



# UPDATED PHILIPPINE STRATEGIC TB ELIMINATION PLAN

Phase 1: 2020–2023





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**Updated Philippine Strategic  
TB Elimination Plan, Phase 1: 2020–2023**

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# ABBREVIATIONS

<b>3HP</b>	three-month isoniazid and rifapentine regimen
<b>ACF</b>	active case finding
<b>BC-TB</b>	bacteriologically confirmed tuberculosis
<b>aDSM</b>	active Drugs Safety Monitoring and Management
<b>AI</b>	artificial intelligence
<b>BHW</b>	barangay health worker
<b>CBO</b>	community-based organization
<b>CSO</b>	civil society organization
<b>CV</b>	community volunteer
<b>DOTS</b>	directly observed treatment, short course
<b>DR-TB</b>	drug-resistant tuberculosis
<b>DST</b>	drug susceptibility test
<b>DSTB</b>	drug-susceptible tuberculosis
<b>ECF</b>	enhanced case finding
<b>FAP</b>	foreign-assisted project
<b>FDA</b>	Food and Drug Administration
<b>FLD</b>	first-line drug
<b>HC</b>	health center
<b>HCPN</b>	Health Care Provider Network
<b>HCW</b>	health-care worker
<b>HPCS</b>	Health Promotion and Communication Strategy
<b>HRH</b>	human resources for health
<b>ICF</b>	intensified case finding
<b>iDOTS</b>	integrated directly observed treatment, short course
<b>IGRA</b>	interferon gamma release assay
<b>IPC</b>	infection prevention and control
<b>IRR</b>	implementing rules and regulations
<b>ITIS</b>	Integrated Tuberculosis Information System
<b>JPR</b>	Joint Program Review
<b>KAP</b>	key affected population
<b>LGU</b>	local government unit
<b>LNSP</b>	Laboratory Network Strategic Plan
<b>LPA</b>	line probe assay
<b>LTBI</b>	latent tuberculosis Infection
<b>MDR-TB</b>	multidrug-resistant tuberculosis
<b>MN</b>	mandatory notification
<b>MOP</b>	Manual of Procedures
<b>MYOA</b>	multiyear obligation agreement

<b>NCC</b>	National Coordinating Committee
<b>NTP</b>	National Tuberculosis Control Program
<b>NTRL</b>	National Tuberculosis Reference Laboratory
<b>PCC</b>	provincial coordinating committee
<b>PD</b>	Pharmaceutical Bureau
<b>PHILCAT</b>	Philippine Coalition Against Tuberculosis
<b>PhilHealth</b>	Philippine Health Insurance Corporation
<b>PhilSTEP1</b>	Philippine Strategic TB Elimination Plan, Phase 1
<b>PhP</b>	Philippine peso
<b>PICT</b>	provider-initiated HIV counseling and testing
<b>PMA</b>	Philippine Medical Association
<b>PMDT</b>	Programmatic Management of Drug-resistant Tuberculosis
<b>PPM</b>	public-private mix
<b>PSCM</b>	Pharmaceutical Supply Chain Management
<b>PRC</b>	Professional Regulatory Commission
<b>PSE</b>	private sector engagement
<b>PSG</b>	patient support groups
<b>RCC</b>	regional coordinating committee
<b>RDT</b>	rapid diagnostic test
<b>RTDL</b>	rapid TB diagnostic laboratory
<b>RHU</b>	rural health unit
<b>RR-TB</b>	rifampicin-resistant tuberculosis
<b>SBCC</b>	social and behavior change communication
<b>SLD</b>	second-line drugs
<b>STC</b>	satellite treatment center
<b>STRiders</b>	specimen transport riders
<b>Sx</b>	symptom
<b>TB</b>	tuberculosis
<b>TC</b>	treatment center
<b>TPT</b>	tuberculosis preventive treatment
<b>TSR</b>	treatment success rate
<b>TST</b>	tuberculin skin test
<b>Tx</b>	treatment
<b>UHC</b>	universal health coverage
<b>WHO</b>	World Health Organization
<b>WISN</b>	workload indicators for staffing needs



# PREFACE

In 2017, the Philippines launched the *2017–2022 Philippine Strategic TB Elimination Plan: Phase 1 (PhilSTEP1)* during the annual convention of the Philippine Coalition Against Tuberculosis (PHILCAT). It served as our road map from 2017 for the next six years, with ambitious targets that aimed to support the global *End TB Strategy*. Three years later, our tuberculosis (TB) program review has shown that much has been achieved.


In the past years, we have seen a significant improvement in TB notification. The total notification of TB cases in 2019 was more than 20% higher than the notification rate in 2016. We have also managed to sustain good treatment outcomes for our drug-susceptible TB patients. A major enabler to these accomplishments was the passage of Republic Act 10767, the Comprehensive TB Elimination Plan Act or the TB Law. Through this law, we were able to implement mandatory notification for TB, and this has largely contributed to the increased notification rate that we reported over the past two years. In addition, the law paved the way to establish the National Coordinating Committee for TB, a collaborative body of various TB stakeholders from Government and non-governmental stakeholders that provides oversight to PhilSTEP1 implementation.

However, gaps and challenges remain present over the past three years, particularly drug-resistant TB, with low case detection and poor treatment outcomes, and minimal coverage of TB preventive treatment. With the current pace of implementation, we are unlikely to reach our commitments to the United Nations for these two important indicators.

Given this midterm status of TB elimination in the country, the Department of Health introduces the updated *Philippine Strategic TB Elimination Plan, Phase 1: 2020–2023* to effectively respond to the renewed and strengthened global response to end TB, and deliver on our commitments through a focused, evidenced-based approach. The updated strategic plan adopts a cascade-of-care framework. We want to ensure that health workers at all levels are abreast with current strategies and protocols. Furthermore, it enumerates our goals for the next four years and strategies in achieving them. Moreover, it recognizes the cross-cutting health system support required to implement these strategies.

Lastly, the update is aligned with the enactment of the Republic Act 11223, the Universal Health Care Act, which aims to ensure that all Filipinos are guaranteed equitable access to quality and affordable health-care goods and services, and protect patients from financial risk. The elimination requires an integrated, comprehensive and systematic approach, and the UHC Law, together with the TB Law, gives us another armament. We intend to utilize its strategies, as well as the current momentum it has created, to ensure that TB services are fully financed and that no TB-affected household will experience catastrophic expenditures and be driven into poverty.

Our resolve to fight TB is firm. Together, we will end TB.



FRANCISCO T. DUQUE, III  
SECRETARY OF HEALTH

# EXECUTIVE SUMMARY

The *Philippine Strategic TB Elimination Plan, Phase 1: 2020–2023* (PhilSTEP1) updates the 2017–2023 Elimination Plan, which was revised following a 2019 Joint Program Review and as a result of various assessments conducted over the past two years. This update employs the four major thematic areas of the tuberculosis (TB) cascade-of-care framework – screening, testing and diagnosis, treatment, and prevention. The implementation period of the original plan has been extended for one year until 2023 to serve as anchor for the next round of support from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

This update was developed through a consultative and participatory approach using evidence-based decision-making. A task force convened by the Department of Health National Tuberculosis Control Program led the development and several consultations and workshops. In addition, online polls were conducted with implementers, local governments, private providers, professional societies, patient groups and development partners.

The goals, objectives and strategies of the Updated PhilSTEP1 2020–2023 are:

<b>GOALS</b>	<p>Reduce the TB burden by:</p> <ul style="list-style-type: none"> <li>➤ Decreasing the number of TB deaths by 15% from 26 000 to 22 000</li> <li>➤ Decreasing the TB incidence rate by 12% from 554 to 488 per 100 000</li> </ul> <p>Reduce catastrophic cost incurred by TB-affected households from 35% to 0%</p> <p>At least 90% of patients are satisfied with TB services</p>
<b>OBJECTIVES</b>	<ol style="list-style-type: none"> <li>1. Screen at least 50 million people for TB using chest X-ray (and 100 million by symptoms)</li> <li>2. Test at least 12.8 million presumptive TB cases with a bacteriologic test</li> <li>3. Initiate TB treatment for at least 1.9 million people with active TB, including 43 000 drug-resistant TB (DR-TB)</li> <li>4. Successfully treat 90% of drug-susceptible TB patients and 85% of DR-TB patients</li> <li>5. Give TB preventive treatment to at least 685 000 patients</li> </ol>
<b>STRATEGIES</b>	<p><b>SCREEN</b></p> <ol style="list-style-type: none"> <li>1. Intensified case finding (ICF)</li> <li>2. Active case finding (ACF)</li> <li>3. Enhanced case finding (ECF)</li> <li>4. Contact investigation</li> </ol> <p><b>TEST/ DIAGNOSE</b></p> <ol style="list-style-type: none"> <li>5. Push compliance to mandatory notification</li> <li>6. Rapid diagnostic test (RDT) expansion and utilization</li> <li>7. Line probe assay/drug susceptibility test (LPA/DST) optimization</li> <li>8. Improve quality of clinical diagnosis</li> </ol> <p><b>TREAT</b></p> <ol style="list-style-type: none"> <li>9. Establishment of Health Care Provider Network (HCPN) offering full TB care continuum</li> <li>10. Adoption of patient-centered care</li> <li>11. Strengthen active Drug Safety Monitoring and Management (aDSM)</li> <li>12. TB-HIV collaboration</li> </ol> <p><b>PREVENT</b></p> <ol style="list-style-type: none"> <li>13. Adoption of short TB preventive treatment (TPT)</li> <li>14. Infection prevention and control (IPC)</li> </ol>

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A Sustainability Roadmap:  
Preparing for the Transition of  
Global Fund-supported Human  
Resources for Tuberculosis

October 15, 2019





## INTRODUCTION: RATIONALE FOR UPDATING THE PLAN

The 2017–2022 *Philippine Strategic TB Elimination Plan: Phase 1* (PhilSTEP1) was updated:

1. to identify priority activities that will contribute to achieving case finding and treatment targets based on the assessment of current implementation; and
2. to add one year of implementation (2023) to the updated Philippine Strategic TB Elimination Plan, Phase 1: 2020–2023 and to serve as basis for the development of the next round of proposal to the Global Fund to Fight AIDS, Tuberculosis and Malaria for 2021–2023.

The revised Elimination Plan follows the conclusion of the midterm period of PhilSTEP1. A notable change in the political environment for tuberculosis (TB) elimination was ushered a year earlier, in 2018, with the United Nations High-level Meeting on the Fight to End Tuberculosis, during which countries including the Philippines committed to finding and treating by 2022 up to 40 million TB cases. Following the New York meeting, a Joint Program Review (JPR) ([http://ntp.doh.gov.ph/downloads/publications/jpr\\_2019.pdf](http://ntp.doh.gov.ph/downloads/publications/jpr_2019.pdf)) was conducted by the Department of Health (DOH) National Tuberculosis Control Program (NTP) that assessed the status of PhilSTEP1 implementation using a cascade-of-care framework. The key recommendations of the 2019 JPR formed the backbone of the major strategies in the updated PhilSTEP1. In addition, findings from various assessments (Box 1) also informed the directions for the TB elimination strategies.

Although the original PhilSTEP1 covered the period 2017 to 2022 (*DOH. 2017-2022 PhilSTEP1 Phase 1*, [http://ntp.doh.gov.ph/downloads/publications/2017-2022\\_PhilSTEP1.pdf](http://ntp.doh.gov.ph/downloads/publications/2017-2022_PhilSTEP1.pdf)), there is a critical opportunity this year in the next cycle of Global Fund grants for TB, which will cover 2021–2023. As such, the updated Elimination Plan includes an extended year – 2023 – to serve as basis for the Global Fund proposal. The updated Elimination Plan will be referred to in this document as the Updated PhilSTEP1: 2020–2023.

#### **BOX 1. References for the updating of the PhilSTEP1**

- 2019 JPR report (NTP)
- Drug Resistance Survey 2018 preliminary results (National Tuberculosis Reference Laboratory)
- 2016 JPR report (NTP)
- Green Light Committee 2018 Mission Report on Social Protection (World Health Organization)
- Human Resources for Health Inventory and Sustainability Planning (United States Agency for International Development Human Resources for Health in 2030 project)
- Universal Health Care Implementing Rules and Regulations (DOH)
- TB Law Implementing Rules and Regulations (DOH)
- PhilSTEP1 document (NTP)
- National Demographic Health Survey (National Demographic and Health Survey) 2017
- Autumn Modeling for Philippines (NTP)
- MEASURE TB (quality-of-care assessment)
- VALUE TB (cost of TB services)
- Situational Analysis of Tuberculosis Treatment and Prevention in Greater Manila using Communities, Rights and Gender tools





# PHILSTEP1 AT THE MIDTERM: WHAT HAS BEEN ACHIEVED

The major achievements and challenges in PhilSTEP1 implementation, organized according to the cascade-of-care framework, are described in detail in the *2019 Philippines TB Joint Program Review*. Below is a summary of the accomplishments in achieving the output indicators of PhilSTEP1. There is no available data during this period for the impact indicators for the mortality rate, incidence rate, patient satisfaction and catastrophic cost.

