HEALTH SECTOR REFORM AGENDA

Updated 2010-2016 Philipine Plan of Action to Control Tuberculosis (PhilPACT)



National TB Control Program

UPDATED 2010–2016 PHILIPPINE PLAN OF ACTION TO CONTROL TUBERCULOSIS

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NATIONAL TB CONTROL PROGRAM

UPDATED 2010–2016 PHILIPPINE PLAN OF ACTION TO CONTROL TUBERCULOSIS

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FOREWORD

The 2010–2016 Philippine Plan of Action to Control TB or PhilPACT was formulated through a participatory process to serve as the country's road map in reducing the problem of tuberculosis. It was issued by the Department of Health (DOH) through Administrative Order 2010-0031. Consistent with the then Health Sector Reform Agenda, the plan contains four objectives, eight strategies and 30 performance targets. In his preface to the document, Secretary Enrique T. Ona states that "a sound strategy and a strong partnership between local government units, civil society, technical and financial partners are the keys to the success of the plan."

Three years had passed since PhilPACT was initiated in 2010 under the leadership of the DOH through the National TB Control Program (NTP). Its monitoring and evaluation framework provides for a stakeholder-participated midterm-evaluation in early 2013. In calling for this assessment, NTP took note of other reasons; (a) the DOH Universal Health Care or *Kalusugang Pangkalahatan* strategy was formulated and executed after the issuance of PhilPACT in early 2010 and numerous health initiatives had been introduced since then, (b) the World Health Organization (WHO) updated its guidelines on TB diagnosis, treatment and reporting, both for susceptible and multi-drug resistant TB, including the use of rapid TB diagnostic tools, (c) additional resources from international partners had been mobilized for TB control, and (d) a WHO-organized external NTP review was planned in mid-2013, five years after it was last conducted.

The processes of review and subsequent revision of PhilPACT, led by the NTP, started with the consultation with the members of the PhilPACT Steering Committee and the Technical Working Group who advised on the process and format of the updated report. Four sub-plans for 2014–2016 that contain specific challenges and approaches to address them were formulated, namely, (a) laboratory network, (b) PMDT, (c) TB and HIV collaboration, and (d) NTP health system strengthening. A long term NTP consultant assisted NTP in developing the first draft of the updated PhilPACT based on initial assessment that underwent critical review of stakeholders in June 6–7, 2013. This resulted in a revised version a month later. This revised document became the basis for the development of a concept note submitted to The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) in July 2013.

In mid-August, 2013, the 17 Center for Health Development reported on the regional status of PhilPACT implementation. Afterwards, the Joint Program Review (JPR) was conducted from August 26 to September 5, 2013 with 80 individuals from international and local organizations participating. The participants were divided into seven teams. They analyzed documents, interviewed key informants and visited 14 provinces and cities from 8 regions. The results and recommendations of these reviews were then incorporated into the July 2013 version of the PhilPACT. Another round of stakeholder consultation was conducted on October 24–25, 2013. The stakeholders reviewed the consolidated results of the review, the revised targets and activities and the monitoring and evaluation plan. A financing expert led the costing of the updated PhilPACT based on agreed financing assumptions. In December 2013, the NTP conducted a three-day harmonization workshop for technical assistance and research initiatives of different partners. The draft updated plan was revised by the consultant and again reviewed by stakeholders last February 14, 2014 led by NTP who endorsed the finalization of the said plan.

This updated PhilPACT will guide the country as it intensifies its efforts to control TB in 2014–2016. Per the original document, "expected users are policy makers, managers of TB control program at all levels, implementers, local and international partners, and everyone who dreams of and is committed to working towards a TB-free Philippines."

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PREFACE

Attaining the Millennium Development Goals in 2015 is one of the three strategic directions of the Universal Health Care. The control of tuberculosis, a major health problem for decades in the country, falls under MDG number 6. This 2010–2016 Philippine Plan of Action to Control Tuberculosis (PhilPACT) succinctly describes the strategies and activities that our country must pursue to control tuberculosis. I am proud to say that based on the estimates of the World Health Organization in its 2013 Global TB Report, the Philippines is one of the seven countries that have achieved the targeted reduction of TB incidence, mortality and prevalence two years prior to 2015. Definitely, this is a result of a multi-stakeholder collaboration based on a clear strategic plan.

Despite this major achievement, the 2013 mid-term review of NTP revealed that a TB patient still faces barriers in seeking TB diagnostic and treatment services. This updated PhilPACT considered all the recommendations to address this problem. It refocused key approaches and activities to expand access to TB care especially to the vulnerable populations such as the poor, indigenous people, children, and victims of disasters. The use of rapid diagnostic tools that detect drug resistance within two hours instead of three months will be scaled up. Intensified case finding strategy will be pursued to promptly detect and treat TB cases, hence, stop the transmission of TB.

We call again on our local and international partners to support the implementation of this updated PhilPACT in 2010–2016 as we accelerate our efforts towards our vision of a TB-free Philippines. Let this be our contribution to our dream of healthy and productive Filipinos.

Enrique T. Ona, MD, FPCS, FACS
Secretary of Health

ABBREVIATIONS AND ACRONYMS

ACSM	Advocacy, Communication, and Social Mobilization
AIDS	Acquired Immunodeficiency Syndrome
AO	administrative order
ARMM	Autonomous Region in Muslim Mindanao
BHS	barangay health station
BHW	barangay health worker
BIHC	Bureau of International Health Cooperation
BJMP	Bureau of Jail Management and Penology
BLHSD	Bureau of Local Health Systems Development
BuCor	Bureau of Corrections
CBO	community-based organization
CDR	case detection rate
CHANGE	Communicationfor Health Advancement thru Net working and Governance Enhancements
CHO	city health office/officer
CHT	community health team
CIPH	City Investment Plan for Health
CNR	case notification rate
CR	cure rate
DCAT	DOTS compliance and assessment tool
CUP	Comprehensive Unified Policy
DepEd	Department of Education
DILG	Department of the Interior and Local Government
DOH	Department of Health
DOJ	Department of Justice
DOLE	Department of Labor and Employment
DOT	directly observed treatment
DOTS	directly observed treatment, short-course
DPCB	Disease Prevention and Control Bureau
DRS	drug resistance survey
DSSM	direct sputum smear microscopy
DST	drug susceptibility test
DSWD	Department of Social Welfare Development
EB	Epidemiology Bureau
EO	executive order
EQA	external quality assurance
ETR	electronic TB registry
FAP	foreign-assisted project
FHSIS	Field Health Services Information System
FLD	first line anti-TB drugs
FP	family Planning
GAA	General Appropriations Act
GDF	Global Drug Facility
GIDA	geographically isolated and depressed area
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOFAR	Good Practices in Local Governance: Facility for Adaptation and Replication
HC	health center

HCP	health care provider
HEPO	Health Education and Promotion Officer
HFSRB	Health Facilities and Services Regulatory Bureau
HFDB	Health Facility Development Bureau
HIV	human immunodeficiency virus
HPCS	Health Promotion and Communication Service
HPDP	Health Policy Development Program
HPDPB	Health Policy Development and Planning Bureau
HUC	highly urbanized city
IC	infection control
IDPCD	Infectious Disease Prevention and Control Division
IEC	information, education, and communication
ILHZ	Interlocal Health Zone
IPCC	Inter-Personal Communication Competence
ISTC	International Standards on TB Care
ITIS	integrated TB information system
JATA/RIT	Japan Anti-TB Association/Research Institute of TB
KMITS	Knowledge Management and Information Technology Service
LCE	local chief executive
LCP	Lung Center of the Philippines
LGU	local government unit
LNSP	laboratory network strategic plan
MC	microscopy center
MDG	millennium development goal
MDR-TB	multidrug-resistant tuberculosis
ME3	monitoring and evaluation for effectiveness and equity
MHO	municipal health office/officer
MNCHN	Maternal, Neonatal, Child Health and Nutrition
MOP	manual of procedures
MSA	Multi-Sectoral Alliance
NASPCP	National AIDS/STI Prevention and Control Program
NCC	National Coordinating Committee
NCIP	National Commission on Indigenous Population
NDHS	National Demographic Health Survey
NDP	Nurses Deployment Program
NEDA	National Economic and Development Authority
NGO	non-government organization
NOSIRS	National Online Stock Inventory Reporting System
NPS/NTPS	National TB Prevalence Survey
NTP	National Tuberculosis Control Program
NTRL	National TB Reference Laboratory
OOP	out-of-pocket
PBG	performance-based grant
PCC	provincial coordinating committee
PIPH	Province-wide Investment Plan for Health
PhilCAT	Philippine Coalition Against Tuberculosis
PhilHealth/PHIC	Philippine Health Insurance Corporation
PhilPACT	Philippine Plan of Action to Control TB
PHO	provincial health office/officer
PHS	Philippine Health Statistics

PIR	program implementation review
PMDT	programmatic management of drug-resistant TB
PPMD	public-private mix DOTS
PQM	Promoting Quality of Medicines
PTSI	Philippine Tuberculosis Society, Inc.
QAS	quality assurance system
RCC	regional coordinating committee
RDC	Regional Development Council
RDT	rapid diagnostic test
RHM	Rural Health Midwife
RHO	Regional Health Office
RHU	rural health unit
RICT	Regional Implementation and Coordination Team
RITM	Research Institute and Tropical Medicine
RIT/JATA	Research Institute of TB / Japan Anti-TB Association
ROMP	Reaching Out to Most-at-risk Population
SDN	Service Delivery Network
SLB	Samahang Lusof Baga
SLD	second line anti-TB drugs
STC	satellite treatment center
TA	technical assistance
TASC	Technical Assistance to Support Country
TB	tuberculosis
TBDC	TB Diagnostic Committee
TB-DOTS OPB Package	TB-DOTS Outpatient Benefit Package
TB LINC	Linking Initiatives and Networking to Control TB
TBS	TB Symptomatic
TC	treatment center
TO	transferred out
TO	treatment outcome
TSR	treatment success rate
UHC	Universal Health Care
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
WPR	Western Pacific Region
ZFF	Zuellig Family Foundation

EXECUTIVE SUMMARY

To assess the progress of the 2010–2016 Philippine Plan of Action to Control Tuberculosis (PhilPACT), a mid-term review was conducted in 2013 in coordination with international and local partners. Methodologies include review of documents, analysis of performance of the 17 regions, conduct of the joint program review (JPR) and validation of findings and recommendations with stakeholders. The mid-term review revealed the following; (a) impact targets such as TB prevalence, incidence and mortality has been achieved, (b) outcome target such as treatment success rate (TSR) has been achieved, (c) among the output targets, one has been achieved, two are on track while two are lagging behind; (d) among the 30 performance targets, 50% has been achieved or on track to be achieved, 33% are lagging behind and 17% had incomplete or no data. The JPR noted the significant accomplishments of the program especially in increasing TB notification rate, but noted existing challenges in terms of detecting and treating TB cases and enabling the environment.

For 2010–2016 implementation of the PhilPACT, the strategic thrust will be to (a) find the missing TB cases through expansion of diagnostic facilities and use of rapid diagnostic tests, full engagement of the private providers and hospitals and adoption of intensified case finding especially for the vulnerable populations; (b) expand PMDT facilities to improve access, hence, detect and treat more MDR-TB cases; (c) enhance services for the vulnerable populations who have higher risk of developing TB such as those with TB-HIV co-infection, the poor and children; (d) improve the human resource, logistical and information systems, and (e) strengthen the managerial capacity of all program managers. The four objectives and eight strategies had been retained but there are changes on the impact, outcome and output targets. Among the original 30 performance targets, one was deleted, three were added and 16 were modified.

The following are the strategies and performance targets of the updated 2010–2016 PhilPACT:

Objective	Strategy	Performance Target
Reduce local variation in TB control program performance	1. Localize implementation of TB control	1.1. Eighty percent (80%) of provinces and highly urbanized cities (HUCs) include TB control plan based on a set criteria within the Province-wide Investment Plan for Health (PIPH) or ARMM Investment Plan for Health (AIPH) or City Investment Plan for Health (CIPH) 1.2. Seventy percent (70%) of provinces and highly urbanized cities (HUCs) are at least DOTS compliant 1.3. Ninety percent (90%) of provinces and HUCs given performance-based grants (PBGs) have achieved and sustained program targets (CDR and TSR) 1.4. At least 70% of national, regional, provincial, and HUC teams have been trained and supported to manage TB control program 1.5. All public-private (PP) coordinating bodies at the national and regional and 70% at the provincial levels/ HUC have been established and sustained to include CUP mechanisms
	2. Monitor health system performance	2.1. Trend of TB burden tracked 2.2. TB information generated on time, analyzed, and used 2.3. TB information system integrated with the DOH Unified Health Management Information System

Objective	Strategy	Performance Target
Scale up and sustain coverage of DOTS implementation	3. Engage both public and private health care providers	3.1 At least 50% of all provinces and HUCs have functional province/city-wide referral system 3.2. 90% of public hospitals and 65% of private hospitals are participating in TB control either as DOTS provider or referring center 3.3. Fifteen percent (15%) of notified TB cases contributed by the private providers 3.4. All DOTS facility staff are equipped to deliver TB services
	4. Promote and strengthen positive behavior of the communities	4.1. Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30% 4.2. 95% of provinces and 70% of HUCs with less than 5% lost to follow-up 4.3 At least 10% of all notified TB cases contributed by the CBOs/CHTs/BHWs
	5. Address MDR-TB, TB/ HIV, and needs of vulnerable population	5.1. A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs 5.2. At least 75% of MDR-TB patients are successfully treated 5.3. At least 80% of registered TB cases in HIV Category A and B areas and drug resistant cases are provided with HIV counselling and testing 5.4. 730,000 children are initiated with anti-TB treatment or given INH preventive therapy 5.5. Jails/Prisons at all levels provide access to DOTS services to all inmates 5.6. Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable populations (DM, elderly, urban & rural poor, disaster affected areas)

Objective	Strategy	Performance Target
Ensure provision of quality TB services	6. Regulate and make available quality TB diagnostic tests and drugs	6.1. At least 95% of all TB microscopy laboratories within the NTP laboratory network are providing TB diagnostic services within EQA standards 6.2. TB microscopy services are expanded to improve access 6.3. Culture, DST and new technologies are scaled up 6.4. No stock-outs of anti-TB drugs (both FLD and SLD) and laboratory supplies in 90% of DOTS/laboratory facilities in the last six months
	7. Certify and accredit TB care providers	7.1 At least 70% of DOTS facilities are DOH/PhilCAT certified and PhilHealth accredited 7.2. DOTS standards/evidence for hospital engagement are included in DOH licensing and PhilHealth accreditation requirements 7.3. Infection control/laboratory biosafety measures in place in all DOTS/PMDT diagnostic & treatment facilities
Reduce out-of-pocket expenses related to TB care	8. Secure adequate funding and improve allocation and efficiency of fund utilization	8.1. Reduced redundancies and gaps by harmonizing financing of TB prevention and control 8.2. National government and PhilHealth funds leveraged to secure LGU commitments 8.3. PhilHealth's role expanded through greater availability of accredited providers and increased utilization of TB-DOTS package 8.4. Alternative funding models developed

The total cost of the plan had increased by 26% from the original cost of PhP23B to PhP29B. Strategies 5 and 6 account for 70% of the cost. The substantial increase of the budget for Strategy 5 is based on the funding requirements of the recently developed Laboratory Network Strategic Plan that contained activities to scale up rapid diagnostic tools and enhance various health systems. Funding sources are from foreign-assisted projects (44%), national government (23%), local government (19%), out-of-pocket (12%), and PhilHealth (2%). The estimated total funding gap is PhP8.1B.

The Monitoring and Evaluation plan was revised to reflect the changes in the impact, outcome, output and performance targets. The 4th National TB Prevalence Survey (NTPS) will be conducted in 2015 to determine the extent and trend of the TB burden and validate program accomplishments. A terminal evaluation of the PhilPACT will be done in early 2016.

There is no change in the implementing structure which will be through the National Coordinating Committee (NCC) at the national level, the Regional Coordinating Committee (RCC) at the regional level and the Provincial/City Coordinating Committee (P/CCC) at the provincial/city level.

RESULTS OF THE MID-TERM ASSESSMENT OF THE 2010–2016 PhilPACT

Below are the results of the mid-term assessment of PhilPACT done in 2013 and coordinated by NTP. The following methodologies were used: (a) review of documents, (b) key informant interviews, (c) analysis of regional performance, (d) epidemiological assessment, (e) site visits and validation during the joint program review by international and local agencies, and (f) consultation with stakeholders.

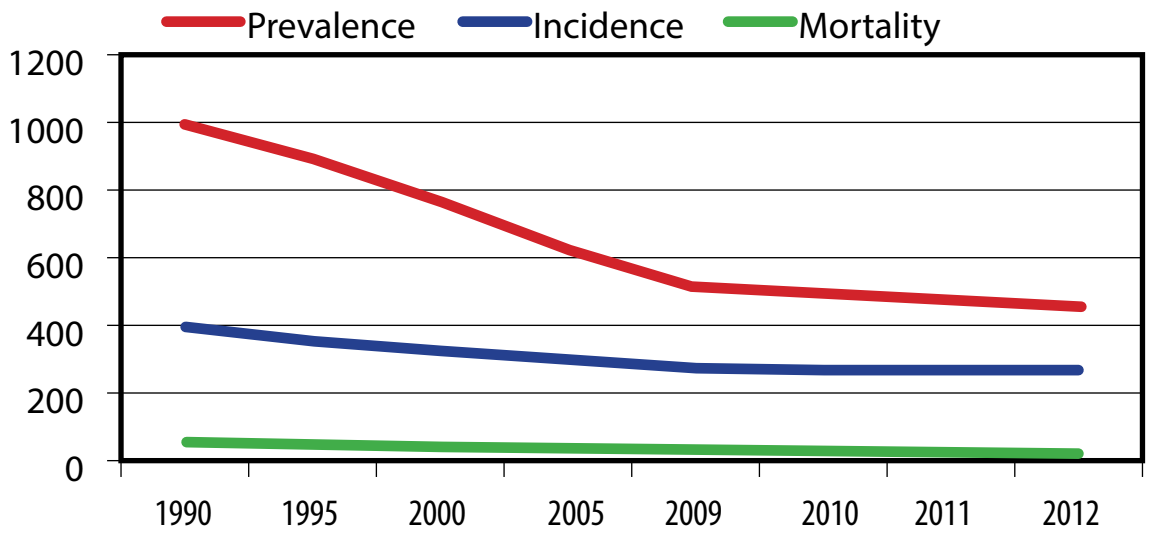
IMPACT TARGETS

The MDG Target 6C is to halt and begin to reverse the incidence of TB by 2015. In support of this, STOP TB strategy aims to reduce by 50% TB prevalence and mortality compared to 1990. These had been achieved, as shown in Table 1. According to the WHO 2013 Global TB report, the Philippines is one the seven countries that reached their target three years ahead of 2015. Figure 1 reveals the decreasing trend of the MDG targets.

Table 1. Status of TB Incidence, Prevalence and Mortality, 1990 and 2012

Indicators	2016 Target	1990 Baseline	2012 (WHO Estimate)	Percent Reduction/Status
Incidence Rate	Less than baseline	393/100,000	265/100,000	35.6% Achieved
Prevalence Rate	400/100,000	799/100,000 Recomputed: 1000/100,000	461/100,000	53.9% (vs. recomputed) Achieved
Mortality Rate	44/100,000	87/100,000 Recomputed 58/100,000	24/100,000	58.6% (vs. recomputed) Achieved

Figure 1. Trend of TB Incidence, Prevalence and Mortality 1990–2012



OUTCOME TARGETS

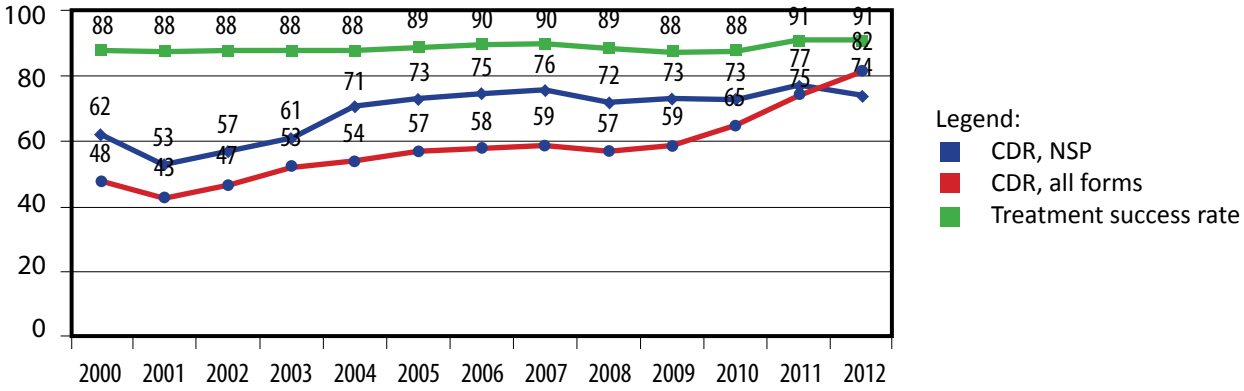
Of the three outcome targets, TSR had been achieved. However, the CDR, new smear positive and MDR-TB targets are not on track.

Table 2. Status of Outcome Indicators, 2012

Indicators	Target	Achievement	Status
Case detection rate, new smear positive	85%	74% (2012)	Not on track
Treatment success rate, new smear positive	90%	91% (cohort of 2011)	Achieved
MDR-TB	15,000 detected and initiated treatment from 2010–2016	From 2010–2012, a total of 3,367 MDR-TB had been detected and initiated treatment (22% of total target)	Not on track

The graph below shows an increasing performance of the program in terms of the CDR and TSR.

Figure 2. Trend of Outcome Indicators, 2000–2012



An epidemiological review was conducted in May 2013 as part of the JPR and the following observations were made:

"In 2012, there were 216,051 notified TB cases, all forms. Almost half are smear positive (NSP) TB cases. The case detection rate (CDR) of all forms and new smear positive had shown an increasing trend. From 62% in 2000, CDR of NSP had increased to 74% in 2012 while CDR of all forms increased from 48% in 2000 to 82% in 2012. CDR, all forms, had a faster rate of increase in the last three years mainly due to the increase in reported children with TB. Extrapulmonary cases remain low at less than 1.5% which could be attributed to non-participation of hospitals where they consult."

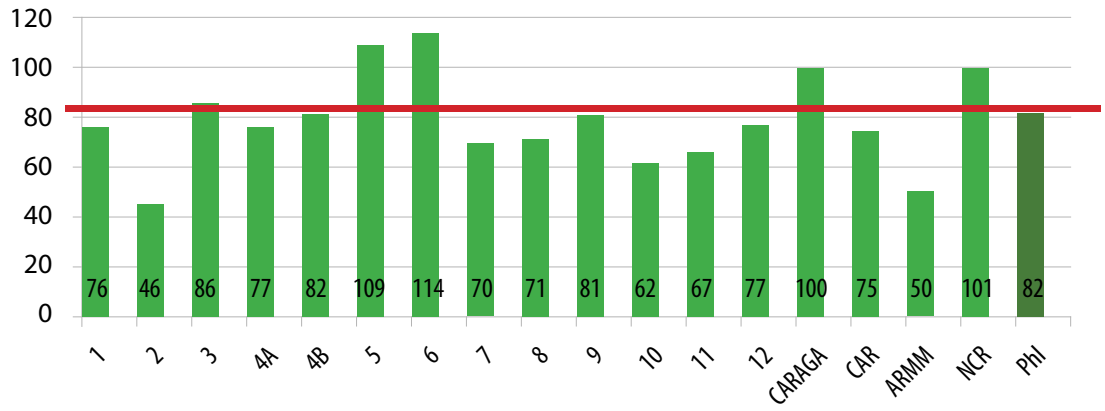
"Proportion of children with TB among the total notified TB cases ranged from 10% to 40%. This is most likely due to over-diagnosis since there is no confirmatory test among smear negative TB cases. There is a decrease in the smear positivity rate among TB symptomatic examined but overall smear positivity rate is still around 15%. This implies that case finding in general is not yet saturated."

