EVALUATION: WHO NORMATIVE FUNCTION AT COUNTRY LEVEL

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PHILIPPINES

COUNTRY CASE STUDY

INTRODUCTION

This is a case study conducted in the Philippines in the frame of the evaluation of WHO's normative function at the country level. It aims to investigate how selected normative products have been used and to what effect, and to identify the role of WHO in supporting the adaptation, use and monitoring of these products. The following normative products were included in this case study:

- **22nd WHO Model List of Essential Medicines (EML)**
- **Mental Health Global Action Programme (mhGAP) Intervention Guide**
- **HEARTS Technical package for CVD management in primary health care**

COUNTRY CONTEXT

In terms of the country context, key figures are:

UHC coverage Index:
58.21 (GHO, 2021)

Medical doctors per 10,000:
7.86 (GHO, 2021)

Current Health Expenditure as % of GDP:
5.11% (GHO, 2020)

WHO MODEL ESSENTIAL MEDICINES LIST (EML)

ADAPTATION/ UPTAKE

The WHO Country Office (WCO) supported the implementation of the Essential Medicines List (EML). When using the EML to inform the Philippines National Formulary, the national EML, the WCO was responsive to any questions by the Department of Health (DoH). WCO supports the regulatory aspects of DoH based on strong collaboration, for example, through capacity building and sponsoring certain activities. WCO contributed to capacity-building activities for the set-up of the Health Technology Assessment Council. Overall, national implementation capacities are high.

USE/IMPLEMENTATION

The universal healthcare law and other prior laws support the implementation of the EML through the Philippines National Formulary. The EML is one of the references for updating the Philippines National Formulary. During Health Technology Assessments for including new drugs and medicines in the Philippines National Formulary, specialists compare background research information and references to those medicines in the EML as a first point of reference. Other reference points include other regulatory agencies from countries such as the UK, Ireland, Singapore and Canada to check for discrepancies. While stakeholders appreciate the clinical focus of the EML, an economic evaluation analysis is missing, being one of the vetting criteria for the Philippines National Formulary. Stakeholders experienced an increased efficacy and acceleration of updating the Philippines National Formulary thanks to the availability of the EML. Given the heavy workload of the Health Technology Assessment for all Drugs, the WHO EML data provides evidence, guides national experts and shortens the process subsequently.

IMPACT/MONITORING

As a result of the EML, some stakeholders noted that faster updating of the Philippines National Formulary resulted in accelerated access to a number of medicines covered by the Philippines Insurance Corporation. As the EML reviewed clinical aspects, a Health Technology Assessment took place that focused on social and ethical impact issues in the country. However, in practice, accessibility of drugs and medicines is sometimes affected by a disconnect between the Philippines National Formulary and the items de facto covered by the Philippines Health Insurance. While drugs and medicines listed on the Philippines National Formulary are fiscally available, affordability can become a problem for patients if they are not covered under the Philippines Health Insurance. DoH is in contact with the Philippines Health Insurance to discuss this issue. In the Philippines, organizational capacities were strengthened with the set-up of the Health Technology Assessment Council in 2019, the guardian of the Philippines National Formulary. WCO supported this process. The frequency of WHO issuing its EML coincides with updating the Philippines National Formulary. The availability and accessibility of the EML facilitate this process. As the WCO is located in the DoH premises, contact and communication with WHO are facilitated, for example, during the weekly flag ceremony. Hindering factors include challenges in accessing the WHO Burden of Diseases Database at one point. Stakeholders also noted that having the clinical reviews of medicines on one website would be helpful. The National Technology Assessment (HTA) Council is short-staffed, which affects its operational capacities.

GENDER EQUALITY AND HEALTH EQUITY

Access to medicines must be assured for women and men in the Philippines. No differentiation between men and women shows, according to interviewees. Access to medicines related to reproductive health seems given. Concerning health equity, the Health Technology Assessment showed, for example during COVID-19, that deployment of mNRA vaccines were unsuitable for some geographic locations in the Philippines, as equal access to the vaccine required cooling at -80 degrees celsius was unsuitable for many parts of the country with over 7000 islands. Based on health equity considerations, the Health Technology Assessment recommended another type of vaccine for remote areas with limited ultra-cold storage capacity [1].