**Table 1. Performance versus target of PhilSTEP1 outcome indicators, 2017–2019**

		2017	2018	2019	2017–2019 TOTAL
<b>Presumptive TB tested</b>	ACCOMPLISHED	1 060 150	1 188 856	1 102 584	3 351 590 <b>(53%)</b>
	TARGET	1 491 576	2 231 331	2 623 746	6 346 653
<b>Notified TB cases, all forms</b>	ACCOMPLISHED	326 773	371 668	403 757	1 102 198 <b>(93%)</b>
	TARGET	372 894	371 888	437 291	1 182 073
<b>Notified DR-TB</b>	ACCOMPLISHED	6453	7328	6510	20 291 <b>(45%)</b>
	TARGET	11 400	12 600	20 674	44 674
<b>TSR, DS-TB</b>	ACCOMPLISHED	91%	<b>90%</b>	NA	
	TARGET	90%	90%	90%	
<b>TSR, DR-TB</b>	ACCOMPLISHED	<b>68%</b> (2017 SSTR cohort)	NA	NA	
	TARGET	71%	75%	85%	
<b>TB preventive treatment</b>	ACCOMPLISHED	(57% PLHIV 12% contacts)	4893 (52% PLHIV 9.2% contacts)	4659	
	TARGET	23 609	27 165	169 139	219 913

SOURCE: DOH NTP Reports (Integrated TB Information System)

NOTE: drug-resistant TB = DR-TB; drug-susceptible TB = DS-TB; PLHIV = people living with HIV; sstr = standard shorter treatment regimen; TSR = treatment success rate

While the country has achieved 93% of the case notification target, more than 65% of this is clinically diagnosed TB, indicating potential overdiagnosis and over-reporting. Further, the accomplishment in testing is only 53% of the target and demonstrates a rate of diagnosis much higher than the positivity of bacteriologic tests. The drug-resistant tuberculosis (DR-TB) notification is more consistent with the testing rate, although lower since Xpert testing among presumptive TB is still not universal. Success in drug-susceptible tuberculosis (DS-TB) treatment has been achieved over the years, but DR-TB outcomes remain low. Success rates have decreased with the increasing number of DR-TB cases. Finally, TB preventive treatment (i.e. latent tuberculosis infection, or LTBI, treatment) has been very low, and this poor level of uptake has been observed since the introduction of tuberculosis preventive treatment (TPT) into the program prior to 2017.







## PROCESS OF PHILSTEP1 UPDATING

The updating of the PhilSTEP1 was based on the following general guidelines. The more detailed description of the process is described in the terms of reference for the updating of PhilSTEP1.

1. The updating was led by the DOH NTP supported by a task force consisting of TB elimination experts from various partner organizations (*Annex 1. List of members – Task Force on PhilSTEP1 updating*)
2. The prioritization of strategies was based on sound evidence from the references cited above (Introduction).
3. The framework employed in revising the strategy was changed from the original seven strategies of PhilSTEP1, which corresponded to health system building blocks (i.e. ENGAGED strategies) to the cascade-of-care framework (screen, test and diagnose, treat, and prevent). Key performance targets and activities from the PHILSTEP1 ENGAGED strategies were reorganized according to this new framework for the review.
4. The general steps in updating that were undertaken included:
  - a. reviewing NTP performance vis-à-vis PhilSTEP1 targets;
  - b. determining major achievements and gaps per cascade thematic area based on 2019 JPR and the other assessments;
  - c. appraising the recommendations as to priority for the 2020–2023 implementation period;
  - d. setting goals, objectives and targets for 2020–2023;
  - e. identifying priority strategies and key activities to be implemented and setting a timeline; and
  - f. budgeting and analysis of the funding gap.

5. The draft of the updated Elimination Plan was presented for broader consultation to collect input from the following key stakeholders: key affected populations (KAP); civil society organizations (CSOs); nongovernmental organizations; academia; the private sector; other DOH bureaus and offices outside the Disease Prevention and Control Bureau (Health Policy Development and Planning Bureau, Bureau of Local Health System Development, Health Facilities and Services Regulation Bureau, the Food and Drug Administration (FDA) and the Philippine Health Insurance Corporation, or PhilHealth); and other government agencies (i.e. members of the National Coordinating Committee for TB).
6. The updated PHISTEP1 was submitted to the DOH Health Policy Development and Planning Bureau for final review and endorsement to the Secretary of Health for approval.

The updated PhilSTEP1 2020–2023 was developed following the above guidelines between October 2019 to March 2020. The contents are described in succeeding sections.



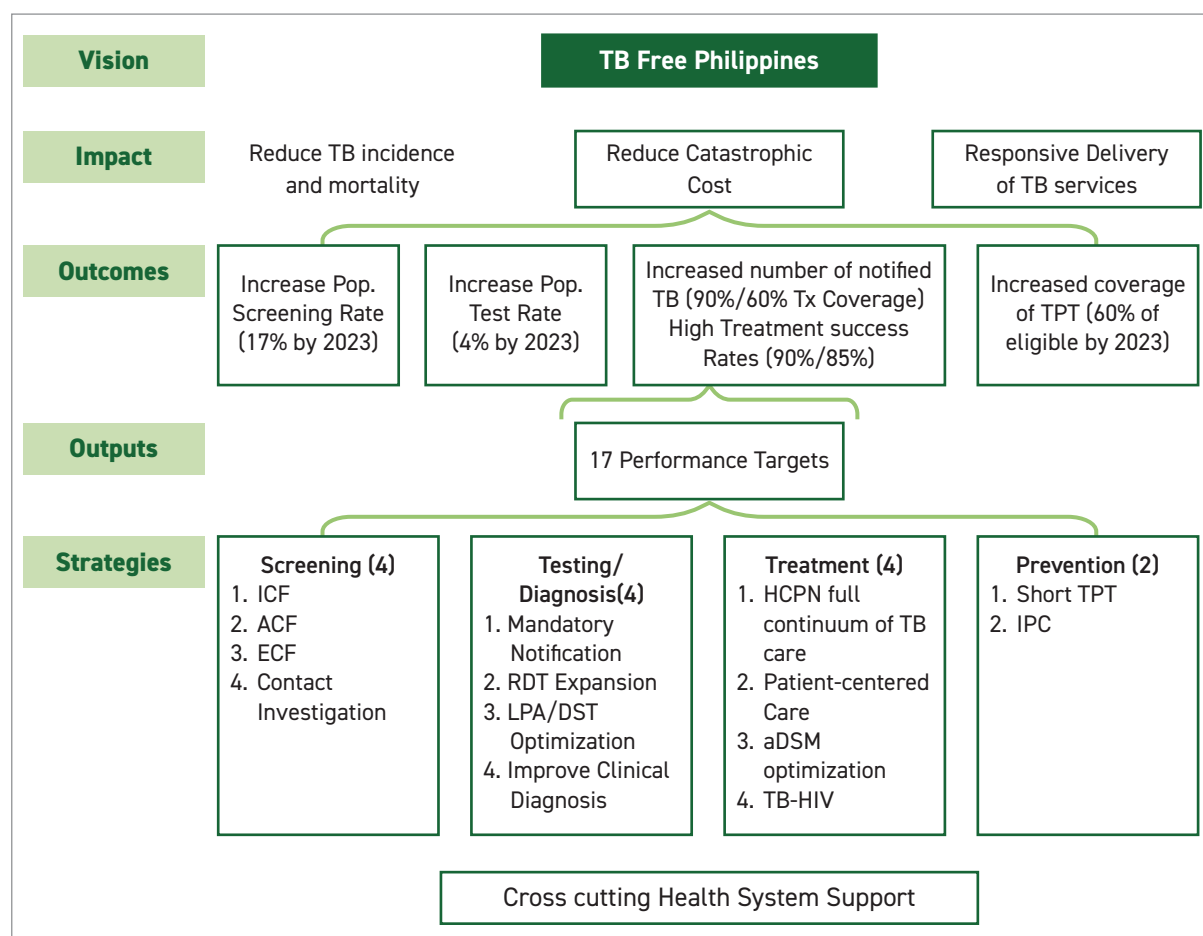




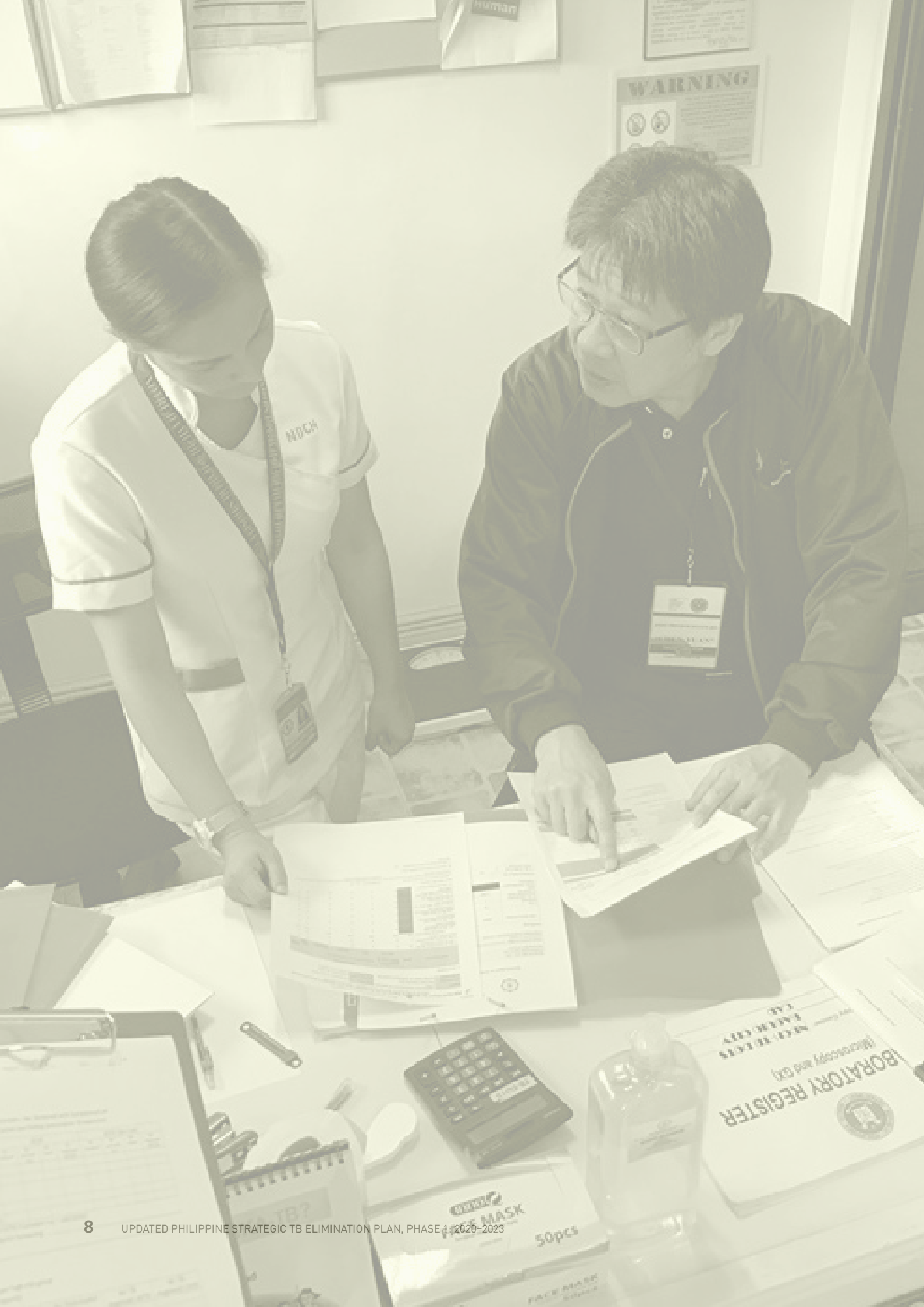
# LOGICAL FRAMEWORK: UPDATED PHILSTEP1 2020–2023

Using the cascade of care, the revised logical framework for the updated PhilSTEP1: 2020–2023 appears in Fig. 1. The vision and impact indicators are unchanged, although the targets were recalibrated. However, the screening and testing rates were added as outcome targets. The performance targets to measure outputs per strategy had been reduced to 17 indicators. Strategies are focused on service delivery but with the recognition of the underlying health system support requirements to ensure these strategies are implemented. A detailed description of strategies are provided in following sections.

**Fig. 1. Logical framework, updated PhilSTEP1: 2020–2023**





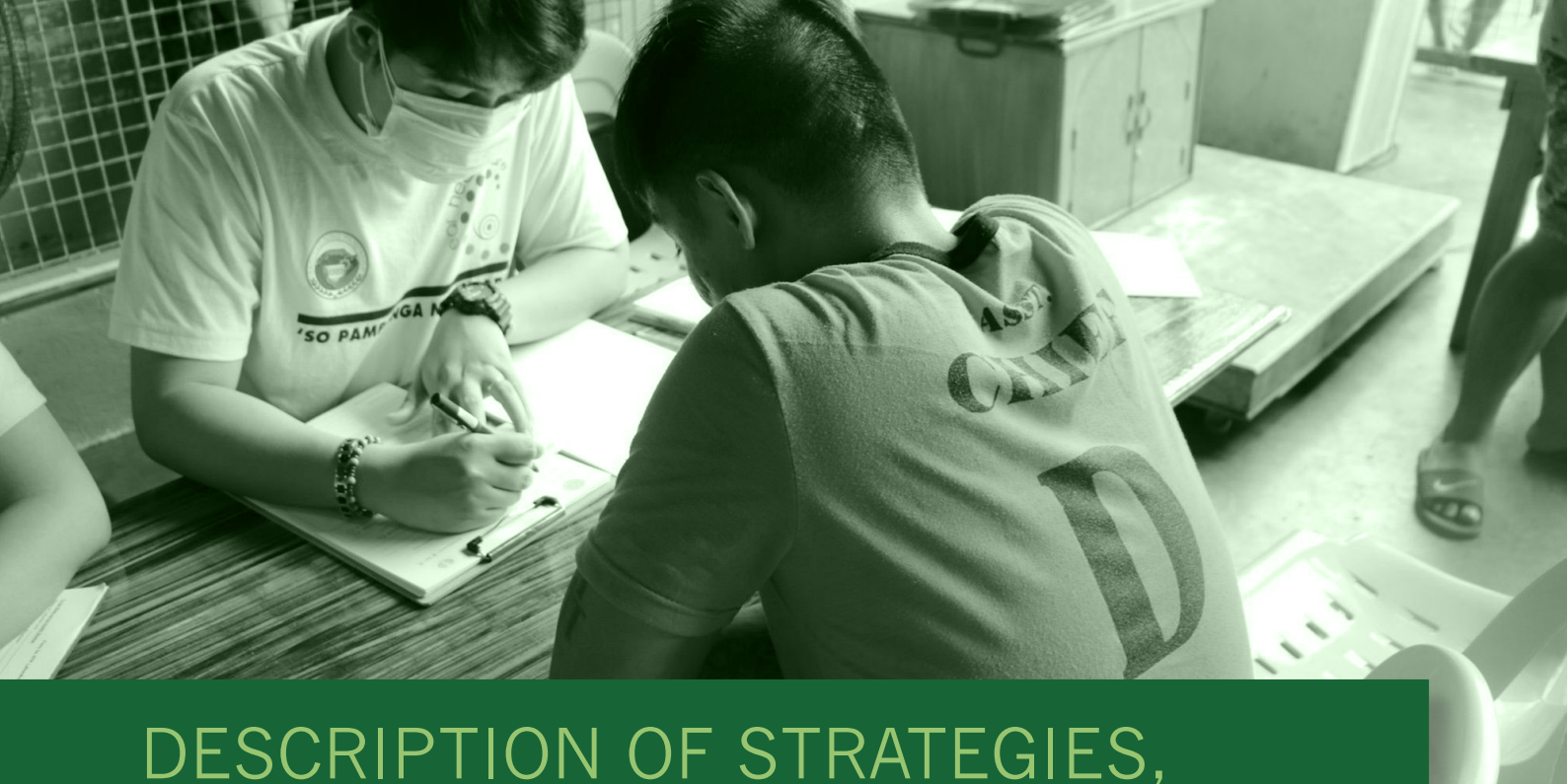




# GOALS, OBJECTIVES, STRATEGIES: UPDATED PHILSTEP1 2020–2023

Described below are the statement of goals, objectives and strategies of the updated PhilSTEP1. The goals are expressed as a vision by 2023, while the objectives will be measured as cumulative accomplishments for four years, 2020–2023. Annex 2 provides an explanation of the process for estimating the updated PhilSTEP1 targets.