The Joint Program Review (JPR) also noted that the national TB case notification rate (CNR) has steadily increased. The team stated that "factors contributing to this achievement have been the countrywide

engagement of all health RHU/HC in the DOTS program and engagement of other health care providers, such as public and private hospitals, private practitioners, prisons and jails and several NGOs. At the primary care level, case finding is facilitated by the availability of smear microscopy laboratories in most RHUs/HCs and the use of barangay health workers and community health teams for intensified case finding activities in remote areas."

However, the CDR, all forms, varied among the 17 regions as shown in Figure 3. It ranges from 46% to 118%. Five regions had achieved or even exceeded the 85% target. The top three performing regions are Regions 6, 5 and NCR.

Figure 3. Case Detection Rate, All Forms, By Region, 2012

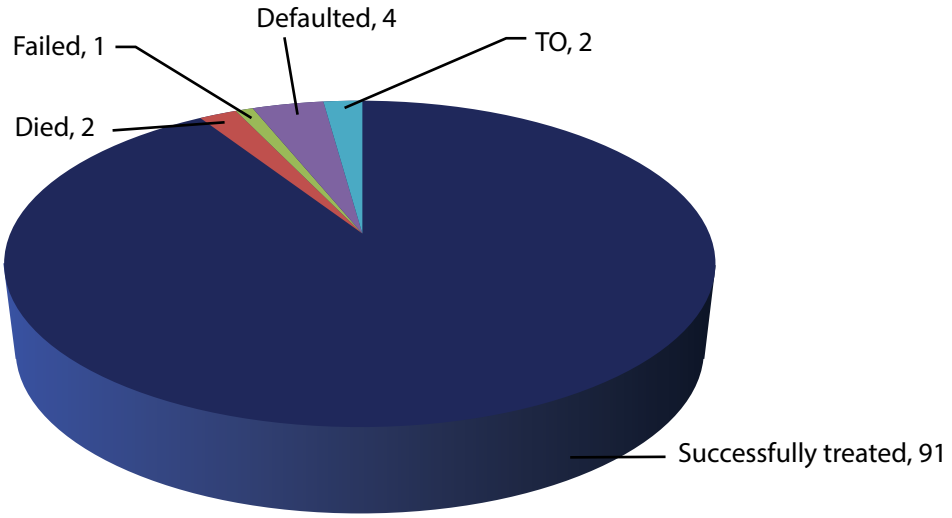


The JPR brought to NTP's attention the following challenges in case finding:

- Although case finding has generally increased, a large number of TB cases in the Philippines are still managed outside the NTP system, and thus remained unreported.
- Among the TB patients who reached DOTS facilities, many may not be diagnosed quickly or accurately. The smear-positivity rate is 15% nationally, with wide variance between LGUs and smear positivity rates of over 30% being common. High smear positivity may reflect a lack of awareness of TB symptoms or willingness to refer for TB diagnosis. TB symptoms may not be elicited among patients consulting the RHU for other illnesses.
- There is low proportion of extra pulmonary cases, and large variations in the proportion of children among detected TB cases. There was concurrent over-diagnosis of children in some regions and under-diagnosis of children in others, raising concerns about the adequate implementation of NTP diagnostic algorithms for children.
- Apart from insufficient reporting of diagnosed cases, many cases still remain undiagnosed due to persistent barriers to care. The NTP has not yet implemented systematic efforts to undertake active case finding to address the needs of vulnerable populations, particularly those living in remote areas. Stigma remains high in many areas of the country, and this situation is aggravated by the general lack of adequate IEC material, both in terms of information on TB for the general population, as well as in terms of specific information on treatment procedures for detected cases. The national policy on contact tracing is frequently not implemented.

Treatment outcome is generally good with treatment success rate (TSR) of more than 85% since year 2000, the latest (2011 cohort) being 91% as shown in Figure 4. Cure rate was 83%. However, there is variation among regions, provinces and cities. Default rate of more than 5% is registered by ARMM (11%), MIMAROPA (6%) and Davao (6%).

Figure 4. Treatment Outcome of 2011 New Smear Positive Cohort



JPR observed that the "countrywide implementation of the DOTS strategy has resulted in generally high TSRs, exceeding 90% in most areas. As part of the DOTS strategy, drugs are available to all patients free of charge. A majority of the staff at the RHU level have been trained in the DOTS strategy. The NTP guidelines regarding case classifications, drug regimens, follow-up examinations and treatment outcome determination are generally followed in all RHUs. The decentralization of treatment services to the community level ensures that all patients are assisted by treatment supporters."

The main challenge in case holding observed by the JPR is "while NTP guidelines on DOT are generally followed, resulting in high TSRs, supervision of treatment supporters is insufficient in some areas, increasing the risk of default or the creation of drug resistance through irregular treatment."

The following are the observations/conclusions regarding TB epidemiology in the country:

1. Impact of NTP on trend of mortality
   Assuming TB mortality data is comparable over time, it is observed that while TB CNR is increasing recently, TB deaths are decreasing. Decrease in TB deaths seems to be faster recently with increase in TB CNR. This may suggest that expanding quality DOTS has impact on the reduction of TB mortality. Although there might be several factors for mortality trend. Further analysis is needed such as by region, age group and sex for better understanding of the situation.
2. Impact of NTP on prevalence
   Prevalence of both smear positive and culture positive TB cases decreased between 1997 and 2007. Not only case finding but also good treatment might reduce prevalence of bacteriologically positive TB.
3. Impact of NTP on incidence
   Source of infection in community has decreased because prevalence of bacteriologically-positive cases decreased. This might contribute to reduction of TB incidence which comes from recent infection. Overall impact needs further assessment.
4. HIV
   Further information is required for non-NCR target areas. Prevalence of HIV among the examined in NCR is low. According to treatment outcome, impact of HIV is still not significant because death rate is not high in TB-HIV target areas. Because HIV may increase, monitoring the situation of co-infection need to be strengthened.

OUTPUT TARGETS

Of the five major outputs in terms of beneficiaries, three are on track to be achieved.

Table 3. Status of Output Targets

Indicators	Targets	Achievement (2010-2012)	Status
No. of presumptive TB to be provided with DSSM	5 million	1,790,000 (36%)	On track to be achieved
No. of TB patients to be provided with treatment	1 million	579,383 (58%)	On track to be achieved
No. of children to be provided with treatment or preventive therapy	750,000	87,936 (12%)	Not on track
No. of MDR-TB detected and provided with second line anti-TB drugs	15,000	3,367 (22%)	Not on track
No. of TB patient provided with PICT	15,000	8,623 (57%) tested	On track to be achieved

The target for children is disappointingly low due to the (a) erratic and limited compliance to the initiative of providing INH chemoprophylaxis to prevent children from developing fatal forms of TB and (b) weak implementation of case finding activities among children in some areas.

STATUS BY STRATEGY AND PERFORMANCE TARGETS

STRATEGY 1: Localize Implementation of TB Control

Table 4. Status of Performance Targets Under Strategy 1

Performance Target	Status as of End of 2012	Remarks
1.1. 70% of provinces and HUCs include clear TB control plan within the PIPH, CIPH and AIPH	81 provinces, 33 cities and ARMM incorporated their TB control plan within PIPH, CIPH and AIPH	Achieved but with undetermined quality of the TB control plan
1.2. 70% of provinces and HUCs are at least DOTS compliant	39% of those assessed in NCR, III, IV-A, 9, 10,11, 12, CARAGA and ARMM are DOTS compliant	Not on track
1.3. 90% of priority provinces and HUCs with performance based grants have achieved targets	No province nor HUC have accessed the NTP-PBG since as of end of 2012 this has not yet been implemented	Not on track
1.4. DOH and partners have capacity to provide TA to provinces and cities	Under the Regional Capacity Building Initiative of TB LINC all RHOs were trained	No data on the capacity of all RHOs and partners

Performance Target	Status as of End of 2012	Remarks
1.5. Public-private coordinating body on TB control at national, regional and provincial levels established and sustained to include CUP mechanisms	Revised AO issued on reconstitution of members and changes in functions of NCC and RCC National CUP group meeting conducted quarterly Two regions with reconstituted RCC 60 provinces with established provincial coordinating committee (PCC) or multi-sectoral alliance (MSA)	Not on track

Achievements

- DOTS compliance assessment tool (DCAT) was developed and used in the assessment of provinces and cities.
- Strong involvement, leadership and technical capability of the NTP central office.
- The technical capacity of staff across the NTP was consistently excellent. The achievements of the NTP, particularly given the small number of TB-dedicated staff, are noteworthy and reflect high levels of staff commitment and innovation.
- TB team in all regions established with members capacitated in implementing the TB control program.
- Partners are providing technical assistance to local government units.
- Local structures (Private-public coordinating bodies, TB councils, PCC, MSA) have been established and are functioning in some areas.

Challenges

- The quality of TB control plan in PIPH/CIPH had not yet been reviewed and evaluated.
- The performance based grants for LGUs had not been implemented yet.
- Variations in the technical and managerial capability of the regional, provincial and city TB teams in terms of performance, level of understanding and execution of feedback. Number of staff has been reduced as a result of the rationalization plan at the regional level

STRATEGY NO. 2 Monitor Health System Performance

Table 5. Status of Performance Targets Under Strategy 2

Performance Target	Status as of End of 2012	Remarks
2.1. Trend of TB burden tracked	Data collection for the second drug resistance study completed Preparation for the 2013 National Demographic Health Survey that include TB questions had started Mortality survey done but findings inconclusive Inclusion of TB into the Annual poverty index survey not done	On track to be achieved
2.2. TB information generated on time, analyzed and used	TB data still generated manually and oftentimes delayed; No published annual report	Not on track

Performance Target	Status as of End of 2012	Remarks
2.3. TB information system integrated with the national M&E and Field Health Information System	Integrated TB Information System (ITIS) developed by DOH-KMITS. Training done in NCR and Region 3 but no preliminary reports generated yet Some TB indicators included in the FHSIS and LGU/RO scorecard	On track to be achieved

Accomplishments

- Presence of standardized and functional NTP recording and reporting tools.
- Presence of a functional FHSIS and ongoing development of the integrated TB information system or ITIS.
- Development of a national TB M&E framework. Different regions conduct NTP data review with the participation of the implementing units.
- Presence and continuous expansion of other DOH information systems such as national online stock inventory reporting system (NOSIRS), the hospital information system (HOMIS) and Clinic Information System (iClinicSys).
- A system for regular monitoring and evaluation activities at the regional, provincial and municipal levels.
- A National Unified Health Research Agenda (NUHRA) was produced by the Research Agenda Committee (RAC) of the Philippine National Health Research System (PNHRS) for 2011-2016. TB is a focus health program in NUHRA.
- The Philippines is internationally visible for its TB research.

Challenges

- Delays in the submission and inaccuracy of some NTP reports at the provincial and regional levels. The recording and reporting system on susceptible and drug-resistant TB and even between NTP and its projects are not harmonized and integrated. TB laboratory and clinical data are not linked.
- ITIS does not yet seem ready for countrywide roll-out because of problems with the design, and lack of infrastructure in many RHUs/HCs to effectively utilize electronic systems. There are redundancies between the ITIS and the existing FHSIS. These information systems do not capture TB data from all private sector and hospitals.
- There are severe problems with the NTP supervision, monitoring and evaluation system: irregular supervision at the RHU level, PIR's are not used to analyze program performance and to develop specific strategies towards improvement, and there appear to be insufficient program management capability at the regional and provincial levels. Data and information are not routinely used for immediate decision making and planning.
- Capacity for operational research within the NTP is still limited, especially at regional level.

STRATEGY 3: Engage Both Public and Private Health Care Providers

Table 6. Status of Performance Target Under Strategy 3

Performance Target	Status as of End of 2012	Remarks
3.1. 60% of all DOTS facilities in the provinces with provincial PP mechanisms have a functional public-private collaboration/referral system (service delivery level)	Incomplete data	No data

Performance Target	Status as of End of 2012	Remarks
3.2. 90% of public hospitals and 65% of private hospitals are participating in TB control either as DOTS provider or referring center	171 of 657 targeted public hospitals (26%) 157 of 649 targeted private hospitals (24%)	Not on track
3.3. 70% of targeted 9,000 private practitioners are referring patients to DOTS facilities	8,513 PPs are referring (135%)	Achieved
3.4. All frontline health workers are equipped to deliver TB services	IMPACT assessment of health workers in selected sites revealed that less than 90% had been trained on DOTS.	On track to be achieved

Achievements

- There are 16 established RCCs (public and private) working with the regional TB Team nationwide. There are also 44 PCCs established but need to be further strengthened and mobilized.
- Capacity and commitment for TB control exist throughout the DOTS network. NTP has worked around the staff shortages by engaging project-based or other contract staff at the central and regional levels, and casual workers at RHU levels.
- The Philippines has been a world leader in the establishment of public private mix (PPM), and has acted as a model for countries in the Western Pacific region and beyond. There are currently 220 operational PPMD units supporting the NTP nationwide. Public hospitals and private practitioners contributed 11% to cases notified in 2012. The variety of models, flexibility in implementation, use of awards to high performing units, and sustained engagement by project staff were identified as critical to the success of the existing PPM efforts.
- Pilot projects have demonstrated the willingness of selected pharmacies to refer presumptive TB to public DOTS sites.

Challenges

- There are not enough DOH/LGU staff to perform all of the functions of the TB control program. The quality of service delivery commonly suffers, as functions such as supervision, TA provision, and supportive monitoring do not routinely occur due to staff shortages. Utilizing project staff and casual workers may not be a sustainable strategy as these positions end when funding ends.
- In the pharmacy sector, a great deal of work remains given the widespread availability of TB drugs without a prescription.
- PPMD associated activities (physician education sessions on ISTC, awards, and outreach to referring physicians) have mostly ceased with the end of project funding, and the number of physicians referring to some PPMD units has dropped by up to 70%.
- The rapid scale-up plan for hospital DOTS is resulting in all activities being devoted to the launches for new sites, with little or no staffing available for the technical assistance provision and supportive monitoring and supervision needed to establish behavior change. Patients referred by the private sector are subjected to diagnostic delays and this becomes a disincentive for the private referring unit.
- PhilHealth is not viewed as a significant source of financial support for sustaining PPM activities. Most of the time, private physicians who refer to these public PPMD units were not compensated for their referral.
- Provincial coordinating committees reportedly did many of the physician mapping activities requested of them, but then, there was limited follow-up or monitoring.

STRATEGY 4: Promote and Strengthen Positive Behavior of Communities

Table 7. Status of Performance Target Under Strategy 4

Performance Target	Status as of End of 2012	Remarks
4.1. Proportion of presumptive TB who are self-medicating and not consulting health care providers reduced by 30%	To be determined during the 2017 National TB Prevalence Survey	No data
4.2. Default rate of provinces and cities with ≥ 7% reduced by 40%	Identified provinces with high lost to follow-up rate rate has been reduced.	Achieved
4.3 No. of barangays that have community based organizations (CBOs) participating in TB control that are linked with DOTS facilities increased by 50%	2,974 of the targeted 1,216 (244%)	Achieved

Achievements

- Development of a planning framework for advocacy, communication, and social mobilization (ACSM) in 2010 to include a national communication sub-plan covering 2013-2016, that focuses on the development and dissemination of messages that promote behavior change. In line with this strategy, a mass media campaign has been launched using television and radio channels.
- Funding for ACSM activities has been secured from the government, The Global Fund, and foreign assistance projects.
- Engagement of multi-sectoral alliances (MSAs), non-governmental organizations (NGOs) and community-based organizations (CBOs) contribute to improved case finding and case holding.
- Creation of TB task forces, TB councils and community groups have increased awareness on TB and addressed stigma in the community.

Challenges

- Stigma, lack of proximity to a health center and treatment partner, and the perceived high cost of TB care remain barriers to timely healthcare seeking, treatment initiation and treatment completion. Misinformation and misconceptions with the causes of TB (e.g., sharing utensils, strenuous physical activity, alcohol consumption) and shame associated with diagnosis among TB patients are contributory to delays in care seeking.
- Access to information about TB services in remote, urban, and hard-to-reach areas remains limited.
- The ACSM strategy and sub-plan has not yet been widely distributed throughout the country. Wide variation in implementing various ACSM activities as shown by the lack of information, education and communication materials in many facilities.
- Monitoring and evaluation of the impact of ongoing ACSM activities have been limited.
- Limited LGU support to the organized CBOs to substantially contribute to case finding and case holding.
- Multi-sectoral alliances have been formed but do not function adequately to contribute to the overall goals of the TB program.

STRATEGY 5: Address MDR-TB, TB-HIV and Needs of Vulnerable Populations

Table 8. Status of Performance Target Under Strategy 5

Performance Target	Status as of End of 2012	Remarks
5.1. A total of at least 15,000 MDR-TB cases have been detected and provided with quality-assured second line ant-TB drugs	3,367 of the targeted 15,000 had been detected from 2010–2012 and initiated treatment (22%)	Not on track
5.2. TB/HIV collaborative activities in areas with populations having high risk behavior and with at least 80% of TB cases tested for HIV	8,623 of the 15,000 had undergone HIV testing (57%)	On track to be achieved
5.3. Nationwide implementation of childhood TB control program	All DOTS facilities are implementing TB in children but reporting of children given treatment or IPT is weak.	Achieved
5.4. DOTS services accessible to all inmates with TB	Jails and prisons implementing TB program covering 54% of targeted inmates	On track to be achieved
5.5. Policies, operational guidelines and models developed, disseminated and locally adopted to address needs of vulnerable populations	Guidelines for the urban poor drafted Profiling of vulnerable groups ongoing	Not on track

Achievements

PMDT

- In 2010, a new coordination team for PMDT was established by NTP/DOH with the Lung Center of the Philippines (LCP) as the implementing arm. Currently, there are 3 organic staff and 15 contractual staff working in the PMDT program management office (PMO) housed in LCP.
- There are 3 DST and 18 culture centers nationwide.
- Three laboratories—National TB Reference Laboratory (NTRL) of the Research Institute of Tropical Medicine (RITM), LCP, and the Cebu TB Regional Reference Laboratory (CTRL)—have passed proficiency testing for performing drug susceptibility testing (DST) for PMDT.
- A total of 23 Xpert machines have been rolled out in 12 out of 17 regions for rapid detection of rifampicin resistance.
- Twenty PMDT Treatment Centers (TCs) and 24 Satellite Treatment Centers (STCs) have been established, covering 16 regions and about 1,000 RHUs have been trained as treatment sites for the decentralization of PMDT.
- The annual number of drug-resistant cases initiated on treatment under PMDT has quadrupled from 538 in 2009, to 2,056 in 2011.
- Patients suspected to be at high-risk for drug-resistant TB are identified at DOTS facilities and referred to PMDT TC/STC for screening and testing. An MDR-TB Suspect Referral Form was developed for referral of patients to TC/STC as well as the Acknowledgement Form for confirmation of patients' arrival at TC/STC.
- A PMDT sub-plan under PhilPACT has been developed, highlighting the challenges of PMDT and outlining the direction of full integration of PMDT services into DOTS facilities and further expansion of PMDT with an increased target of cases for enrollment.

TB HIV

- HIV patients are tested for TB in the HIV treatment hubs.
- Testing of TB patients for HIV has started in the high HIV prevalence areas, particularly in NCR.
- The NTP has procured isoniazid for adults and it has been supplied to the HIV program. It also bought HIV testing kits and distributed them to DOTS facilities in category A sites.

Vulnerable populations (children, prisoners, poor)

- Various approaches to reaching marginalized populations have been launched through the assistance of GFATM, USAID, WHO/CIDA, ICRC, World Vision, KOFIH/KOICA and RIT/JATA. These include: (1) engagement of TB task forces and barangay TB management councils; (2) involvement of BHWs, CHTs, CBOs, FBOs and NGOs; and (3) recruitment and training of sputum collectors from remote areas to increase access to diagnostic services.
- In 2012, a prevalence survey of TB in prisons and jails was conducted which showed four to five times higher prevalence of bacteriologically confirmed pulmonary TB compared to the general population.
- Implementation of tuberculosis control in jails and prisons started in 7 pilot sites in 2009. To date, 117 (25%) out of 459 jails and 4 (57%) out of 7 prisons have been implementing DOTS, covering 54% of inmates in jails, and 83% of inmates in prisons.
- The number of inmates with tuberculosis reported to NTP increased from 135 in 2008 to 815 in 2010.
- In May 2013, the NBP was established as a PMDT satellite treatment center with access to Xpert.

Challenges

PMDT

- In 2011, PMDT screened 40% of all re-treatment cases and 1% of the new cases versus the 100% target for re-treatment and 20% for new cases. Low screening is attributed to lack of access to screening sites, policy limitation on who are eligible for MDRTB screening, low number of referrals coming from the peripheral health facilities, and patient's poor health-seeking behavior.
- A very high proportion of *M. tuberculosis* negative Xpert results in the Philippines likely indicated that a substantial proportion of patients who had Xpert test were both smear negative and culture negative.
- Advice provided by regional consilium may not have been appropriate due to poor communication between central and regional consilium.
- Initial default rate is high at 26% (2011) which is due to poor access to treatment facility, patient's lack of willingness to start treatment, inadequate manpower to track and verify patients, and inappropriate health care worker attitude.
- The proportion of patients with successful treatment decreased from 73% in the 2005 cohort to 56% in the 2009 cohort; the proportion of lost-to-follow-up cases increased from 13% to 33%.
- The two-way referral system is weak. The linkages between DOTS facilities and PMDT TC/STC are insufficient to monitor and evaluate patient referral, diagnosis, and management of PMDT.
- Limited number of Drug Susceptibility Testing centers that will ensure national coverage.
- Due to human resource constraints, supervision was not regularly conducted.

HIV

- Although the National AIDS/STI Prevention and Control Program (NASPCP) collects data on TB among people living with HIV (PLHIV), this information is not routinely shared among care providers due to confidentiality issues.
- NTP policies and guidelines were not followed in the provision of TB services among PLHIV. IPT was not implemented, referral mechanism for TB and HIV services is not effective, limited access to HIV services that is centralized in urban areas and inadequate logistics.
- IPT for HIV+/TB- patients is not yet widely provided as health workers await the publication of operational guidelines on IPT.
- Fast turnover of staff, especially medical technologists, providing HIV testing and recording and reporting system was not yet functional.

Vulnerable Populations

- Experiences from pilot project such as the urban poor had not been translated into national policy and guidelines, hence, initiatives are not yet expanded to other areas.
- Of the jails and prisons that are implementing DOTS, coordination and supervision are weak. Funding for TB diagnostic activities and medications was limited and insufficient. Generally, there was no TB microscopy or X-ray in the prison/jail, and diagnosis had to take place in the civilian sector. Therefore, many jails/prisons have limited access to smear microscopy and chest radiography.
- No systematic initiatives had been implemented and documented to respond to the needs of other vulnerable, high risk populations such as the malnourished, diabetics, smokers, indigenous population, internally displaced population, etc.

