Funding Request Form
Full Review
Allocation Period 2023-2025

Summary Information

Country(s)	Philippines
Component(s)	Tuberculosis
Planned grant start date(s)	January 1, 2024
Planned grant end date(s)	December 31, 2026
Principal Recipient(s)	Philippine Business for Social Progress
Currency	USD
Allocation Funding Request Amount	136,020,179
Prioritized Above Allocation Request (PAAR) Amount	104,333,144

Matching Funds Request Amount (if applicable)	4,000,000
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Refer to the [Full Review Instructions](#) for detailed elements related to each question which should be addressed for a response to be considered complete. The Instructions also include information, resources, and a description of necessary documents to be submitted along with this form.

Section 1. Funding Request and Rationale

1.1 Prioritized Request

- A. For each module, provide information on the funding being requested from the Global Fund and what is expected to be achieved due to the Global Fund's investment.

Module #1	DRTB Diagnosis, Treatment, and Care
Intervention(s)	DR TB Diagnosis and DST <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
	DR TB Treatment, Care, and Support <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
Population, geographies, and barriers addressed	<p>Population: All presumptive TB clients, DR TB clients, DR TB contacts, re-treatment cases, PLHIV</p> <p>Geography: Nationwide</p> <p>Barriers: Limited access to RDT for TB diagnosis and DR TB treatment coverage in 2022 is only at 64%</p>

List of activities	<p>This FR is a scale-up of most interventions included in the ongoing GFTB grant for 2021-2023. What is critical in this FR is (1) the full implementation of iDOTS whereby DS and DR TB diagnosis, treatment, and care are integrated into the primary care facilities. This reduces the FR request for clinic personnel from 350 to 120 staff, converting most PMDT satellite treatment centers (PMDT STC) into iDOTS. The role of the STCs has been transferred to referral hospitals and the scale-up of TB Medical Advisory Councils (TB MAC) for every region; (2) Full adoption of BPaL and BPaLM for eligible patients beginning July 2023; (3) Mainstreaming of DAT and aDSM; (4) Increasing government procurement of SLD, particularly Bedaqueline for DR TB treatment; (4) shifting some social protection support to other national government agencies (NGA) and LGUs (e.g., nutritional support, transportation subsidy, livelihood support, etc.); and (5) scaling up the use of specimen and commodity transport riders to increase access to RDTs nationwide – which is included in RSSH/PP: Laboratory Strengthening.</p> <p><u>DR TB Diagnosis and DST:</u></p> <ul style="list-style-type: none"> • Procurement of GeneXpert cartridges approximates 10% of the country target for DR TB detection annually. • Support operations of 872 GeneXpert sites, 29 TB culture centers, eight DST centers, one LPA site, and five Xpert XDR sites. This includes the deployment of 63 laboratory personnel in culture and DST centers. <p><i>The current distribution, coverage, and operational status of the GeneXpert machines are attached as Annex 24.</i></p> <p><u>DR TB Treatment, Care, and Support:</u></p> <ul style="list-style-type: none"> • Full implementation of iDOTS (integration of DS and DR management in primary care facilities) • Procurement of BPAL and BPaLM, reflecting annual country target enrolment requirements of 73% (2024), 68% (2025), and 63% (2026). The government will procure the difference annually to meet the country's target. The country will buy 100% of DS TB drugs for adults and children. Ancillary medicines for DR TB cases are included in the FR. DOH and LGUs provide ancillary medications for DS TB and share those that DR TB cases can also use. • Subsidy for patient medical & laboratory needs and psycho-social support. • Mainstreaming use of digital adherence tools to improve treatment adherence. • Management of ADRs, including aDSM. Regional TB Medical Advisory Committees will be strengthened to manage ADRs referred from iDOTS facilities. • Continuous training, coaching, and mentoring of DRTB staff/case managers on TB MOP.
Amount requested	USD 55,656,570 [40% of the total FR]