[1] Due to temperature requirements and other reasons.

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mhGAP INTERVENTION GUIDE

ADAPTATION/ UPTAKE

Following Typhoon Haiyan hitting the Philippines in November 2013, killing over 6,000 people, the lack of implementation of a national mental health programme became evident. The number of mental health cases tripled after the typhoon. This national emergency, coupled with the lack of implementation of the current mental health programme, resulted in the prompt introduction of mhGAP, including in the Visayas region in Central Philippines. As part of the reconstruction of the health care system, many primary health care providers are now trained to address mental health issues.

Contextualization and adaptation to the Philippines context was required for adopting mhGAP, and this is still ongoing. The Department of Health (DoH) used strong national expertise in academia and NGOs to contextualize mhGAP with guidance from the WCO. This was funded in the frame of WHO technical assistance to DoH, through the WHO Special Initiative for Mental Health[2]. One example is the assessment of medication available with the support of the Philippines Association of Epilepsy. To date, mhGAP modules on depression, suicide, and epilepsy have been contextualized. Work on other modules is required, for example, on how to apply mhGAP to indigenous populations.

[2] https://www.who.int/initiatives/who-special-initiative-for-mental-health/philippines

USE/IMPLEMENTATION

Interviews indicated that with the engagement of members of the Philippines Psychiatric Association and other specialist societies, 40 trainers were trained, a number still increasing, now covering about 10% of the 500 psychiatrists in the country. Given DoH's ambitious training plan, challenges emerged to roll out training of trainers sessions simultaneously.

- Capacity building: The main entry point for mhGAP implementation was capacity-building using contextualized mhGAP modules. WCO used Agreements for Performance of Work under the WHO Special Initiative for Mental Health to develop a training strategy and components, and integrate mhGAP modules into academic curricula. The in-service training strategy included a training of trainer approach.
- Health systems approach: The National Centre for Mental Health offers mhGAP training for health facilities, including in communities and rural settings. The incentive for primary health care providers to get trained in mhGAP is that they obtain the status of medicine access sites only after training. This process started in 2014, and the Implementing Guidelines on Medicine Access Program for Mental Health (MAP-MH) DoH Administrative Order was officially signed on 14 January 2021. This approach provides incentives for national coverage for mhGAP training[3]. mhGAP training also targeted specialized nurses for in-depth capacity building. mhGAP training reached 15 out of 333 nursing schools nationwide. Targeting centres of excellence allows them to run the course easily as they have the necessary resources. Natural disasters, such as typhoons or earthquakes and armed conflicts, were triggers to accelerate training roll out. Training focused on resident hospitals on the

[3] The Medicine Access Program for Mental Health (MAP-Mh), started in 2012 by the DOH Pharmaceutical Division (PD) and operationalized by the National Centre for Mental Health (NCMH), was designed to ensure availability of mental health drugs in the community.

three main islands, training neurologists, psychiatrists and nurses. Training provincial hospital staff is essential to reach remote parts of the Philippines. A hub to reach the provinces proved helpful, and a training schedule was created after consulting municipal health officers. Stakeholders reported that in 2022, the government procured medicines for mental health treatments worth US$ 10.4m for 142,000 service users nationwide.

BOX 1: MHGAP IN THE VISAYAS REGION

USE OF MHGAP

In the aftermath of typhoon Haiyan in 2013, every municipality out of the 143 affected had an opportunity to receive training on mhGAP. The training programme was divided into two parts, focusing on doctors and nurses. For doctors, there was a specialized session on pharmacology. Nurses and midwives attended a session on essential care practices and psychosocial treatment. The psychosocial treatment component focused on providing emotional support and counselling to individuals affected by the typhoon. It is worth noting that while five out of the six provinces affected were covered by the WHO training programme, the remaining province was covered by the International Medical Corps.

IMPACT ON ACCESS TO MENTAL HEALTH SERVICES

DoH has established hotlines and outpatient services for referrals through tertiary hospitals. These services can be crucial in providing medical support and guidance to municipal doctors in the affected areas. This helps ensure that patients receive appropriate care and are directed to suitable facilities or specialists for further treatment.