GOALS	<p>Reduce the TB burden by:</p> <ul style="list-style-type: none"> <li>➤ Decreasing the number of TB deaths by 15% from 26 000 to 22 000</li> <li>➤ Decreasing the TB incidence rate by 12% from 554 to 488 per 100 000</li> </ul> <p>Reduce catastrophic costs incurred by TB-affected households from 35% to 0%</p> <p>At least 90% of patients are satisfied with TB services</p>
OBJECTIVES	<ol style="list-style-type: none"> <li>1. Screen at least 50 million people for TB using chest X-ray (and 100 million by symptoms)</li> <li>2. Test at least 12.8 million presumptive TB cases with a bacteriologic test</li> <li>3. Initiate TB treatment for at least 1.9 million with active TB, including 43 000 DR-TB.</li> <li>4. Successfully treat 90% of DS-TB patients and 85% of DR-TB patients</li> <li>5. Give TB preventive treatment to at least 685 000 patients</li> </ol>
STRATEGIES	<p><b>SCREENING</b></p> <ol style="list-style-type: none"> <li>1. Intensified case finding (ICF)</li> <li>2. Active case finding (ACF)</li> <li>3. Enhanced case finding (ECF)</li> <li>4. Contact investigation</li> </ol> <p><b>TESTING AND DIAGNOSIS</b></p> <ol style="list-style-type: none"> <li>5. Push compliance to mandatory notification</li> <li>6. Rapid diagnostic test (RDT) expansion and utilization</li> <li>7. Line probe assay/drug susceptibility test (LPA/DST) optimization</li> <li>8. Improve quality of clinical diagnosis</li> </ol> <p><b>TREATMENT</b></p> <ol style="list-style-type: none"> <li>9. Establishment of a Health Care Provider Network (HCPN) offering a full TB care continuum</li> <li>10. Adoption of patient-centered care</li> <li>11. Strengthen active Drug Safety Monitoring and Management (aDSM)</li> <li>12. TB–HIV collaborationn</li> </ol> <p><b>PREVENTION</b></p> <ol style="list-style-type: none"> <li>13. Adoption of short tuberculosis preventive treatment (TPT)</li> <li>14. Infection prevention and control (IPC)</li> </ol>



# DESCRIPTION OF STRATEGIES, PERFORMANCE TARGETS AND KEY ACTIVITIES

The updated PhilSTEP1 has identified 14 major strategies to achieve the results listed in the previous section (Goals, Objectives, Strategies). These are organized below according to the four major thematic areas of the cascade of care: 1) screening; 2) testing and diagnosis; 3) treatment; and 4) prevention. A brief description of the strategy is provided, followed by the performance target and specific key activities.

Annex 3 shows the timelines of key activities of the strategy. Annex 4 shows the monitoring and evaluation matrix with annual targets, when applicable, for impact, outcome and output indicators.

## I. STRATEGIES FOR SCREENING

A priority for 2020–2023 is wide-scale implementation of systematic screening in various settings – in health facilities, communities and high-risk settings. Passive case finding is estimated to account for majority of TB cases currently detected. But to increase number of TB cases notified by up to 40 000 annually, massive screening will be required beyond passive case finding. The use of chest X-rays as screening tool is a major part of the overall screening strategy, with about one-third of the target for screening to be conducted through chest X-rays. The target outcomes for screening are shown in Table 2.

**Table 2. Main targets for screening, updated PhilSTEP1 2020–2023**

	2020	2021	2022	2023
Number screened by chest X-ray	8 390 000	10 770 000	13 790 000	17 060 000
Population (chest X-ray) Screening rate*	8%	10%	14%	17%

\*Number screened by chest X-ray/population

## 1. Intensified case finding (ICF)

This refers to the implementation of systematic screening in health facilities by offering chest X-ray screening among all adult consults (for various chief complaints) who do not exhibit TB signs and symptoms. This is distinct from passive case finding, wherein all who consult due to TB symptoms are immediately tested with a bacteriologic test.

A chest X-ray will be recommended at least annually. Financing through a chest X-ray voucher – from DOH, a local government unit (LGU), projects or other means – will be proposed or through the PhilHealth benefit package, subject to implementation research that will be undertaken for the implementation of the Universal Health Care Act.

This intervention will also include:

- i. surveillance of health staff by annual chest X-rays;
- ii. linking chest X-rays related to employment to diagnostic tests by working with the Department of Labor and Employment and the private sector; and
- iii. the reporting of a chest X-ray census by radiology facilities through a regulatory mechanism such as licensing requirement.

Performance target	Key activities
Number of people screened using chest X-rays in health facilities during ICF	<ul style="list-style-type: none"><li>Expand chest X-ray voucher system</li><li>Explore Chest X-ray in PhilHealth package, e.g. expansion of Primary Care Benefit</li></ul>
Baseline: no data	<ul style="list-style-type: none"><li>Health-care worker staff surveillance</li></ul>
2020: 6 300 000	<ul style="list-style-type: none"><li>Online reporting system for workplace chest X-ray screening</li></ul>
2021: 8 310 000	<ul style="list-style-type: none"><li>Develop regulatory policies for mandatory reporting of chest X-ray census and results</li></ul>
2020: 11 040 000	<ul style="list-style-type: none"><li>Adoption of ICF approach in hospitals</li></ul>
2023: 14 380 000	

## 2. Active case finding (ACF)

ACF refers to a form of systematic screening in which the services, i.e. screening chest X-rays, are brought to the community. A community-based mobile chest X-ray unit, with a diagnostic test, will be made available under this strategy. The target of community-based screening will be high-risk communities (for example, urban and rural poor), workplaces or congregate settings (for example, jails and prisons). Digital chest X-rays and artificial intelligence will be used to ensure point-of-care reading that will also facilitate on-site testing and decrease patients lost to follow-up.

To be able to undertake screening on a massive scale, the proposal is to maximize outsourcing of chest X-ray services or to have at least one mobile van per province-wide or citywide network. An alternative is to outsource this service in areas with available private services. The specific strategy shall be defined once an analysis of a more cost-effective measure per province or city is undertaken.

To facilitate adoption of the above, regulatory policies on the use of digital chest X-rays and artificial intelligence shall be developed. Likewise, a social and behavior-change campaign to increase participation in chest X-ray screening programs will be implemented as described in the NTP Health Promotion and Communication Strategy:

DOH.2020.HPCS, [http://ntp.doh.gov.ph/downloads/publications/Health\\_Promotion\\_and\\_Communication\\_Strategy.pdf](http://ntp.doh.gov.ph/downloads/publications/Health_Promotion_and_Communication_Strategy.pdf)

Performance target	Key activities
Number of people screened using chest X-rays during ACF  Baseline: no data 2020: 2 520 000 2021: 3 320 000 2020: 4 420 000 2023: 5 750 000	<ul style="list-style-type: none"> <li>• Develop policy on use of digital chest X-ray with artificial intelligence</li> <li>• Guidelines on how to conduct ACF</li> <li>• Outsourcing chest X-ray provider, or deployment of one-stop mobile chest X-ray with RDT (1 per province-wide or citywide health system)</li> <li>• Social behavior change campaign as part of social preparation</li> </ul>

### 3. Enhanced case finding (ECF)

In areas where chest X-rays are not easily accessible for both ACF or ICF, ECF will be a priority strategy. It refers to maximizing symptom screening through community-based workers who conduct home- or community-based symptom screening and provide sputum collection and transport services. These workers, or health navigators, can be barangay health workers (BHWs), community volunteers (CV) or members of patient support groups (PSG), community-based organizations (CBOs) or civil society organizations (CSOs). The health navigators are expected to have integrated health function not just for TB elimination but also for other public health programs.

To operationalize this strategy, activities to professionalize the health navigators need to be undertaken including development of guidelines or standard operating procedures, standardized messages, capacity-building and incentive mechanisms. This strategy also includes maximizing referral of presumptive TB patients from pharmacies through working with professional societies (i.e. Philippine Pharmacists Association) and pharmacy owners.

While it is ideal to measure the number of people screened with TB symptoms as a performance target for this strategy, the current limitations of the NTP reporting system will not be able to handle this task. Hence, measurement of number of presumptive TB cases identified by health navigators during ECF is used instead, and it will contribute to the main output of the testing and diagnosis strategies.

Performance target	Key activities
Number of presumptive TB cases identified by PSGs, CSOs, CBOs, CVs  Baseline: (17%*) 2020: 470 000 2021: 620 000 2022: 830 000 2023: 1 080 000	<ul style="list-style-type: none"> <li>• Professionalize BHW, PSGs and task forces including incentive mechanisms to improve capacity as Health navigators</li> <li>• Develop capacity-building program and tools, orientation for Health navigators</li> <li>• Formation and capacity-building of PSGs</li> <li>• Community-based sputum collection and transport system</li> <li>• Expand and scale up pharmacy referral for identified presumptive TB</li> </ul>

\*in 2019, 17% of TB, all forms were referred (no data on presumptive TB from community)

### 4. Contact investigation

While already a part of NTP policy, investigation of contacts has been inconsistently implemented, resulting to very low coverage of TB preventive treatment (TPT). Hence, it is identified as a priority strategy in this update both for case finding of active TB as well



as for TPT. Emphasis is placed on social and behavior change communication (SBCC) that will address different market segments, for example health-care workers (HCWs), patients and family members through customized messages and appropriate channels.

The activities under this strategy may be integrated in the prior screening strategies – ICF, ACF, and ECF. All contacts of active TB cases identified during these screening activities should immediately undergo contact investigation. Those in which active TB is ruled out should be offered TB preventive treatment subject to eligibility criteria. The health human resource deployment program, for example nurse deployment programs (NDPs), as well as TB navigators in the community, shall be maximized to lead contact investigation activities.

The program will also explore the use of interferon gamma release assay (IGRA), in addition to tuberculin skin test (TST), as a tool for screening contacts for LTBI.

Performance target	Key activities
Percentage of contacts screened with chest X-ray or symptoms	<ul style="list-style-type: none"> <li>Integrated contact investigation (and LTBI case finding) in ICF, ACF and ECF</li> <li>Utilize Nurse Deployment Program/human resources for health (HRH) and TB navigators for contact investigation and sputum collection</li> <li>Expand use of TST (or IGRA) for screening of LTBI</li> </ul>
Baseline: {5%*}	
2020: 50%	
2021: 65%	
2022: 80%	
2023: 90%	

\*no data on % contact investigated. But in 2018, 5% of eligible contacts given TPT (WHO, 2019)

## II. STRATEGIES FOR TESTING AND DIAGNOSIS

The priorities for testing and diagnosis are improving access to new rapid diagnostics tests such as Xpert or line probe assay (LPA), improving the compliance to mandatory TB notification and improving the quality of clinical diagnosis. These strategies are aimed at increasing both coverage and the quality of testing to minimize false-positive as well as false-negative diagnoses.

**Table 3. Main targets for testing and diagnosis, updated PhilSTEP1 2020–2023**

	2020	2021	2022	2023
Number of presumptive TB tested	2 450 000	2 900 000	3 450 000	4 060 000
Population testing rate	2.3%	2.7%	3.3%	4.0%

### 5. Push compliance to mandatory case notification

Based on lessons learned in the initial implementation of mandatory notification, the updated plan will continue to implement sustainable engagement of private physicians. Approaches will be enhanced and streamlined through the following:

- systematic engagement of health facilities (hospitals and clinics) to install facility-level notification systems by designating facility notification officers;

- ii. making notification a basic requirement for hospital licensing using a list generated by the Integrated Tuberculosis Information System (ITIS) of notified TB cases as one of the licensing requirements replacing the TB Referral Logbook;
- iii. outreach to stand-alone practitioners through notification officers or using user-friendly digital and mobile platforms;
- iv. explore data integration of ITIS with Professional Regulatory Commission (PRC) for physician registration for TB notification, and requiring TB notification for claims processing with Social Security System (SSS), the Government Service Insurance Corporation (GSIS) and PhilHealth; and
- v. integrate TB in the development of implementing rules and regulations (IRR) for notifiable diseases with strong regulatory provisions for compliance.

TB notification officers, either from an LGU or project support, will facilitate registration and reporting utilizing user-friendly digital platforms. A focus will also be added on reporting of treatment outcomes. NTP will collaborate with professional societies to improve advocacy with their member physicians, as well as for monitoring of notifications within each specialty society. In addition to private physicians, linkage of bacteriologic laboratories and pharmacies to notification will be explored.

As an incentive for notification, the following are considered: advocacy for the PhilHealth package to include payment for physicians who provide notification; accessibility of rapid diagnostic test laboratories (RTDLs) to patients of private physicians will be enhanced, and; simplification of registration and verification of physicians for ITIS use. Partnering with the PRC to link renewal of professional license with notification will also be studied as a regulatory push.

