COUNTRY PROFILE

The Philippines

Overview of TB control system

The central, regional, and provincial governments in the Philippines each have clearly delineated roles in delivering health care. The central level of the NTP is responsible for overall programme management including the formulation of technical norms, provision of technical support, and drug procurement. Regional offices coordinate with, and provide technical support to, provincial governments. Following a national programme review conducted in 2002 by WHO and other partners, TB control in 2003 focused on maintaining quality, on expansion of DOTS to the remainder of the country, and on involving other sectors in TB control.

Surveillance, planning, operations

The notification rates of smear-positive cases and of all TB cases have been falling at an average of 7% per year since 1993. This rate of decline is biologically plausible, but surprising in view of the fact that DOTS expansion began only in 1995. The apparent trend in case notifications therefore needs to be verified. The smear-positive case detection rate by the DOTS programme was 58% in 2002, but questions about the dynamics of TB in the Philippines – raised by observations on the notification series – cast doubt on the accuracy of this estimate. Treatment success in the 2001 cohort was 88%, but 13% of patients completed treatment without documented smear conversion, and 6% defaulted.

TB first became a priority for the national government in 2002, and the first Philippine TB summit culminated in the signing of the Comprehensive and Unified Policy for TB Control in the Philippines in 2003. As a result of this policy, human resources for management at the central level of the NTP are sufficient. The number of managerial staff has increased from 8 to 12. Capacity was also increased regionally so that technical assistance can now be provided by the central level to provinces, and by provinces to local government units.

World TB Day and Lung Month were commemorated to increase political commitment. An advocacy campaign was launched in 2002, expanded in 2003, and will be continued in 2004 with new GFATM funding. The campaign promotes ownership of the TB problem by all sectors, including health care workers and the community, using social mobilization, community participation programmes, and a multi-media approach to increase local funding. Particular attention has been given to fostering ownership in the most peripheral administrative units, the barrangays. The broad goal is to increase demand for DOTS at all levels.

Implementation of an outpatient benefit package for TB control began in 2003, meaning that DOTS treatment for TB is now a reimbursable benefit in a pilot public-private financing scheme under the national insurance plan (PHILHEALTH). A PPM DOTS framework was developed, implementation of PPM DOTS clinics began in 2003, and operational guidelines for both public-initiated and private-initiated PPM DOTS are expected to be finalized in the first quarter of 2004. Funding for PPM projects is through the GFATM and the GDF. The Comprehensive and Unified Policy for TB Control will help to ensure adherence to the DOTS strategy by other public sector organizations including the Social Insurance System, the Indigenous Commission, and the Departments of National Defence, Education, Interior, Social Welfare, Labour, and Justice. Medical education institutions began to include DOTS training in their curricula in 2003.

Following decentralization, and consistent with the expected shift in responsibilities, the provinces have begun to make TB control a priority. Training workshops that reinforced new DOTS treatment guidelines were

PROGRESS IN TB CONTROL IN THE PHILIPPINES

Indicators

Indicator	Value
Treatment success 2001 cohort	88%
DOTS detection rate, 2002	58%
NTP budget available, 2003	95%
Government contribution to NTP budget, including loans, 2003	62%
Government contribution to total TB control costs, including loans, 2003	93%
Government health spending used for TB, 2003	3%

Constraints to achieving targets

- Inadequate supervision and monitoring of TB programme
- Under-use of DOTS services in some areas due to low public awareness
- Under-development of private sector partnerships for DOTS delivery

Remedial actions needed

- Establish supervision guidelines and reinforce central monitoring team
- Intensify advocacy for TB screening, diagnosis, and treatment
- Increase private sector involvement through widespread implementation of new DOTS treatment guidelines and PPM projects

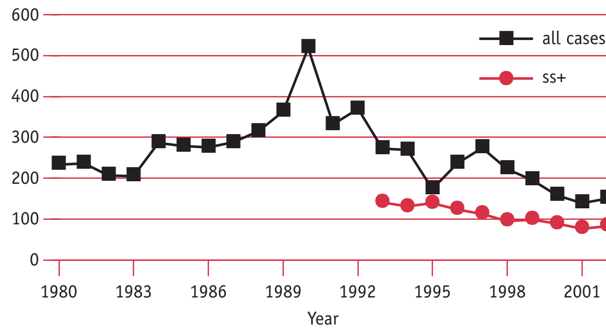
THE PHILIPPINES

LATEST ESTIMATES[a]	
Population	**78 580 228**
Global rank (by est. number of cases)	8
Incidence (all cases/100 000 pop)	320
Incidence (new ss+/100 000 pop)	144
Prevalence (ss+/100 000 pop)	224
TB mortality per 100 000 pop	57
% of adult (15-49y) TB cases HIV+	0.4
% of new cases multi-drug resistant	3.2