The presence of mental health coordinators in the DoH, with one coordinator assigned to each region, shows a proactive approach to addressing mental health issues. Mental health services have been extended to primary health care facilities, enabling greater reach and accessibility for the population. By bringing mental health services closer to the community through primary health care facilities, individuals can access support and treatment more conveniently without the need to travel to specialized facilities.

Programme implementation reviews indicate that these mental health services are being heavily utilized. Regular reviews allow for assessing programme effectiveness, identifying any challenges or gaps, and improving based on healthcare provider and patient feedback. In addition to primary health care facilities, the involvement of family medicine in mental health further strengthens the integration of mental health care into primary care settings. The accreditation requirement in mhGAP by primary service providers, including primary care facilities and specialized facilities like hospitals with outpatient clinics, underscores the importance of ensuring quality mental health services.

A referral system to the Eastern Visayas Medical Centre is in place for complex cases requiring specialized care. This facility serves as a referral centre where psychiatrists and psychologists are based, indicating the availability of expert care for complex mental health cases. Establishing patient registries in all municipalities helps track patients and ensure continuity of care across different health care facilities.

HEALTH EQUITY

Specifically for the Visayas regions, interviews with frontline health workers indicated that mental health service access and delivery have vastly improved since Typhoon Haiyan in 2013 and the introduction of mhGAP. Rather than having to travel to a hospital, access is now facilitated through rural health units serving as primary care facilities. At least one staff/personnel is available for each of the 143 municipalities for primary mental health care, thanks to mhGAP. As a result of mhGAP training, doctors, nurses and some midwives were reached in the region, enhancing, and in many cases creating, their capacity and confidence to deliver basic mental health services. For the engagement of community health workers, who are non-health professionals, DoH provided a simplified version of mhGAP[4].

Before introducing mhGAP, the Eastern Visayas Medical Centre registered about 1000 patients. This number increased to 7717 patients under the mhGAP program. Due to grassroots engagement and better awareness raising in primary health care facilities, case findings increased. Also, patients with conditions show more openness to access services, knowing that services are available.

[4] Based on a DoH-led, WHO supported, Community Based Mental Health Framework

IMPACT/MONITORING

Interviewees suggested that by using mhGAP, differences in the public mental health system become visible. Access to services improved as more capacities in the country were available. However, given the geography of the Philippines, with over 7000 islands, there are still underserved regions in the country where there are no available psychiatrists, neurologists or relevant specialists.

To facilitate lasting change, DoH organizes supervision sessions, returning to trainees after 2-3 months to see how materials were used. Issues identified for using new skills relate to the availability of medication and, at times, lack of human resources. Particularly, municipal doctors as primary healthcare providers have diverse responsibilities well beyond mental health.

Facilitating factors for the adoption of mhGAP in the Philippines include the high-level political leadership with legislators supporting mental health services in the country, as enshrined in the Mental Health Act, which was signed into law on 21 June 2018[5].

Besides, the COVID-19 pandemic caused an increased demand for mental health interventions at a time when the Mental Health Act was at the beginning of its implementation. The latter resulted in increasing budgets for mental health drugs. Also, a health system approach to mental health catalyzed the mhGAP rollout, for example, through the involvement of Regional Mental Health Committee Councils[6] to reach the entire country to the extent possible.

Another positive factor was the strong support of international NGOs and academia in the mhGAP implementation in the disaster response context. Spillover to national and local NGOs further drove the mhGAP roll out, facilitated by WCO contractual engagements as part of the overall technical assistance to DoH. Beyond the supply side, the demand side facilitated the mhGAP implementation. Communities showed readiness to accept mental health support, and patients were encouraged to seek treatment.