Performance target	Key activities
% of mandatory notification contribution to total notification, TB all forms  Baseline: 18% (2018) 2020: 20% 2021: 25% 2022: 30% 2023: 30%	<ul style="list-style-type: none"> <li>• Dissemination and implementation of the TB Law and IRR on mandatory notification</li> <li>• Development of DOH administrative order on mandatory TB notification</li> <li>• Develop reporting platforms for notification</li> <li>• Deployment of TB notification project associates</li> <li>• Enhancement of referral mechanism between facilities</li> <li>• Explore notification from pharmacies and bacteriologic laboratories</li> <li>• Diagnostic connectivity for private laboratory notification</li> <li>• Engagement of professional societies, private hospitals and private physicians</li> <li>• Incentive scheme to encourage private sector notification</li> </ul>

## 6. Rapid diagnostic test (RDT) expansion and utilization

As more RDT machines (e.g. Xpert) become available, the diagnostic algorithm will be simplified to make Xpert the primary diagnostic test for all presumptive TB cases both in the public and private sector. The dissemination of the *NTP Manual of Procedures, 6th edition (MOP)* and the *Clinical Practice Guidelines on the Diagnosis, Treatment, Prevention and Control of Tuberculosis* will facilitate this.

Expansion of the RTDL network will be prioritized through procurement of additional Xpert instruments – or equivalent RDTs prequalified by the World Health Organization (WHO) to ensure availability as well as sustainability. Details of the expansion plan are

described in the *National Tuberculosis Control Program Laboratory Network Strategic Plan (LNSP) 2018–2022*, [http://ntp.doh.gov.ph/downloads/publications/LNSP\\_2018-2022.pdf](http://ntp.doh.gov.ph/downloads/publications/LNSP_2018-2022.pdf). But this will be detailed further in a road map for RDT that will tackle use of TrueNAT, Xpert Ultra and strategic expansion in the private sector, among other things.

This strategy will also require establishing quality-assurance systems for RDTs, developing equipment maintenance systems, providing the necessary competent human resources for health (HRH), an uninterrupted supply of commodities, introducing diagnostic connectivity to improve turnaround time and monitoring, and sustaining the private sector diagnostic consortium. Expanding indications for RDT by conducting operational research on extrapulmonary specimens from children will also be undertaken.

An integral part of this strategy is the optimized specimen referral and transport mechanism similar to specimen transport riders (STRiders) supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Key addition for the updated plan is to expand their scope to include private hospitals and stand-alone practitioners.

Performance target	Key activities
<p>% of notified new and relapse tested with RDT</p> <p>Baseline: 36% (2018)* 2020: 60% 2021: 70% 2022: 80% 2023: 90%</p>	<ul style="list-style-type: none"> <li>• Sustain and establish additional RTDLs through procurement and placement of RDT machines and consumables (e.g., cartridges)</li> <li>• Simplification of diagnostic algorithms</li> <li>• Enhancement of the referral mechanism between facilities</li> <li>• Provision of additional STRiders for all RTDLs and expand coverage to private facilities</li> <li>• Establish diagnostic connectivity for TB laboratories and treatment facilities</li> <li>• Capacity-building of health providers (private and public)</li> <li>• Establish and sustain quality-assurance mechanisms and ensure equipment maintenance for TB laboratories</li> <li>• Sustain and expand private sector laboratory consortium</li> <li>• Laboratory network strategic plan implementation and monitoring (road map for expansion of rapid molecular testing)</li> <li>• Operational research on RDTs among pediatric patients using extrapulmonary specimens</li> </ul>

\*WHO. 2019 Global TB Report.

## 7. Line probe assay/drug susceptibility testing (LPA/DST) optimization

An important strategy in improving diagnosis for DR-TB is the optimization of the line probe assay (LPA) and drug susceptibility test (DST) while anticipating newer diagnostics that might become available for the TB laboratory network. A road map for sustaining these diagnostic tests will be developed with attention to improving turnaround time, a susceptibility test for new TB drugs and RDT expansion in the private sector. Developing capacity for a rapid molecular susceptibility test to first-line drugs (FLDs) will also be undertaken to address isoniazid monoresistance and to better guide choice of treatment regimens for DR-TB.

Support systems required include a quality management system for culture, LPA and DST laboratories, private laboratory engagement, and improved research capacity in TB diagnostics. Details of laboratory expansion for LPA and DST are in the 2018–2022 LNSP.

Performance target	Key activities
% of rifampicin-resistant tuberculosis (RR-TB) notified that are tested with first- and second-line rapid DST  Baseline: 94%* (2019) 2020: 85% 2021: 90% 2022: 95% 2023: 95%	<ul style="list-style-type: none"> <li>• Increase capacity of existing LPA and phenotypic DST</li> <li>• Establish additional LPA laboratories</li> <li>• Optimize the specimen transport systems for LPA, DST</li> <li>• Capacity-building of health providers (private and public)</li> <li>• Quality assurance, maintenance of equipment</li> </ul>

\*This baseline is only for second line LPA

## 8. Improving quality of clinical diagnosis

While improved access to the RDT Xpert test is expected to increase bacteriologic positivity, the issue of high proportion of clinically diagnosed TB cases remains as a potential problem, especially during the transition period to Xpert as primary test. Hence, an assessment on the determinants of clinical diagnosis will be conducted. The findings of this assessment shall be translated to capacity-building for health workers supplemented by the appropriate communication campaign to be able to provide better-quality clinical diagnosis.

In addition, coordination with radiologists will be undertaken to standardize official chest X-ray readings on TB findings and to advise bacteriologic testing for findings suggestive of TB. This will better guide clinicians before they make a clinical diagnosis.

Performance target	Key activities
% of bacteriologically confirmed tuberculosis (BC-TB) among notified TB cases  Baseline: 33% (2019) 2020: 40% 2021: 50% 2022: 60% 2023: 70%	<ul style="list-style-type: none"> <li>• Assessment of clinical diagnosis of TB</li> <li>• Social and behavior change communication (SBCC) for private and public providers</li> <li>• Development and dissemination of technical guidelines (NTP Manual of Procedure and Clinical Practice Guidelines)</li> <li>• Capacity-building for HCWs on clinical diagnosis for public and private providers</li> <li>• Coordinate with radiologists to standardize chest X-ray reading</li> </ul>

## III. STRATEGIES FOR TREATMENT

While treatment success rates for DS-TB have been consistently more than 90%, which needs to be sustained, most of the interventions prioritized for treatment are aimed at improving treatment outcomes for DR-TB. This includes ensuring treatment initiation for all diagnosed TB cases. Hence, decentralization of services within the province-wide and citywide health-care provider network, implementation of patient-centered care, and active Drug Safety Monitoring and Management (aDSM) are vital parts of this strategy. Social protection, which is a component of patient-centered care, is emphasized for both DS-TB and DR-TB. In addition, the continuous rollout of TB-HIV collaborative activities will be a major activity over the next four years.

**Table 4. Main targets for treatment, updated PhilSTEP1 2020–2023**

	2020	2021	2022	2023
Treatment coverage rate, all forms	75%	80%	85%	90%
Total notified, all forms	442 600	470 600	493 300	507 300
Treatment coverage rate, DR-TB notified, DR-TB	52%	56%	64%	71%
TSR, DS-TB	≥ 90%	≥ 90%	≥ 90%	≥ 90%
TSR, DR-TB	71%	75%	85%	85%

## 9. Develop the province/citywide Health Care Provider Network (HCPN) that provides full TB care continuum

All activities under this strategy shall be undertaken in accordance with the overall HCPN establishment under the Universal Health Care (UHC) Law, which includes not just service or technical integration, but also other facets such as finance, governance and human resources. In this respect, the NTP and partners will work with other stakeholders within the province/city for integration of different health programs into a single health care provider network. Specific for TB, the full continuum of care for both DSTB and DRTB shall be provided by the HCPN.

Since integration of DR-TB into the program in 2007, the services under the Programmatic Management of Drug-resistant Tuberculosis (PMDT) had been provided mostly by specialized centers, known as treatment centers or satellite treatment centers. Even with introduction of integrated Delivery of TB Services (iDOTS), most patients are still initiated treatment at treatment centers or satellite treatment centers, and most of patient management is provided in these specialized centers. The next step, referred to as iDOTS Phase 2, entails the full provision of DR-TB services by the primary care facilities – rural health units (RHUs) and health centers (HCs) – from screening until recording and reporting.

In the updated plan, the direction is towards RHUs and HCs providing integrated delivery of TB services for both DS-TB and DR-TB. Referral centers, at least one hospital-based facility with experience in managing DR-TB per province or city, will be identified to manage complicated cases. In addition to this main feature of (DR-TB and DS-TB) integration, there will also be an integrated approach for co-morbidity management (e.g. diabetes mellitus, HIV) and implementation of the patient-centered TB care package.

This establishment of the HCPN for TB will entail the following activities:

- development of guidelines and plans for iDOTS rollout and implementation;
- hiring, training, mentoring and supportive supervisions of health workers;
- uninterrupted supply of anti-TB drugs;
- development of social and behavior change materials;
- revision of NTP certification process;
- improvement of information systems; and
- establishment of referral system to have seamless TB services, including the private sector.

Performance targets	Key activities
<p>Enrollment rate of diagnosed multidrug-resistant tuberculosis (MDR-TB) and RR-TB</p> <p>Baseline: 85% (2018)</p> <p>2020: 85%</p> <p>2021: 90%</p> <p>2022: 95%</p> <p>2023: 95%</p>	<ul style="list-style-type: none"> <li>• Mapping of health facilities providing various TB services</li> <li>• iDOTS Phase 2 expansion plan</li> <li>• Establish provincewide and city-wide HCPN with referral system</li> <li>• Implement iDOTS with overall HCPN implementation</li> <li>• Implement integrated approach for co-morbidity management (HIV, diabetes mellitus, etc.)</li> <li>• Intensive monitoring and mentoring of iDOTS facilities</li> <li>• Revised certification process for facilities and HCPN</li> <li>• SBCC for HCPN providers and patients</li> <li>• Sustain and enhance integrated TB Information system</li> </ul>
<p>% of primary care service delivery points (RHU/ HC) fully implementing iDOTS</p> <p>Baseline: no data</p> <p>2020: 30%</p> <p>2021: 50%</p> <p>2022: 85%</p> <p>2023: 100%</p>	<p>% of TB service delivery points submitting timely ITIS reports</p> <p>Baseline: 97%</p> <p>2020: 100%</p> <p>2021: 100%</p> <p>2022: 100%</p> <p>2023: 100%</p>

## 10. Adoption of patient-centered care

Patient-centered care is an approach that recognizes and respects the patient's rights and values, and considers the patient as an important partner who actively participates in the decisions regarding their TB care. To sustain good treatment outcomes among DS-TB patients and improve outcomes among DR-TB patients, the patient-centered approach is a major strategy. Adoption of community- and home-based treatment will be an option for all, whether DS-TB or DR-TB with BHWs, patient support groups, community-based organizations, family members, etc. acting as treatment supporters. This will also include provision of enablers to patients (e.g. food and transportation costs), incentives and home-care kits for treatment supporters, and performance-based incentives for health-care providers. Provision of wider social protection programs through collaboration with other government agencies (e.g. the Department of Social Welfare and Development, Employees' Compensation Commission, SSS, GSIS) and organizations will be included.

The use of new all-oral treatment regimens, new anti-TB drugs and patient-friendly adherence tools is part of this strategy to improve outcomes. Adherence tools will include testing of digital adherence tools to monitor treatment and appraisal of which methods are suitable for scale up.

The health system support requirements for this strategy include:

- orientation of treatment supporters
- provision of job-aid materials
- mentoring and supportive supervision
- updating of guidelines and training of health workers and
- provision of social protection package.

More importantly, feedback on patient experiences in accessing TB services need to reach the program managers and the patient groups and civil society organizations (CSOs) will be vital to ensure this.

Performance target	Key activities
% of patients on home-and community-based care  Baseline: no data 2020: 75%/80% (DR-TB and DS-TB) 2021: 80%/95% 2022: 85%/100% 2023: 90%/100%	<ul style="list-style-type: none"> <li>• Implement patient-centered TB care package</li> <li>• Adoption of home- and community-based treatment</li> <li>• Establish patient support groups and pool of treatment supporters</li> <li>• Development and implementation of reporting system on patient experience, including patient hotline</li> <li>• Interventions to assess and improve quality of care and treatment (e.g. mortality review, continuous quality improvement)</li> <li>• Roll out shorter all-oral regimens</li> <li>• Implement novel tools (new all-oral treatment regimens, new anti-TB drugs, adherence tools)</li> </ul>

## 11. Strengthen active Drug Safety Monitoring and Management

This strategy is particularly important for patients on new anti-TB drugs, novel treatment regimens and regimens for extensively drug-resistant tuberculosis. Measures to strengthen active Drug Safety Monitoring and Management (aDSM) will focus on the following activities:

- monitoring and mentoring to ensure compliance with recommended baseline and follow-up clinical, laboratory and diagnostic tests;
- rational use and availability of ancillary drugs to combat the adverse drug reactions;
- support for patient hospitalization; and
- implementation of simple standard reporting system to capture serious adverse events and adverse events of special interest.

Health system support requirements include the issuance of policies and guidelines on aDSM, training of health workers on clinical management and reporting tools, and mentoring and supportive supervision. Strong collaboration among the program, the DOH Pharmaceutical Bureau (PD) and the Food and Drug Administration (FDA) is required to implement these activities.

Performance target	Key activities
% TB facilities implementing aDSM  Baseline: 12% 2020: 50% 2021: 75% 2022: 90% 2023: 100%	<ul style="list-style-type: none"> <li>• Issuance of policy on aDSM</li> <li>• Develop and implement aDSM reporting system</li> <li>• Capacity-building of health workers on aDSM</li> <li>• Regular conduct of causality analysis</li> <li>• Monitoring and mentoring in TB facilities</li> <li>• Collaboration with DOH-PD and FDA for aDSM implementation</li> </ul>



## 12. TB–HIV Collaboration

Expansion of TB–HIV collaboration has begun with the development of integrated TB–HIV package of services for UHC implementation. Provider-initiated HIV counseling and testing (PICT) for all TB patients aged 15 years and above shall be rolled out nationwide beyond the HIV Category A and B sites. The TB screening of PLHIV in treatment hubs will be sustained as part of the screening strategies conducted, such as ICF in health facilities.