Expected outcome	Indicator	Baseline 2022	2024	2025	2026
	No. of people with confirmed RR TB and MDR TB notified	8,165	9,873	11,582	13,468
	Percentage of people with confirmed RR TB and MDR TB that began SL treatment	95.3% (7,850/8,235)	100% (9,873/9,873)	100% (11,582/11,582)	100% (13,468/13468)
	Percentage of patients with RR/MDR TB successfully treated.	73.5% in 2021 (4,146/5,641)	85% (5,472/6,438)	90% (8,359/9,288)	90% (9,589/10,655)
	Percentage of RR/MDR TB patients with DST results for FLQ among the total number of notified RR/MDR TB	98.6% (8,119/8,235)	100% (9,873/9,873)	100% (11,582/11,582)	100% 13,468/13468)
	Percentage of TB patients with DST result for at least Rifampicin among the total number of notified.	71% (337,262/476,754)	75% (393,027/524,036)	78% (435,934/558,890)	80% (476,569/595,711)
	<ul style="list-style-type: none"> • DR-TB treatment coverage increased to 78% in 2026 from 31% in 2021. • Fully integrated DS and DR TB care in primary care facilities (iDOTS). • 872 RDT sites with 961 GeneXpert machines are optimized. 				
Module #2	TB/DR TB Prevention				
Intervention(s)	Screening/testing for TB infection <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	Preventive Treatment <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				

Population, geographies, and barriers addressed	<p>Population: All TB contacts</p> <p>Geography: Nationwide</p> <p>Barriers: Coverage is low with TB contacts, given that TPT in 2022 is only 31,211 out of 47,343 eligible (66%). A shorter TPT regimen has yet to be fully implemented. Misconceptions about the benefit of TPT among HCWs and clients are high and need to be addressed by SBCC interventions and interrupted supplies for TST. The use of IGRA is part of the MOP, but no investment for operationalization.</p>				
List of activities	<ul style="list-style-type: none"> • Procurement & dispensing of PPD and 3HP. • Enhance and disseminate SBCC materials on TPT for HCWs and target clients. • Engaging professional groups to provide TPT orientation for new healthcare workers. • Improving TPT recording and reporting mechanisms in ITIS. • Continuous deployment of 450 community volunteers (currently onboard under the GF Grant 2021-2023) for contact investigation and support active case-finding interventions (under the KVP module). 				
Amount requested	USD 6,463,345 [5% of the total FR]				
Expected outcome					
	Indicator	Baseline 2022	2024	2025	2026
	Number= of people in contact with TB patients who began preventive therapy.	30,492	77,996	135,559	216,735
	<ul style="list-style-type: none"> • SBCC materials on TPT developed and disseminated to increase TPT acceptance of health care workers and TB contacts. • TPT monitoring and evaluation mechanism improved. 				
Module #3	Collaboration with other providers and sectors				
Intervention(s)	Private Provider engagement in TB/DR TB care <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	Community-based TB/DRTB care <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				