[5] https://www.officialgazette.gov.ph/2018/06/20/republic-act-no-11036/
[6] The Philippine Council for Mental Health is at the national level – as mandated by the law. Some regions may have councils, as shown in the evaluation interviews, but are not yet systematically present

The traumatic aftermath of natural disasters and armed conflict, as well as the COVID-19 pandemic, reduced the stigmatization of patients. Hindering factors affecting the implementation of mhGAP include differing opinions concerning the normative product in the Philippines Psychiatric Association. As the mhGAP roll out advances, mental health treatment focuses more on providing medication, lacking psychosocial interventions. This contrasts with a situation of early mhGAP implementation where patients were provided mainly psychosocial support in emergency settings due to a lack of medication. Some community leaders are still struggling to understand the concept of mental health. As a mitigation measure, DoH is lobbying them through awareness raising and dialogue with community leaders to show the costs of mental health problems in society.

HEARTS, Technical package for cardiovascular disease management in primary health care

ADAPTATION/UPTAKE

The Philippines is one of the HEARTS programme implementation countries, where the whole HEARTS package is implemented. In the Philippines, the contextualization of HEARTS was undertaken by the DoH in partnership with the Philippines Society of Hypertension and WHO. HEARTS is the basis of the Philippines Healthy Hearts Programme. The partnership helped build the capacity of local health workers from screening, detection, and management, while policy and governance interventions were also targeted for local leaders and decision-makers. The WCO provided a technical package to DoH, including, for example, job aids/hypertensive management, blood pressure checklist, and hypertension protocols, facilitated the application of protocols, and provided an e-registry. The latter was adopted and harmonized with an existing one. HEARTS was rolled out at the national level and piloted in the regions. The national Healthy Hearts programme identified demonstration sites for HEARTS, for example, in the Western Visayas region. The implementation of HEARTS benefitted from a multi-sectoral and multi-disciplinary approach, with the participation of NGOs, universities, municipalities, the media, international organizations and national legislators.

This coalition supports the DoH in promoting awareness about hypertension and driving behaviour change among the population, one of the objectives of the Health in promoting awaren

Stakeholders know no single actor could have embarked on this behaviour change process independently. DoH strengthened implementation capacities through its DoH Academy. In April 2022, the DoH Academy launched an online course as part of the Healthy Hearts Programme, reaching health workers at the height of the pandemic. The self-paced course, which is still open to attend, was targeted at one district of the city of Iloilo and subsequently to the entire Western Visayas region. Through the DoH Academy, 193 people were trained in District 1 in Iloilo, including doctors, nurses, midwives and programme staff.

WHO, DoH, and the Philippines Society of Hypertension used a primary health care approach when designing the training content together. Stakeholders underscored the strong commitment of WCO to HEARTS, with four staff in WCO dedicated to the topic.

USE/IMPLEMENTATION

WCO, in partnership with DoH, built the capacity of local health workers for enhanced/improved screening, detection, and management of CVDs and hypertension to implement HEARTS. In the Western Visayas region, interviewees recalled WCO's visits to project sites and the valuable training of municipal health officers and Barangay health workers[7]. Concerning training, DoH targeted all 143 local government units in the Western Visayas region, including 200 training of trainers for Barangay health workers to catalyze capacity building at the community level.

IMPACT/MONITORING

One stakeholder observed that health outcomes are improving at a small scale. During a site visit, the interviewee observed that hypertension medicines are arriving at pharmacies and being distributed.

In the Iloilo province, seven municipalities with 246,000 inhabitants were targeted with HEARTS as part II of the programme implementation.

[7] People who have undergone training under any accredited government or non-government organization, and voluntarily render primary health care services, referrals and follow-up in the community (BHW Facilitator Guide, 2022). https://tciurbanhealth.org/courses/philippines-toolkit-demand-generation/lessons/engaging-barangay-health-workers/topic/bhw-facilitators-manual/

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The analysis of morbidity and mortality data analyzed by consulting regional statisticians showed that changes in health outcomes related to the Healthy Hearts Programme could not be confidently assessed due to the COVID-19 affected behaviour of people, which overshadowed NCDs. However, in 2022, cases of hypertension patients consulting health facilities were increasing. Of the 246,000 persons whose blood pressure was taken in the Iloilo district, 21,000 were identified with hypertension. Eighty-six per cent of hypertension patients return to health facilities after high blood pressure detection. This rate compares to a 30-40% control rate on a national average.