Close collaboration between the NTP and the National AIDS and STI Prevention and Control Program as stipulated in current TB–HIV administrative orders shall be sustained for implementation of both bidirectional screening and to explore avenues for integrated use of new RDTs.

Performance target	Key activities
% of TB patients with known HIV status  Baseline: 27% (2018) 2020: 35% 2021: 60% 2022: 80% 2023: 90%	<ul style="list-style-type: none"> <li>• Whole package of services for TB and HIV developed</li> <li>• Rollout of PICT (screening of all TB for HIV)</li> <li>• TB screening among PLHIV (integrated in ICF)</li> <li>• Guidelines, plans and implementation of integrated use of Xpert for TB diagnosis and HIV viral load testing</li> </ul>

## IV. STRATEGIES FOR PREVENTION

There is now wide recognition in the global community that simply treating the existing pool of active TB cases will not lead to a decline in incidence that is required to reach the targets in the global *End TB Strategy*. Identifying and treating inactive or latent TB infection is likewise important. While this was emphasized in the original PhilSTEP1, uptake of TB preventive treatment (TPT) has been very low.

There will be two priority areas for TB prevention under this updated PhilSTEP1. First is the adoption of shorter TPT regimens coupled with a communication campaign for both health workers and patients to increase the uptake of TPT. Second is IPC in health facilities to prevent new infections.

**Table 5. Main targets for prevention, updated PhilSTEP1 2020–2023**

	2020	2021	2022	2023
Number given TPT	68 500	123 910	214 350	345 550

## 13. Adoption of short TB preventive treatment (TPT)

The strategy focuses on use of short regimens for TPT including the three-month isoniazid and rifapentine regimen (3HP) as a means to increase coverage with LTBI treatment. This will entail social and behavior change campaigns directed at both public and private providers, as well as clients. Guidelines have to be integrated in the revised NTP Manual of Procedures to include the introduction and scale-up of 3HP, TST (or IGRA), and chest X-ray and symptom screening. Hence, this is directly related to the strategies on systematic screening including contact investigation.



Performance target	Key activities
<p>TPT Coverage Rate</p> <p><b>Contacts:</b>  Baseline: 5% (2018)  2020: 15%  2021: 25%  2022: 40%  2023: 60%</p> <p><b>PLHIV:</b>  Baseline: 52% (2018)  2020: 65%  2021: 70%  2022: 75%  2023: 80%</p>	<ul style="list-style-type: none"> <li>• Policy review and issuance (NTP MOP 6<sup>th</sup> edition roll out)</li> <li>• Develop road map for TPT Strategy</li> <li>• Introduction and scale up of 3HP and other shorter regimens</li> <li>• Monitoring TPT implementation, including reporting from the private sector</li> <li>• Development and dissemination of SBCC package for provider specific and client specific</li> </ul>

#### 14. Infection control capacity-building, certification and monitoring

Prevention of transmission, especially in health facilities, is of utmost importance. Given the recent WHO guidelines, which recently were translated into an online learning course by the NTP and DOH Health Human Resource Development Bureau, focus will be on ensuring compliance and implementation. A system of measuring compliance and subsequent mentoring and supervision has to be developed and implemented.

Performance target	Key activities
<p>% of TB facilities complying with WHO infection control guidelines</p> <p>Baseline: no data  2020: 70%  2021: 80%  2022: 90%  2023: 100%</p>	<ul style="list-style-type: none"> <li>• Promotion of infection prevention and control e-training modules</li> <li>• Development of TB infection control compliance checklist</li> <li>• Monitoring and supervision</li> <li>• Updating TB facility certification process</li> <li>• IPC e-training certificate as part of revised certification requirement</li> </ul>



# HEALTH SYSTEMS AND CROSS-CUTTING INTERVENTIONS

While the major strategies discussed in the above section are focused on service delivery across the cascade of care, there are many support system requirements that are necessary to implement these strategies. There are also cross-cutting concerns discussed across the different strategies. This section consolidates the major interventions for these cross-cutting areas: Health system support (financing, human resources, pharmaceutical and supply chain management, information system), CSO and KAP engagement, private sector engagement, and health promotion and communication. Key milestones (i.e. process indicators) are illustrated in the emphasis box after each section.

## I. Health systems support

### 1. Ensuring adequate financing for the updated PhilSTEP1 2020–2023

The period of implementation coincides with the transition period in health financing to the UHC Law. Under the law, there will be integration of the health system into province-wide and citywide health-care provider networks (HCPN) that will pool resources for health through the creation of a Special Health Fund by the sources – the DOH, PhilHealth and LGUs. Services will be classified as either population-based services, which will be funded by the DOH and LGUs, or individual-based services, which will be funded by PhilHealth.

Based on these factors, an important intervention during this transition period will be to ensure that PhilHealth funding for TB services is maximized under the UHC Law. TB services must be deliberately considered in the implementation research leading to reforms in the PhilHealth benefit package delivery, not just for treatment but to include screening, testing and diagnosis. Within the purview of the updated PhilSTEP1, PhilHealth is expected to launch a transitional primary care benefit package (*Konsulta* package) that will cover basic diagnostics services such as chest X-rays and sputum microscopy. Aside from this, expansion of benefit coverage to DR-TB will still be pursued.

Other than increasing PhilHealth funding, advocacy for increased TB budget will be undertaken at the national, regional and local levels. There will be two approaches for this. First, the capacity of key affected population (KAP) groups and civil society organizations (CSOs) to advocate shall be developed. This is discussed in more detail below. Second, to provide a venue for both civil society participation and multisectoral collaboration, coordinating committees shall be established at the national, regional and local levels.

At the national level, the TB National Coordinating Committee (NCC) established in 2019 is a model that hopes to foster multisectoral accountability for TB elimination efforts. It is composed of various government agencies, private sector representatives, academia, development partners and KAP. Similar structures shall be established, including regional coordinating committees (RCCs) and provincial coordinating committees (PCCs). At the LGU level, advocacy will be directed towards securing counterpart budgets to support TB drugs and laboratory commodities. Participation of the private sector in the local coordinating committee shall also be advocated.

The need to advocate for increased budgets for TB at the local level is timely due to the implementation of the Mandanas Ruling, wherein additional funds will be reallocated to LGUs. Given the prospective rise in LGU budgets, efforts should be in place to ensure that allocation for health and for TB is also proportionately increasing. Advocating for increased budgets will also require improvements in fund disbursement given the shift to a cash-based budgeting system. To ensure this, procurement processes will be streamlined and enhanced stock monitoring at all levels will be practiced.

Finally, one of the specific agenda points at the national level is to utilize the multiyear obligation agreement (MYOA) framework for TB budgeting wherein up to three years of budget commitments can be secured. This will help ensure that the DOH commitment to funding the updated PhilSTEP1 is met.

### **Key milestones**

- MYOA for TB budget 2021–2023 (2020)
- Establish NCC, RCCs (17) and PCCs for multisectoral accountability (2021)
- LGUs providing budgets for TB drugs and laboratory commodities, e.g. cartridge (2021–2023)
- PhilHealth benefit package includes screening by chest X-ray, TB rapid diagnostic test, notification by private practitioners, DS-TB and DR-TB drugs and TB preventive treatment (2023)

## **2. Adequate and competent human resource**

One of the challenges in implementing PhilSTEP1, with its enormous scale, is the presence of adequate and competent human resources. Currently, more than 775 health workers are supported by the Global Fund, with 88% in service delivery points and the rest in program management offices, according to the HRH2030 project report on GF HR Sustainability in 2019. An human resources analysis and sustainability plan has been developed, but it needs to be included in the HRH Masterplan of the Health Sector, which will be developed in line with UHC provisions.

While the above is ongoing, advocacy and multisectoral accountability should be directed towards increasing the number of health workers based on an appraisal of required

human resource needs. The Workload Indicators for Staffing Needs (WISN) is a tool that may be used to determine this requirement. This can be done at the LGU level.

For capacity-building, the main thrust is to transition from traditional types of training towards online learning platforms with corresponding units for continuing professional development. The current rollout of the sixth edition of the NTP MOP aims to utilize this learning platform. Aside from training, a strong monitoring and mentoring program, which can be integrated with a quality-improvement program shall be established to ensure post-training competencies are met.

#### **Key milestones**

- Online learning platforms established (2020)
- Monitoring and supervision system established (2020)
- Human resources sustainability plan integrated into health sector HRH Masterplan (2021)
- Human resources complement consistent with WISN estimated requirement (2023)

### **3. Pharmaceutical and supply chain management (PSCM)**

The year 2019 was beset with major challenges in the supply chain as the program experienced stockouts in Xpert cartridges and adult first-line drugs (FLDs) for about three months, while pediatric FLDs were limited throughout the year (2019 JPR). These resulted in lower case detection and enrollment rates. The reasons for stockouts cited in the 2019 JPR report include: increasingly strict market authorization requirements by the FDA; procurement focused on domestic market; insufficient available budget leading to quantification based on budget rather than actual needs; and lack of safety stocks.

Increasing the procurement budget has been discussed in section above on ensuring adequate financing, and the activities includes CSO/KAP advocacy, multisectoral accountability through the NCCs and RCCs, and a multiyear budget framework.

To address issues of cost, availability and quality, it is important to adopt the most efficient procurement method from either local or international sources. The program has already ventured into this using the Philippine Pharma Procurement Inc. as procurement agency for the 2019 budget. But international procurement, although conducted in the past, has not been tapped recently.

Registration of new drugs has to be expedited with continuous coordination between the program and FDA. When necessary and feasible, the WHO collaborative registration procedure has been recommended. A major issue in registration is the identification of a local market authorization holder; however, the Philippine Pharma Procurement Inc. or other local agents can be engaged for this.

Finally, the importance of establishing a logistics management information system cannot be overstated as it is an important tool not just for inventory control but to have an inventory for all commodities, an essential step in advocating and procuring based on actual needs.

### Key milestones

- All TB drugs are registered (2020–2022)
- Alternative procurement methods (international, local procurement agent) undertaken (2021)
- Logistics management information system functional (2021)
- Distribution system of TB commodities including second-line drugs (SLDs) established (2021)

## 4. Information system

The performance indicators of the program need to be captured accurately, analyzed and used in decision-making. Across the cascade-of-care continuum, it was noted that the activities on screening had the biggest gap in data. Hence, the NTP reporting system shall maximize the Integrated Tuberculosis Information System (ITIS) to ensure collection of all relevant indicators throughout the cascade. This will require connectivity solutions so that information (such as laboratory results and diagnosis/treatment information) are linked seamlessly and there is avoidance of redundant or duplicate entries. For analysis, the currently used TB dashboard shall be continually upgraded to include various tools on data analysis to ensure that focus is on the use of data for decisions, rather than simply organizing data.

Aside from optimizing the content of ITIS, a transition to user-friendly formats such as mobile applications (both Android and IOS) will be undertaken to expand use by both public and private providers. Efforts will be continued for data integration of ITIS with other systems like facility- level electronic medical records; SSS, GSIS and PhilHealth.

### Key milestones

- ITIS version for mobile app launched (2020)
- TB dashboard implemented and sustained (2020)
- TB information disseminated and used, e.g. TB newsletter (2020–2023)
- ITIS modules on laboratory with connectivity is established (2021)

## II. CSO and KAP engagement

Engagement of patient support groups have long been a part of the TB strategic plans but mainly as partners in service delivery. Roles initially were limited to the referral of presumptive TB and providing support to peers during treatment. But a situational analysis on TB prevention and treatment using communities, rights and gender tools was recently conducted through Stop TB support, and one of the key recommendations was “ensuring genuine and meaningful engagement of Civil Society Organizations working on TB, and communities affected by TB (key populations, TB patients, survivors and their families) in all levels of decision-making, policy and program development, implementation, monitoring and evaluation.”

Although KAPs have been included as members of multisectoral governing bodies for TB, most notably in the TB NCC, the representation has been limited to existing groups with a moderate reach of membership, for example, mostly in greater Metropolitan Manila area. There is no



systematic mechanism to gather feedback from various existing groups throughout the country. The performance of advocacy functions with key decision-makers has also been limited.

Under the current strategic plan, the capacity of KAP groups CSOs to advocate shall be developed. Patient support groups will be established where nonexistent and linked with existing KAP groups or CSOs into regional or national networks. The objective is to improve feedback from patient experiences that can be filtered into a collective agenda and increase their voice in decision-making. Related to this, a mechanism to regularly obtain, organize and analyze feedback on patient experiences shall be established. And to communicate this effectively, a pool of KAP speakers will be supported to be champions for advancing their interests.

The role of KAPs in patient support will not be abandoned, and they continue to be a major resource for community mobilization for case finding and treatment adherence.

#### Key milestones

- National network of CSOs and KAP groups advocating at various levels (2021)
- Patient feedback mechanism established to gather patient experience nationwide (2021)
- Pool of speakers from KAP supported (2022)

### III. Private sector engagement

Private sector engagement (PSE), or public–private mix (PPM), is a critical component in TB elimination efforts. Since 2015, the private sector has contributed 15–17% to total annual notification. This includes patients from private hospitals that were engaged intensively under a previous TB Strategic Plan – the 2010–2016 Philippine Plan of Action to Control Tuberculosis (PhilPACT) and up to the first three years of PhilSTEP1 implementation. Upon implementation of mandatory TB notification in 2018, an additional 10–18% was contributed to total notification (2018–2019) despite majority of the activities and patients coming from the three biggest regions (Regions 3 and 4, and the National Capital Region). The *National Action Plan for Public-Private Mix on Private Sector Participation in TB Care and Prevention, Philippines (2018–2022)* was also developed to ensure effective leadership and stewardship for PPM, strengthen service delivery models, improve collaboration with professional societies, and enhance monitoring and evaluation for PPM contributions. The introduction of the UHC Law offers a unique opportunity to revisit and update the PPM National Action Plan to recalibrate and update targets for PSE aligned with the updated PhilSTEP1.