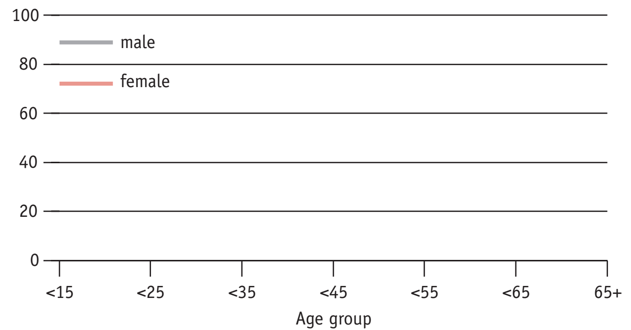
TRENDS	1999	2000	2001	2002
DOTS population coverage (%)	43	90	95	98
Notification rate (all cases/100 000 pop)	196	158	139	151
Notification rate (new ss+/100 000 pop)	99	89	77	83
Detection of all cases (%)	62	50	44	47
Detection of new ss+ cases (%)	69	62	54	58
DOTS detection of new ss+ (%)	19	46	54	58
DOTS detection of new ss+/coverage(%)	45	52	56	59
DOTS treatment success (new ss+, %)	87	88	88	—

Notification rate (per 100 000 pop)

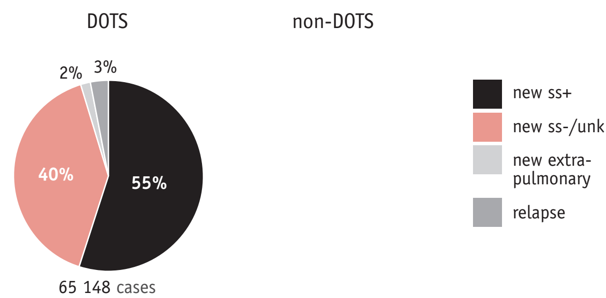
Notification (all cases) = 118 408 in 2002



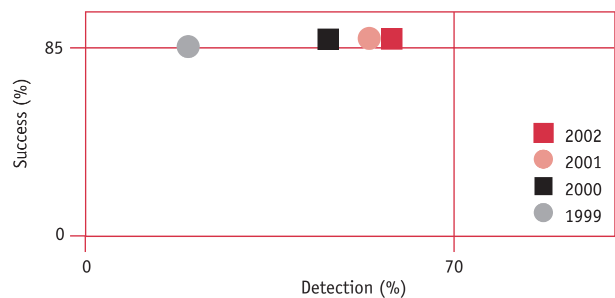
Notification rate by age and sex (new ss+)[b]



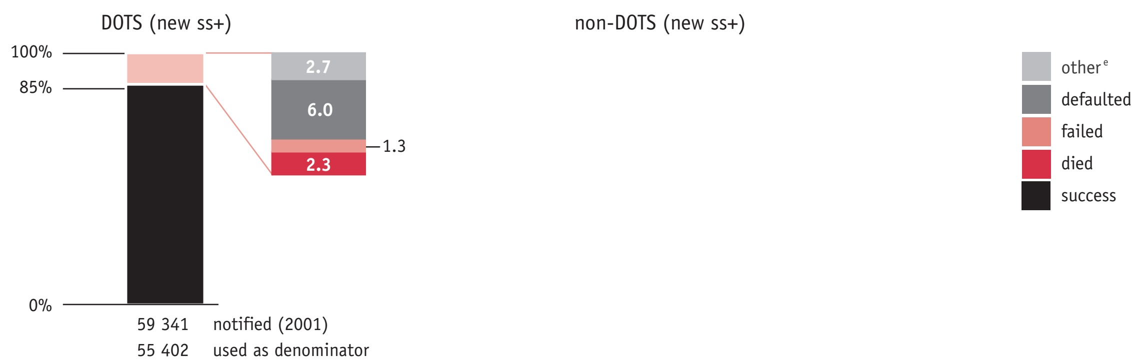
Case types notified[c]



DOTS progress towards targets[d]



Treatment outcomes[c]



Notes

ss+ Indicates smear-positive; ss-, smear-negative; pop, population; unk, unknown.

[a] See Methods for data sources.

[b] The sum of cases notified by age and sex is less than the number of new smear-positive cases notified for some countries.

[c] Non-DOTS is blank for countries which are 100% DOTS, or where no non-DOTS data were reported.

[d] DOTS progress towards targets: DOTS detection rate for given year, DOTS success rate for cohort registered in previous year.

[e] "Other" includes transfer out and not evaluated, still on treatment, and other unknown.

Budget estimates, existing funding and budget gaps for fiscal year 2003, US$ millions

	REQUIRED FUNDING	EXPECTED FUNDING				FUNDING GAP
		GOVERNMENT	LOANS	GRANTS	OTHER	
NTP budget						
Drugs	4.2	2.0	1.5	0.7	—	—
Dedicated staff working exclusively for TB control[a]	0.2	0.2	—	—	—	—
New activities to raise case detection and cure rates	1.9	0.2	—	1.4	—	0.3
Buildings, equipment, vehicles	NA	NA	—	—	—	—
All other line items	0.2	0.2	—	—	—	—
TOTAL NTP BUDGET	**6.5**	**2.6**	**1.5**	**2.1**	**—**	**0.3**
Costs not covered by NTP budget [b,c]						
Hospital stay	—	—	—	—	—	—
Clinic visits for DOT and monitoring	29.2	29.2	—	—	—	—
TOTAL COSTS NOT COVERED BY NTP BUDGET	**29.2**	**29.2**	**—**	**—**	**—**	**—**
TOTAL TB CONTROL COSTS	**35.7**	**31.8**	**1.5**	**2.1**	**—**	**0.3**

— Indicates zero; NA, not available

[a] There are 10 dedicated NTP staff at central level. At other levels dedicated NTP staff do not exist.

