). Entomological activities will be coordinated with parasitological and epidemiological activities. The teams will be respon-sible for the routine and special entomological activities in the area.

c. Participation of rural health services

In Administrative Order No. 91, dated 20 December 1968, the Secretary of Health directed all regional health directors, provincial health officers, city health officers, chief of hospitals, and rural health physicians to support the passive case detection activities of the MES and invited attention to the fact that "the malaria eradication programme is not a separate or independent public health agency but an integral part in the general public health service dedicated to the health of the people." Under this directive, regional health directors, provincial health officers, city health officers, and rural health physicians are designated as representatives of the Secretary of Health in the supervision of MES personnel working within the jurisdiction of their respec-tive offices. The chief field malariologists are, in addition to their regular supervisory duties, designated as advisers and consultants to the regional health directors on matters pertaining to malaria passive case detection and co-ordination of malaria

eradication activities with the general public health service.

All public hospitals under the Department of Health and all rural health units are designated as passive case detection posts. In addition to their regular duties, city health officers, rural health physicians, nurses, midwives, and sanitary inspectors are charged with the detection and treatment of malaria per MES standard procedures. Likewise, hospital personnel who come across a malaria case or malaria suspect are directed to take blood films. Blood films are collected by MSE epidemiological aides who submit them to MES microscopists and return the results of the examinations to the PCD posts. Supplies needed in passive case detection are provided by the MES. One hundred and fifty PCD aides are hired for the job. In addition, passive case detection posts are also established by the malaria unit heads in strategically located communities within their areas of operation. The collection of blood films in these cases is undertaken by senior canvassers of the MES.

d. Projection for consolidation phase

During CY 1969, the number of population covered by attack measures and projected for consolidation phase will be 3.14 million. Out of this, it is expected that 2.4 million may qualify for entering the consolidation phase in CY 1970.

e. Training

During the fiscal year 1969, one-half of the sector technicians and sector leaders will undergo an in-service training by groups in Tala. The other half is scheduled for fiscal year 1970. Likewise, one-half of the microseopists will take up a refresher course on malaria microscopy in Tala during fiscal year 1969 and the other half in fiscal year 1970. Pre-service training is given to all newcomers to the service, Pre-service training is always given to old and new spraymen before every spraying season. In-service training of the professional level is conducted in Tala and at the METC. The kind of training and the number of trainees of local nationals in Tala is determined by the planning committee and those at the METC, by the PHS/AID and WHO.

f. Studies

The response of P. falciparum to camoquine and primaquine is under observation, with the co-operation of METC and the San Lazaro Hospital. The same observation is being extended to the six areas. Studies to determine the role of A. litoralis as a malaria vector are being carried out in Tatalan, Sulu of Area "E."

COMMITMENTS OF THE GOVERNMENT

The Government's commitments during the fiscal year 1969 and fiscal year 1970 are as follows:

Fiscal Year 1969 P10,217,455
Fiscal Year 1970 P 10,217,455

COMMITMENTS OF THE WHO

The WHO agrees to provide, subject to the availability of funds, person-nel, fellowships, supplies and equipment as follows:

a. Personnel for 1969 and 1970

1. One malariologist (to act as WHO Senior Adviser)
2. One epidemiologist (to assist in epidemiological operations)
3. One sanitary engineer (to assist in geographical reconnaissance and spraying operations)

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4. One training officer (to assist in the METC).

The WHO also assist in assigning three WHO short-term consultants to be attached to three independent assessment teams who will be assigned by the Government annually towards the end of 1969 and 1970 to confirm the passage of certain areas from the attack to the consolidation phase in accor-dance with the WHO epidemiological criteria developed for the purpose.

b. Fellowships

WHO will provide fellowships during 1969 and 1970 for national em-ployees to study and/or observe malaria eradication procedures and tech-niques at centres in country/countries approved by WHO.

c. Supplies and equipment

WHO will provide a few items of laboratory supplies requested by the programme during 1969 and 1970.

FINAL PROVISIONS

This Addendum will come into effect upon signature by the parties concerned and will remain in effect until 31 December 1970. During the last three months of the period covered by this Addendum, a thorough assessment of the progress of the programme will be made so as to provide a basis for drafting the future plan of action.

All terms and conditions of the original plan of operation and the revised one, except in so far as these are modified by this Addendum, apply equally to this Addendum.

IN WITNESS WHEREOF, the undersigned being duly authorized, have signed this first Addendum to the Revised Plan of Operation.

DONE in five copies in English.

At Manila, on 15 October 1969. FOR THE GOVERNMENT OF THE PHILIPPINES:

(Sgd.) JOSE D. INGLES
Acting Secretary of Foreign Affairs

At Manila, on 5 June 1969. FOR THE WORLD HEALTH ORGANIZATION:

(Sgd.) FRANCISCO J. DY, M.D.
Regional Director

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