STRATEGY 6: Regulate and Make Available Quality TB Diagnostic Tests and Drugs

Table 9. Status of Performance Target Under Strategy 6

Performance Target	Status as of End of 2012	Remarks
6.1. TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all microscopy centers are within EQA	96% (1,932/2016) among TB microscopy laboratories participating in EQAs Estimated 85% of all within the NTP network NTRL organizational assessment done	On track to be achieved
6.2. TB microscopy services expanded in city and underserved areas	There are additional hospital-based microscopy centers but quantity is not known Remote smearing stations (RSS) model developed and implemented in selected sites	No data
6.3. Every province and highly urbanized cities with access to functional TB Diagnostic Committee	Selected provinces and HUCs with TBDCs but no data Memorandum issued by DOH to manage smear negative cases if TBDC could not issue recommendation within two weeks	No data
6.4. Quality-assured anti-TB drugs always available in DOTS facilities	NTP purchased anti-TB drugs that passed quality requirements of FDA Shortages of category II and pediatric drugs reported in some facilities In 36 IMPACT areas, 63% of DOTS facilities in NCR, 29% in Northern Luzon, 50% in Southern Luzon and 30% in Mindanao reported drug shortage	Not on track

Achievements

Diagnostics

- The laboratory network strategic plan (LNSP) , a sub-plan of PhilPACT, was recently developed by NTRL and NTP to strengthen laboratory management systems and services.
- A network of sputum microscopy laboratories has been established across the country that is integrated within the primary care health services. Remote smearing stations (RSS) have also been established in some localities to increase access to microscopy services for people living in geographically inaccessible areas. A quality assurance system for sputum microscopy is in place and implemented by provincial/city NTP laboratory.
- There has been an adequate supply of stains, microscopy and laboratory supplies needed for the TB program.
- Specialized diagnostic services prioritized for drug-resistant TB cases, including culture/DST and Xpert MTB/RIF, have been made available in 16 culture laboratories and 4 hospital laboratories. Line Probe Assay (LPA) is currently operational at the NTRL. Chest X-ray is widely used at the local level to support the diagnostic process for detecting smear negative TB cases.
- Staff at all levels of the NTP laboratory network are trained including informal laboratory workers that complement medical technologists in the microscopy services.
- Funding from national and local governments has increased to support the expansion of microscopy services. Funds from The Global Fund have been leveraged by the NTP to finance the specialized diagnostic services (i.e., culture, DST, Xpert MTB/RIF, LPA) including laboratory infrastructure, human resources, and operations.

Drug Management

- First Line anti-TB Drugs (FLD), needed to adhere to the WHO recommended regimens for adult first line treatment, are provided as Fixed Dose Combinations (FDC), and are supplied as patient kits that contain a full course of treatment.
- The FLD for children are provided as kits consisting of R, H and Z suspensions.
- Government is financing the procurement of these adult and pediatric FLD as well as basic laboratory stains and reagents. The prices paid by DOH Central Office Bids and Awards Committee (COBAC) for the adult FLD compare well with international references.
- The regimens used in the PMDT program are based on 18 month treatment and have been standardized and aligned with WHO recommendations. Second Line anti-TB Drugs (SLD) and Xpert cartridges are entirely financed with Global Fund grants. SLDs are distributed quarterly from the Materials Management Division (MMD) warehouse.
- COBAC's quality assurance measures include that products must have cGMP, FDA Certificate of Product Registration and a License to operate. The Food and Drug Authority (FDA) impresses as well-organized and is capable of analyzing TB formulations in its ISO 17025 accredited QC laboratory. The FDA gets support from USP PQM to strengthen the quality monitoring of medicines with a distinct focus on TB medicines.
- In 2012, FDA detected substandard FDC in Category II kits procured by COBAC from a local manufacturer. This was handled professionally and resulted in the recall of the concerned batches.
- The distribution of FLD, SLD, and laboratory supplies has been outsourced and this arrangement is working out well.
- The SIAPS project has assessed the current pharmacovigilance systems in the country in 2012.

Challenges

Diagnostics

- Access to TB diagnostic services, including specialized diagnostics, is still limited especially for vulnerable groups including residents of urban poor settlements, rural poor in geographically inaccessible areas, people in congregate settings and highly vulnerable populations such as children, elderly, and the immune-compromised (e.g. PLHIV).
- Issues related to smear/staining quality were observed in some peripheral laboratories. Standardized staining protocols are not available at the peripheral level resulting in variable practices that impact on overall smear quality and results. A related finding is that the quality assurance system for smear microscopy is not yet fully functional. Factors such as staff shortages, weak supervisory skills, and inadequate logistical support, hinder the local government QA teams' capacity to effectively implement external quality assessment and supervision of peripheral laboratories. These factors result in long delays in the slide rechecking process and feedback. In addition, quality improvement is not given emphasis in the system.
- Not all facilities for culture/DST are functional (16 out of the target 29) at this time. Specimen transport time takes several days in some areas. Transmittal of results also takes a long time which prolongs overall turnaround time; thus, reducing the potential benefit of new rapid tests.
- There is no standard checklist to monitor the implementation of Xpert MTB/RIF. In addition, significant module failures were observed during the Xpert MTB/RIF calibration process.
- The NTP laboratory network sub-plan or strategic plan is not yet implemented at this time. The role and future direction of specialized diagnostics in the NTP, particularly Xpert MTB/RIF and LPA, need to be further clarified.
- Policies and guidelines on quality assurance, certification, and accreditation, regarding the use of specialized diagnostics also need to be developed or updated.
- Financing of the specialized laboratory services is heavily dependent on The Global Fund support with no alternative and sustainable financing mechanism in place when The Global Fund support ends.
- Laboratory biosafety is not adequately implemented.
- Staff shortages have been observed at all levels of the laboratory network. A large proportion of technical laboratory staff are contractual employees hired under GFATM. However, some policies prevent the hiring of organic staff at national and local level to fill the gaps.
- There is no standard laboratory data management system for the NTP at this time.
- Chest X-rays are widely used by the health services in support of the diagnostic process, particularly for diagnosis of smear negative TB. However, chest X-ray quality issues are quite prevalent. The role of radiology in the NTP diagnostic process needs to be redefined in the presence of new diagnostic technologies.

Drug Management

- Frequent stock outs of adult and pediatric FLD, and PPD. During the JPR visits, there were neither Category I/III, nor Category II kits at central level. Category I/III were still in stock on most facilities but Category II kits had been out of stock for more than a year across the country. Most facilities were also out of stock of pediatric kits and PPD. Patients are commonly referred to private pharmacies to buy these medicines out of pocket. Reasons are:

i. Procurement challenges

- In 2012, locally manufactured Category II kits were found to contain substandard FDC and had to be recalled resulting in a yearlong stock out.
- The current contract holder for Category II kits cannot supply due to non-availability of a source for Streptomycin.
- Suppliers are not interested to supply NTP with single drug formulations as volumes are too small.
- The latest PPD procurement failed as no supplier can supply the requested 18-month shelf life.

ii. Lack of coordination between central and LGU procurement

- The program sends a mixed message to the LGUs. On one hand, there is the assurance that TB medicines will be procured centrally. On the other hand, LGUs are expected to procure the single dose formulations themselves and should undertake contingency procurement when needed to prevent stockout of other TB medicines. The supply by Central Government and augmentation by various LGU levels results in an uncoordinated and fragmented procurement scenario that has repeatedly resulted in both excesses and stock outs as there was no clarity as to which was going to be procured by whom.

iii. Lack of systematic forecasting (tool) for FLD

- NTP lacks a systematic approach or tool to forecast the national needs of FLD in a consistent and rational manners partly due to the absence of a reporting mechanism.
- MMD is currently piloting NOSIRS (National Online Stock Inventory Reporting System) that would provide instant overview of all stock in public health facilities in the country. It is aimed to have all regions report all drug stock details via NOSIRS by end of 2013 and all provinces by end of 2014. So far however, only some products are being entered in some regions and this does not include any TB medicines. It is unlikely that NTP will obtain reliable data from NOSIRS in the near future.

iv. Insufficient national FLD Safety stocks

- The Philippines has not been maintaining significant levels of safety stock and this is one reason why the country experiences regular large scale stock outs of some FLD. During the JPR there was a nationwide stock out of Category II kits, as well as considerable shortages of pediatric TB medicines and PPD. Category I/III kits were also out of stock at the central level.
- Insufficient storage space at LMD central warehouse. The space available in the warehouse does not allow for separation of batches, easy adherence to First Expiry First Out, efficient stock counting. Deliveries from suppliers have to be denied or delayed due to lack of warehouse space.
- The drug storage conditions at ROs, provinces and sites are generally okay but some inadequacies in storage conditions and practices have been observed at individual locations.
- There is no standard system regarding FLD drug reporting and requisition. In many cases, this implies a push system of FLD drug distribution.
- Uncontrolled availability of TB medicines in the private sector. A 2013 study by WHO WPRO office into market characteristics for TB drugs in the Philippines found that while publicly procured TB drugs were sufficient to treat all reported new TB cases from 2007 to 2011 the volume of TB drugs that was channeled through this private market suffices to treat an additional 250,000 TB patients annually.
- SLD funding entirely dependent on The Global Fund and is expected to end in three years' time.
- Reports on Adverse Drug Reaction (ADR) usually do not reach beyond facility level. For SLD, side-effects are reported to LCP but there is no procedure to flag severe ADRs that need to be reported to FDA.

STRATEGY 7: Certify and Accredit TB Care Providers

Table 10. Status of Performance Target Under Strategy 7.

Performance Target	Status as of End of 2012	Remarks
7.1. At least 70% of DOTS facilities are DOH/PhilCAT-certified and PhilHealth-accredited	56% (1,236/2,187) DOTS facilities are certified and accredited	On track to be achieved
7.2. Standards for hospital participation in TB control included in DOH licensing and PhilHealth accreditation requirements	DOTS standards included in PhilHealth benchbook	On track to be achieved
7.3. Infection control measures in place in all treatment centers/sites and DOTS centers	Infection control guidelines developed and TOT conducted. Training rolled-out in NCR. Repaired or upgraded DOTS facilities considered infection control guidelines but quantity unknown.	Not on track

Achievements

- PhilHealth claims and reimbursement for outpatient TB have been increasing since 2008. The JPR teams saw numerous good practices in utilizing PhilHealth reimbursement as a sustainable source of funding for operations and directly or indirectly benefiting the health workers.
- PhilHealth streamlined its accreditation policies such that certified TB DOTS facilities are automatically accredited.
- Guidelines on infection control (IC) for tuberculosis were published in 2011. Training of trainers targeting regional NTP staff was conducted in 2011 by the NTP central office. In NCR, staff at city/municipality were trained in 2012 and all (465) DOTS facilities in May 2013.

Challenges

- Lack of physicians constrains many facilities to meet requirements for certification and accreditation.
- TB IC remains a highly neglected issue in the Philippines. The NTP manager, who has too much responsibility, is also the national focal person of TB IC. There is no national sub-plan or TB IC committee to implement the 2011 policy. After the national training of trainers conducted in 2011, 16 of 17 regions have not yet conducted training to roll out TB IC. In several health care facilities visited, natural ventilation was inadequate, with a high risk of transmission. In a city health office visited by the PMDT monitoring team, DOTS area was placed next to a waiting area of little children, imposing a high risk of infecting this vulnerable group. In most facilities, symptomatic patients were not provided with masks.
- Despite the increasing reimbursement, PhilHealth's contribution to TB control remains minimal. There is a huge disparity between number of claims filed and number of cases treated in government facilities. Reasons are: (1) sharing of the reimbursement does not adequately (or in any way benefit the health worker who must file the claim, and (2) difficulty in confirming PhilHealth eligibility of patients.
- Patient eligibility/enrollment in PhilHealth cannot be easily confirmed. As a matter of national policy and in-line with WHO recommendations, TB diagnosis and treatment is free through government facilities, regardless of PhilHealth eligibility. Although this is a good national policy, this results in limited motivation by TB patients to confirm their PhilHealth enrollment, or to document their eligibility. Therefore, the burden of documenting PhilHealth eligibility falls on the provider.

STRATEGY 8: Secure Adequate Funding and Improve Allocation and Efficiency of Fund Utilization

Table 11. Status of Performance Target Under Strategy 8

Performance Target	Status as of End of 2012	Remarks
8.1. Reduced redundancies and gaps by harmonized financing of TB prevention and control	Harmonized project activities/TA plan developed Harmonization of activities done during TB TWG meetings	On track to be achieved
8.2. National government funds leveraged to secure LGU and PhilHealth commitments	NTP drugs and laboratory supplies used to leverage with LGUs for manpower counterpart Performance-based grant not yet implemented Unknown number of LGUs with budget for TB control	Not on track
8.3. PhilHealth's role expanded through greater availability of accredited providers and increased utilization of TB-DOTS package	Increased number of PhilHealth accredited providers to 57% Amount reimbursed increasing Advocacy for MDR-TB package ongoing Revision of the current package: include re-treatment and allowing health providers to share from re-imbursement proposed	On track to be achieved

Achievements

- Political commitment to TB control is strong. This is visible through the sustained and increasing budget from the DOH for TB control.
- NTP has successfully integrated TB-related indicators and supportive policies within the agendas of other sectors. For example, the National Economic and Development Agency (NEDA) actively monitors TB among the indicators that measure progress toward development at LGU and national levels. Labor policies and systems ensure the protection of TB patients from unlawful termination. The Department of Justice is increasingly connected to the DOTS network. The involvement of the private sector in TB control is increasing. The multi-sectoral engagement in TB control provides a strong foundation for a sustainable program.
- NTP collaborates with different foreign assistance projects (FAPs). These are the (a) USAID-funded projects namely, the Innovation and Multi-sectoral Partnership to Control TB (IMPACT), System Improvement for Access to Pharmaceutical Products and Services (SIAPS), TA Support to Country (TASC) and PSQM, (b)the Global Fund Against AIDS, TB and Malaria (Global Fund) through the principal recipient (PR), Philippine Business for Social Progress (PBSP), (c) the RIT/JATA , (d) the DETEC TB project, funded by the Korean Foundation for International Health (KOFIH) and (e) the Korean International Cooperation Agency (KOICA) .
- The coordination of government and external funding sources is well managed at central level, and is emerging at provincial level through the use of PIPHs.
- As of 2012, 84% of the population was enrolled in PhilHealth. Under UHC, all indigents should have PhilHealth coverage.

Challenges

- There remains large inter-regional variation in terms of the level of commitment to TB demonstrated through budget support, and reflected by program performance.

Summary of accomplishments based on the mid-term review

- Targets on TB incidence, prevalence and mortality rate reduction were achieved.
- The targets on the number of TB cases and TB symptomatics are on track to be achieved.
- Treatment success rate is above the target of 90%.
- Number of MDR-TB cases detected and initiated treatment is not on track.
- Number of TB-HIV planned to be tested is on track but with limited coverage area.

Table 12. Status of Performance Targets by Strategy

Strategy	No. of Performance Targets	Achieved/On Track to be Achieved	Not on Track	No Data
1	5	1	3	1
2	3	2	1	0
3	4	2	1	1
4	3	2	0	1
5	5	3	2	0
6	4	1	1	2
7	3	2	1	0
8	3	2	1	0
	30	**15 (50%)**	**10 (33%)**	**5 (17%)**

The key challenges for NTP for 2014–2016 are as follow:

1. There still are many missing TB cases due to the following:
   a. Lack of access to quality assured TB diagnostic services
   b. Limited involvement of non-NTP care providers
   c. Persisting stigma on TB
   d. Passive case finding
2. Low number of detected and enrolled MDR-TB cases with high defaulter rate
3. Weak TB HIV collaboration especially at the service delivery level. Geographic coverage is still limited
4. Slow development and implementation of initiatives to increase access to TB services by the marginalized/vulnerable groups
5. Weak health system
   5.1. Weak logistics and information management systems
   5.2. Variable capacity in TB control program management by TB teams at all levels
   5.3. Lack of manpower at the service delivery levels
6. Other funding sources/models not yet maximized

THRUSTS, OBJECTIVES, AND STRATEGIES FOR 2010–2016

THRUSTS FOR 2014–2016

The cross-cutting strategic thrust in the last three years of the plan will focus on key areas that will accelerate and scale-up implementation of interventions that will have major impact on TB prevalence and mortality. These are:

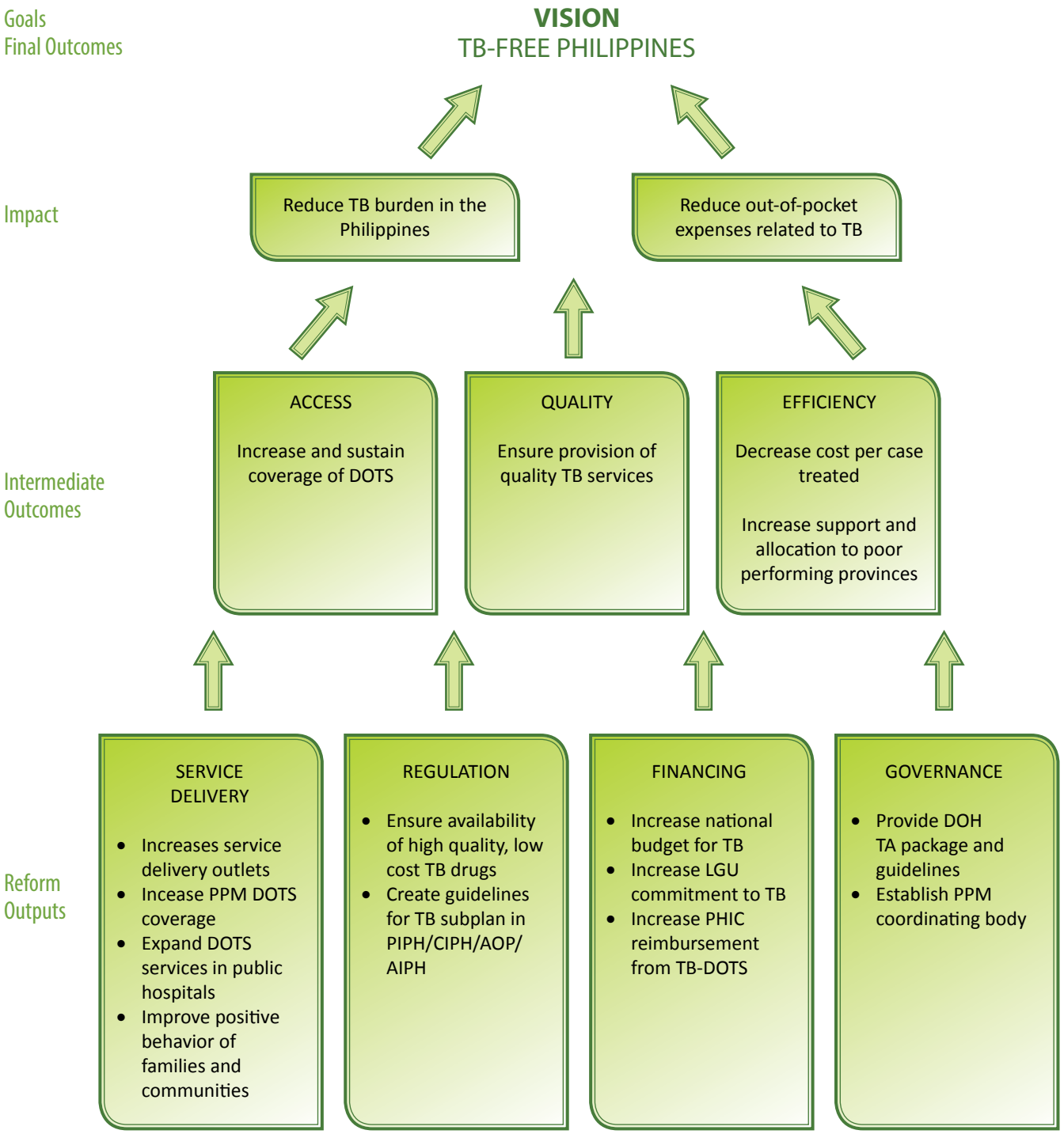
1. Intensification of DOTS implementation to promptly detect and treat more TB cases to reduce deaths and transmission and prevent MDR-TB through:
    - 1.0.1. Conduct of intensified case finding among the high risk groups where TB prevalence is high and where patients face barriers such as the poor and other vulnerable groups.
    - 1.0.2. Full engagement of health facilities and providers where majority of the TB cases consult such as the hospitals, both public and private and private providers.
    - 1.0.3. Establishment of more quality-assured TB laboratories and rolling-out of rapid diagnostic tests to improve access and reduce delay in the diagnosis and initiation of treatment. This requires providing logistical support such as microscopes to the newly engaged TB laboratories, scaling-up of the Xpert MTB/RIF, strengthening the quality assurance system, enhancing the support systems and organizational development of NTRL.
    - 1.0.4. Development of effective communication strategies and tools.
2. Expansion and strengthening of service delivery points to detect more MDR-TB cases and improve treatment compliance through integration of PMDT services into the DOTS facilities, building capability of health care providers, empowerment of patients and support groups and enhancement of support systems.
3. Strengthening TB-HIV collaboration at all levels especially at the service delivery points through geographic expansion to Category A and B areas, enhancement of policy environment, expansion of service delivery points and strengthening of the referral and other support systems.
4. Enhancement of key health systems to ensure that TB diagnostic and treatment services are always available. This implies improving the logistic management system and information system including monitoring and evaluation system. Interventions to improve the former include capability-building of both TB teams and supply officers and establishment of early warning system. For information management, the key approach is to scale-up ITIS nationwide and link it to the other DOH information systems.
5. Enhancing the managerial capacity of TB teams at various levels to ensure that service delivery points are providing TB care in accordance with national policies. Key approaches include outsourcing the training on program management, enhancing collaboration of NTP with other DOH offices and tapping NGOs to implement other management tasks.