Population, geographies, and barriers addressed	<p>Population: Private healthcare clinics</p> <p>Geography: Highly urbanized cities and provinces with a high density of private providers</p> <p>Barriers: Mandatory case notification (among private providers) is 23% of all cases notified in 2021. Treatment outcome reporting from mandatory case notification is 23% (12,935/56,377) in 2022- a cohort of 2021 notified cases, which reduced the TSR for all forms to 76% in the same year. Private sector compliance with TB MOP is low, with the majority being clinically diagnosed (22%). Private sector access to RDT remains limited. The provision of TPT by the private sector is still being determined but is perceived to be very low. CBOs and CSOs' engagement in the primary care network are very limited. There are very few TB advocates to represent KAP's voice in the TB program. The Uptake of RxPASS is slowly increasing.</p>
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List of activities	<p><u>Private Provider engagement in TB/DR TB care:</u></p> <p>The ongoing GFTB grant 2021-2023 implemented the Prescription for patients' access to screening services for TB (RxPASS) to support mandatory case notification.</p> <p>This FR will scale up private sector engagement by adopting recommendations to include: (1) facilitating accreditation as primary care facilities of LGUs, (2) improving access to free Xray and RDTs for TB screening and diagnosis, (3) improving access to free DS and DR TB drugs from government, (4) initiating non-financial incentives, and (5) further enhancing ITIS lite for case notification and treatment outcome reporting.</p> <ul style="list-style-type: none"> • <i>Training for private care providers on mandatory case notification and outcome reporting.</i> • <i>Training for private care providers to become primary care facilities that will provide access to free DS/DR TB drugs and appropriate outpatient benefit packages (provider incentives/ reimbursements from PhilHealth).</i> • <i>Enhancing ease of use and mainstreaming ITIS lite for mandatory case notification and treatment outcome reporting.</i> • <i>Provision of financial incentives for mandatory case notification, bacteriological confirmation of notified cases, treatment outcomes reporting, and non-financial incentives such as recognition events and accreditation of TB courses for Continuing Professional Development units necessary for professional license renewal.</i> • <i>Upskill and deployment of 210 TB case notification officers to support private providers.</i> • <i>Increase access to RDT sites for TB diagnosis through scale-up of the specimen and commodity transport riders to increase access to RDTs (budgeted in RSSH module)</i> • <i>Increase access to free TB medicines and commodities for DS and DR TB patients.</i> • <i>Increase access to free X-rays for indigent patients (Xray Voucher system).</i> <p><i>Geographical locations covered by notification officers and the full mechanism of RxPASS are attached as Annex 23.</i></p> <p><u>Community-based TB/DRTB care:</u></p> <p>The CSO and CBO engagement in TB care has always been in the spirit of volunteerism. Both the JPR 2022 and the KAP consultations in preparing this FR highlighted the strong desire of CSOs and CBOs to be professionally engaged in TB care. Adopting this key recommendation, this FR will support the capacity strengthening of CSOs and CBOs to become part of the primary care network and be paid by local government units for their services.</p>
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	<ul style="list-style-type: none"> Capacity building of CSOs and CBOs as part of the TB-HIV primary care provider network. This will include upskilling CSOs, CBOs & KAP members in TB-HIV care cascade delivery, supporting their accreditation as primary care providers as applicable, supporting their inclusion in the primary care network, and training them to market their services to LGUs. 				
Amount requested	USD 14,154,968 [10% of the total FR]				
Expected outcome					
	Indicator	Baseline 2022	2024	2025	2026
	Percentage of notified patients with all forms of TB contributed by non-NTP providers/ non-government facilities.	21% (99,240/476,754)	25% (131,009/524,036)	25% (139,723/558,890)	25% (148,928/595,711)
	Percentage of TB patients (all forms) bacteriologically confirmed plus clinically diagnosed, successfully treated in the private sector.	22.94% (12,935/56,377)	55% (66,273/120,497)	65% (85,156/131,009)	75% (104,792/139,723)
	<ul style="list-style-type: none"> Increase private notification of bacteriologically confirmed TB patients. Train 30 CBOs/CSOs included in the primary care provider network. Train and engage 120 KAP members nationwide as part of the TB service delivery care network. 				
Module #4	Key and vulnerable populations (KVP)-TB/DRTB				
Intervention(s)	KVP-People in prisons/jails/detention centers <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	KVP-Urban poor/Slum Dwellers <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	KVP-Others <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				