[b] WHO estimates, data not provided by the NTP

[c] Estimates differ from those in Global Tuberculosis Control 2003 due to a change in methods made possible by the availability of new data. See Methods section for full details.

held at provincial level, though follow-up is needed to ensure that the training leads to better monitoring and supervision. So far, it appears that the guidelines have not been fully implemented, and that training for provincial and district staff has been insufficient. Changes in local government every 3 years have meant that commitment to DOTS is fragile at this level.

At provincial and municipal levels, despite some increase in capacity, the workforce remains inadequate with about 20% of staff positions unfilled. There is a high turnover of staff caused by low salaries, overwork, and frequent administrative changes that lead to staff reorganization. Given that salary standardization does not allow sector-specific raises, proposed solutions include travel incentives and improved recognition of staff accomplishments.

The budget for anti-TB drugs was recently shifted from the centre to the regions. A private company was to have implemented an efficient drug procurement and distribution system, but did not do so because of contractual delays. Instead, drugs are now being procured through a new GDF mechanism, which has improved delivery of all drugs, including 4-drug FDCs.

A pilot survey to assess drug-resistance began in 2002 with support from WHO and JICA, and this survey was extended countrywide in 2003. New GFATM support that became available in 2003 is allowing continuation of a GLC-approved DOTS-Plus project that was first established in 2000 at the Makati Medical Centre in metropolitan Manila with a cohort of 200 patients. An additional 750 MDR-TB patients will be enrolled in the project between 2003 and 2007. The NTP is planning to expand DOTS-Plus to 2 more centres in 2004, in preparation for countrywide, community-based implementation as part of regular DOTS activities.

Diagnostic capacity is now supported by adequate staff. Partner support was mobilized in 2003 to enable expansion of the QA system and establishment of the laboratory network. JICA, in collaboration with WHO, is finalizing QA guidelines and a manual, with plans for implementation across the country by the end of 2005.

A national TB/HIV coordinating body has been established. Systematic testing of TB patients for HIV does not occur yet, but there is a plan to establish a system and to intensify the implementation of TB/HIV collaborative activities. By 2004, the NTP will be involved in delivery of ART for HIV-infected TB patients.

Partnerships

Through creative use of partnerships, the Philippines continues to be dynamic and flexible in adapting to the changing health system following decentralization, and in responding to fluctuations in financial and human resources. PACT (Project Assistance to Control TB) members, for example, have helped to monitor DOTS activities within, and outside of, their catchment areas. PACT contributed to establishment of the CCM that was required by the GFATM, enabling the Philippines more easily to manage new funds. Overall external technical collaborations are led by WHO, and it is through close collaboration between WHO and the Philippines government that support for partnership development has been fostered. During the expansion phase of DOTS now underway, technical quality of services has been maintained through support from JICA, USAID, the World Bank, World Vision

Canada, Spain's Medicos del Mundos, KNCV, and CDC. In addition to the technical and other support that they provide, the main financial donors in the Philippines are the World Bank, CIDA, JICA, USAID, and the GFATM.

Partnerships within the country have been facilitated by the formation of the Philippines Coalition Against TB (PHILCAT), comprising more than 50 NGOs and private sector groups that have worked together to reach consensus on TB control, especially in the private sector, and to mobilize local resources. The DoH, being part of PHILCAT, will improve private sector involvement in the DOTS strategy by conducting a series of training workshops for private physicians to educate them about DOTS, and to encourage referral of TB patients to public health centres and public-private mix DOTS (PPMD) centres. PHILCAT members will also be asked to participate in monitoring.

Budgets and expenditures

NTP expenditure in fiscal year 2002 (from 1 January) was US$ 6.1 million (US$ 53 per patient). Total TB control costs (NTP expenditure plus the cost of clinic visits not covered by the NTP budget) can be estimated at US$ 34.0 million, equivalent to US$ 296 per patient. The NTP budget for fiscal year 2003 was only slightly higher than the budget for 2002, at US$ 6.5 million. The NTP estimated that they would treat 120 000 patients during this period, equivalent to US$ 54 per patient. Most of the budget was for drugs and new activities to increase case detection and cure rates (primarily expansion of PPM-DOTS). Almost all of the required funding was available, mostly from the government, with only a small funding gap of US$ 0.3 million. If the NTP succeeds in treating 120 000 patients, then total TB control costs would amount to around US$ 35.7 million in 2003, equivalent to US$ 298 per patient.