There are no changes in the objectives and strategies of PhilPACT as shown below:

Table 13. PhilPACT Objectives and Strategies

OBJECTIVES	STRATEGIES
Reduce local variation in TB control program performance	1. Localize implementation of TB control 2. Monitor health system performance
Scale up and sustain coverage of DOTS implementation	3. Engage both public and private health care providers 4. Promote and strengthen positive behavior of the communities 5. Address MDR-TB, TB/HIV, and needs of vulnerable population
Ensure provision of quality TB services	6. Regulate and make available quality TB diagnostic tests and drugs 7. Certify and accredit TB care providers
Reduce out-of-pocket expenses related to TB care	8. Secure adequate funding and improve allocation and efficiency of fund utilization

Figure 5: 2010–2016 PhilPACT Strategic Logical Framework



Some key programmatic targets, performance targets and activities of PhilPACT had been revised due to the following reasons:

1. Achievement or near achievement of targets
2. Need to expand coverage to accelerate impact
3. Need to change approach
4. Availability of tools/models that will accelerate implementation
5. Need to make targets clearer and measurable

Table 14. Changes in PhilPACT Targets and Activities

Indicators	Original PhilPACT Targets for 2016	Targets for 2016 in Updated PhilPACT	Rationale for the Change/ Comments
IMPACT			
TB incidence rate	< 393/100,000	246/100,000*	Target already achieved
TB mortality rate	27.5 100,000 (recomputed)	23/100,000*	Target already achieved
TB prevalence rate	500/100,000 (recomputed)	414/100,000*	Target already achieved
OUTCOME			
Susceptible patients			
Case detection rate, all forms	None (only for new smear positive)	90%*	Changed from CDR, NSP to CDR, all forms
Treatment success rate, all forms	None (only for new smear positive)	90%*	Added TSR all forms
MDR-TB patients			
Notification rate	None	62%*	To achieve impact through new strategies
Treatment success rate of MDR	None	75%*	Needed to measure quality of intervention

OUTPUTS	Original PhilPACT Targets	Targets in Updated PhilPACT	Comments
Total number of presumptive TB examined	5 million	5.5 million*	Increased due to increase in CDR target
Total number of TB cases provided with treatment	1 million	1.5 million*	Increased due to increase in CDR target
Total number of children given treatment or INH preventive therapy	730,000	730,000	Retained
Total number of MDR-TB cases detected and registered	15,000	19,500*	Increased to achieve impact
Total TB patients who underwent provider initiated HIV counselling and testing	15,000	45,000*	Increased for wider geographic coverage

*Revised target

Performance Targets

For 2014–2016 PhilPACT implementation, some of the performance targets have been dropped, partly modified or substantially changed as show in the table below. New activities were also introduced. The status of the performance targets are as follows:

New performance targets	3
Deleted	1
Revised	16
No change	13
Total performance targets for 2016	**32**

Table 15. Performance Targets and New Activities

Strategy and Updated Performance Targets	Changes in the Performance Targets and Activities for 2014–2016
Strategy 1: Localize TB Implementation of TB control	
1.1. Eighty percent (80%) of provinces and highly urbanized cities (HUCs) include TB control plan based on a set criteria within the Province-wide Investment Plan for Health (PIPH) or ARMM Investment Plan for Health (AIPH) or City Investment Plan for Health (CIPH)*	Increased target from 70% to 80% No new activities
1.2. Seventy percent (70%) of provinces/ highly urbanized cities are at least DOTS compliant	Target retained New activity is the training of the local chief executives on health and governance to enable them to support TB control program.
1.3. Ninety percent (90%) of provinces and HUCs given performance based grants (PBGs) have achieved and sustained program targets (CDR and TSR)*	Added "sustained" to target PBG guidelines were not formulated earlier, hence, this was reset to 2014. At the local level, additional activity includes supporting those who will apply for the PBG.
1.4. At least 70% of national, regional, provincial, and HUC teams have been trained and supported to manage TB control program*	The performance target had been broadened from enhancing skills in TA provision by the program managers at all levels to enhancing their overall TB control program management skills to include clinical, programmatic and laboratory matters. It includes also information, logistics, and financial management among so many topics. A training institution will be engaged to develop the training program after a situational assessment and later assist the ROs in rolling this out to the provinces and cities. Local and international exchange programs will be pursued. An organizational development (OD) plan for NTP and CHDs will also be formulated and implemented. This includes strengthening collaboration of NTP with other DOH offices. Due to human resource constraints at the national and regional level, some managerial tasks such as project management, training, research and logistics will be outsourceds.
1.5. All PP coordinating bodies at the national and regional and 70% at the provincial and HUC levels have been established and sustained to include CUP mechanisms	Target retained No new activities

Strategy and Updated Performance Targets	Changes in the Performance Targets and Activities for 2014–2016
Strategy 2: Monitor Health System Performance	
2.1. Trend of TB burden tracked	Target retained Due to unavailability of complete data to do the national TB mortality survey, a sub-national survey will be conducted per advise of a WHO consultant. LGUs will be assisted in improving its skills to validate TB deaths. Per consultation with the stakeholders, the national TB prevalence survey will be reset from 2014 to 2015. Preparatory activities will be done in 2014.
2.2. TB information generated on time, analyzed, and used	Target retained All M&E activities and research activities on TB are placed under this performance target. The development and nationwide implementation of the integrated TB information system (ITIS) will be done in phases. This will be based on the revised recording and reporting system under the MOP 5th edition. Reports will be shared with key stakeholders to help ensure the use of information for planning and decision making.
2.3. TB information system integrated with the DOH Unified Health Management Information System (UHMIS)*	The target was revised to integrate the TB information system not only to FHSIS but also with other DOH health management information systems. A critical activity strongly recommended during the JPR is the advocacy to DOH management to re-include TB in its list of notifiable diseases. This will improve the TB case notification since private sector and hospitals will report their TB cases. The ITIS will be integrated into the existing and planned DOH health management information system such as the Clinic Information System (iClinicSys), hospital information system (HOMIS), and national online stock inventory reporting system (NOSIRS).
Strategy 3: Engage Both Public And Private Health Care Providers	
3.1. At least 50% of all provinces and HUCs have functional province/city-wide referral system*	The unit for the target was changed from a municipality to a province to capture referral of all provincial level health care providers such as the hospitals and NGOs. At the national level, guidelines and tools for establishment of a TB DOTS referral system will be developed and disseminated. This will take into consideration existing guidelines on PPM with updating of the latter as needed. Both these interventions were not undertaken in the first two years of PhilPACT as planned but are still deemed relevant and will be pursued. New interventions recommended in this update include creation of a national DOTS directory, including TB laboratories, and the assessment of previous PPM mechanisms in provinces or cities. The DOH will also provide support to local PP mechanisms to improve sustainability. The functional referral system must provide for the routine feedback to referring party. Other new activities include development of local DOTS directories to aid TB referrals and for LGU to explore provision of enablers to incentivize participation in the referral network. The PhilHealth TB package is still one of the viable options for this incentive mechanism.

Strategy and Updated Performance Targets	Changes in the Performance Targets and Activities for 2014–2016
3.2. 90% of public hospitals and 65% of private hospitals are participating in TB control either as DOTS provider or referring center	Target retained A more definite tool for hospital engagement in the form of the hospital TB guidelines and its accompanying toolkits that draw evidence from various projects and local initiatives will be employed. To promote use of these guidelines, further recommendation is the recruitment of hospital directors to act as champions for hospital DOTS by advocating the intervention to other facilities. The updated plan also stresses the need to sustain supervision and monitoring of hospitals and, thus, go beyond installation and training as measure of successful engagement. TB cases detected by the hospitals must be measured and must contribute to performance target 3.3, the percentage contribution by non-NTP care providers.
3.3. Fifteen (15%) percent of notified TB cases contributed by the private providers	The original target of 70% of the targeted 9,000 private practitioners are referring patients to DOTS facilities had been exceeded. Thus, this was changed to a higher output indicator of proportion of TB cases contributed by them. The activities in PhilPACT aimed at engaging individual private practitioners will continue to be adopted. Recent revisions in the NTP Manual of Procedures that give clear guidelines on how to approach patients after partial private sector treatment is expected to increase participation of private physicians. Due to emphasis on PP mechanisms, strengthening of inter-local health zones to engage physicians beyond already existing PPMD units will be a key intervention.
3.4. All DOTS facility staff are equipped to deliver TB services	Target retained Additional activity is the development of alternative learning platforms (e.g., web-based training programs) as opposed to the traditional training methods being currently employed. To assure that objectives of trainings are met, a more systematic post-training evaluation that focuses on outcomes rather than just processes and outputs will be developed. The main indicator of success will be ability to apply learnings in service provision.
Strategy 4: Promote and Strengthen Positive Behavior of Communities	
4.1. Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Target retained In the next three years, the NTP will aggressively scale up the implementation of the National Communication Plan by supporting the LGUs to develop and implement localized communication strategies to identify and reach presumptive TB in the communities. Information officers will be engaged by the TB program managers as well to disseminate these strategies for wider implementation coverage. At the national level, the NTP will spearhead the development and implementation of tools and guidelines on ACSM-related activities to ensure harmony and synchrony of all TB promotion activities. It will likewise support and supervise the roll out of these activities in collaboration with the Health Promotion and Communication Service (HPCS). The ACSM Strategic Plan will be fully implemented across levels.

Strategy and Updated Performance Targets	Changes in the Performance Targets and Activities for 2014–2016
4.2. 95% of provinces and 70% of HUCs with less than 5% lost to follow-up*	The target was changed to have better clarity. Lost to follow up target was revised from a cut-off of 7% to 5%. The target for the number of provinces and cities was also increased. At the local levels, LGUs will continue to build the capacity of BHWs, CHTs, health AIDERS (accelerating implementation of DOTS enhancements to reach special population) and community volunteers on treatment supervision to ensure patients finish treatment and cure. Effective mechanisms on enablers and incentives provision will be implemented to support treatment partners and marginalized patients. To assess the effectiveness of this intervention, an Operational Research (OR) will be conducted at the national level.
4.3. At least 10% of all notified TB cases were contributed by CBOs/CHTs/BHWs	The performance target was changed from a process indicator to output indicator—from number of community based organizations (CBOs) engaged to number to their contribution to all notified TB cases. The NTP direction in the next three years is to continue to build the capacity of LGUs to ensure that engaged CBOs, CHTs, NGOs, and faith-based organizations at the grassroots level will be supported in their TB work. Two new activities include formulating and implementing comprehensive TB patient empowerment strategy and standardizing guidelines and tools for referrals in the communities.
Strategy 5: Address MDR-TB, TB/HIV, and Needs of Vulnerable Populations	
5.1. A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs*	The target was increased from 15,000 to 19,500. A major approach will be integrating the PMDT services to all DOTS facilities to improve access to diagnostic and treatment services. Policies will be updated and the training modules will be revised to consider recent NTP and WHO policy changes.
5.2. At least 75% of MDR-TB patients are successfully treated**	This is a new performance target to emphasize the need to improve compliance to treatment by MDR-TB patients. All activities are new. Provision of enabler package and capability-building of the providers, hopefully, will reduce the high defaulter rate. Studies to be conducted include reasons for lost to follow up, assessment of current and revised enabler package and the nine-month treatment regimen.
5.3. At least 80% of registered TB cases in Category A and B areas and MDR-TB cases are provided with HIV counselling and testing*	The performance target was revised to specify expansion sites which are the Category A and B areas and to also include MDR-TB for HIV screening. Focus of the activities will be on improving the services to TB HIV co-infected patients including provision of ARV treatment through capability-building and strengthening the referral system.
5.4. 730,000 children initiated with anti-TB treatment or given INH preventive therapy*	Target was changed from nationwide implementation of childhood TB program to a higher level indicator and which is measurable. Referral of cases from schools to the health facilities will be enhanced and training modules for TB in children will be integrated with the adults.
5.5. Jails and prisons at all levels provide access to DOTS services to all inmates*	Performance target unit was changed from the percent of inmates with access to DOTS to percent of jails and prisons with access to DOTS . The policies and M&E on TB and prison will be revised to incorporate changes in the MOP, 5th ed.

Strategy and Updated Performance Targets	Changes in the Performance Targets and Activities for 2014–2016
5.6. Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable populations	The targeted vulnerable population had been explicitly stated. These are (a) rural/urban poor, (b) indigenous population, (c) those living in congregate setting, (d) those in disaster affected areas and (e) diabetics. Major activity will be the deployment of "health AIDERS" to at least 300 poor municipalities. Another one is to support the implementation of MDG 12.
Strategy 6: Regulate and Make Available Quality TB Diagnostic Tests and Drugs	
6.1. At least 95% of all TB microscopy laboratories within the NTP laboratory network are providing diagnostic services within EQA standards*	Target retained but re-phrased to make it clearer. Key activities came from the recently-developed NTP laboratory network strategic plan. In general, the sub-plan aims to enhance the laboratory policies, leadership, and laboratory management systems (human resource, logistics, information, certification, facility and equipment) to ensure the provision of quality-assured, effective, and sustainable TB diagnostic services.
6.2. TB microscopy services are expanded to improve access*	Target changed by deleting "cities and underserved areas" to include all areas. Access to TB diagnostic services will be improved through the establishment of new facilities such as microscopy laboratories and remote smearing stations, in underserved rural and urban areas, and areas affected by disasters or calamities. The integration of laboratory services, where applicable, and the increased engagement of private sector laboratories will also be pursued to improve access and efficiency in service delivery and management.
6.3. Culture, DST and new technologies are scaled up.**	This is a new performance target. A major activity is to scale-up the implementation of Xpert MTB/RIF (i.e. GeneXpert) and culture/DST to enhance the program's capacity to diagnose drug-resistant TB and smear negative TB. This will help improve the detection of drug-resistant TB, TB among vulnerable groups, and among people with high-risk for TB.
6.4. No stock-outs of anti-TB drugs (both FLD and SLD) and laboratory supplies in 90% of DOTS/lab facilities in the last 6 months*	The performance target was re-phrased to make it measurable. The activities aim to improve supply management of TB drugs and diagnostics by addressing challenges at all points of the supply management cycle that will be identified through a comprehensive study of the system. Interventions will include deploying a logistics team to NTP, building the skills of the TB control managers and adopting an early warning system through the NOSIRS. The rational use of anti-TB drugs will also be strengthened especially in the private sector to reduce inappropriate treatment with TB medicines, prevent the development of new drug-resistance and other untoward events among patients under treatment. Finally, pharmaco-vigilance (PV) in the NTP will be strengthened to address issues on TB medicines safety. The PV system will help improve the tracking, management, and prevention of adverse drug reactions and adverse drug events.
	Performance target 6.3 from the original document " Every province and HUC with access to functional TB Diagnostic Committee" was dropped. In 2012, NTP made this mechanism optional due to delay in the start of treatment of cases that will need treatment because of the irregular meeting of the TBDC. Instead, the attending physician may decide if the patient needs treatment or not.

Strategy and Updated Performance Targets	Changes in the Performance Targets and Activities for 2014–2016
Strategy 7: Certify And Accredit TB Care Providers	
7.1. At least 70% of DOTS facilities are DOH/PhilCAT certified and PhilHealth accredited	Target retained Policies, guidelines and standards for PHIC accreditation and TB DOTS outpatient benefit package will be revised to increase the number of accredited DOTS facilities especially in the public sector. This will help facilitate the filing of claims, improve the utilization of reimbursements so that this becomes more beneficial and acceptable to health care providers, and contribute to the increase in PHIC support to the NTP.
7.2. DOTS standards/evidence for hospital engagement are included in DOH licensing and PhilHealth accreditation requirement	Target retained No new activities.
7.3 Infection control/laboratory biosafety measures in place in all DOTS/PMDT facilities and laboratories*	Included laboratories in the target. New activity will be to develop IC plan and to organize a national IC committee.
Strategy 8: Secure Adequate Funding and Improve Allocation and Efficiency of Fund Utilization	
8.1. Reduced redundancies and gaps by harmonizing financing of TB prevention and control	Target retained Deleted two activities (a) formulation of multi-year local budget plan for TB prevention and control for 2014–2016 and (b) development of the a national TB control account and five-year national rolling TB financial plan. New activity includes reviewing and harmonizing financing resources for TB to include those of different government agencies such as the Employees Compensation Committee (ECC), Social Security System (SSS), Government Social Insurance System (GSIS) and other agencies participating under the Comprehensive and Unified Policy (CUP) agencies.
8.2. National government and PhilHealth funds leveraged to secure LGU commitments*	The performance target was changed for PhilHealth to partner with DOH in leveraging for LGU support to TB control. New activities include lobbying for issuance of local policies and budgets for TB and communicating to the LGUs the support provided by DOH and partners on TB control.
8.3. PhilHealth's role expanded through greater availability of accredited providers and increased utilization of TB-DOTS package.	Target retained No new activities.
8.4. Alternative funding models developed**	This is a new performance target, hence, all activities in the planning matrix for 2014–2016 are new.

*revised/modified
**additional

STRATEGY 1. Localize Implementation of TB Control

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
1.1. Eighty percent (80) of provinces and highly urbanized cities include clear TB control plan within the Provincewide Investment Plan for Health (PIPH), ARMM investment plan for Health (AIPH) or City Investment Plan for Health (CIPH)	**Local**							
	Assess status of local TB control program implementation	■	■	■	■	■	■	■
	Develop local TB strategic plan based on the analysis considering the absorptive capacity of the LGUs and national plan	■	■	■	■	■	■	■
	Incorporate TB strategic/operational plan within the PIPH/AIPH/CIPH and AOP	■	■	■	■	■	■	■
	Update TB control plan yearly and incorporate into AOP		■	■	■	■	■	■
	Support advocacy to integrate PIPH/AIPH with the Comprehensive (medium term) development plan of the LGUs	■			■			■
	National							
	Provide technical assistance in the development of TB control plan vis-à-vis assessment results	■	■	■	■	■	■	■
	Consolidate, review and analyze all PIPHs/AOPs	■	■	■	■	■	■	■
1.2. Seventy (70%) of provinces/HUCs are at least DOTS compliant	**Local**							
	Conduct self-assessment versus DOTS standards to identify gaps and needs		■	■	■			
	Develop and implement plan to be DOTS compliant		■	■	■	■	■	■
	Train LCEs on health and governance*					■		
	National							
	Develop/revise standards, assessment tools and implementing guidelines for a DOTS-compliant, performing and sustaining province/city in collaboration with HPDPB*	■	■			■		
	Build capacity of national and regional units to use the assessment tools		■	■	■			
	Assess provinces/cities vis-à-vis standards		■	■	■	■	■	
	Provide TA based on the local needs	■	■	■	■	■	■	■
1.3. Ninety (90%) of priority provinces and HUCs with performance based grant have achieved and sustained program targets	**Local**							
	Apply for PBG*					■	■	■
	Conduct annual PIR	■	■	■	■	■	■	■
	Submit quarterly progress monitoring report to CHD	■	■	■	■	■	■	■
	National							
	Identify priority provinces based on TB burden, performance and absorptive capacity using DCAT tool*	■		■		■		■
	Develop and implement performance-based grant mechanism					■	■	■
	Conduct quarterly assessment of provinces given grants					■	■	■

STRATEGY 1. Localize Implementation of TB Control

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
1.4. At least 70% of national, regional and provincial/ city teams have been trained and supported to manage TB control program	**Local**							
	Identify TA needs and request for assistance	■	■	■	■	■	■	■
	Train on integrated TB control program management*					■	■	■
	National							
	Develop guidelines for provision of TA to provinces and cities	■	■	■	■			
	Building capability of national and regional staff on TA provision	■	■	■				
	Strengthen RCC to oversee PhilPACT implementation	■	■	■	■	■	■	■
	Prioritize requests for TA on capability-building activities for regions and partners and implement		■	■	■			
	Coordinate TB control project plans	■	■	■	■			
	Develop and implement OD plan for Infectious Disease Prevention and Control Division (IPC) and regional health officers (RHOs)*	■	■	■	■	■	■	■
	Advocate for change of policy allowing contractual staff to be trained using government funds*				■			
	Develop criteria for effective program management at different levels and collect baseline data*					■		
	Engage an institution to develop an integrated training program for NTP managers (clinical, programmatic and laboratory management) including training modules and tools*					■		
	Implement the training program on program management for all levels*					■	■	
	Provide long term local technical provider per zone*					■	■	■
	Organize exchange programs, locally and internationally*					■	■	■
	Strengthen collaboration with other DOH offices*					■	■	■
	Outsource to some NGOs to help manage certain managerial tasks such as project management, training, research, logistics (outsourcing)	■	■	■	■	■	■	■

STRATEGY 1. Localize Implementation of TB Control

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
1.5. All PP coordinating bodies—national, regional and provincial levels—have established and sustained to include CUP mechanisms	**Local**							
	Organize provincial public-private (PP) coordinating body such as CUP or similar coordinating group	■	■	■				
	Develop and implement plan on PP collaboration	■	■	■	■	■	■	■
	CUP partners implement agency's policies and guidelines	■	■	■	■	■	■	■
	National							
	Develop and issue policy instrument that would establish and sustain a National TB Coordinating Committee (NCC) and expand Regional Coordinating Committee (RCC) for PhilPACT	■	■			■		
	Sustain NCC and RCC	■	■	■	■	■	■	■
	Coordinate with Regional Coordinating Councils	■	■	■	■	■	■	■
	Convene CUP members to develop and issue policies and guidelines on TB in accordance with the agency's mandate in coordination with DOH	■	■	■	■	■	■	■
	Conduct regional and provincial orientation on PhilPACT	■	■			■	■	■
	Engage key professional societies	■	■	■	■	■	■	■
	Build capacity of provinces and cities to organize PP collaborating mechanisms	■	■	■	■	■	■	■

STRATEGY 2. Monitor Health System Performance

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
2.1. Trend of TB burden tracked	**Local**							
	Build capacity in collecting and reporting TB mortality data		■	■	■			
	Conduct activities to validate TB deaths including conferences*						■	■
	National							
	Conduct the National TB Prevalence Survey						■	
	Conduct National Drug Resistance Survey		■					■
	Conduct TB sub national mortality study*						■	
	Incorporate TB questions in NDHS				■			
	Develop guidelines for LGUs on validating TB deaths*					■		

STRATEGY 2. Monitor Health System Performance

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
2.2. TB information generated on time, analyzed and used	**Local**							
	Conduct course on TB data management	■	■	■	■			
	Utilize program information to support program planning, monitoring and evaluation and policy development	■	■	■	■	■	■	■
	Conduct regular evaluation and monitoring of all NTP initiatives to include data quality monitoring.*	■	■	■	■	■	■	■
	Adopt web-based TB information system through provision of equipment and capability building on use of software application.				■	■	■	■
	Develop and implement operational researches*				■	■	■	■
	National							
	Develop and implement a web-based electronic information system ITIS)		■	■	■	■	■	■
	Consolidate, analyze and generate annual program performance report and disseminate to stakeholders both for drug-susceptible and drug-resistant TB cases*	■	■	■	■	■	■	■
	Conduct regular evaluation and monitoring of all NTP initiatives*				■	■	■	■
	Simplify and standardize NTP records and reports*				■			
	Develop and support implementation of operational researches*				■	■	■	■
2.3. TB information system integrated with the DOH Unified Health Management Information System (UHMIS)	**Local**							
	Implement, collect data and assess LGU scorecard	■	■	■	■	■	■	■
	Improve staff capability for MSE activities* (cost with 2.2)					■	■	■
	National							
	Enhance Epidemiology Bureau (EB) and Knowledge Management Information and Technology Service (KMITS) capacity to manage an integrated TB information system**	■	■			■	■	■
	Develop, update and implement national TB M&E**(cost with 2.2)	■	■			■		
	Support reforms in health information system		■	■				
	Consolidate and analyze TB program data as part of LGU scorecard	■	■	■	■	■	■	■
	Develop standardized assessment tool for use during PIRs*					■		
	Link the ITIS system to other DOH info systems such as the Clinic Information Systems, FHSIS, HOMIS and NOSIRS*					■	■	■
	Ensure provision of technical and logistical support to implement expanded IT IS to include hardware support*					■	■	■
	Renew TB as a notifiable disease*					■		