Population, geographies, and barriers addressed	<p>Population: TB contacts, urban and rural poor, elderly, children, people with comorbidities (smokers, diabetes), and people deprived of liberty.</p> <p>Geography: Nationwide</p> <p>Barriers: PDL access to TB care remains limited. Access to TB care among urban and rural poor, which are primarily in geographically & depressed areas, remains limited.</p>
List of activities	<p>In the ongoing GFTB grant 2021-2023, reaching KVPs is done through LGU-led systematic screening events using 12 Konsutayo Vans, X-ray vans with AI CAD, provision of free Xray through an Xray voucher system, and implementation of TB program in jails. Five private service contractors are also engaged to supplement the Konsultayo Vans nationwide. Additional nine Konsultayo vans are currently being procured. Five mobile vans will be added for the same purpose under the HIV FR.</p> <p>In this FR, interventions will be scaled up with the full operationalization of 21 mobile vans beginning January 2024 and five service contractors. This will increase coverage in all regions nationwide.</p> <ul style="list-style-type: none"> • Active/Intensive/Enhanced case finding Konsultayo vans and free x-ray vouchers for TB screening and diagnosis targeting key populations nationwide. • Payment for AI CAD • Private service contractors will still be engaged to reach other areas. • Maintain nationwide implementation of the TB program in all jails and prisons (USD 4,320,432).
Amount requested	USD 31,663,535 [22% of the total FR]

Expected outcome					
	Indicators	Baseline 2022	2024	2025	2026
	VulPoP	31,689	32,880	34,380	35,880
	Inmates	4,186	5,000	4,600	4,000
	TSR all forms DSTB (exclude private)	76% (2021)	90%	90%	90%
<p>Note that screening in jails/prisons is 200,000 PDLs per year. With a 2.5% positivity rate targeted in 2024, 2.3% in 2025, and 2% in 2026.</p> <ul style="list-style-type: none"> • Optimization of 21 Konsultayo Vans for active case finding • Reduce out-of-pocket expenses for X-rays using the voucher system. • Prevent TB transmission and strengthen TB programs in jails and prisons. 					
Module #5	TB/HIV				
Intervention(s)	TB/HIV-Screening testing, and diagnosis <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	TB/HIV-Treatment and Care <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	TB/HIV-Prevention <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
Population, geographies, and barriers addressed	<p>Population: People with TB, PLHIV, and people with TB-HIV</p> <p>Geographies: Nationwide</p> <p>Barriers: Confidentiality makes PLHIVs uncomfortable accessing TB services in TB facilities. Programs use GeneXpert machines exclusively, i.e., not shared for TB diagnosis and HIV VL testing. High turnaround of HRH, which needs regular offering for PICT training. Lack of HRH for RDT (TB diagnosis and VL testing)</p>				

List of activities	<p>In the ongoing GF TB grant 2021-2023, support is on the nationwide expansion of PICT, facility-based HIV testing, and cross-referral between TB facilities and HIV hubs nationwide.</p> <p>Based on the TB-HIV co-financing plan 2024-2026, the TB-HIV integration points include: (1) Enhancing selected HIV Treatment hubs to provide a complete TB care cascade among PLHIVs, (2) optimizing all DOH GeneXpert machines for multi-disease use, including TB diagnosis and VL testing, (3) expanding role of TB specimen and commodity transport riders for HIV specimens and ARV transport, (4) Joint ACF activities, (5) TB-HIV proficiency training, and (6) TB-HIV Program in jails.</p> <p>For this FR, the focus will be:</p> <ul style="list-style-type: none"> • Provision of PICT and TB-HIV proficiency training and coaching to new staff. • Conduct of annual external quality assurance survey for clinic-based HIV testing. • TPT orientation among treatment hubs. • Deployment of 35 medical technologists (PICT & ART) and ten nurses (TB screening and TPT) • Introduction of Urine LAM for TB screening among PLHIV. <p>To address confidentiality concerns making PLHIVs uncomfortable accessing TB services in TB facilities, high-volume HIV hubs will be capacitated to be a one-stop shop for TB care services.</p>
Amount requested	USD 5,247,246 [4% of the total FR]