But the full extent of private sector engagement has not yet been met according to the 2019 JPR. Sustainable PSE will require a full range of incentives and enablers along with an appropriate regulatory environment to improve compliance. The UHC Law is an important opportunity in moving TB PSE forward as long as provinces and municipalities include all levels and types of private providers in the HCPN, including hospitals, stand-alone physicians, laboratories and pharmacies. There are also important challenges raised for mandatory notification. First, the notification was primarily driven by notification project associates of the Global Fund project in the three regions. Expanding this to other regions is a challenge given the HRH issues in local governments. Second, as much as 97% of the private sector notification are clinically diagnosed, compared to 65% in the mostly public facilities that offer directly observed treatment, sort course (DOTS). Third, while contribution to notification is significant, there are no reports on treatment outcomes among these patients. These are some of the challenges that the current interventions will seek to address.

Some of the key activities mentioned under the cascade-of-care framework that will have significant PSE components are: linking of chest X-rays conducted in the private sector such as workplace or X-ray facilities to RDTs; outsourcing ACF to private agencies; optimizing mandatory notification including reporting treatment outcomes; using notified cases as licensing requirement for facilities; improving access by private practitioners to RDT; improving clinical diagnosis through dissemination of Clinical Practice Guidelines; exploring pharmacies as reporting units for TB notification; and implementation of TPT by private practitioners. But to successfully implement all these activities, the support systems for PSE in TB have to be strengthened.

Towards this end of creating a supportive environment for participation, the objectives of PSE are:

- i. active participation and accountability of the private sector through the Philippine Medical Association (PMA), various professional societies, the Philippine Coalition Against Tuberculosis (PHILCAT) and various sectoral representatives;
- ii. improving the quality of TB services by complying with standards of care in TB screening, diagnosis, treatment and prevention;
- iii. providing the full range of incentives and enablers for private sector participation; and
- iv. making the private sector an integral part of the health-care provider network under UHC.

The limitations of a public-led PSE have been noted even in previous reviews. It is important that the current strategic plan look at leadership in PSE from the private sector itself, in this case with PMA and PHILCAT as a national coalition representing various private societies. They have already begun establishing accountability from various medical professional societies in mandatory notification and this has to be continued over the next four years. The ultimate end is the development of road-map objectives for the private sector (e.g. full implementation of mandatory notification) that will be included in the TB NCC Performance Framework. This road-map shall also include the expansion of RDTs in the private sector and a framework for TB-free workplace.

The compliance of the private sector to standards of care remains a difficult challenge with 97% of mandatory notifications being clinically diagnosed (as opposed to 65% in the mostly public DOTS facilities). This issue and the absence of treatment outcome reporting are the major gaps to be addressed in continuing and further expanding the mandatory notification. As recommended in the 2019 JPR: “Notification Agents should encourage private providers to use STRiders’ services to increase use of Xpert and increase bacteriologically confirmed TB cases to at least 40% of cases. Notification Agents should conduct or ensure home visits, with counselling, contact tracing and preventive therapy as appropriate, for all privately notified patients, and support them through treatment completion, including by facilitating a switch to program-procured anti-TB medicines if preferred by the patient. This is likely to require use of digital tools for both data management and adherence support.” Further, provisions of program drugs to private hospitals and workplace clinics to support patient-centered care will be pursued.

Ongoing discussions on an amendment to Republic Act 10767, officially known as the Comprehensive TB Elimination Plan Act or, more popularly, as the TB Law has included a legal sanction for noncompliance, specifically to mandatory notification. However, a full set of incentives and enablers should be used to complement these sanctions. As stated in the JPR 2019, included here are recommendations to: “implement automatic online certification-accreditation of private providers; a streamlined notification function fully integrated within ITIS; deployment of an app to facilitate prescription reporting by pharmacies, with patient follow-up by outreach staff; establishment of a call center to support private providers and their patients in notification, referrals and treatment; sputum transport to free, same-day or overnight Xpert, via STRiders or similar mechanisms; and increased use of chest X-ray and RDT vouchers for private patients.”

These enablers will be reviewed and considered in implementation research for the rollout of the UHC.

Finally, as the country moves towards UHC, it is imperative that all activities that will influence the design of the financing for UHC, whether PhilHealth, DOH grants or LGU subsidies, should take into consideration the private sector. Under the integration of the health system into a province-wide and citywide HCPN, the private sector should be made an integral part and be included in the referral mechanisms (such as sputum transport and access to RDTs), in feedback mechanisms (such as in laboratory connectivity and the follow-up of notified patients), and in financing (e.g. contracting as part of health care provider network, PhilHealth reimbursements for notification/treatment and performance-based grants for conduct of ACF activities), among other aspects of the HCPN.

#### Key milestones

- Road map for private sector engagement developed and integrated in TB NCC Performance Framework (2020)
- Incentives for private sector engagement established: access to Xpert via STRiders (2020), follow-up of notified patients for outcome (2021)
- Performance-based grants to private sector for conduct of ACF under the HCPN (2021)
- Private sector notification linked to PhilHealth reimbursements (2022)
- Compliance by private sector to standards of care manifest by at least 50% of notified cases bacteriologically confirmed and at least 80% that have treatment outcome (2023)

## IV. Health promotion and communication

There is a PhilSTEP1 sub-plan, the *National TB Health Promotion and Communication Strategy* ([http://ntp.doh.gov.ph/downloads/publications/Health\\_Promotion\\_and\\_Communication\\_Strategy.pdf](http://ntp.doh.gov.ph/downloads/publications/Health_Promotion_and_Communication_Strategy.pdf)) that outlines the various health promotion strategies aimed at both the influencers (i.e. decision-makers at all levels of government, health service providers, media practitioners, civil society and allies from other sectors) and the individuals affected by TB (i.e. patients, survivors, their families and contacts). Based on the perceived gaps in health behavior, as identified in the plan's situational analysis, the Health Belief Model was used as framework to identify what messages and campaigns will achieve optimal behavior change by targeting perceived barriers, benefits, self-efficacy and threats.

The communication objectives are clearly enumerated according to desired knowledge, feelings and actions, both of influencers and individuals affected. These desired behaviors are all anchored on the cascade-of-care continuum. Hence, a decision-maker will have desired actions for screening (e.g. fund activities for screening), testing/diagnosis (e.g., invest in recommended diagnostic tools), treatment (e.g. ensure adequate drug supply) and prevention (e.g. fund TPT initiatives). Similar behaviors are spelled out for the other participants or targets of the messages.

There are five strands of communication strategies that will be implemented, namely:

- i. policy advocacy
- ii. media advocacy
- iii. interpersonal communication and counseling
- iv. community mobilization, and
- v. behavior change communication.



Different activities are planned for each of the five strands with messages and methods suited to the target audience. For behavior change communication, which aims to influence specific behavior of the direct beneficiaries of the program, activities include digital activation (social media campaigns); health education during ACF, IFC and EC; radio and television promotions; and out-of-home media promotion (e.g. billboards and signage).

### Key milestones

- Launch of the NTP Health Promotion and Communication Strategy (2020)
- Implementation of Waves 1 to 4 of the Health Promotion and Communication Campaign (2020–2023)





# FINANCING REQUIREMENTS

## I. Budgeting process

The budgeting process for the updated PhilSTEP1 is similar to the original plan and made use of the same costing tool. Detailed cost scenarios were provided based on proposed strategies and key activities as well as annual program targets. Unit cost assumptions and funding commitments are gathered from stakeholder consultations, a review of related documents and known current costs. These unit costs are applied to the required quantity as needed in the identified cost items under each key activity.

The costing tool presents computations by key activities then aggregates amounts into a summary table of financing requirements by strategy. Each costing table for each strategy has computation details by year and potential funding source. Further, charts are available in the costing tool to provide visualization of these results. The costing tool also computes for possible funding gap per year, given the known or projected funding commitments of the various funding sources.

In addition, the costing tool is designed to adopt some changes due to target setting, possible funding source realignment, and updates on unit costs to make it user-friendly for planning and budgeting requirements. The costing tool tabs are linked with each other and contain embedded formula that automatically applies changes when targets, funding source, funding commitments and unit costs are revised.

## II. Financing requirements and vulnerability to funding gap

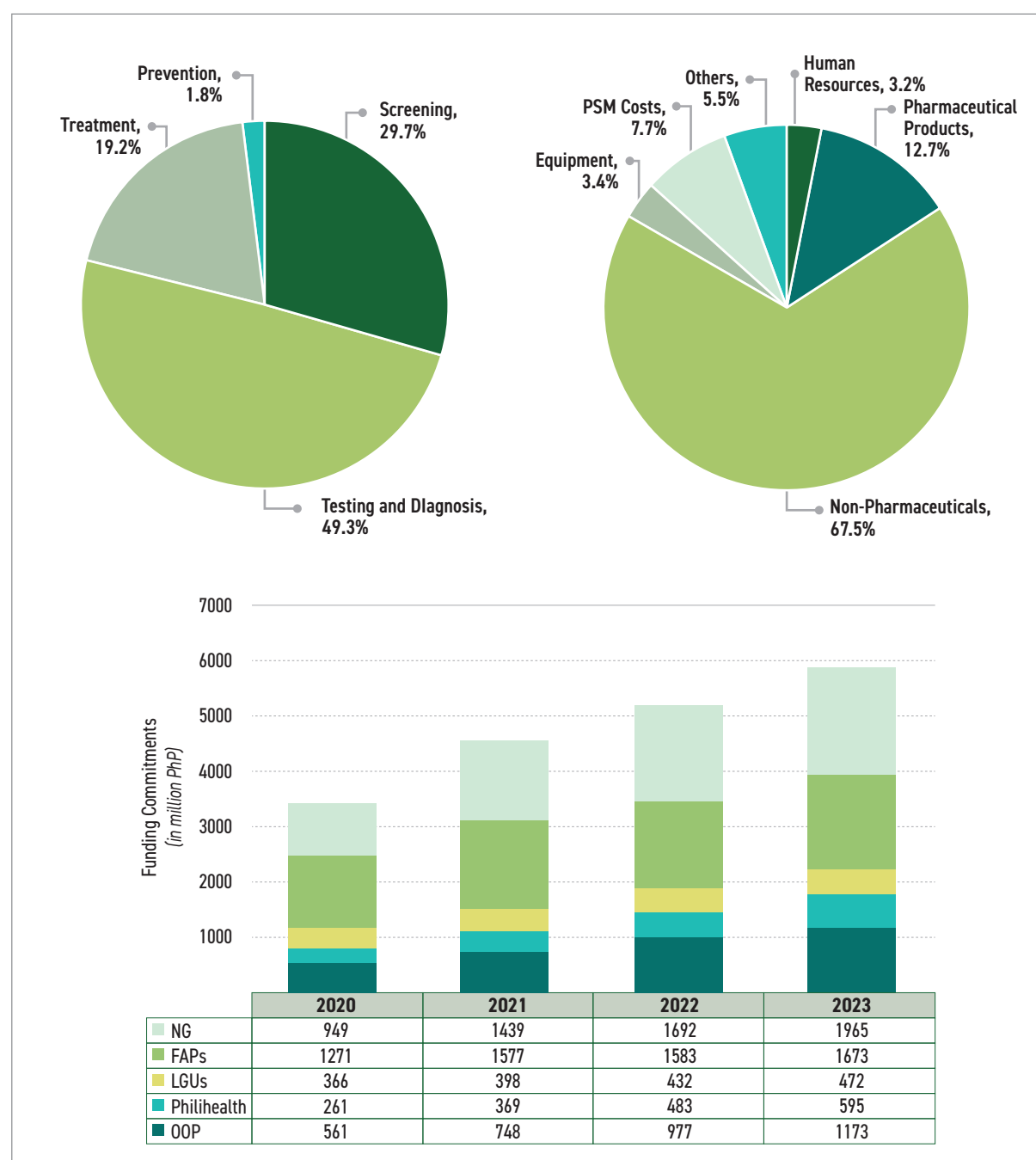
The full implementation of the updated PhilSTEP1 for 2020–2023 has a total funding requirement of 61.2 billion Philippine pesos (PhP). The largest portion of the funding requirement is for testing and diagnosis (49.3%), followed by screening (29.7%), treatment (19.2%) and Prevention (1.8%). The distribution of the PhilSTEP1 funding requirement is shown in Fig. 1.

The main cost driver of the PhilSTEP1 funding requirement amounting to PhP 41.3 billion (67.5% of total requirement) is for non-pharmaceutical products, which accounts for the cost of chest X-rays, GeneXpert cartridges and supplies, and diagnostic costs for all forms of TB. PhP 7.8 billion or 12.7% of the PhilSTEP1 funding requirement is for the procurement of pharmaceutical



products or anti-TB drugs and ancillary medicines. PhP 4.7 billion (7.7% of total requirement) is allocated for procurement and supply chain management costs, which is assumed to be 10% of procurement cost of TB drugs. Costs for human resources and equipment take up 3.4% and 3.2% of the total funding requirement, respectively. The equipment cost requirement equivalent to PhP 2.1 billion is for the procurement of GeneXpert machines that will be distributed to health facilities. Other cost requirements for PhilSTEP1 amounting to PhP 3.4 billion comprise payment for external professional fees, travel-related costs and living support to the client/target population.

**Fig. 2. Distribution of funding requirement by cascade of care (left) and by cost group (right)**



Note: NG = national government; FAPs = foreign-assisted projects; LGUs = local government units; OOP = out-of-pocket expenditures.

A critical consideration in the financial analysis of the PhilSTEP1 funding requirement is the possibility that a portion of the funding requirements may not be supported by funding commitments and thus presents vulnerability for the funding gap. To identify these vulnerable segments of funding support, an examination of current and expected funding commitments needs to be undertaken. To do this, funding commitments from funding sources were assigned on a per activity basis. Assigning of different commitments to PhilSTEP1 activities were based on the details or breakdown of expected funding support from the national government, foreign-assisted projects (FAPs), local government units (LGUs), PhilHealth and out-of-pocket (OOP) expenditures.

Two scenarios were considered in the programming of funding commitments: Scenario 1 assumes a status quo in the funding of TB services and assumes no health reforms will take place within the period of PhilSTEP1; Scenario 2 assumes the onset of reforms that are expected to affect financing for TB services. Two reforms are considered in the second scenario: the rollout of the PhilHealth outpatient benefit package that will include payments for chest X-rays and the implementation of Mandanas Ruling, which is expected to increase LGU funds.