STRATEGY 3. Engage Both Public and Private Health Care Providers

Original/Revised Performance Targets	Key Activities	2010	2011	2012	2013	2014	2015	2016
3.1. At least 50% of provinces and cities have functional province/citywide referral system	**Local**							
	Collect information on the different TB service delivery points (RHUs, HC, PPMDs, government and private clinics, HMOs, etc.) and their capacities	■	■	■	■	■	■	
	Develop local DOTS directory (e.g. DOTS facilities, microscopy centers, culture centers, jails, drugstores, etc.)*					■		
	Establish public-private/public-public referral network among service delivery points/Implement the TB DOTS referral system**	■	■	■	■	■	■	■
	Provide enablers to participating facilities e.g. (drugs, lab supplies, PhilHealth package)*					■	■	
	Implement sustainability measures for the old and new PPMDs/PP network	■	■	■	■	■	■	■
	National							
	Develop, update and disseminate guidelines and tools for the establishment and maintenance of TB-DOTS referral networks*	■	■			■		
	Assess sustainability mechanisms	■	■					
	Develop and disseminate DOTS packages for service delivery points	■	■					
	Review national policies and guidelines on PPM, update and disseminate		■	■				
	Update national DOTS directory to include laboratory facilities*					■		
	Assess the status of PPM mechanism in provinces and cities where they were installed*					■	■	
	Provide support to provincial/city PP mechanisms**					■	■	■
3.2. 90% of public hospitals and 65% of private hospitals are participating in TB control either as DOTS provider or referring center	**Local**							
	Assess hospital capacity to participate in TB control	■	■	■	■	■		
	Conduct a phased implementation of hospitals as DOTS referring (P2P) or as service provider							
	Government	20%	30%	50%	70%	80%	90%	90%
	Private	5%	20%	30%	40%	50%	60%	65%
	Implement financial incentives and regulatory measures in hospitals	■	■	■	■	■	■	■
	National							
	Revise hospital-based DOTS policies and guidelines				■	■		
	Develop hospital DOTS manual					■		
	Coordinate with other organizations such as Philippine Hospital Association and professional societies	■	■	■	■	■	■	■
	Introduce and implement financial incentives for hospital adherence to DOTS			■	■	■	■	■
	Engage the medical directors in successfully implementing hospital-based TB DOTS to advocate to and mentor additional hospitals*					■	■	

STRATEGY 3. Engage Both Public and Private Health Care Providers

Original/Revised Performance Targets	Key Activities	2010	2011	2012	2013	2014	2015	2016
3.3. Fifteen (15%) percent of notified TB cases contributed by the private providers	**Local**							
	Train members of the six signatory professional societies on ISTC	■	■	■	■	■		
	Link PPs to DOTS facilities, both basic DOTS and PMDT facilities)	■	■	■	■	■	■	■
	National							
	Adapt ISTC to the Philippine context	■						
	Assist the six professional societies and LGUs to plan and roll-out training of its members on ISTC	■	■	■				
	Advocate to other medical and paramedical societies e.g. (AMHOP, PNA, PAMET, PHA, PPHA, etc.)		■	■	■	■		
	Advocate and incorporate ISTC in medical and paramedical curricula				■	■	■	
	Develop and implement mechanism to promptly pay PP share in PhilHealth outpatient benefit package	■	■	■	■	■	■	■
	Develop and implement private market incentive mechanisms to ensure compliance (e.g. competitive pricing for both public and private sector)		■	■	■	■	■	■
	Support inter-local health zones to expand DOTS beyond the existing PPMD and hospital DOTS sites to reach neighboring hospitals and associated physicians*					■	■	■
	Issue clear guidance on how to manage patients referred after partial private sector treatment*				■	■	■	■
3.4. At least 95% of all DOTS facility staff are equipped to deliver quality TB services	**Local**							
	Identify appropriate staff for training	■	■	■	■			
	Conduct capability-building activities based on needs	■	■	■	■	■	■	■
	Conduct orientation on MOP 5th edition*					■		
	National							
	Integrate some DOTS trainings with training courses of other infectious diseases		■	■	■			
	Develop integrated DOTS training program and conduct TOT*					■		
	Support development of CPG for adults and children*					■		
	Establish and update HR information system	■	■	■	■	■	■	■
	Develop other learning platforms (e.g. NTP web-based training program/ learning module (offline/online)) and link with DOTS certification and PRC (requirement for renewal of license)*				■	■	■	■
	Develop and implement post-training evaluation (level 3 and 4 – application of learnings)*				■	■	■	■
	Support implementation of health human resource strategic plan managed by the DOH-HHRDB	■	■	■	■	■	■	■
	Develop and implement a regular, semi-annual human resource development program	■	■	■	■	■	■	■

STRATEGY 4. Promote and Strengthen Positive Behavior of Communities

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
4.1. Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	**Local**							
	Conduct TB service barrier analysis based on Client satisfaction survey (CSS) results*		■	■	■			
	Develop and implement local TB Strategic Communication Plan based on the national communication sub-plan	■	■	■	■	■	■	■
	Produce and disseminate behavior change communication (BCC) strategies to reach critical mass.		■	■	■	■	■	
	Advocate and enforce compliance with policies on anti TB drugs dispensing)**			■	■	■	■	
	Engage LGUs/information officers in the dissemination of communication strategies*					■	■	
	National							
	Develop and Implement framework, tools and policies for ACSM related activities e.g. guidelines, ACSM planning guide, tools for barrier analysis, recording/reporting systems, referral systems, etc.	■	■			■		
	Roll out and conduct orientation of the developed tools, policies and communication sub-plan from the national to the local level to include engagement of journalist and media partners.*					■	■	■
	Develop and implement Advocacy, Communication and Social Mobilization strategic plan in collaboration with NCHP*	■	■	■	■	■	■	■
	Develop capacity building plans for regional and provincial HEPOs and Information officers	■	■					
	Capacitate regional/provincial health education and promotion (HEPOs)/ information officers (IOs) in collaboration with NCHP**		■	■	■	■	■	■
	Establish quality control for material development with built-in evaluation in collaboration with NCHP	■	■					
	Evaluate effectiveness of behavior change strategies				■	■	■	
	Conduct client satisfaction survey				■	■	■	■
4.2. 95% of provinces and 70% of HUCs with less than 5% lost to follow-up	**Local**							
	Build capacity of BHWs, community health teams and community volunteers as treatment partners			■	■	■	■	■
	Conduct enhancement of counselling skills of treatment partners			■	■	■	■	■
	Provide enablers/incentives for treatment partners and patients			■	■	■	■	■
	Regularly supervise BHWs/community volunteers/CHTS	■	■	■	■	■	■	■
	Empower patients through dissemination of ISTC or other means		■	■	■	■	■	
	National							
	Conduct ORs related to defaulters, treatment partners, patient enablers and Health AIDERS (included in 2.2)		■	■		■	■	■
	Develop standard BCC packages for clients and providers based on TB service barrier analysis		■	■	■			
	Develop and disseminate guide on enhancing interpersonal communication (IPC) by health care providers		■	■	■	■	■	■

STRATEGY 4. Promote and Strengthen Positive Behavior of Communities

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
4.3. At least 10% of all notified TB cases were contributed by CBOs/CHTs /BHWs	**Local**							
	Conduct an inventory of and mobilize community based organizations (CBOs) such as CHTs, TB Task Force, NGOs, faith based organizations (FBOs) and patient groups.**		■	■	■	■	■	■
	Build capacity of CBOs, CHTs and other groups to support TB Control activities**		■	■	■	■	■	■
	Establish working partnerships with CBOs and CHTs in support of TB control**		■	■	■	■	■	■
	Develop and implement local policies to sustain participation of CBOs/CHTs*					■	■	■
	National							
	Evaluate TB interventions associated/linked with CBOs and CHTs support to TB control**		■				■	
	Formulate and implement a comprehensive TB patient empowerment strategy*					■	■	■
	Develop and implement policies and guidelines on community participation in TB control	■	■	■				
	Standardize guidelines and tools for referrals in the community and implement and monitor.*				■	■		

STRATEGY 5: Address MDR-TB, TB/HIV and Needs of Vulnerable Populations

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
5.1. A total of 19, 500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs.	**Local**							
	Integrate PMDT case finding services in basic DOTS facilities*					■	■	■
	Screen and detect MDR-TB cases	■	■	■	■	■	■	■
	Build capacity of all PMDT implementing units in case finding*					■	■	■
	Supplement manpower of PMDT implementing units*					■	■	■
	Strengthen referral network to include both public and private facilities for PMDT to include other vulnerable populations**	■	■	■	■	■	■	■
	Provide access to diagnostic services for MDRTB suspects*					■	■	■
	National							
	Designate and capacitate DOH unit as manager of PMDT	■	■	■	■	■	■	■
	Update/develop policies and implementing guidelines on PMDT case finding activities to include enabler package**	■	■	■	■	■	■	■
	Revise PMDT training modules*					■		
	Establish PMDT treatment facilities in selected provinces and cities nationwide, both public and private*					■	■	■
	Ensure continuous operations of PMDT treatment and laboratory facilities*					■	■	■
	Pursue the on-going development of PMDT packages under PhilHealth	■	■					
	Continue developmental activities such as development of guidelines, policy templates, advocacy tools	■	■	■				

STRATEGY 5: Address MDR-TB, TB/HIV and Needs of Vulnerable Populations

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
5.2. At least 75% of MDRTB patients are successfully treated	**Local**							
	Support the operations of MDR-TB treatment facilities including community-based PMDT services*					■	■	■
	Ensure treatment of all MDR-TB patients*	■	■	■	■	■	■	■
	Provide need based and customized enablers and support (e.g. psychosocial, hospitalization, feeding program to MDR-TB patients)*	■	■	■	■	■	■	■
	Build capacity of MDR-TB patients as counsellor and or treatment partner to reduce lost to ff-up rate*	■	■	■	■	■	■	■
	Build capacity of MDR-TB patients to organize patient support group and implement livelihood programs*					■	■	■
	National							
	Facilitate procurement and distribution of second-line anti-TB drugs and ancillary medicines* (laboratory and Xpert machines and cartridges in Strategy 6)*	■	■	■	■	■	■	■
	Strengthen capability of regional consilium*					■	■	■
	Conduct operational/clinical researches (e.g. nine-month regimen, effectiveness of incentives, decentralization)* (included in 2.2)					■		
5.3. At least 80% of enrolled TB cases in HIV Category A and B areas and 80% MDR-TB cases are provided with HIV counselling and testing	**Local**							
	Expand TB-HIV collaborative activities to high risk areas through the local AIDS councils	■	■	■	■	■	■	■
	Provide HIV counselling and testing for registered susceptible TB cases in Category A and B areas**	■	■	■	■	■	■	■
	Provide HIV counselling and testing to registered drug resistant TB patients nationwide*				■	■	■	■
	Standardize records and reports*					■		
	Ensure that TB patients with HIV are provided with ART and CPT**	■	■	■	■	■	■	■
	Establish functional referral system among DOTS facilities, PMDT treatment facilities, Xpert MTB/RIF sites and HIV treatment hubs*					■	■	■
	Capacitate HIV treatment hubs in the management of PLHIV with TB*					■	■	■
	Provide assistance for PLHIV patients screened for TB (e.g. DSSM, Chest x-ray examination, Xpert MTB/RIF)*					■	■	■
	National							
	Conduct joint surveillance of HIV/AIDS among TB patients and vice versa		■		■		■	
	Establish and maintain TB-HIV collaboration activities in priority areas	■	■	■	■			
	Facilitate the issuance of the revised "Policies and guidelines on the collaborative approach for TB HIV prevention and control*					■		
	Formulate guidelines on IPT for PLHIV*				■			
	Strengthen the HIV/AIDS treatment hubs to manage TB/HIV co-infected clients	■	■	■	■	■	■	■
	Conduct operational researches (cost under Strategy 2)					■		

STRATEGY 5: Address MDR-TB, TB/HIV and Needs of Vulnerable Populations

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
5.4. 730,000 children provided with anti-TB treatment or given INH preventive therapy	**Local**							
	Implement childhood TB program	■	■	■	■	■	■	■
	Engage the private sector at the local level through the local pediatric chapters	■	■	■	■	■	■	■
	Detect and treat children with TB	■	■	■	■	■	■	■
	Provide IPT to children	■	■	■	■	■	■	■
	Support conduct of studies*						■	■
	National							
	Revise and implement policy on pediatric drugs – shift from SDF to FDC					■		
	Conduct external evaluation of current guidelines and review current estimates of childhood TB cases		■					
	Reactivate TWG on childhood TB*					■		
	Integrate in the guideline on the use of Xpert among presumptive TB among children*					■		
	Coordinate with Family Health Office to include childhood TB in their IMCI manual and training*					■		
	Coordinate with PPS the quarterly reporting of children with TB through their chapters*					■		
	Develop and implement communication plan on childhood TB*					■		
	Evaluate the diagnostic algorithm for children*						■	
	Assess factors affecting childhood TB screening and treatment and IPT implementation*						■	
	Continue collaboration with CUP government agencies such as DSWD, DepEd, NCIP	■	■	■	■	■	■	■
	Orient school health personnel on NTP including referral system**	■	■	■	■	■		
	Review and update the integrated Adult and TB in Children Training Module*					■		
5.5. Jails and prisons at all levels provide access to DOTS services to all inmates	**Local**							
	Conduct phased expansion of TB program in jails (municipality, city, district, provincial)/prisons initiative to cover all facilities.	40%	50%	60%	75%	90%	100%	100%
	Detect and provide treatment	■	■	■	■	■	■	■
	National							
	Revise TB policy and M&E among inmates*					■		
	Coordinate implementation of TB prison initiatives with national government partners (BuCor, BJMP and others)	■	■	■	■	■	■	■
	Conduct external evaluation and monitoring of TB program in jails/prisons* (cost with Strategy 2)			■	■			

STRATEGY 5: Address MDR-TB, TB/HIV and Needs of Vulnerable Populations

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
5.6. **Policies, operational guidelines and models developed, disseminated and locally adopted to address needs of vulnerable population**	**Local**							
	Identify and profile vulnerable groups in the locality		■	■	■			
	Supplement health center/RHU staff with "health AIDERS" (accelerating the implementation of DOTS enhancements to reach special sub-group) in 300 "poor" municipalities*					■	■	■
	Implement local initiatives in accordance with national guidelines		■	■	■	■	■	■
	National							
	Conduct a comprehensive study on the size, distribution, health-seeking behavior, needs and rights of vulnerable population (IPs, rural/urban poor, those living in congregate settings, victims of disaster, diabetics)	■	■	■	■	■		
	Develop plan, policies and models to ensure access to DOTS services by the vulnerable populations		■	■	■	■	■	
	Develop implementation tools such as operational guide, training module, training materials, advocacy, etc.		■	■	■			
	Coordinate implementation and monitoring of models with concerned government agencies (e.g. DSWD, NCIP, NASPCP)		■	■	■	■	■	■
	Support the implementation of MDG12					■	■	■

STRATEGY 6. Regulate and Make Available Quality TB Diagnostic Tests and Drugs

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
6.1. At least 95% of all TB microscopy laboratories within the NTP laboratory network are providing diagnostic services within EQA standards	**Local**							
	Strengthen local implementation of quality assurance program for laboratory services: a) Expand province/city-wide EQA for direct smear sputum microscopy (DSSM) of both public and private* b) Build capability-building for provincial/city QA center validators	■	■	■	■	■	■	■
	Implement all systems developed at the national level*				■	■	■	■
	National							
	Review, revise and implement guidelines for microscopy centers including QA**	■	■			■	■	■
	Establish and implement QA for Culture and DST and RDT					■	■	■
	Establish and implement certification of quality assured TB laboratories					■	■	■
	Build leadership and managerial capacity of the TB laboratory network managers including NTRL and CHDs*	■	■	■	■	■	■	■
	Capacitate and deploy NTRL engineering team for certification*					■	■	■
	Develop and implement human resource development program*	■	■	■	■	■	■	■
	Develop and implement facility and equipment management system and maintenance*				■	■	■	■
	Strengthen supply management system*				■	■	■	■
	Procure and distribute laboratory supplies	■	■	■	■	■	■	■
	Conduct semi-annual TB laboratory performance review (include in M&E)	■	■	■	■	■	■	■
	Explore new diagnostics through ORs			■	■	■	■	■

STRATEGY 6. Regulate and Make Available Quality TB Diagnostic Tests and Drugs

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
6.2. TB microscopy services are expanded to improve access.	**Local**							
	Identify/assess needs of GIDA and urban areas	■	■	■	■			
	Improve existing TB laboratories by upgrading space**	■	■	■	■	■	■	■
	Establish at least additional 300 TB microscopy centers across the country to attain one TB laboratory for less than 100,000 population either through establishment of new TB laboratory or utilizing hospital/private laboratory or utilizing malaria microscopy centers**	■	■	■	■	■	■	■
	Engage private laboratories*				■	■	■	■
	Adopt innovative approaches in expanding DSSM/Establish 1,200 remote smearing stations*	■	■	■	■	■	■	■
	Conduct capability-building activities for microscopists	■	■	■	■	■	■	■
	Augment laboratory supplies and reagents	■	■	■	■	■	■	■
	National							
	Develop policies and guidelines on innovative approaches to expand services to GIDA and other population groups	■	■	■	■	■		
	Procure and distribute 900 light microscopes and 600 FM LED microscopes**	■	■		■	■	■	■
6.3. Culture, DST and new technologies are scaled up.	**Local**							
	Establish and support 155 sites that will use Xpert MTB/RIF for diagnostics and MDR-TB screening*				■	■	■	■
	National							
	Develop policies for the roll out and use of new diagnostic tools and conduct TOT*				■	■		
	Establish and maintain 29 culture laboratories*	■	■	■	■	■	■	■
	Support seven culture laboratories in also doing DST*	■	■	■	■	■	■	■
	Conduct researches on TB diagnostics based on research agenda*				■	■	■	■

STRATEGY 6. Regulate and Make Available Quality TB Diagnostic Tests and Drugs

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
6.4. No stock-outs of anti-TB drugs (both FLD and SLD) and laboratory supplies in 90% of DOTS/ laboratory facilities in the last 6 months	**Local**							
	Distribute at least one quarter supply of drugs and laboratory supplies to DOTS facilities**	■	■	■	■	■	■	■
	Augment supply of anti- TB drugs and laboratory supplies when needed**	■	■	■	■	■	■	■
	Improve local pharmaceutical management system	■	■	■				
	Monitor compliance to "prescription only" policy of selling of anti-TB drugs in drug stores	■	■	■	■	■	■	■
	Conduct sample testing of locally procured anti-TB drugs*					■	■	■
	National							
	Conduct comprehensive study of logistics management*					■		
	DOH central procurement of all quality-assured, first line anti-TB drugs (FDCs) and laboratory supplies to include buffer stock through appropriate delivery schedule**	■	■	■	■	■	■	■
	Address supply chain issues for TB such as forecasting, selection, procurement, distribution and storage.					■	■	■
	Develop logistics management manual*					■		
	Establish procurement mechanism for LGU to access quality assured and reasonably prices drugs and laboratory supplies				■			
	Enhance effective drug/laboratory supply procurement/distribution system and establish corresponding information system through NOSIRS**		■	■	■	■		
	Build supply management skills at regional and provincial levels*		■	■	■	■	■	■
	Explore restricting access of anti-TB drugs in the private market*	■	■	■	■	■	■	■
	Implement early warning system through a tracking system*					■	■	■
	Hire and train logistics team assigned to NTP with TA support from partners*					■	■	■
	Strengthen pharmacovigilance*					■	■	■
	Procure vehicles for the 17 regions primarily for drug distribution*					■	■	

STRATEGY 7. Certify and Accredit TB Care Providers

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
7.1. At least 70% of DOTS facilities are DOH certified and PhilHealth accredited	**Local**							
	Address gaps identified in the self-assessment based on Quality Assurance Plan	■	■	■	■	■	■	■
	Implement social marketing activities	■	■	■	■	■	■	■
	Establish and implement mechanism for public facilities to utilize reimbursement based on policies, such as trust fund for TB outpatient package	■	■	■	■	■	■	■
	National							
	Implement PhilHealth automatic accreditation of DOH certified facilities*				■	■	■	■
	Review and revise certification/accreditation processes based on assessment**	■	■	■	■			
	Incorporate DOTS facility standards into the PhilHealth Benchbook*				■	■		
	Organize and capacitate more certifiers team	■	■	■	■	■	■	■
	Develop/revise TB DOTS PHIC manual on accreditation	■	■	■		■		
	Certify and accredit DOTS facilities	25%	35%	45%	55%	65%	70%	70%
	Explore additional financial incentives to influence behavior of health care providers	■	■					
	Improve information dissemination of certified DOTS facilities (e.g. DOH website)		■	■				
7.2. Standards for hospital participation in TB control included in DOH licensing and PhilHealth accreditation requirements	**Local**							
	Incorporate DOTS standards for hospitals in training activities						■	■
	Implement DOTS standards in local hospitals						■	■
	National							
	Incorporate DOTS standards in PhilHealth benchbook (focus on implementation of DOTS among hospitals)					■		
	Incorporate DOTS standard in DOH licensing requirements					■		
	Train assessors					■		

STRATEGY 7. Certify and Accredit TB Care Providers

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
7.3. Infection control/ laboratory biosafety measures in place in all DOTS facilities and laboratories	**Local**							
	Formulate & implement TBIC plan per facility. Conduct training on infection control/laboratory biosafety			■	■	■	■	■
	Implement local infection control based on national guidelines			■	■	■	■	■
	National							
	Develop and disseminate national policies and guidelines on infection control/laboratory biosafety		■	■		■	■	■
	Develop IC plan and organize national IC committee**					■	■	■
	Provide technical assistance to LGUs in order to put in place infection control/laboratory biosafety		■	■	■	■	■	■
	Evaluate and monitor infection control practices		■	■	■	■	■	■

STRATEGY 8. Secure Adequate Financing and Improve Allocation and Efficiency of Fund Utilization

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
8.1. Reduced redundancies and gaps by harmonizing financing of TB prevention and control	**Local**							
	Develop the TB subplan in the AOP/PIPH using the TB costing module	■						
	Present the plan to local LCE for approval and support	■	■	■	■	■	■	■
	Update yearly the TB control plan under AOP/PIPH		■	■	■	■	■	■
	Lobby for local budget for TB control (e.g. to include provision of anti-TB drugs buffer stock)**	■	■	■	■	■	■	■
	Obtain and utilize performance-based grant	■	■	■	■	■	■	■
	National							
	Establish FAPs development pipeline and enhance coordinating mechanism for FAPs for TB	■			■			
	Manage the FAPs development pipeline and coordinating mechanism		■	■	■	■	■	■
	Develop a province-wide investment plan framework and TB costing module	■						
	Incorporate a TB funding requirements in DOH health sector expenditure framework	■	■	■	■	■	■	■
	Incorporate a TB module in the DOH-LGU resource tracking module		■					
	Develop and implement TB performance based grant monitoring tool		■	■	■	■	■	■
	Sign MOA between CHDs and LGUs for performance-based grants	■	■	■	■	■	■	■
	Review and harmonize financing resources for TB; explore benefits for the patients from ECC, SSS, GSIS; Review CUP policies.*					■		

STRATEGY 8. Secure Adequate Financing and Improve Allocation and Efficiency of Fund Utilization

Performance Target	Key Activities	2010	2011	2012	2013	2014	2015	2016
8.2. National government and PhilHealth funds leveraged to secure LGU commitments	**Local**							
	Submit timely and accurate program report as basis for release of funds and commodities	■	■	■	■	■	■	■
	Leverage for issuance of local policies and budgets for TB*				■	■	■	■
	National							
	Allocate NTP resources in cash or in kind based on performance reports	■	■	■	■	■	■	■
	Communicate to the LGUs the support given for TB and provide technical support*					■	■	■
8.3. PhilHealth's role expanded through greater availability of accredited providers and increased utilization of TB-DOTS package	**Local**							
	Expand membership to the informal sector*			■	■	■	■	■
	Advocate for issuance of PhilHealth revised guidelines ensuring that LGUs adhere to the allocation guidelines for the TB DOTS OPB Package*	■	■	■	■	■	■	■
	Identify the number of enrolled vs. number of cases paid for TB DOTS OPB Package through PhilHealth info system and IT IS*	■	■	■	■	■	■	■
	National							
	Enhance PHIC case payment guidelines based on PHIC Benefit Delivery Review results. Review the TB specific results of BDR, If none, conduct TB BDR*	■	■	■				
	Expand PHIC coverage for treatment cases and explore coverage for MDR-TB patients**	■	■	■	■	■	■	■
	Develop mechanism for LGUs to follow guidelines on allocation (e.g. trust fund mechanism for TB-DOTS package)		■					
	Strengthen social marketing of TB DOTS package	■	■					
	Propose to include the number of enrolled versus number of cases paid for TB-DOTS package by LGUs in the LGU score card	■						
8.4. Alternative funding models developed	**Local**							
	Implement financial models for health such as business model, resource mobilization from non-traditional sources, user fees*					■	■	■
	National							
	Assess existing financing models for health*				■	■		
	Develop financing models/guidelines for health*					■		
	Pilot financing models for health*						■	■

*new activity
**modified activity

FINANCING REQUIREMENTS

Costing Methodology

The PhilPACT costing tool developed in 2009 to estimate the financing requirements of the medium-term TB control strategy is the same tool used in determining the costing requirements of the updated PhilPACT. While the costing tool's structure is patterned to that of WHO's budgeting tool for NTP, it is also aligned with PhilPACT and computes the annual costs requirements for all activities listed under the eight strategies of PhilPACT which now includes additional activities to achieve new/revised performance targets. Annual costs are estimated within the period 2010–2016.