Expected outcome	Indicators				
	Baseline 2022	2024	2025	2026	
	Percentage of registered new and relapse TB patients with documented HIV status	72% (236,152/328,201)	80% (276,691/345,864)	85% (313,537/368,867)	90% (353,852/393,169)
	Percentage of HIV-positive new and relapse TB patients on ART during TB treatment	98% (1,961/2,001)	95% (1,709/1,798)	95% (1,936/2,038)	95% (2,185/2,300)
	Percentage of PLHIV currently enrolled on ART who started on TPT	74% (3,690/4,990)	75% (10,190/13,586)	80% (10,550/13,118)	85% (11,573/13,615)
<ul style="list-style-type: none"> Policy recommendation/implementation guidance for Urine LAM developed. 					
Module #6	Removing Human Rights and Gender-related Barriers to TB services				
Intervention(s)	Eliminating TB-related stigma and discrimination <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	Ensuring people-centered and rights-based TB services at health facilities <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	Ensuring people-centered and rights-based law enforcement practices <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	Increasing access to justice <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
	Monitoring and reforming policies, regulations, and laws: <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down				
Population, geographies, and barriers addressed	<p>Population: journalists, media professionals, public and private health care workers, law enforcement officers, correction officers, CBOs, and CSOs.</p> <p>Geography: Nationwide</p> <p>Barriers: 11 of the 17 regions have no redress mechanisms in place. The use of gender data in health planning and decision-making is low.</p>				

List of activities	<p>The Philippines has a National TB Program Community Engagement, Human Rights, and Gender- National Action Plan 2021-2023 (NTP CRG NAP). The January 2023 updates were included in the various KAP consultations conducted. The list below details key insights and recommendations to be included in this FR. The NTP CRG NAP will be assessed in quarter 4 of 2023 to guide the plan's development for the next three years.</p> <p>The ongoing GFTB grant 2021-2023 supports the (1) formation of regional CSO/CBO networks and (2) their inclusion in a national patient support group network, (3) establishment of CLM in six regions, (4) establishment of redress mechanism in six regions through a patient hotline, (5) capacity building on CRG for NTP providers, and (6) creating a pool of NTP providers able to conduct gender analysis and using gender data in planning.</p> <p>Specific for capacity building on CRG among NTP providers, a four-hour "CRG fit-for-work Learning Module" was developed and piloted focused on media professionals, health workers, and correction officers. Positive feedback and recommendations for scale-up were received, and a preference for face-to-face over virtual learning was expressed. On the other hand, the HIV program is also conducting an intensive 4-day HRG course, which already incorporates TB, HIV, and COVID-19. Within 2023, the TB and HIV programs will review and consolidate the modules and develop a standard learning module that will be disseminated in 2024-2026, as applicable.</p> <p>Specific to the redress mechanism, six regions are currently piloting a redress mechanism for TB, which is anchored on a TB patient hotline being operated by trained CSOs/CBOs. The patient TB hotline serves as an information resource, patient experience feedback, and patient navigation/referral system (for medical, clinical, laboratory, psycho-social, and legal support). By the end of 2023, an assessment will be conducted to enhance the mechanism for scale-up in 2024-2026 to cover 11 other regions to provide nationwide coverage. The DOH is developing a national primary care telemedicine platform based on the COVID one hospital command mechanism. The TB patient hotline will likely be incorporated into the DOH telemedicine platform in the long term.</p> <p><u>Eliminating TB-related stigma and discrimination:</u></p> <ul style="list-style-type: none"> ● Roll out HRG training for journalists and media professionals. ● Explore including the HRG orientation/training as part of the pre/in-service training. ● Developing and disseminating gender-sensitive SBCC materials (men, women, and LGBTQIA ++). <p><u>Ensuring people-centered and rights-based TB services at health facilities:</u></p> <ul style="list-style-type: none"> ● Roll out HRG training for facility and community-based health care workers. ● Explore including the HRG orientation/training as part of the pre/in-service training.
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	<ul style="list-style-type: none"> • Roll out of gender analysis and data utilization training among gender and development point persons in 120 LGUs nationwide. • SOGIE orientation for TB care providers nationwide. <p><u>Ensuring people-centered and rights-based law enforcement practices:</u></p> <ul style="list-style-type: none"> • Roll out HRG training for law enforcement and correction officers. • Explore including the HRG orientation/training as part of the pre/in-service training. <p><u>Increasing access to justice:</u></p> <ul style="list-style-type: none"> • Establishing an additional TB patient hotline to cover 11 regions. The TB patient hotline includes a redress mechanism and patient navigation support. Specific to legal help, the TB patient hotline will be used to report the incidence of human rights violations and to access legal aid. The mechanism includes maintaining lawyers (on a retainer basis) to provide legal assistance services. <p><u>Monitoring and reforming policies, regulations, and laws:</u></p> <ul style="list-style-type: none"> • Review and enhancement of the TB Law & IRR provisions to be CRG conscious. <p><i>Related documents on HRG assessment and ongoing responses are attached as Annex 26.</i></p>
Amount requested	USD 546,495
Expected outcome	<ul style="list-style-type: none"> • Train 80 CRG Trainers to reach journalists/media, correction officers, and health care workers. • Dissemination of gender-sensitive SBCC materials. • SOGIE orientation for all TB care facilities. • Train GAD officers from 120 LGUs on gender analysis and data utilization. • All 17 regions with operational redress mechanisms. • Policy provisions on HRG included in the IRR of the enhanced TB Law.
Module #7	RSSH: Health Sector Planning and Governance for Integrated People-centered Services
Intervention(s)	National Health Sector Strategy, Policy, and Regulation <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down