The expected funding from the national government stands at PhP 6.0 billion for the updated PhilSTEP1 period. This is considering that the budget of the NTP has been consistent, with no noticeable increases over recent years. The commitment from national government is for the procurement of Xpert cartridges, FLDs, TPT and second-line drugs (SLDs) starting 2021.

The funding commitment from FAPs is estimated to be around PhP 6.1 billion given the new funding request to Global Fund (2021–2023) and possible funding support from other donors. The largest share of the funding commitment from FAPS is expected to come from the Global Fund at around PhP 5.1 billion, with the remaining PhP 1.0 billion coming from the other foreign donors. A bulk of the expected funding commitment from the Global Fund is for the procurement of SDLs and Xpert cartridges, support to case finding and diagnostic activities, and deployment of STRiders and patient enablers. Aside from these, all costs related to the provision of technical assistance is expected to be shouldered by United States Agency for International Development and other foreign donors.

The majority of the total expected funding support from LGUs is for the salaries of local health-care personnel (PhP 1.4 billion). In addition, LGUs are expected to fund maintenance of GeneXpert machines. Additional funding support is expected from LGUs due to the anticipated inflow of funds from the implementation of Mandanas Ruling. The additional expected support coming from LGUs is programmed under Scenario 2.



The total expected funding support from PhilHealth stands at PhP 1.7 billion for the reimbursement of case payments for the outpatient TB DOTS benefit package. On the other hand, Scenario 2 accounts for PhilHealth payments from the outpatient benefit package (*Konsulta*) which is expected to be rolled-out by the last quarter of 2020.



Lastly, OOP expenses (Php 3.5 billion) are expected to be incurred from payments for chest X-rays and anti-TB drugs. OOP expenses for chest X-rays is expected to be incurred from employee annual physical examinations, which require X-ray testing.

Table 6 shows the PhilSTEP1 funding gap per year for Scenario 1. The total expected funding commitments from all funding sources totals Php 18.4 billion, which puts the total funding gap at Php 42.8 billion, or 70% of the total PhilSTEP1 requirements. The funding gap for is lower for Scenario 2 (Table 7). The lower funding gap of Php 32.7 billion (53% of total requirement) is due to additional commitments from LGUs and PhilHealth, assuming the implementation of the Mandanas Ruling and the *Konsulta* benefit package. Regardless of the scenario, the funding gap remains to be more than half of the total funding requirement. This further emphasizes the need to advocate for more funding for the realization of the PhilSTEP1 targets.

**Table 6. Scenario 1: PhilSTEP1 funding gap by year, in million PhP**

	2020	2021	2022	2023	TOTAL
Funding requirements	11 226	14 916	15 780	19 261	61 183
Funding commitments	3308	4399	4992	5654	18 353
National government	949	1439	1692	1965	6046
Foreign-assisted Projects	1271	1577	1583	1673	6105
Local government units	366	398	432	472	1668
PhilHealth	261	369	483	595	1708
Out-of-pocket	462	615	802	948	2827
<b>Funding gap</b>	<b>7918</b>	<b>10 517</b>	<b>10 788</b>	<b>13 607</b>	<b>42 830</b>

**Table 7. Scenario 2: PhilSTEP1 funding gap by year, in million PhP**

	2020	2021	2022	2023	TOTAL
Funding requirements	11 226	14 916	15 780	19 261	61 183
Funding commitments	3758	6762	8196	9750	28 466
National government	949	1439	1692	1965	6046
Foreign-assisted projects	1271	1577	1583	1673	6105
Local government units	366	398	506	560	1830
PhilHealth	711	2733	3613	4603	11 659
Out-of-pocket	462	615	802	948	2827
<b>Funding gap</b>	<b>7469</b>	<b>8153</b>	<b>7584</b>	<b>9511</b>	<b>32 717</b>

In terms of cascade of care, the highest funding gap is observed for testing and diagnosis for both scenarios (Tables 8 and 9), which corresponds to 52% and 68% of the total funding gap, respectively. While the *Konsulta* package may be a new financing modality to fund screening activities, national government and LGU funds should also be mobilized for the procurement of equipment and supplies for testing and diagnostic activities.

**Table 8. Scenario 1: PhilSTEP1 funding gap by cascade of care, in million PhP**

	Screening	Testing and Diagnosis	Treatment	Prevention	TOTAL
Funding requirements	18 158	30 159	11 743	1123	61 183
Funding commitments	2553	7849	7210	741	18 353
<i>National government</i>	–	4356	1500	190	6046
<i>Foreign-assisted projects</i>	971	2113	2813	208	6105
<i>Local government units</i>	–	1380	288	–	1668
<i>PhilHealth</i>	–	–	1708	–	1708
<i>Out-of-pocket</i>	1581	–	902	344	2827
<b>Funding gap</b>	<b>15 605</b>	<b>22 309</b>	<b>4533</b>	<b>382</b>	<b>42 830</b>

**Table 9. Scenario 2: PhilSTEP1 funding gap by cascade of care, in million PhP**

	Screening	Testing and Diagnosis	Treatment	Prevention	TOTAL
Funding requirements	18 158	30 159	11 743	1123	61 183
Funding commitments	12 503	8012	7210	741	28 466
<i>National government</i>	–	4356	1500	190	6046
<i>Foreign-assisted projects</i>	971	2113	2813	208	6105
<i>Local government units</i>	–	1542	288	–	1830
<i>PhilHealth</i>	9951	–	1708	–	11 659
<i>Out-of-pocket</i>	1581	–	902	344	2827
<b>Funding gap</b>	<b>5655</b>	<b>22 147</b>	<b>4533</b>	<b>382</b>	<b>32 717</b>



# IMPLEMENTING ARRANGEMENTS

The implementing arrangements described in the original PhilSTEP1 2017–2022 are mostly unchanged in the updated Elimination Plan. Oversight will be provided at the national level by the TB NCC, chaired by the DOH Secretary. Similar structures with multisectoral representation will be developed at the regional level through Regional Coordinating Committees and at the local level through Provincial Coordinating Committees. A new development that will impact the previous arrangements will be the implementation of UHC with integration of health systems at province-wide and city-wide health-care provider networks. Hence, TB services will be organized by LGUs within these networks and this should not be limited to technical integration, but also address the financial, governance and human resource components.

The dissemination of this update will be led by the Centers for Health Development (CHD) through their respective Regional Coordinating Committees.

## **Annex 1. Task Force on PhilSTEP1 Updating**

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Technical Assistance:

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Global Fund Proposal: Eric Camacho (CLAimHealth)

CLAimHealth	Collaborating, Learning and Adapting for improved Health
DOH-NTP	Department of Health-National TB Control Program
HRH2030	Human Resource for Health 2030
IHSS	Innovations and Health Systems Strengthening
MTaPS	Medicines, Technologies and Pharmaceutical Services
NTRL	National Tuberculosis Reference Laboratory
NTP	National Tuberculosis Control Program
PBSP-GF	Philippine Business for Social Progress-Global Fund
PHILCAT	Philippine Coalition Against Tuberculosis
RITM-NTRL	Research Institute for Tropical Medicine- National TB Reference Laboratory
TASC	Technical Assistance Support to Countries
TBP	TB Platforms
USAID	United States Agency for International Development
WHO	World Health Organization



## Annex 2. Estimation of Updated PhilSTEP1 Targets

The following were the key considerations and assumptions used for estimating the targets:

1. The major considerations for setting targets were baseline performance, resources available and targeted decline in incidence.
2. Decreasing annual incidence rate from 554 (baseline) to 488 per 100 000 in 2023 is based on WHO projections.
3. To get the target for notification (all forms), there was an assumed increasing treatment coverage rate from baseline of 60% (2019) to 90% by 2023 (i.e. 75–80% to 85–90%)
4. To get the DR-TB notification target, an estimate was developed from the target for notification, using the following:
  - a. 87% of total notifications are new and 13% are retreatment
  - b. To get estimated MDR-TB, prevalence of MDR-TB among new is 1.8% and among retreatment is 16.6% (Drug Resistance Survey 2018 interim results)
  - c. DR-TB treatment coverage target increasing from 36% (baseline) to 71% by 2023 (i.e. 52–56%–64%– 71%)
5. To get the target for testing, an estimate was developed from target notification using the following:
  - a. A portion of TB notification was assumed to be detected without undergoing testing (i.e portion of children, portion of mandatory notification from private providers)
  - b. Among those TB cases who will be tested, we used number to test to get 1 TB case which is increasing from 7:1 in 2020 to 10:1 in 2023. The increase in the number needed to test to get 1 TB case is due to more active case finding activities in later years as a result of screening many asymptomatic patients.
6. Presumptive TB are identified from four different modes of screening:
  - a. Baseline of presumptive TB tested (2018) was assumed to be mainly from passive case finding and increased by 2% per year until 2023.
  - b. The remaining balance of the target for testing was divided into intensified case finding (50%), active case finding (20%) and enhanced case finding (30%).
  - c. Passive case finding and enhanced case finding is screening by symptoms, while intensified case finding and active case finding is screening by chest X-ray.
7. To get the target for screening, we used number to screen with symptoms to get 1 presumptive TB which is 1:15 (7%), while number to screen by chest X-ray to get 1 presumptive TB is 1:8 (12%).
8. To get target for TB preventive treatment (TPT), TPT coverage (as % of notified TB cases) was set from a baseline of 5% among contacts (2018) to 60% by 2023 (i.e. 15–25% to 40–60%). Note here that WHO estimates for TPT eligible population is 75% of total notifications annually.

## Annex 2. (continued) Estimation of Updated PhilSTEP1 Targets

Based on considerations above, this table shows the estimate of main outputs (as stated in the updated PhilSTEP1 objectives). The cumulative total for the original 2017–2022 period is shown, which includes actual accomplishments for 2017–2019 and targets for 2020–2022. The targets presented in the narrative are rounded off whenever applicable.

PHILSTEP1 TARGETS	2020	2021	2022	2023	Total 2020–2023	Total 2017–2022	Assumptions/ computation
Population	109 908 955	111 835 329	113 800 381	115 507 387			
Predicted incidence rate (per 100 000)	537	526	510	488			For targeting purposes, used flat/fixed incidence rate (from WHO 2019 Global TB Report)
Target treatment coverage	75%	80%	85%	90%			Baseline is 63% (2019)
Target case notification rate	416	443	471	499			(Incidence rate) X (treatment coverage)
<b>Target notification, all forms</b>	<b>442 658</b>	<b>470 603</b>	<b>493 325</b>	<b>507 308</b>	<b>1 913 894</b>	<b>2 510 784</b>	(Pop) X (Incidence rate) X (Treatment coverage)
Children	53 119	56 472	59 199	60 877	229 667		(Target, all forms) X (% children, 12%)
Not tested among children	39 839	42 354	44 399	45 658	172 251		(Children) X (% child TB not tested, 75%)
Adult	389 539	414 131	434 126	446 431	1 684 227		(Target, all forms) X (% adults, 88%)
Not Tested among adults, i.e. from mandatory notification (MN)	52 588	66 261	65 119	55 804	239 772		(Adults) X (% Adults from MN) X (% from MN not tested) ➤ by 2023, 25% of total notification will be from MN and 50% of MN will not be tested bacteriologically. ➤ Increasing % of MN and decreasing, % from MN not tested from 2020 to 2023.
Number of notified that were bacteriologically tested	350 231	361 988	383 807	405 847	1 501 872		(Target, all forms) less (children not tested) less (adults not tested)
Number to test to get 1 TB Case	7	8	9	10			15% (1/7) of tested are diagnosed with TB in 2020 and 10% (1/10) in 2023. Decreasing positivity/diagnosis rate based on more ACF activities in later years.
<b>Presumptive to be tested</b>	<b>2 451 619</b>	<b>2 895 903</b>	<b>3 454 259</b>	<b>4 058 468</b>	<b>12 860 249</b>	<b>12 153 371</b>	(No. notified that were bacteriologically tested) X (No. to test to get 1 TB case)

Annex 2. (continued) Estimation of Updated PhilSTEP1 Targets (Con't)

PHILSTEP1 TARGETS	2020	2021	2022	2023	Total 2020-2023	Total 2017-2022	Assumptions/ computation
Population testing rate	2.2%	2.6%	3.0%	3.5%			(Presumptive tested) divided by (population)
Presumptive TB identified by passive case finding	953 700	972 774	992 229	1 012 074	3 930 778		Estimated a 2% increase per year based on a baseline performance in 2019 (baseline = 935 000)
Presumptive TB identified by systematic screening	1 497 919	1 923 129	2 462 030	3 046 393	8 929 471		(Presumptive to be tested) less (Presumptive by passive case finding). Reflects total of ACF, ICF, ECF.
➤ Presumptive TB identified by ICF	748 959	961 565	1 231 015	1 523 197	4 464 736		50% of presumptive by systematic screening
➤ Presumptive TB identified by ACF	299 584	384 626	492 406	609 279	1 785 894		20% of presumptive by systematic screening
➤ Presumptive TB identified by ECF	449 376	576 939	738 609	913 918	2 678 841		30% of presumptive by systematic screening
<b>No. to Screen by chest x-ray</b>	<b>8 388 345</b>	<b>10 769 522</b>	<b>13 787 366</b>	<b>17 059 803</b>	<b>50 005 038</b>		(Presumptive, ACF) + (Presumptive, ICF) X 8 chest X-ray: 1 presumptive
Population chest X-ray screening rate	8%	10%	12%	15%			(Chest X-ray screening) divided by (population)
<b>Number to screen by symptoms</b>	<b>21 046 135</b>	<b>23 245 691</b>	<b>25 962 576</b>	<b>28 889 882</b>	<b>99 144 283</b>		(Presumptive, passive) + (Presumptive, ECF) X 15 Symptom screen: 1 presumptive
Population Sx (symptom) screening rate	19%	21%	23%	25%			(Sx screening) divided by (population)
<b>TOTAL screened</b>	<b>29 434 480</b>	<b>34 015 213</b>	<b>39 749 943</b>	<b>45 949 685</b>	<b>149 149 321</b>		Total of chest X-ray and symptom screening
Population screening rate	27%	30%	35%	40%			(Chest X-ray + Sx screening) divided by (population)
estimate MDR-TB from target notified, all forms	16 485	17 525	18 371	18 892	71 273		Among total notified, 87% estimated to be new and 13% retreatment. Prevalence of RR-TB is 1.8% among new and 16.6% among retreatment.
Treatment coverage for DR-TB	52%	56%	64%	71%			Baseline is 34% (2019)