Facilitating factors to the use of the HEARTS package in the Philippines include the well-defined roles in the partnership between WCO, DoH, NGOs, and the Philippines Society of Hypertension, among others, with technical staff engaged in following clear objectives. There are focal points in DoH supporting the engagement of provinces and local government units in HEARTS for the past two years. DoH stakeholders underscored the critical advantage of WHO understanding the Philippines' health system at the grassroots level, including the essential knowledge of local languages to engage at the community level. Also, WCO and DoH shared costs for rolling out the Healthy Hearts programme in the Western Visayas region. At the local level, the active role of the Department of Local Government is a driving factor for the implementation of the Healthy Hearts Programme. Local chief executives proved open-minded to accept the programme by understanding that health costs can be reduced if, for example, blood pressure controlled data availability was instrumental in mayors' behaviour change, given the high number of diagnosed hypertension patients in the Iloilo district and other parts of the Western Visayas region.

Mayors outside the pilot sites of Iloilo volunteered to implement the programme, earmarking human and financial resources for the programme. WCO's presence in the target sites helped convince them. While the e-Registry system showed some weaknesses, it allowed tracking of patients' blood pressure control, mostly in real time. Local Government Units showed responsibility for encoding data using tablets from WCO as part of an earlier project/study on e-registry. Hindering factors relate to COVID-19, as the pandemic was the top health priority in the country for nearly two years, affecting the roll out of HEARTS and other health programmes. Besides, the regional DoH offices initially depended on medication from Manila, a situation mitigated by the Philippines Health Insurance Cooperation, which supported a package to ensure continuous provision of medication.

The involvement of Barangay health workers, who are not health professionals, resulted in mixed quality of services. DoH tried to mitigate this by reproducing WCO posters providing systematic health advice to Barangay health workers and communities for healthy lifestyle behaviour. The use of the posters increased the confidence of Barangay health workers and their service delivery

GENDER EQUALITY/HEALTH EQUITY

According to stakeholders, the prevalence and burden of the disease show:

NO GENDER DIFFERENCES, AND BOTH GENDERS ARE TREATED EQUALLY UNDER HEARTS IN THE PHILIPPINES.

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CONCLUSIONS

CONCLUSIONS ON THE EML

The uptake of the EML seems strong in the Philippines. The recommendatory nature of the list is appreciated, and less prescriptiveness is valued. Having the EML as a living document with real-time updates would add value to its users in the Philippines. Otherwise, the timing of EML updates would need to be communicated well in advance. Also, stakeholders would appreciate for WHO to communicate which topics it will focus on in the upcoming EML revision.

CONCLUSIONS ON MHGAP

Overall, integrating mental health services into primary healthcare, accreditation requirements, referral systems, and patient registries all contribute to a comprehensive and coordinated approach to mental healthcare, ensuring that individuals receive the support and treatment they need at various healthcare system levels.

The presence of hotlines, outpatient services, mental health coordinators, and the acknowledgment of broader psychosocial issues by the DoH reflects a concerted effort to provide holistic healthcare services to the affected municipalities, ensuring that both physical and mental health aspects are addressed.

Stakeholders identified the following actions for the WCO to strengthen the mhGAP rollout:

- More training on psychosocial interventions is required, compared to pharmacological interventions (which are better covered in the national system than psychosocial interventions).
- Monitoring and evaluation of mhGAP training would be required to identify training results and how training could be further improved. Also, impact assessments should be considered.
- Stakeholders are willing to learn from other experiences the WHO can share concerning mhGAP implementation.

CONCLUSIONS ON HEARTS

Following the rollout of the HEARTS technical package, monitoring its application seems timely. Questions like the sufficiency and sustainability of medicine supply at primary care, realistic forecasting, and drug utilisation and their correct distribution should be tracked. The potential for learning and knowledge exchange could be better exploited. Sharing good practices in parts of the Philippines for replication through municipal exchanges could be helpful, as well as exchanges with municipalities and cities at the mayoral level in other countries. Also, other WCOs could learn from HEARTS' experience in the Philippines.

Scan for evaluation report