	Integration/coordination across disease programs and at the service delivery level <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
Population, geographies, and barriers addressed	<p>Population: 120 LGUs (UHC implementation sites)</p> <p>Geography: Nationwide</p> <p>Barriers: In compliance with the UHC Law and the EO138, LGUs must build their capacity to implement the UHC in a fully devolved healthcare system. JPR findings reflect a need for more competency among LGUs to fulfill their enhanced mandate.</p>
List of activities	<p><u>National Health Sector Strategy, Policy, and Regulation</u></p> <ul style="list-style-type: none"> Capacity building for Local Health Boards to support the implementation of the provisions of the UHC law. The intervention package will be three courses to include: (1) Organizational Development Planning, (2) Resource Mobilization, and (3) Financial Management, particularly the special health fund. Depending on the identified needs, LGUs may avail of all three. Support BLHSD in developing and disseminating the LHB Handbook Strengthening Local Health Boards will enable the use of local health data to support their planning and budgeting functions, ensuring proper allocations for TB, HIV, and Malaria. <p><u>Integration/coordination across disease programs and at the service delivery level</u></p> <ul style="list-style-type: none"> Continuous support to CHD 4B and its UHC IS (5 provinces and 1 HUC) on capacity strengthening to achieve their target UHC maturity Index and demonstrate technical, financial, and managerial integration for their local healthcare system. The TB program will serve as the tracer program in setting up their healthcare provider network and testing social contracting and pooled procurement models. Continuous OD support to DOH-DPCB and Philippine CDC based on World Bank OD assessment in 2023. Capacity building for regional development councils on health.
Amount requested	USD 977,327
Expected outcome	<ul style="list-style-type: none"> 120 LHBs capacitated on technical, financial, and managerial integration of its local health system. All UHC IS on Region 4B achieving UHC maturity index targets on time. Effective and efficient DOH-DPCB performance, particularly for TB, HIV, and Malaria. LHB handbook developed and disseminated.