Annex 2. (continued) Estimation of Updated PhilSTEP1 Targets (Con't)

PHILSTEP1 TARGETS	2020	2021	2022	2023	Total 2020-2023	Total 2017-2022	Assumptions/ computation
DR-TB notification	8500	9900	11 700	13 500	43 600	50 391	(Pop.) X (DR-TB incidence rate) X (Treatment coverage)
LTBI treatment targets	66 399	117 651	197 330	304 385	685 764	390 990	(Service target %) X (Target, all forms) Annual Service targets: 15-25% to 40-60% (WHO estimates that 75% of total notifications per year eligible for TPT. Baseline is 9000 TPT in 2018)
TSR, DS-TB	≥90%	≥90%	≥90%	≥90%			Baseline is 91% (cohort of 2017)
TSR, DR-TB	71%	75%	85%	85%			Baseline 58% (cohort of 2015)



### Annex 3. Timelines of key activities per strategy

KEY ACTIVITIES		2020	2021	2022	2023
<b>STRATEGIES ON SCREENING</b>					
<b>STRATEGY 1: Intensified case finding (ICF)</b>					
Expand chest X-ray voucher system					
Inclusion of chest X-ray benefit in PhilHealth package under UHC					
Health-care worker surveillance					
Online reporting system for workplace chest X-ray screening					
Develop regulatory policies for mandatory reporting of chest X-ray census and results					
Adoption of ICF approach in hospitals					
<b>STRATEGY 2: Active case finding (ACF)</b>					
Develop policy on use of digital chest X-ray and artificial intelligence for reading					
Guidelines on how to conduct ACF (and ICF)					
Outsourcing chest X-ray provider, or deployment of one-stop mobile chest X-ray with RDT (1 per province-wide/citywide health system)					
Social and behavior change campaign for ACF					
<b>STRATEGY 3: Enhanced case finding (ECF)</b>					
Professionalize community volunteers (capacity-building and incentives) as TB navigators					
Develop capacity-building program and tools for TB navigators					
Formation and capacity-building of patient support groups					
Community-based sputum collection and transport					
Expand and scale up pharmacy referral for identified presumptive TB					
<b>STRATEGY 4: Contact investigation</b>					
Integrate contact investigation in ACF and ICF					
Utilize NDPs and TB navigators for contact investigations and sputum collection					
Expand use of TST (or IGRAs) for screening of LTBI					

### Annex 3. Timelines of key activities per strategy (Con't)

KEY ACTIVITIES	2020	2021	2022	2023
<b>STRATEGIES ON TESTING AND DIAGNOSIS</b>				
<b>STRATEGY 5: Push mandatory notification</b>				
Dissemination and implementation of TB Law and IRR (mandatory notification)				
Development of administrative order on mandatory TB notification				
Develop reporting platforms for notification				
Deployment of TB notification project associates in regions				
Enhancement of referral mechanisms between facilities				
Explore notification from pharmacies and bacteriologic laboratories				
Diagnostic connectivity for private laboratory notification				
Engagement of professional societies, private hospitals and private physicians				
Incentive schemes for private sector notification (e.g. through PhilHealth)				
<b>STRATEGY 6: RDT expansion and utilization</b>				
Sustain and establish additional RTDLs through procurement and placement of RDT machine and consumables (e.g. cartridges)				
Simplification of diagnostic algorithm				
Provision of additional STRiderS to include private facilities as catchment				
Diagnostic connectivity for TB laboratories and treatment facilities				
Capacity-building of health providers (public and private)				
Establish and sustain quality assurance mechanisms and ensure equipment maintenance for TB laboratories				
Sustain and expand private sector laboratory consortium				
Laboratory Network Strategic Plan (LNSP) implementation and monitoring (Road map for expansion of rapid molecular testing)				
Operational researches on RDT among pediatric patients using extrapulmonary specimens				
<b>STRATEGY 7: LPA/DST Optimization</b>				
Increase capacity of LPA and phenotypic DST labs (additional LPA sites)				
Establish additional LPA laboratories				
Optimize specimen transport systems for LPA and culture centers				
Capacity-building of laboratory workers				

### Annex 3. Timelines of key activities per strategy (Con't)

KEY ACTIVITIES	2020	2021	2022	2023
Quality assurance and equipment maintenance				
<b>STRATEGY 8: Improving quality of diagnosis</b>				
Assessment of clinical diagnosis of TB				
Social and behavior change communication for private and public providers				
Development and dissemination of technical guidelines				
Capacity-building for HCWs on clinical diagnosis				
Coordinate with radiologists to standardize chest X-ray reading				
<b>STRATEGIES ON TREATMENT</b>				
<b>STRATEGY 9: Province-wide/citywide HCPN providing full continuum of TB care</b>				
Mapping of health facilities providing various TB services				
iDOTS expansion plan (capacity-building of primary HCWs in DR-TB treatment)				
Establish the HCPN with referral network				
Implement iDOTS with overall HCPN implementation				
Implement integrated approach for co-morbidity management				
Intensive monitoring and mentoring of iDOTS facilities				
Revised certification process for facilities and HCPN				
SBCC for providers and patients				
Sustain and enhance integrated TB information system				
<b>STRATEGY 10: Adopt patient-centered care</b>				
Implement patient-centered TB care package				
Adoption of community- and home-based treatment				
Establish patient support groups and pool of treatment supporters				
Develop reporting system on patient experience (feedback)				
Interventions to assess and improve quality of care/treatment (e.g. mortality review, continuous quality improvement)				
Rollout of shorter all oral regimens for DR-TB				
Implement novel tools to improve adherence (digital adherence tools)				

### Annex 3. Timelines of key activities per strategy (Con't)

KEY ACTIVITIES	2020	2021	2022	2023
Provide social protection measures, enablers				
<b>STRATEGY 11: Strengthen aDSM</b>				
Issuance of policy on aDSM				
Develop and implement aDSM reporting system				
Capacity-building of health workers on aDSM				
regular conduct of causality analysis				
Monitoring and mentoring in TB facilities				
Collaboration with DOH-PD and FDA for aDSM implementation				
<b>STRATEGY 12: TB-HIV collaboration</b>				
Whole package of services for TB- HIV developed				
Rollout of PICT nationwide				
TB screening in PLHIV (may be integrated in screening/ICF)				
Guidelines, plans and implementation of integrated use of Xpert for TB diagnosis and HIV viral load testing				
<b>STRATEGIES FOR PREVENTION</b>				
<b>STRATEGY 13: Adopt short TB preventive treatment (TPT)</b>				
TPT policy review and issuance (part of MOP)				
Develop road map for TPT strategy				
Introduction and scale-up use of 3HP and other shorter regimens				
Monitoring TPT implementation (including reporting from private sector)				
Development and dissemination of SBC package for provider specific and client specific				
<b>STRATEGY 14: Infection prevention and control capacity-building, certification and monitoring</b>				
Promotion of infection prevention and control e-modules				
Development/updating of TB Infection Control compliance checklist				
Monitoring and supervision on IPC				
Updating of TB facility certification process				
Infection control e-training certificate as part of revised certification requirement				

## Annex 4. Monitoring and evaluation matrix

### Impact targets

	BASELINE	BASELINE YEAR	2020	2021	2022	2023	Remarks
TB deaths	26 000	2018	24 180	23 485	22 760	21 940	WHO projections
Incidence rate	554	2018	537	526	510	488	WHO projections
% households with catastrophic costs	35%	2016				0%	Based on catastrophic cost study (20% of household income)
Patient satisfaction	96%	2018				>=95%	Based on MEASURE evaluation (method for determining this indicator in 2022–2023 should be same as baseline, but additional coverage of private for the “PhilSTEP2” baseline.

### Outcome targets

	2019	2020	2021	2022	2023	Total 2020–2023
<b>SCREENING TARGET (CHEST X-RAY)</b>		<b>8 388 345</b>	<b>10 769 522</b>	<b>13 787 366</b>	<b>17 059 803</b>	<b>50 005 038</b>
(Population chest X-ray screening rate)		[8%]	[10%]	[14%]	[17%]	
<b>TESTING TARGET</b>	<b>1 083 867</b>	<b>2 451 619</b>	<b>2 895 903</b>	<b>3 454 259</b>	<b>4 058 468</b>	<b>12 860 249</b>
(Population testing rate)	[1%]	[2.3%]	[2.7%]	[3.3%]	[4.0%]	
<b>NOTIFICATION TARGET (All)</b>	<b>403 757</b>	<b>442 658</b>	<b>470 603</b>	<b>493 325</b>	<b>507 308</b>	<b>1 913 894</b>
(Treatment coverage)	[67%]	[75%]	[80%]	[85%]	[90%]	
<b>DRTB NOTIFICATION TARGET</b>	<b>6510</b>	<b>8500</b>	<b>9900</b>	<b>11 700</b>	<b>13 500</b>	<b>43 600</b>
(DR-TB treatment coverage)	[36%]	[52%]	[56%]	[64%]	[71%]	
<b>LTBI TARGET</b>		<b>66 399</b>	<b>117 651</b>	<b>197 330</b>	<b>304 385</b>	<b>685 764</b>
(% of total notification)		[15%]	[25%]	[40%]	[60%]	
<b>TSR, all forms (new and notification)</b>		<b>≥90%</b>	<b>≥90%</b>	<b>≥90%</b>	<b>≥90%</b>	
<b>TSR, DR-TB</b>		<b>71%</b>	<b>75%</b>	<b>85%</b>	<b>85%</b>	



#### Annex 4. Monitoring and evaluation matrix (Con't)

##### Performance (output) targets

INDICATOR (Performance Target)	BASELINE	BASELINE YEAR	2020	2021	2022	2023	Remarks
(1) Number of people screened by chest X-ray in HF, ICF (Strategy 2)	no data		6 302 122	8 309 134	11 040 177	14 381 138	50% of presumptive TB from systematic screening
(2) Number of people screened by chest X-ray, ACF (Strategy 1)	no data	-	2 520 849	3 323 654	4 416 071	5 752 455	Will result to 20% of target presumptive TB from systematic screening [outside passive case finding]
(3) No. of presumptive TB identified by CSO, PSG, CBO, CV (Strategy 3)	17%*	2019	472 659	623 185	828 013	1 078 585	*No data for presumptive identified by community. But 17% of total notified TB cases referred by community. 30% of presumptive TB from systematic screening. This contributes to output indicator in testing but included here because no data source for number screened by symptoms.
(4) % of contacts screened with symptoms or chest X-ray (Strategy 4)	5%*	2018	50%	65%	80%	90%	*no data on % contact investigated. But in 2018, 5% of eligible contacts given TPT (WHO 2019)
(5) % of mandatory notification contribution to total notification (Strategy 5)	18%	2019	20%	25%	30%	30%	18% baseline is mostly from Regions 3 & 4, and the National Capital Region. With target increase in cases from other regions, MN contribution might slightly decrease in 2020 while roll-out of MN in these regions ongoing.
(6) % of notified new and relapse tested with RDT	36%	2018	60%	70%	80%	90%	% of presumptive TB tested with RDT (including RIF susceptibility testing) (Strategy 6) [will be a process indicator]

Annex 4. Monitoring and evaluation matrix (Con't)

INDICATOR (Performance Target)	BASELINE	BASELINE YEAR	2020	2021	2022	2023	Remarks
(7) % of RRTB notified that are tested with FL and SL rapid DST (Strategy 7)	94%*	2019	85%	90%	95%	95%	*Only for single-line LPA. The target will include both first-line and second-line LPA, and among all notified (not enrolled RR-TB).
(8) % of BCTB cases among notified TB cases (Strategy 8)	33%	2019	40%	50%	60%	70%	Baseline includes both DOTS-facility registered and MN (to be adjusted after clinically diagnosed TB assessment)
(9) Enrollment rate of diagnosed DR-TB (Strategy 9)	85% (baseline only from PMDT facilities- TC/STC)	2019	85%	90%	95%	95%	5% estimated loss from pretreatment death, and lost to follow-up Accomplishment should include both PMDT facilities and mandatory notification
(10) % of primary care service delivery points (RHU/HC) fully implementing iDOTS	no data number of RHU/HC that are STC	-	30%	50%	85%	100%	Plan for iDOTS phase 2 is ongoing development – will provide details on definition, checklist, etc.
(11) % of TB service delivery points submitting timely ITIS reports (Strategy 9)	97% (check)	2019	100%	100%	100%	100%	Refers to report on case-based data for treatment
(12) (12) % of TB patients on home- and community-based care (Strategy 10)	no data	-	75% 80%	80% 95%	85% 100%	90% (DRTB) 100% DSTB	this refers to the daily treatment (formerly DOT) for DR-TB, those on ITR with second line injectable and some difficult to manage cases may be treated in health facilities
(13) % of TB facilities reporting aDSM (Strategy 11) Eligible, using new drugs	12%	2019	50%	75%	90%	100%	Zero reporting should be practiced by facilities Facilities are "DOTS facilities"

Annex 4. Monitoring and evaluation matrix (Con't)

INDICATOR (Performance Target)	BASELINE	BASELINE YEAR	2020	2021	2022	2023	Remarks
(14) % of TB patients with known HIV status (Strategy 12)	27%	2018	35%	60%	80%	90%	15 years old and above TB patients; both TB facility registered  (exclude MN for now, will ask National AIDS and STI Prevention and Control Program how private sector reports testing and HIV notification)
(15) TPT coverage rate, contacts (Strategy 13)	5%	2018	15%	25%	40%	60%	Eligible contacts all ages (<5 both BC and CD index; >=5 BCTB index) "service target"
(16) TPT coverage rate, PLHIV (Strategy 13)	52%	2018	65%	70%	75%	80%	Coverage = number given TPT/number eligible among PLHIV
(17) % of TB facilities complying with infection control guidelines (Strategy 14)	no data	–	70%	80%	90%	100%	facilities are DOTS facilities





**NATIONAL TUBERCULOSIS CONTROL PROGRAM  
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