Similar costing assumption parameters were used for the period 2010-2013. Hence, most of the costing requirements per activity for this period did not change while some activities that were not accomplished within the scheduled year were either removed or moved into latter period. Changes in costing requirements for the period 2014–2016 were due to the following circumstances or conditions:

- Increase in program targets based on latest data and results of recent assessments
- Integration of the four sub-plans into the updated PhilPACT which resulted in addition or deletion of performance targets and activities
- Scaling up of activities due to availability of new diagnostics
- Systems improvement/strengthening
- Additional activities due to increased program targets and the availability of funds from the Global Fund's new funding model (NFM) and other FAPs
- Harmonization of unit cost assumptions based on current price or any changes relative to 2009 price previously used in the original computation
- Number of LGUs and health facilities were updated, as needed

The estimated financing commitments were updated based on the information gathered from DOH budget and FAPs documents. Identification of potential financing are estimated per strategy level due to inadequate information per activity level. The costing tool provides the financing commitments per strategy per year. However, USAID other projects' budget was incorporated into the total financing commitments for FAPs.

The funding gap is computed as financing requirements less financing commitments. This is done per strategy, and aggregated across all strategies and for all years of PhilPACT planning.

Summary of Financing Requirements and Funding Gaps

The total financing requirement for PhilPACT implementation is PhP29 billion, more than 26 percent increase based on its previous requirement. The breakdown by strategy and year is shown in the next table.

Table 16: PhilPACT Financing Requirements by Strategy and Year in Philippine Pesos

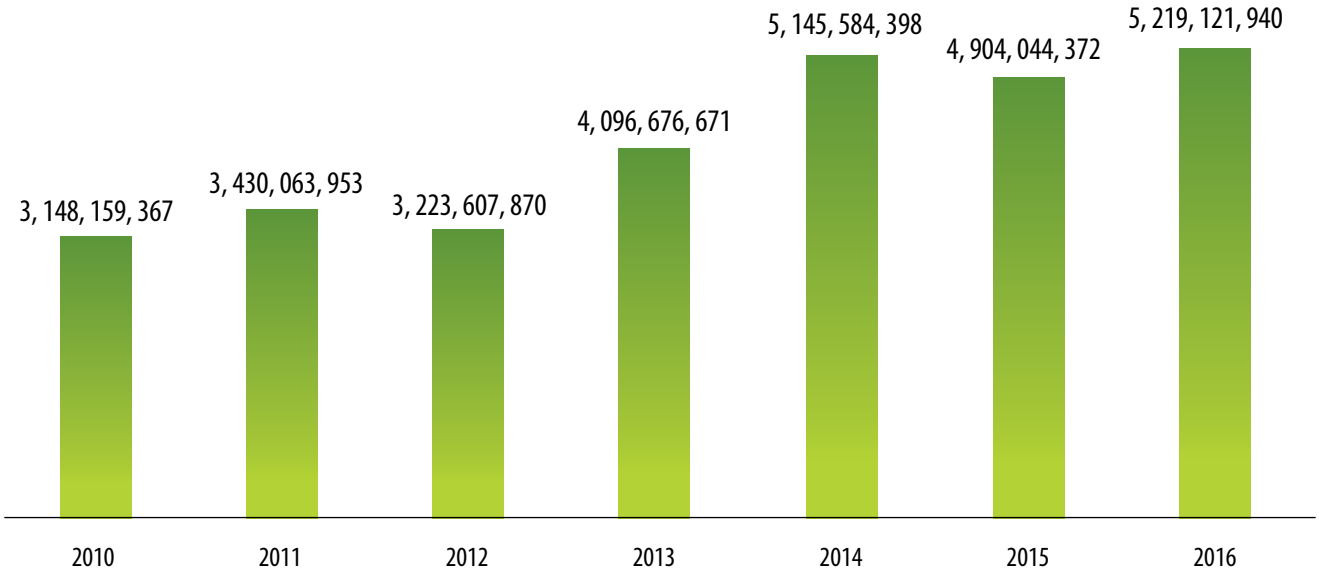
Strategy	2010	2011	2012	2013	2014	2015	2016	TOTAL
1. Localize TB control program implementation	238,669,191	223,129,174	230,529,176	238,803,522	244,845,859	241,267,204	246,313,821	1,663,557,947
2. Monitor health system performance	65,392,583	106,323,271	11,828,600	39,683,600	98,466,779	90,301,673	95,543,187	507,539,693
3. Engage both public and private TB care providers to adopt DOTS	464,521,801	469,746,850	442,525,867	418,834,505	449,421,045	433,998,396	433,708,408	3,112,756,872
4. Promote and strengthen positive TB behavior of communities	415,087,013	485,016,758	523,858,854	486,888,466	446,203,003	379,704,833	357,370,358	3,094,129,284
5. Address MDR-TB, HIV/TB co-infection and needs of vulnerable populations	1,118,853,018	1,523,895,763	1,331,419,417	1,413,029,293	1,647,409,698	1,759,705,370	1,976,128,257	10,770,440,817
6. Regulate and make available quality TB diagnostic tests and anti-TB drugs	825,157,617	593,388,492	615,403,375	1,429,501,843	2,199,978,170	1,946,753,053	2,058,244,066	9,668,426,616
7. Certify and accredit TB care providers	12,260,644	22,991,644	62,674,580	63,709,944	51,269,844	40,458,344	39,958,344	293,323,341
8. Secure adequate funding and improve efficiency of fund utilization	8,217,500	5,572,000	5,368,000	6,225,500	7,990,000	11,855,500	11,855,500	57,084,000
TOTAL	3,148,159,367	3,430,063,953	3,223,607,870	4,096,676,671	5,145,584,398	4,904,044,372	5,219,121,940	29,167,258,571

Costing requirements of updated PhilPACT for 2010–2016 based on the original costing increased in all strategies except for strategy 7 and strategy 8. The decrease in cost was due to the deletion or transfer of some of the activities under these strategies based on the results of PhilPACT midterm review.

Table 17. Cost Per Strategy, Original and Updated PhilPACT, 2010–2016

Strategy	PhilPACT 2010–2016	Updated PhilPACT 2010–2016
1. Localize TB control program implementation	1,190,931,988	1,663,557,947
2. Monitor health system performance	269,536,054	507,539,693
3. Engage both public and private TB care providers to adopt DOTS	2,874,237,942	3,112,756,872
4. Promote and strengthen positive TB behavior of communities	3,032,629,660	3,094,129,284
5. Address MDR-TB, TB-HIV co-infection and needs of vulnerable populations	9,694,498,410	10,770,440,817
6. Regulate and make available quality TB diagnostic tests and anti-TB drugs	4,610,888,260	9,668,426,616
7. Certify and accredit TB care providers	436,415,897	293,323,341
8. Secure adequate funding and improve efficiency of fund utilization	922,674,000	57,084,000
TOTAL	23,031,812,212	29,167,258,571

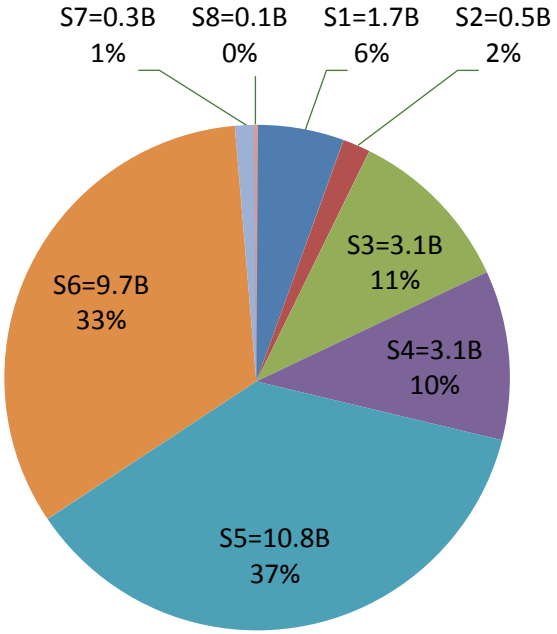
Figure 6. Estimated Annual Financing Requirements of PhilPACT, 2010–2016, in Philippine Peso



Annual costs vary from PhP3.2 billion in 2010 to PhP5.7 billion in 2016. Frontloading of activities occurs mostly during the first two years and again in 2013-2014 due to implementation of new activities including establishment of additional laboratories and procurement of new equipment. Highest financing requirement is on 2016 comprised of costly activities such as the next DRS scheduled on 2016 and higher PBGs.

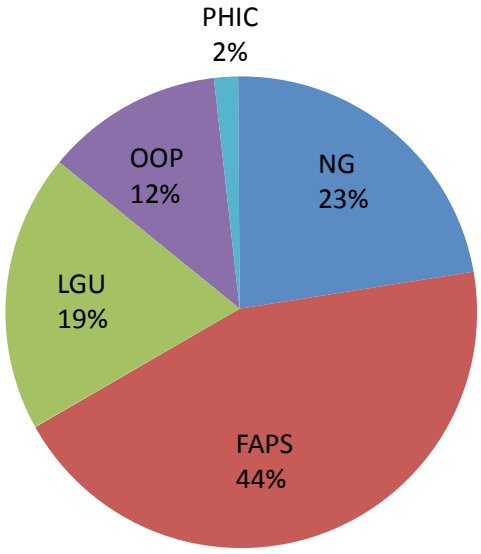
Strategy 5 and strategy 6 account for most of the financing requirements at 70 percent of the total. Although strategy 6 increased almost in double, strategy 5 is still highest in financing requirement per total. Strategy 8 has the least cost at less than $ 1 B.

Figure 7. Distribution of Estimated PhilPACT Cost by Major Strategy



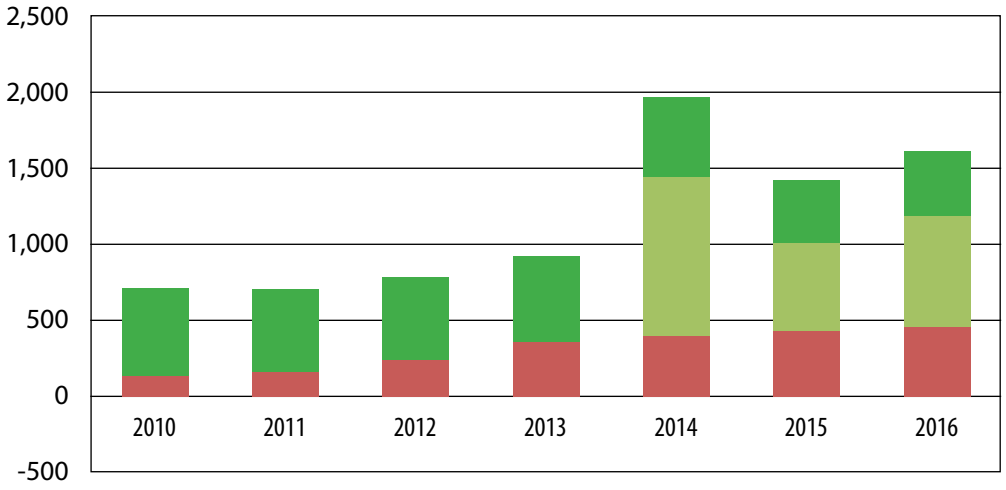
FAPs account for the lion's share of prospective PhilPACT funding (44%) which is attributed to the additional funding commitment from FAPs to fund new interventions, followed by the national government (23%) and LGUs (19%). Projected out-of-pocket expenditures for TB DOTS remains significant at 12% due to payments to private providers as well as the transportation costs incurred.

Figure 8. Share of PhilPACT Financing by Stakeholder/Source



Despite known commitments of FAPs and expected national government funding, funding gaps are expected to persist due to out-of-pocket expenditures and programmed LGU expenditures that have yet to be secured. The total funding gap is PhP8 billion and is expected to increase in 2014 due to additional activities for scaling up of interventions.

Figure 9. Estimated Funding Gap, 2010–2016 (in Million Pesos)



	2010	2011	2012	2013	2014	2015	2016	TOTAL
NG	0	0	0	0	0	0	0	0
FAPS	0	0	0	0	1,035	578	742	2,356
LGU	144	164	245	361	400	434	454	2,202
OOP	563	541	542	561	536	415	425	3,582
PHIC	0	0	0	0	0	0	0	0
TOTAL	706	705	786	922	1,971	1,427	1,622	8,140

IMPLEMENTING ARRANGEMENTS

The implementing structure of the updated PhilPACT as described in pp. 84 – 85 of the original document is not changed.

MONITORING AND EVALUATION

Shows the "modified" monitoring and evaluation matrix that contains the indicators, definition, baseline and targets, sources of data, data collection methodologies and the frequency of reporting.

Due to the revision in the targets corresponding changes in the indicator and targets had been done. It is also harmonized with the recording and reporting system of the Manual of Procedures, 5th ed. Additional column "definition" was added to make the indicator clearer. With the planned expansion of the integrated TB information system, most of the data will be generated electronically by 2016. The NTPS will be conducted in 2015. A terminal evaluation of PhilPACT is planned in early 2016.

NTP Harmonized Technical Assistance Needs Matrix (2014 – 2016)

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
1	S1	1.1 80% of provinces/ highly urbanized cities (HUCs) include TB based on a set criteria within PIPH/AIPH/ CIPH	• Develop guidelines and checklist in developing LGU plans with TB control initiatives and training of ROs as evaluators • Enhance the PhilPACTized TB sub-plan of PIPH, CIPH, AIPH, and AOP	IMPACT		National		x	x	
2	S1	1.2 70% of provinces/ HUCs are at least DOTS compliant	• Revise the DOTS compliance assessment tool (DCAT) • Conduct regional orientation on the revised DCAT	IMPACT			Ongoing	x	x	
3	S1	1.2 70% of provinces/ HUCs are at least DOTS compliant	Training of LCEs on Health Leadership and Governance Program (HLGP)	ZFF	IMPACT	11 USG sites (Mindanao)	Ongoing	x	x	
4	S1	1.3 90% of provinces/ HUCs given performance-based grants (PBGs) have achieved and sustained program targets (CDR and cure rate)	• Development guidelines on TB PBG • Craft monitoring tool to track utilization of TB PBG	HPDP	IMPACT	National		x	x	
5	S1	1.4 At least 70% of national, regional, and provincial/city teams have been trained and supported to manage TB control program	• Develop integrated training course on TB control program management (clinical, programmatic, laboratory, and logistics management) • Operations and strategic management workshop for regional TB managers • Update and integrate MSE training course in NTP program management course • Capability building of DOH NTP MO on PMDT management	IMPACT SIAPS (on pharma-ceuticals)	TASC WHO			x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
6	S1	1.4 At least 70% of national, regional, and provincial/city teams have been trained and supported to manage TB control program	Conduct local exchange program on TB control best practices	NTP IMPACT (local); GF (inter-national)		IMPACT/local – in USG sites; NTP/ local – non-USG sites	2015	x		
7	S1	1.4 At least 70% of national, regional, and provincial/city teams have been trained and supported to manage TB control program	• Develop and train DOH regional offices (ROs) on budgeting, expenditure management, procurement, and contracting • Training on how to outsource NTP support services (ROs/provinces/ cities), including DOH procurement law and processes • Identify private TA providers of outsourced TB services	HPDP IMPACT		Nationwide		x		
8	S1	1.4 At least 70% of national, regional, and provincial/city teams have been trained and supported to manage TB control program	Organizational development (planning, HR, finance, etc.); plan for NTP national/regional level (IDO) – with PMDT	IMPACT GF	TASC	Central and Regional	2015	x		
9	S1	1.4 At least 70% of national, regional and provincial/city teams have been trained and supported to manage TB control program	Pharmaceutical management workshop and mentoring at central level only (includes NTRL)	SIAPS	IMPACT	Central		x	x	

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
10	S1	1.5 All PP coordinating bodies national, regional, and provincial levels – have established and sustained to include CUP mechanisms	• TA to strengthen/operationalize NCC (PhilPACT oversight), RCC, and PCC • Formation of provincial multisectoral alliances (PMSAs) (Note: IMPACT covers provinces and highly urbanized cities only) • Assist provincial and HUC health offices in the formation/ maintenance of MSAs	IMPACT	World Vision CHANGE NCHP	National, Regional, USG for PCC	Ongoing	x		Note: Also answers the S4 indicator
11	S1	1.5 All PP coordinating bodies -national, regional and provincial levels - have established and sustained to include CUP mechanisms	Support LGUs in policy development for no prescription-no dispensing of anti-TB drugs	IMPACT	LGU leagues ZFF		Ongoing	x		
12	S1	1.5 All PP coordinating bodies- national, regional and provincial levels - have established and sustained to include CUP mechanisms	Provide technical assistance to CUP partners: Writeshop with DILG GO-FAR	IMPACT		National	Ongoing	x		
13	S1	1.5 All PP coordinating bodies - national, regional and provincial levels- have established and sustained to include CUP mechanisms	Technical assistance to CUP partners	IMPACT		National	Q1-Q4 2015	x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
14	S1	1.5 All PP coordinating bodies national, regional and provincial levels- have established and sustained to include CUP mechanisms	Streamline and integrate TB-in-the-workplace program in DOLE training modules (includes identification and development of TA provider for workplace)	IMPACT	National	IMPACT/local – in USG sites; NTP/ local – non-USG sites		x		
15	S1	1.5 All PP coordinating bodies - national, regional and provincial levels - have established and sustained to include CUP mechanismsm	Training on OR	TASC	National	Nationwide		x		March 9-13
16	S2	2.1 Trend of TB burden tracked	Policies and guidelines on mandatory reporting of TB (JPR) - include TB as a notifiable disease	IMPACT WHO	National	Central and Regional		x		
17	S2	2.1 Trend of TB burden tracked	Participate in the 2015 National TB Prevalence Survey	HPDP WHO		Central		x		
18	S2	2.2 NTP information generated on time, analyzed, and used	• Human resource support for ITIS rollout • Assist in the rollout of ITIS in USG sites with KMITS as resource persons; design and develop a GIS to display TA provided and status of assisted sites	KMITS/GF	Nationwide		2015	x		
19	S2	2.2 NTP information generated on time, analyzed, and used	ITIS users training	GF	Nationwide		2016		x	

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
20	S2	2.2 NTP information generated on time, analyzed, and used	ITIS users conference (Luzon, Mindanao)	GF		Nationwide	2016		x	Note: Also answers the S4 indicator
21	S2	2.2 NTP information generated on time, analyzed, and used	ITIS training of trainers	GF		Nationwide	2015	x		
22	S2	2.2 NTP information generated on time, analyzed, and used	Roll out ITIS in all TCs/STCs within the network of project sites	IMPACT		National	Q1-Q4	x		
23	S2	2.2 NTP information generated on time, analyzed, and used	ITIS sustainability planning workshop	GF		Nationwide	2015	x	x	
24	S2	2.2 NTP information generated on time, analyzed, and used	Conduct data quality check	IMPACT		National	2016	x		
25	S2	2.2 NTP information generated on time, analyzed, and used	• Develop M&E plan • Support to NTP in routine M&E	IMPACT TASC		Nationwide	Q1-Q4	x	x	
26	S2	2.2 NTP information generated on time, analyzed, and used	NTP annual performance report	GF		Central and Regional	2015	x		
27	S2	2.2 NTP information generated on time, analyzed, and used	Establish Xpert MTB/RIF electronic networking system	IMPACT WHO		National	2015-2016	x		
28	S2	2.3 TB information system integrated with national M&E framework and with the Unified Health Management Information System (UHMIS)	Develop electronic laboratory information system integrated in ITIS	GF		Central		x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
29	S2	2.3 TB information system integrated with national M&E framework and with the UHMIS	Develop defaulter tracking system integrated into ITIS	IMPACT		Central		x		
30	S3	3.1 At least 50% of all provinces/HUCs have functional province/city-wide referral system	• Reproduction of updated DOTS providers directory • Assist provincial and HUC health offices in the formation/maintenance of MSAs	IMPACT	WHO	IMPACT (USG sites); NTP			x	
31	S3	3.1 At least 50% of all provinces/HUCs have functional province/city-wide referral system	• Develop TA package for establishing local TB DOTS service delivery network • Establish local TB DOTS referral network (TDRN) • Establish referral system between CBOs and RHUs (2015-2016) • Develop local referral system with DepEd schools (part of TDRN), including monitoring of Y2 engagement	IMPACT RIT/JATA	TASC	National, NCR, South Luzon, Visayas, Mindanao USG sites Baliuag Bocaue Calumpit Meycauayan Paombong San Ildefonso	Q1-Q4 2015	x		
32	S3	3.1 At least 50% of all provinces/HUCs have functional province/city-wide referral system	Participate in the 2015 National TB Prevalence Survey	IMPACT TASC		NCR, Mindanao, ARMM	Q1-Q4 2015	x		
33	S3	3.2. 90% of public hospitals and 65% of private hospitals are participating in TB control either as DOTS provider or referring center	• Engage public hospitals and other government facilities as part of TDRN • Engage 200 public hospitals and 400 private hospitals	IMPACT GF			Q1-Q3 2015	x		
34	S3	3.1 At least 50% of all provinces/HUCs have functional province/city-wide referral system	Pharmacy DOTS Initiative	IMPACT	PPhA SIAPS	IMPACT: USG sites ROs: non- USG sites	Ongoing	x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
35	S3	3.2. 90% of public hospitals and 65% of private hospitals are participating in TB control either as DOTS provider or referring center	ITIS users conference (Luzon, Mindanao)	GF		Nationwide	2016		x	Note: Also answers the S4 indicator
36	S3	3.3. All DOTS facility staff are equipped to deliver TB services	ITIS training of trainers	GF		Nationwide	2015	x		
37	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Roll out ITIS in all TCs/STCs within the network of project sites	IMPACT		National	Q1-Q4	x		
38	S3	3.3. All DOTS facility staff are equipped to deliver TB services	ITIS sustainability planning workshop	GF		Nationwide	2015	x	x	
39	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Conduct data quality check	IMPACT		National	2016	x		
40	S3	3.3. All DOTS facility staff are equipped to deliver TB services	• Develop M&E plan • Support to NTP in routine M&E	IMPACT TASC		Nationwide	Q1-Q4	x	x	
41	S3	3.3. All DOTS facility staff are equipped to deliver TB services	NTP annual performance report	GF		Central and Regional	2015	x		
42	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Establish Xpert MTB/RIF electronic networking system	IMPACT WHO		National	2015-2016	x		
43	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Develop electronic laboratory information system integrated in ITIS	GF		Central		x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
44	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Develop new enhanced modules on TB diagnosis in children with TST	IMPACT		National	Q1-Q4 2015	x		
45	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Support public health/NTP track during the PhilCAT annual convention	IMPACT		National		x	x	
46	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Roll out the revised PhilPACT and localize per region	IMPACT					x	
47	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Establish Regional Offices (ROs) as TB technical resource centers (reference hub in the region)	IMPACT			Ongoing	x	x	
48	S3	3.3. All DOTS facility staff are equipped to deliver TB services	Engage and capacitate target private TA providers for outsourcing	IMPACT		x	Q1-Q4 2015	x		
49	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	• Update/Integrate ACSM framework, policies, plans, and tools • Disseminate the manual on practical tools and guidelines for ACSM among ROs • ACSM training for HEPOs	IMPACT	CHANGE World Vision SIAPS TASC CHANGE World Vision NCHP	Nationwide		x		
50	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Organize and operate the ACSM trainers' Community of Practice (CoP)	IMPACT		National	Q1-Q4 2015	x		
51	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Assist DOH ROs and the PHOs in facilitating the formulation of ACSM plans of the MSAs	IMPACT		All sites except ARMM	Q1-Q4 2015	x		
52	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Assist NTP in maximizing social media (Facebook, Twitter)			National	Q1-Q2 2015	x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
53	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Assist in developing national policy for private sector involvement (pharmacy-related laws: Pharmacy Bill, TESDA accreditation of the course for pharmacy assistants)	IMPACT		National	Q3-Q4 2015	x	x	
54	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Review past ACSM (social mobilization teams) initiatives in project sites to look into sustainability of TB task force and other initiatives	World Vision			2015	x		
55	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Include ACSM initiatives in strategic plan	IMPACT		All sites	2015-2016	x	x	
56	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Develop and disseminate IEC materials	CHANGE	All partners	Nationwide	Ongoing	x		
57	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Develop messages and IEC materials for Phase 3 TB mass media campaign (Sticking to DOTS and avoiding development of MDR-TB)	CHANGE		National	Q2-Q4 2015	x		
58	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Media implementation of "Drive-to-DOTS" TV and radio commercial	CHANGE	All partners	Nationwide	Ongoing	x		
59	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Phase 3 TB mass media campaign	CHANGE	IMPACT	National	Q3-Q4 2015	x		
60	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Develop, produce, and market/disseminate a TB music album containing key TB messages through the engagement of performing musical artists as IEC providers	IMPACT		National	Q2-Q3 2015	x		
61	S4	4.1 Proportion of TB symptomatics who are self-medicating and not consulting health care providers reduced by 30%	Develop and implement a comprehensive TB patient empowerment strategy plan (NOTE: Harmonize all identified advocates)	GF	World ision JATA SLB ROMP GF PSG	Nationwide		x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
62	S4	4.2 Number of provinces/cities with ≥5% default rate reduced by at least 50%	• TOT and rollout of IPCC and IEC • Training on barrier analysis for RO, PHO, and CHO staff	IMPACT	World Vision	IMPACT (USG sites); ROs (non-USG sites)	Ongoing	x	x	
63	S4	4.2 Number of provinces/cities with ≥5% default rate reduced by at least 50%	Capacity building for RHMs on supervising treatment partners	IMPACT			Ongoing	x		
64	S4	4.2 Number of provinces/cities with ≥5% default rate reduced by at least 50%	Capacity building for community-based organizations (2015-2016)	RIT/JATA		Bocaue Baliuag Calumpit Meycauayan Paombong San Ildefonso	Q2-Q4 2015	x		
65	S4	4.2 Number of provinces/cities with ≥5% default rate reduced by at least 50%	Monitor and evaluate results/effects of IPCC rollouts and midwives' supervisory training in terms of contribution to TBS referral and diagnosis, and CDR/CR improvement in RHUs	IMPACT				x		
66	S4	4.3 Percentage contribution on referral of TB cases by CBOs/CHTs at least 10% of total TB cases notified	Empower TB-HIV patient groups	GF	ROMP IMPACT			x		
67	S4	4.3 Percentage contribution on referral of TB cases by CBOs/CHTs at least 10% of total TB cases notified	• Engage CBO for local TB control • Engage the Catholics Bishops' Conference of the Philippines (CBCP) in mainstreaming TB in parochial community health care • Support partnership between CBOs/CHTs and DOTS facilities, and refine tools to measure CBO contribution to CNR • Monitor contribution of engaged CBOs to CNR of partner-RHUs	IMPACT				x	x	
68	S4	4.3 Percentage contribution on referral of TB cases by CBOs/CHTs at least 10% of total TB cases notified	Produce directory of NGOs/CBOs that can be tapped as technical assistance providers for community-based DOTS (printing)	IMPACT		Natiowide		x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
69	S4	4.3 Percentage contribution on referral of TB cases by CBOs/CHTs at least 10% of total TB cases notified	• Engage women's groups for TB control and harmonize TB/FP/ MNCHN messages and initiatives • Support youth and children's groups, IEC providers, educators, and treatment partners	IMPACT		National Cebu Leyte All sites	Q1-Q4 2015	x		
70	S4	4.3 Percentage contribution on referral of TB cases by CBOs/CHTs at least 10% of total TB cases notified	Providing technical support to maximize AIDERS	GF	TASC			x	x	
71	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Revise PMDT national policies and guidelines	WHO IMPACT	HPDP SIAPS TASC	Nationwide		x		
72	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Develop and disseminate IEC materials	WHO TASC	IMPACT	Nationwide		x		
73	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Revise training course and tools as part of integrated DOTS training course	WHO	IMPACT SIAPS	Nationwide		x		
74	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	• Guidelines on expansion of PMDT facilities • Update and finalize PMDT Sub-plan (2014-2016) • Develop 2015 operations plan	GF TASC	WHO SIAPS IMPACT	Nationwide		x		
75	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Capacitate DOTS facilities on expanded PMDT services	GF (Non- USG sites) IMPACT (USG sites)		Nationwide		x		
76	S4	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Utilize NDP staff/community health teams as service providers in island municipalities (ambulant PMT treatment provider)	IMPACT		National	Q1-Q4 2015	x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
77	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Train DR TB patients on livelihood activities to provide them a means of generating income	IMPACT		National	Q1-Q4 2015	x		
78	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Empower patients as peer counselors/educators	GF			Nov 2014	x		
79	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Develop integrated TB services in ARMM	IMPACT		ARMM		x		
80	S5	5.1 A total of 19, 500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Green Light Committee visit	WHO	TASC	Selected sites	Per NTP schedule	x		
81	S5	5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Revise local TB policy to include PMDT	IMPACT		USG sites	Ongoing	x	x	
82	S5	5.2 At least 75% of MDR-TB patients are successfully treated	• Advance implementation of community-based PMDT services	TASC GF	IMPACT	NCR		x		
83	S5	5.2 At least 75% of MDR-TB patients are successfully treated	Advance implementation of integrated DOTS (iDOTS)	TASC	GF IMPACT	New selected regions		x		
84	S5	5.2 At least 75% of MDR-TB patients are successfully treated	Capacitate PMDT staff on ADR detection and management, including 9-month and BDQ regimens	GF TASC	IMPACT	Nationwide		x		
85	S5	5.2 At least 75% of MDR-TB patients are successfully treated	Capacitate PMDT staff on ADR detection and management, including 9-month and BDQ regimens	WHO IMPACT		Nationwide		x		
86	S5	5.3 At least 80% of enrolled TB cases in Category A and B areas and 80% MDR-TB cases are provided with HIV counselling and testing	• Capacitate consilium members on MDR-TB case management • Develop consilium operational • guidelines	IMPACT		National		x		Quarterly case presentation for national and regional consilium.

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
87	S5	5.3 At least 80% of enrolled TB cases in Category A and B areas and 80% MDR-TB cases are provided with HIV counselling and testing	• Rapid HIV testing for medical technologists (full and refresher) • Medtech HIV proficiency training	GF		Nationwide	Ongoing	x		
88	S5	5.3 At least 80% of enrolled TB cases in Category A and B areas and 80% MDR-TB cases are provided with HIV counselling and testing	Regular meetings of SDN for PLHIV			Cebu tri-city	Oct 2014 to Sept 2015	x		
89	S5	5.3 At least 80% of enrolled TB cases in Category A and B areas and 80% MDR-TB cases are provided with HIV counselling and testing	• Develop IEC materials on TB-HIV • Reproduce TB-HIV IEC materials developed by GF	GF IMPACT	CHANGE			x		
90	S5	5.3 At least 80% of enrolled TB cases in Category A and B areas and 80% MDR-TB cases are provided with HIV counselling and testing	Monthly meeting of CMT - Klinika Bernardo - Social Hygiene Clinic	ROMP		Quezon City Cebu Lapu-Lapu Mandaue	Oct 2014 to Sept 2015	x		
91	S5	5.3 At least 80% of enrolled TB cases in Category A and B areas and 80% MDR-TB cases are provided with HIV counselling and testing	Capability building of treatment hubs, SHCs, and RHUs on TB-HIV	GF (treatment hubs)		Nationwide		x		
92	S5	5.3 At least 80% of enrolled TB cases in Category A and B areas and 80% MDR-TB cases are provided with HIV counselling and testing	Provider-initiated counseling and testing (PICT) training for Category A and B sites; PMDT sites	GF		Nationwide		x		
93	S5	5.4 Nationwide implementation of childhood TB control program	Scale up behavior change and service delivery models for TB in children as part of integrated DOTS delivery services	IMPACT		Pampanga	Ongoing	x		
94	S5	5.4 Nationwide implementation of childhood TB control program	Intensify TB case finding among children (household contact tracing, integration in nutrition programs)	IMPACT		Cavite Caloocan, Las Piñas, Samar, Sarangani		x		
95	S5	5.4 Nationwide implementation of childhood TB control program	Coordinate with DepEd regional offices to improve TB-in-children program implementation	IMPACT		USG sites (18 sites)	Ongoing	x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
96	S5	5.5 Jails, prisons at all levels provide access to DOTS services to all inmates	• Revision of policy and M&E for TB among inmates; to include PMDT • Revision of policies on TB in prisons (DOH, BJMP, BuCor)	IMPACT	ICRC WHO SIAPS TASC	National All sites		x		
97	S5	5.5 Jails, prisons at all levels provide access to DOTS services to all inmates	Sustain implementation of TB control in prisons and jails	IMPACT		National		x		
98	S5	5.5 Jails, prisons at all levels provide access to DOTS services to all inmates	Capacity building of BJMP regional coordinators in MSE functions	IMPACT ICRC		National		x		
99	S5	5.5 Jails, prisons at all levels provide access to DOTS services to all inmates	• Technical and logistical assistance to detention authorities to improve quality of TB services • Provision of logistical support for intensified case finding	ICRC	IMPACT	Quezon City Jail National Bilibid Prison (NBP)	Ongoing	x		
100	S5	5.5 Jails, prisons at all levels provide access to DOTS services to all inmates	TB mass screening in GIDAs, jails, and prisons using Xpert MTB/RIF	IMPACT		North Luzon Mindanao		x		
101	S5	5.5 Jails, prisons at all levels provide access to DOTS services to all inmates	TB screening in Puerto Princesa City, Palawan provincial jails, and Iwahig prison using digital X-ray, LED-FM, and Xpert MTB/RIF	WHO		Puerto Princesa City, Palawan Province		x	x	
102	S5	5.5 Jails, prisons at all levels provide access to DOTS services to all inmates	Enhance tracking system for inmates released while still on TB treatment	ICRC	IMPACT	Quezon City Jail NBP	Ongoing	x	x	
103	S5	5.5 Jails, prisons at all levels provide access to DOTS services to all inmates	Consultative meeting among jails	ICRC		Nationwide		x		
104	S5	5.6 Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable population	Profiling of vulnerable groups	IMPACT		National Quezon City		x		
105	S5	5.6 Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable population	Expand assistance to the urban poor in other cities by Q2 and Q3 of Y3	IMPACT		Laguna Pampanga Cebu City		x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
106	S5	5.6 Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable population	• Process documentation of TB care initiatives and good practices among indigenous peoples, the urban poor, and youth/adolescents (in school, out-of-school) • Process documentation of other models (IPs, TB among inmates, GIDA)	IMPACT		All sites		x		
107	S5	5.6 Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable population	Develop guidelines for vulnerable groups: congregate setting, PWD, the elderly	IMPACT	World Vision JATA SIAPS HPDP	National; Rizal (Elderly); Muntinlupa (PWD)		x		
108	S5	5.6 Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable population	• Assist in developing national guidelines for TB implementation among vulnerable populations o the urban poor o indigenous peoples o congregate settings o disaster-affected populations	IMPACT		National		x		
109	S5	5.6 Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable populations	• Prepare and implement action plan to rapidly respond to disaster-affected areas • Develop TB-in-disaster materials	IMPACT	All partners			x		
110	S5	5.6 Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable populations	Develop guidelines for the vulnerable group: diabetes	WHO	TASC			x		
111	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Develop quality assurance (QA) guidelines for TB laboratories (DSSM, Xpert MTB/RIF, LPA); training module and rollout	SIAPS NTRL	IMPACT TASC PQM	Nationwide	Amended AO on DSSM: Q2 2014; QA for Xpert and LPA: Q4 2014; final QA for culture and MGIT: Q3 2014	x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
112	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services	• Rapid assessment of o EQA implementation o Xpert MTB/RIF	SIAPS TASC						
113	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services	Laboratory strengthening: Assist LNSP TWG in developing/revising o QAS policy o RSS implementing guidelines	TASC SIAPS IMPACT		National	Q1-Q3 2015	x		
114	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Guidelines on certification of TB laboratories to do TB diagnosis	SIAPS	IMPACT WHO TASC PQM	Nationwide	Guide-lines: Q4 2014		x	
115	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Develop guidelines for laboratory facility and equipment management, pharmaceuticals/ supplies management, and infection control	SIAPS	PQM IMPACT	Nationwide	2015		x	
116	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Develop training materials on biosafety for TB laboratories; pilot training	IMPACT	SIAPS NTRL	NCR		x		
117	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Laboratory strengthening: • Enhance manuals and orientation on microscope maintenance • Review and roll out biosafety guidelines	IMPACT		USG sites (Mindanao, ARMM, North Luzon, Visayas)	Q2-Q3 2015	x		
118	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Organizational strengthening (LNSP)	SIAPS	IMPACT TASC	National	Ongoing	x		
119	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	DSSM policy revision, training, and QA (LNSP) - rollout	SIAPS TASC	IMPACT (USG sites)	Nationwide	Ongoing	x		
120	S6	6.2 TB microscopy services are expanded to improve access	Package revised training modules and TOT on DSSM (LNSP) rollout (includes LED-FM)	IMPACT	SIAPS	National		x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
121	S6	6.2 TB microscopy services are expanded to improve access	Establish remote smearing stations (RSS)	IMPACT	SIAPS	23 sites	Ongoing	x		
122	S6	6.2 TB microscopy services are expanded to improve access	aboratory strengthening: Develop malaria microscopy centers into TB microscopy laboratories	IMPACT		IMPACT sites		x		
123	S6	6.2 TB microscopy services are expanded to improve access	Hire itinerant medical technologists	IMPACT		7 provinces	Ongoing	x		
124	S6	6.3 Culture, DST, and rapid diagnostics centers are scaled up	• TOT on Xpert MTB/RIF	GF	WHO IMPACT			x		
125	S6	6.3 Culture, DST, and rapid diagnostics centers are scaled up	• Develop manual on 4 diagnostic tests (Xpert MTB/RIF, MGIT, LED FM, LPA) • Develop SOPs on new diagnostics	SIAPS	IMPACT TASC	Nationwide USG project sites		x		
126	S6	6.3 Culture, DST, and rapid diagnostics centers are scaled up	Disseminate Administrative Order on the use of rapid diagnostic tests	IMPACT		National	Q1 2015	x		Depends on problems of case finding
127	S6	6.3 Culture, DST, and rapid diagnostics centers are scaled up	• Develop good clinical laboratory practices (GCLP) in laboratory network • Laboratory strengthening: Assist in ISO accreditation of NTRL	SIAPS	PQM IMPACT TASC FDA	National		x		
128	S6	6.4 No stock-outs of anti-TB drugs (both FLD and SLD) and laboratory supplies in 90% of DOTS/ laboratory facilities in the last 6 months	TOT on practical guide for pharmaceutical management	SIAPS	IMPACT PQM	Nationwide		x		
129	S6	6.4 No stock-outs of anti-TB drugs (both FLD and SLD) and laboratory supplies in 90% of DOTS/ laboratory facilities in the last 6 months	Improve drug supply management using the Practical Guide to Pharmaceutical Management: Roll out practical guidelines	IMPACT	SIAPS PQM	North Luzon, South Luzon, Visayas, Mindanao, ARMM		x		
130	S6	6.4 No stock-outs of anti-TB drugs (both FLD and SLD) and laboratory supplies in 90% of DOTS/ laboratory facilities in the last 6 months	Conduct comprehensive assessment of drug supply management in the Philippines	USAID SIAPS		Nationwide	Q3 2014 Done	x		
131	S6	6.4 No stock-outs of anti-TB drugs (both FLD and SLD) and laboratory supplies in 90% of DOTS/ laboratory facilities in the last 6 months	Develop the framework for, tools of, and guidelines on pharmacovigilance	SIAPS	PQM IMPACT TASC FDA	National		x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
132	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services	• Rapid assessment of o EQA implementation o Xpert MTB/RIF	SIAPS TASC						
133	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services	Laboratory strengthening: Assist LNSP TWG in developing/revising o QAS policy o RSS implementing guidelines	TASC SIAPS IMPACT		National	Q1-Q3 2015	x		
134	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Guidelines on certification of TB laboratories to do TB diagnosis	SIAPS	IMPACT WHO TASC PQM	Nationwide	Guide-lines: Q4 2014		x	
135	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Develop guidelines for laboratory facility and equipment management, pharmaceuticals/ supplies management, and infection control	SIAPS	PQM IMPACT	Nationwide	2015		x	
136	S6	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Develop training materials on biosafety for TB laboratories; pilot training	IMPACT	SIAPS NTRL	NCR		x		
137	S7	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Laboratory strengthening: • Enhance manuals and orientation on microscope maintenance • Review and roll out biosafety guidelines	IMPACT		USG sites (Mindanao, ARMM, North Luzon, Visayas)	Q2-Q3 2015	x		
138	S7	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	Organizational strengthening (LNSP)	SIAPS	IMPACT TASC	National	Ongoing	x		
139	S7	6.1 TB laboratory network managed by the National TB Reference Laboratory to ensure that 90% of all participating laboratory diagnostic services are within EQA standards	DSSM policy revision, training, and QA (LNSP) - rollout	SIAPS TASC	IMPACT (USG sites)	Nationwide	Ongoing	x		
140	S7	6.2 TB microscopy services are expanded to improve access	Package revised training modules and TOT on DSSM (LNSP) rollout (includes LED-FM)	IMPACT	SIAPS	National		x		

Row No.	Strategy	Performance Target	TA Needs/Major Activities	Lead Provider	Support Providers	Coverage (National/ Project Sites)	Due Date	2015	2016	Remarks
141	S7	7.1 At least 70% of DOTS facilities are DOH certified and PhilHealth accredited	Technical assistance to DOH regional offices, RCC NTP, and LGU sites (P/C/M) in DOTS certification and accreditation	IMPACT		All regions, all USG sites	Q1-Q4 2015	x		
142	S7	7.1 At least 70% of DOTS facilities are DOH certified and PhilHealth accredited	Pilot implementation of PHIC e-claims submission system and the IHCP e-portal access in select USG sites	IMPACT				x		
143	S7	7.1 At least 70% of DOTS facilities are DOH certified and PhilHealth accredited	Assess and enhance/strengthen the RCC NTP regulatory function TB DOTS certification	IMPACT		Nationwide		x		
144	S7	7.3 Infection control (IC) measures in place in all DOTS facilities and laboratories	Training on and monitoring infection control (IC) for health facilities, including development of IC plan plus monitoring its implementation	IMPACT	GF (for TB-HIV)		Ongoing	x		
145	S8	8.1 Reduced redundancies and gaps by harmonizing financing of TB prevention and control	Engage LGU leagues to solicit policy and funding support	IMPACT		IMPACT USG sites	Ongoing	x		
146	S8	8.1 Reduced redundancies and gaps by harmonizing financing of TB prevention and control	Local TB policy monitoring and tracking	IMPACT		IMPACT USG sites	Ongoing	x		
147	S8	8.3 PhilHealth's role expanded through greater availability of accredited providers and increased utilization of TB-DOTS package	• Revise guidelines of the current TB-DOTS package to include: o Point-of-care enrolment o Increased benefit package o One-time release of benefit	IMPACT	HPDP SIAPS	National USG sites	Ongoing	x		
148	S8	8.3 PhilHealth's role expanded through greater availability of accredited providers and increased utilization of TB-DOTS package	• Develop MDR-TB package • Regional dissemination workshops	IMPACT	TASC HPDP	National		x		
149	S8	8.4 Develop sustainable financing strategies	Develop business model for PMDT laboratories and treatment facilities	GF	IMPACT	Nationwide	2015	x		
150	S8	8.4 Develop sustainable financing strategies	Policies and guidelines on other financing models/ strategies	IMPACT	GF	Nationwide		x		

Table _____. PHILPACT INDICATORS and TARGETS

INDICATORS	DEFINITION	BASELINE & TARGET	DATA SOURCE	FREQUENCY	AGENCIES RESPONSIBLE
IMPACT INDICATORS					
TB Incidence Rate	Estimated number of new TB cases, all forms, per year per 100,000 population	Baseline: 1990: 393 / 100,000 2012: 265 / 100,000 Target by 2016: 246 per 100,000	WHO estimate based on Global TB Report	Annual	NTP/WHO
TB Mortality Rate	Estimated number of deaths due to TB per year per 100,000 population	Baseline: 1990: 55 / 100,000 2012: 24 / 100,000 Target by 2016: 23 per 100,000	WHO estimate based on Global TB Report	Annual	NTP/WHO
TB Prevalence Rate	Estimated number of TB cases per 100,000 population	Baseline: 1990: 1,000 / 100,000 2012: 461 / 100,000 Target by 2016: 414 per 100,000	WHO estimate based on Global TB Report	Annual	NTP/WHO
OUTCOME INDICATORS					
Case Notification Rate (all forms)	Numerator: No. of notified TB cases, all forms (new and relapse) Denominator: Population / 100,000 "Notified" means all forms of TB who were detected, registered and reported to NTP	Baseline: 2009: 166 / 100,000 2012: 223 / 100,000 Target by 2016: 221 per 100,000	NTP report	Annual	NTP
TB Case Detection Rate (all forms)	Numerator: No. of all forms of TB cases detected Denominator: Total no. of all forms estimated to occur countrywide each year	Baseline: 2009: 56% 2012: 82% Target by 2016: 90%	NTP report	Annual	NTP
Treatment Success Rate (all forms)	Numerator: No. of all forms of TB cases cured and treatment completed Denominator: Total no. of all forms of TB cases registered during a specified period	Baseline: 2009: 88% 2012: 90% Target by 2016: 90%	NTP report	Annual	NTP

INDICATORS	DEFINITION	BASELINE & TARGET	DATA SOURCE	FREQUENCY	AGENCIES RESPONSIBLE
Cure Rate (new bacteriologically confirmed)	Numerator: No. of new bacteriologically confirmed TB cases cured Denominator: Total no. of the new bacteriologically confirmed TB cases registered during a specified period	Baseline: 2009 NSP cohort: 80% 2011 NSP cohort: 84% Target by 2016: 2015 cohort: 85%	NTP report	Annual	NTP/WHO
Notification Rate of MDR-TB	Numerator: No. of registered bacteriologically confirmed drug resistant-TB cases (RR/MDR-TB) Denominator: Estimated MDR TB cases among the new and retreatment TB cases	Baseline: 2009: 6% 2012: 15% Target by 2016: 62%	NTP report	Annual	NTP/WHO
Treatment Success Rate of MDR-TB	Numerator: No. of registered bacteriologically confirmed drug resistant-TB cases (RR/MDR-TB) cases cured and treatment completed Denominator: No. of registered bacteriologically confirmed drug resistant-TB cases (RR/MDR-TB) during a specified period	Baseline: 2006 cohort: 63% 2009 cohort: 55% Target by 2016: 2013 cohort: 75%	NTP report	Annual	NTP/WHO

Table 2. PhilPACT Strategies and Indicators

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/ AGENCIES RESPONSIBLE	REMARKS
Strategy 1: Localize TB Implementation of TB control							
1.1. Eighty percent (80%) of provinces and highly urbanized cities (HUCs) include TB control plan based on a set criteria within the Province wide Investment Plan for Health (PIPH) or ARMM Investment Plan for Health (AIPH) or City Investment Plan for Health (CIPH)	% of provinces and HUCs with TB control plan based on set criteria within PIPH/AIPH/CIPH	Numerator: No. of provinces and HUCs with TB control plan based on set criteria within PIPH/CIPH/AIPH Denominator: Total no. of provinces and HUCs	Baseline: 2008: 44 provinces out of 81 (54%) 2012: 81 provinces, 33 cities and ARMM have TB control plan (quality undetermined) Target by 2016: 80%	Review of approved CIPH/PIPH/ AIPH plans with TB control plan	Annual	BLHSD/NTP	

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/ AGENCIES RESPONSIBLE	REMARKS
Strategy 1: Localize TB Implementation of TB control							
1.2. Seventy percent (70%) of provinces and HUCs are at least DOTS compliant	% of provinces and HUCs that are at least DOTS compliant	Numerator : No. of DOTS - compliant provinces and HUCs based on DCAT assessment tool Denominator: Total no. of provinces and HUCs	Baseline: 2009: No data (new initiative) 2012: 39% of those assessed in NCR, III, IVA, IX, X ,XI, XII CARAGA and ARMM Target by 2016: 70%	National registry kept by NTP based on assessment	Annual	NTP	DOTS compliant provinces and HUCs – compliance is based on 8 standards of the DOTS compliance assessment tool (DCAT)
1.3. Ninety percent (90%) of provinces and HUCs given performance grants (PBGs) have achieved and sustained program targets (CDR and TSR)	% of priority provinces and HUCs with performance grants that have achieved and sustained targets	Numerator : No. of priority provinces and HUCs with performance grants that achieved and sustained the target Denominator: Total no. of priority provinces and HUCs that have received PBGs (Cumulative of all provinces that have previously received PBG)	Baseline: 2009: No data/ new initiative 2012: none Target by 2016: 90% of provinces and HUCs with performance grants	Quarterly/ Annual reports by provinces and HUCs	Annual assessment of PBGs	NTP	Priority provinces and HUCs – these are provinces and HUCs as determined by NTP based on CDR, Cure Rate, performance, and absorptive capacity
1.4. At least 70% of national, regional, provincial, and HUC teams have been trained and supported to manage TB control program	Percent of national, regional, and provincial and HUC teams trained to managed TB control program	TB control management to include all capacities (planning, logistics, information, advocacy and MSE) Numerator: No. of teams (national, regional or provincial, HUC) trained to manage TB control program Denominator: Total no. of NTP teams (3 national - NTP, LCP and NTRL teams; 17 regional teams; 81 provinces and 33 HUCs)	Baseline: 2009: No data (included only in 2014) 2012: No data Target by 2016: All (based on criteria to be developed) 1. All national and regional 2. 70% of provinces and HUCs	BLHSD/NTP assessment report Project reports	Annual	NCDPC NTP CHDs	

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/ AGENCIES RESPONSIBLE	REMARKS
Strategy 1: Localize TB Implementation of TB control							
1.5. All PP coordinating bodies at the national and regional and 70% at the provincial/HUC levels have been established and sustained to include CUP mechanisms	% of functional PP coordinating bodies • National • Regional • Provincial/ HUC	Definition of functional PP coordinating body: 1. Written policy (e.g. DO, ordinance, MOA, etc.) that includes: mandate, membership, roles and responsibilities, implementing rules and regulations. 2. Work and financial plan (part of operation plan of program) 3. Minutes of meetings 4. M&E reports Numerator: No. of functional PP coordinating body Denominator: Total no. of "administrative units" National – 1, regional – 17, province – 81, HUC – 33	Baseline: 2009: National Coordinating Committee, National CUP group, Regional Coordinating Committee in 16 regions, very few PP at provincial level 2012: No data Target by 2016: Present at National level, all regions, and 70% of provinces and HUCs	Monitoring reports by NTP and partners	Annual	NTP	These committees are to oversee PhilPACT implementation per issued administrative order
Strategy 2: Monitor health system performance							
2.1. Trend of TB burden tracked	Updated results of surveys to determine TB burden is disseminated	Updated results of the following surveys to determine TB burden are disseminated: 1. Second and Third Drug Resistance Survey (DRS); 2. First sub-national TB Mortality study; 3. 2013 National Demographic Health Survey (NDHS) - specific questions on TB are included Preparatory activities for 2017 NTPS completed	Baseline NPS: 2007: NPS completed Target by 2016: preparation complete for 2017 NTPS	NTP report	2016 (study done in 2017)	NTP	Reset from 2015 to 2017 based on the advice of WHO
			Baseline DRS: 2003: 1st DRS 2012: 2nd DRS data collection completed Target by 2016: 3rd DRS data collection started	Population survey 2nd DRS report NTRL report	2016	NTP/ntrl	
			Baseline in TB mortality study: 2009: None 2012: Assessment done but data inconclusive Target by 2016: 2014 TB sub-national mortality done	Survey	2014	NTP/EB	Per advice of a consultant, this will be done at sub-national level
			Baseline in NDHS: 2008: NDHS completed 2013: NDHS completed Next NDHS in 2018	Population survey Annual NDHS report	2013	NSO	Being done every 5 years

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/AGENCIES RESPONSIBLE	REMARKS
2.2. TB information generated on time, analyzed, and used	Annual NTP report published	MEAsured by the developmental phases, generating outputs within 3 months The annual NTP report to be published by DOH should include: 1. Program accomplishments – national, regional and provincial/ HUC 2. Status of PhilPACT implementation and performance target	BASeline: 2009: No published annual report 2012: No published annual report Target by 2016: 1 report per year to start 2013	Published annual NTP reports	Annual starting 2013	NTP/EB	Report may be both soft and hard copy
2.3. TB information system integrated with the DOH Unified Health Management Information System (UHMIS)	Functional integrated TB information system (ITIS) that is integrated in the Unified Health Management Information System (UHMIS)	Functional TB information system: 1. System design with cross validation application 2. Generate timely accurate reports 3. Nationwide implementation	Baseline: 2009: TB information system not integrated with FHSIS 2012: Integrated TB information system (ITIS) developed Target by 2016: ITIS expanded nationwide and integrated with UHMIS	Generated reports from ITIS KMITS report	Annual	EB KMITS NTP	Integration-harmonization of UHMIS and ITIS data
Strategy 3: Engage Both Public And Private Health Care Providers							
3.1. At least 50% of all provinces and HUCs have functional province / city-wide referral system	Percent of provinces and cities with contribution of non-NTP providers of at least 30% of all notified TB cases, all forms	Functional referral system – with TB cases notified, all forms, who were referred from non-NTP providers (private, other public and community) Numerator: Number of provinces and cities with at least 30% contribution by other public, private and community Denominator: All provinces and cities	Baseline: 2009: No data 2012: No data Target by 2016: at least 50% of all provinces and HUCS	NTP reports	Annual	NTP	Elevated level of referral system from municipality to province or city for wider coverage

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/AGENCIES RESPONSIBLE	REMARKS
3.2. 90% of public hospitals and 65% of private hospitals are participating in TB control either as DOTS provider or referring center	% of hospitals participating in DOTS either as DOTS provider or referring center	Numerator: No. of public hospitals participating in TB control either as DOTS provider or referring center Denominator: Total no. of public of hospitals Numerator: No. of private hospitals participating in TB control either as DOTS provider or referring center Denominator: Total no. of private hospitals	Baseline: 2009: Estimated to be less than 10% of total hospitals 2012: Public: 171/657 (26%) Private: 157/649 (24%) Target by 2016: 90% of public hospitals and 65% of private hospitals	Monitoring of hospitals NTP report by hospitals Project reports PIR	Annual	NTP/ HFDB	
3.3. At least 15% of notified TB cases are from the private providers	% of notified TB cases, all forms who are referred by private providers	Numerator: No. of notified TB cases, all forms, contributed by the private providers Denominator: Total no. of notified TB cases, all forms	Baseline: 2009: different target 2012: 11% of NSP Target by 2016: 15%	NTP report	Annual	NTP	
3.4. At least 95% of all DOTS facility staff are equipped to deliver TB services	% of DOTS facility staff trained/oriented in providing DOTS services (Basic DOTS and DSSM)	Numerator: No. of doctors, nurses, med techs and midwives trained in providing TB services Denominator: Total no. of doctors, nurses, midwives, med techs in the DOTS facility	Baseline: 2009: Estimated to be less than 90% 2012: IMPACT study less than 90% Target by 2016: 95%	RO / project report on the status of training of DOTS facility staff Survey	Annual	NTP	Equipped – HWs are said to be equipped to deliver TB services if they are trained on Basic DOTS including children and PMDT referral (doctors, nurses and midwives), or DSSM (MTs)
Strategy 4 : Promote and strengthen positive behavior of communities							
4.1. Proportion of presumptive TB who are self-medicating and not consulting health care providers reduced by 30%	% of presumptive TB who are self-medicating and not consulting	Numerator: No. of presumptive TB who self-medicated and did consult any provider Denominator: No. of respondents	Baseline: 2007 NPS: 68% Target by 2016: Average of 48% among selected regions	KAP survey in selected regions	2016	NTP	National data collection will be part of the 2017 NTPS, hence, data will be collected in some regions in 2015

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/AGENCIES RESPONSIBLE	REMARKS
4.2. 95% of provinces and 70% of HUCs with lost to follow-up of less than 5% (all forms)	Percent of provinces and HUCs with lost-to-follow up less than 5% (disaggregate by province & HUC)	Numerator: No. of provinces and HUCs with lost-to-follow up less than 5% Denominator: Total no. of provinces and HUCs	Baseline: 2009: different target 2012: 43 provinces/HUCs (NSP only) Target by 2016: 95% provinces and	NTP report	Annual	NTP	
4.3. At least 10% of all notified TB cases were contributed by CBOs/CHTs/ BHWs	Percent of TB cases notified who were referred by CBOs/CHTs/BHWs	Numerator: Total no. of notified TB cases referred by CBOs/CHTs/BHWs Denominator: Total no. of notified TB cases Referrals from CBOs/CHTs/BHWs are counted as long as there is an LGU approved referral form	Baseline: 2009: different target 2012: 4% based on World Vision evaluation reports Target by 2016: 10% of notified cases are referred by CBOs/CHTs/ BHWs	NTP report	Annual	NTP	Organized CBOs - conducts ACSM activities, referral and management of patients; with group and officers who have been trained to support TB control
Strategy 5: TB/HIV, and needs of vulnerable Populations							
5.1. A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs	Cumulative number of registered multi-drug resistant TB cases detected and enrolled to treatment	Cumulative number of drug resistant-TB cases (RR/MDR-TB) cases from 2010 - 16	Baseline: 1999 - 2009: 2,024 cases 2010 - 12: 5,495 Target in 2010 - 2016: 19,500 cases	NTP report	Annual	NTP	
5.2. At least 75% of MDR-TB patients are successfully treated	Percent of MDR-TB who were successfully treated (cured + treatment completed)	Proportion of registered bacteriologically confirmed RR/MDR-TB cases who were cured and completed treatment under PMDT Numerator: Total no. of bacteriologically confirmed RR/MDR-TB cases initiated on Cat IV treatment who were cured and completed treatment Denominator: Total no. of bacteriologically confirmed RR/MDR-TB cases initiated on Cat IV treatment	Baseline: 2006 cohort reported in 2009: 63% 2009 cohort reported in 2012: 55% Target by 2016: 2013 cohort reported in 2016: 75%	NTP report	Annual	NTP	
	Percent of bacteriologically confirmed MDR-TB cases with negative culture after six months of treatment (interim outcome)	Numerator: No. of bacteriologically confirmed RR/MDR-TB cases with negative culture after six months of Cat IV treatment Denominator: Total no. of bacteriologically confirmed RR/MDR-TB	Baseline 2012 cohort: 66% Target by 2016: 2015 cohort: 80%	NTP report	Annual	NTP	

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/AGENCIES RESPONSIBLE	REMARKS
5.3. At least 80% of registered TB cases in HIV Category A and B areas and drug-resistant cases are provided with HIV counselling and testing	Percent of TB cases in HIV Category A and B areas provided with HIV counselling and testing among aged 15 y.o. and above Percent of drug resistant TB cases provided with HIV counselling and testing among aged 15 y.o. and above	Numerator: No. of registered TB cases in Category A and B areas provided with HIV counselling and testing among 15 years old and above Denominator: No. of registered TB cases aged 15 y.o. and above in Category A and B areas Numerator: No. of registered DR-TB cases provided with HIV counselling and testing among aged 15 y.o. and above Denominator: No. of registered DR-TB cases among aged 15 y.o. and above	Baseline: 2009: less than 20% in NCR (1,136) Target by 2016: 80% 2012: started among DR-TB but no data Target by 2016: 80%	NTP report	Annual	NTP	
5.4. 730,000 children initiated with anti-TB treatment or given INH preventive therapy	Number of children given treatment or given IPT	Number of children given treatment or given IPT for 2010 – 16	Baseline: 2008: no data 2010 – 2012: 87,936 (12%) Target by 2016: 730,000	NTP report	Annual	NTP	Children – less than 15 years of age
5.5. Jails and prisons at all levels provide access to DOTS services to all inmates	Percent of prisons and jails with access to DOTS services	Numerator: No. of jails and prisons with access to DOTS services Denominator: Total no. of jails and prisons nationwide	Baseline: 2009: 23% 2012: Jails: 117/459 (25%) Prisons: 4/7 (57%) Target by 2016: 100%	BJMP / BuCor report	Annual	NTP	Prisons - may either be DOTS providing or referring No. of prisons - 103 provincial city jails, 1,075 prisons + 7 prisons and penal farms
5.6. Policies, operational guidelines, and models developed, disseminated, and locally adopted to address needs of vulnerable populations	Number of vulnerable populations with models and policies, guidelines on addressing TB problem. These are (a), urban/ rural poor, (b) congregate settings (c) IPs, (d) victims of disaster and (e) diabetics	Number of vulnerable groups with policies, guidelines, and models on TB control	Baseline: 2009: none among the 5 vulnerable populations listed 2012: draft guidelines for the urban poor Target by 2016: Models and policies for the 5 vulnerable populations	NTP report Project / CUP reports	Annual	NTP/ National CUP group	

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/AGENCIES RESPONSIBLE	REMARKS
Strategy 6: Regulate and make available quality TB diagnostic tests and drugs							
6.1. At least 95% of all TB microscopy laboratories within the NTP laboratory network are providing TB diagnostic services within EQA standards	% of Cities and provinces with functional QA center	Numerator: Provinces and cities with at least one functional QA center Denominator: Total no. of provinces and cities	Baseline: 2009: Less than 80% 2012: 90% (103 provincial and city QA centers) Target in 2016: 95% of 82 provincial and 33 cities	NTP report Laboratory monitoring PIR	Quarterly/ Annual	NTRL	Functional QA center– QAC has space, manpower, logistics, produces reports and conducts activities as specified in the Administrative Order 2007-0019
	% of TB microscopy laboratories (TMLs) within EQA standards	Numerator: No. of TMLs that have <5% major errors Denominator: All TMLs providing TB laboratory services within the NTP laboratory network	Baseline: 2009: 74% 2012: 96% among participating Estimated 85% among those within network Target by 2016: 95%	NTP / NTRL report Laboratory mapping	Annual	NTRL	
6.2. TB microscopy services are expanded to improve access	Number of new functional TMLs established	Number of new functional TMLs established	Baseline: 2009: 15 cities with poor TML to population ratio Population standard (>one per 100,000) 2010-12: no data Target in 2013-2016: 305 new microscopy centers	Monitoring reports Mapping of laboratories	Annual	NTRL/NTP	
	Total number of presumptive TB examined	Number of presumptive TB examined from 2010 – 2016	Baseline: 2008: 530,000 2010 – 12: 1,790,000 Target in 2010- 2016: 5.5 million	NTP report	Quarterly	NTRL/NTP	
6.3. Culture, DST and new technologies are scaled up.	Total number of facilities within the laboratory network providing a. Culture b. DST c. Xpert MTB/RIF d. Microscopy using LED-FM	Number of facilities within laboratory network providing culture, DST and new technologies	Baseline: 2009: no target 2012: Culture: 13 DST: 3 Xpert MTB/RIF: 16 LED-FM: 3 Target by 2016: Culture: 29 DST: 7 Xpert MTB/RIF: 155 LED-FM: 603	NTRL monitoring reports	Annual	NTRL	

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/AGENCIES RESPONSIBLE	REMARKS
6.4. No stock-outs of anti-TB drugs (both FLD and SLD) and laboratory supplies in 90% of DOTS and laboratory facilities in the last 6 months	Percent of DOTS and Laboratory facilities with no stock-outs of anti-TB drugs and lab supplies in the last 6 months	Numerator : No. of DOTS and Laboratory facilities with no stock-outs of 1st line and 2nd line anti-TB drugs and lab supplies Denominator : Total no. of DOTS and Lab facilities	Baseline: 2008: Widespread shortage of anti-TB drugs 2012: shortages of Cat 2 and pediatric drugs Target by 2016: 90% DOTS / laboratory facilities with no stock-outs in the last 6 month	NTP report Monitoring reports NOSIRS generated report in areas where it is implemented	Quarterly at the RO level Annual at NTP level	NTP	Available- no stock outs of all anti-TB drugs at any point in time
	Number of TB patients provided with first line anti-TB drugs (all susceptible TB cases)	Number of TB patients provided with first line ant-TB drugs, all susceptible TB cases, for 2010 – 16	Baseline: 2008: 140,000 TB cases 2010 - 2012: 579,383 TB cases Target by 2010 - 16: 1.5 Million	NTP report	Quarterly	NTP	
Strategy 7: Certify And Accredit TB Care Providers							
7.1. At least 70% of DOTS facilities are DOH/PhilCAT Certified and Philhealth accredited	Percent of certified and accredited DOTS facilities	Numerator : No. of certified and accredited DOTS facilities (public and private) Denominator: Total no. of DOTS facilities	Baseline: 2009: Only 10% (235) facilities were certified out of 2,266 (PhilPACT data) DOTS facilities Less than 20% of DOTS facilities were accredited out of all the DOTS facilities (public and private) in December 2008 (Philhealth) 2012: 57 % Target by 2016: 70% of DOTS facilities (RHUs / HCs / PPMDs) certified and accredited	NTP report PhilHealth information system report	Annual	NTP PhilHealth	DOTS facility- a facility that submits reports and follow NTP protocol in TB case holding and case management including EQA and has its own NTP registry

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/AGENCIES RESPONSIBLE	REMARKS
7.2. Standards for hospital participation in TB control are included in DOH licensing and PhilHealth accreditation requirements	DOTS standards for hospitals included in licensing and accreditation standards	DOTS standards/evidence for hospitals included in licensing and accreditation standards	Baseline: 2009: Not included 2012: Standards included in the PhilHealth Bench book already Target in 2016: Included in the HFSRB licensing standards evidence	DOH-HFSRB/ PhilHealth policy issuances	End of 2014	NTP HFSRB PhilHealth	The indicator refers to the policy issuance, not the actual implementation
7.3. Infection control/ laboratory biosafety measures in place in all DOTS / PMDT facilities and laboratories	Percent of DOTS / PMDT with infection control/lab biosafety policy / plan	Numerator: No. of health facilities with infection control/lab biosafety policy/plan Denominator: Total no. of DOTS / PMDT facilities	Baseline: 2009: All PMDT Treatment Centers and less than 25% of DOTS facilities 2012: IC not yet rolled-out except in NCR Target by 2016: 100% of DOTS / PMDT facilities	Monitoring reports Survey	Annual Every 3 years	NTP-RO NTP	Infection Control measures in place – refers to adherence to infection control measures
Strategy 8: Secure adequate funding and improve allocation and efficiency of fund utilization							
8.1. Reduced redundancies and gaps by harmonizing financing of TB prevention and control	Out-of-pocket expenses on TB care	Out-of-pocket expenses refers to the amount of money patient has to pay to avail of TB services	Baseline: 2009: No data 2012: no data Target by 2016: 50% reduction	Survey	2014 2012, 2016	NTP	
	TB control financing gap	Financing gap refers to the estimated funding requirements of PhilPACT less the committed funds	Baseline: 2010 estimate: Php 706 million 2013 estimate: Php 786 million Target by 2016: 50% Reduction compared to 2010	Review of all sources of funds	Annual	NTP	Financing gap–difference between the financing requirements and the available/ committed funds
	Existence of harmonized policy on TB benefits for patients under GSIS, SSS, ECC & PhilHealth	Existing policies on TB benefits /medical reimbursements reviewed, harmonized and enhanced	Baseline: 2012: TB benefits / medical reimbursement fragmented Target by 2016: Harmonized policies and guidelines	Issuances of GSIS, SSS, ECC and PhilHealth	Annual	NTP Projects	

PHILPACT STRATEGIES AND PERFORMANCE TARGETS	INDICATORS	DEFINITION	BASELINE &TARGET	DATA SOURCE	FREQUENCY	PERSONS/AGENCIES RESPONSIBLE	REMARKS
8.2. National government and Philhealth funds leveraged to secure LGU commitments	Number of provinces and HUCs granted with performance-based grants (PBGs)	Number of provinces and HUCs granted with PBGs	Baseline: 2009: none 2012: none Target by 2016: : All priority provinces/ HUCs (as identified by NTP)	BLHSD report	Annual	BLHSD	
	No. of provinces and HUCs with policies and budgets supporting TB	Number of provinces and HUCs with policies and budgets supporting TB	Baseline: 2009: No data 2012: no data Target by 2016: 40 provinces and 16 HUCs	Monitoring reports Project reports	Annual	NTP	
8.3. PhilHealth's role expanded through greater availability of accredited providers and increased utilization of TB- DOTS package.	Percent of DOTS facilities availing of PhilHealth TB-DOTS benefit package	Numerator: No. of DOTS facilities that received PhilHealth TB-DOTS benefit package reimbursements Denominator: No. of DOTS facilities	Baseline: 2009: no data 2012: 3% Target by 2016: 50% of accredited DOTS facilities	Report on PhilHealth claims	Annual	PhilHealth	
8.4 Alternative funding models developed	No. of alternative funding models developed	Alternative funding models are strategies or mechanisms to generate additional resources to support TB control initiatives such as sustaining private sector participation outside of the current funding models	Baseline: 2012: none Target by 2016: at least 4 models	Project reports	Annual	NTP	

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