Module #8	RSSH: Community Systems Strengthening
Intervention(s)	Community-Led Monitoring <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
	Community-led research and advocacy <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
	Community engagement, linkages and coordination <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
Population, geographies, and barriers addressed	<p>Population: CBOs and CSOs</p> <p>Geography: Nationwide</p> <p>Barriers: 11 out of 17 regions with no CLM mechanism established. Weak KAP voice in health governance and planning, lacking champion advocate to push for a better quality of services and increased domestic investment.</p>

List of activities	<p>The ongoing GFTB grant 2021-2023 includes establishing CLM systems for TB in six regions. It is currently in a development phase and will be assessed & enhanced by the end of 2023, to be scaled up in 2024-2026 for nationwide coverage.</p> <p>The end goal is to establish a multi-disease CLM. However, given that the CLM for TB is under development and the CLM for HIV is also changing, it is unlikely that the CLM for TB-HIV can be integrated within 2024-2026. The vision for integration is to have a CLM mechanism that will not be disease-specific, with standardized tools and common oversight bodies.</p> <p>The TB CLM mechanism will be engaging one CLM team per region. CLM activities will be done at the facility level. Using standardized tools, data will be regularly collected and reported to the DOH regional office for action. The DOH regional office will discuss and address concerns with the local government units. For findings needing legal aid, the CLM teams will have access to retainer lawyers that are part of the redress mechanisms in place.</p> <p>This FR will also further scale up the identification and capacity building of TB champions to (1) represent the KAP in health governance and planning at the national and local levels, (2) advocate for a better quality of services, (3) advocate for higher domestic funding for TB, and (4) communicate at the national and local levels to address human rights and gender-related barriers in accessing quality TB care.</p> <p><u>Community-Led Monitoring:</u></p> <ul style="list-style-type: none"> • <i>Establishment and operationalization of CLM mechanisms in 11 regions.</i> • <i>Support CLM advocacy and communication activities for the 17 regions.</i> <p><u>Community-led research and advocacy:</u></p> <ul style="list-style-type: none"> • <i>Capacity building of TB champions (advocates/survivors) for program advocacy and communication.</i> <p><u>Community engagement, linkages, and coordination</u></p> <ul style="list-style-type: none"> • Support improved selection of CSO representation and active participation in the LHB
Amount requested	USD 387,228
Expected outcome	<ul style="list-style-type: none"> • All 17 regions with operational CLM mechanisms in place. • CLM advocacy and communication activities conducted nationwide. • Additional 17 TB champions trained, one per region.
Module #9	RSSH: Health Financing Systems

Intervention(s)	Health Financing Strategies and Planning <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
	Social Contracting: <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
Population, geographies, and barriers addressed	<p>Population: Philippine Health Insurance Corporation (PhilHealth)</p> <p>Geography: PhilHealth central office</p> <p>Barriers: Most public health facilities have stopped reimbursing for the TB, HIV, and Malaria reimbursement packages of PHIC due to difficulty in the processes related to accreditation, reimbursement, reimbursement tracking, and reimbursement utilization. Several facilities expressed the need for additional staff to perform the required tasks. One of the significant challenges in realizing the UHC law provisions is the need for more social contracting schemes to enable public financing of private provider services.</p>
List of activities	<ul style="list-style-type: none"> • To address difficulties surrounding PhilHealth reimbursement, experts will be engaged to support PhilHealth review and enhance its primary care benefit packages for TB, HIV, and Malaria, simplify accreditation and reimbursement processes, and establish tracking tools for reimbursement processing and accounting utilization. • To ensure facilities are aware and capacitated to access PhilHealth, support nationwide dissemination of the new PhilHealth packages and the reimbursement mechanisms. • To facilitate financial integration and support the development of the particular health fund among the Commission on Audit, PhilHealth, Department of Finance, and LGUs. • To help operationalize local healthcare networks, engage experts to support DOH and PhilHealth design, and implement social & network contracting models that can be included in the sandbox. The FR will help demonstrate the models in region 4B UHC IS. Other international donors are also adopting other regions like USAID operating in 12 UHC IS. Successful models are documented and submitted to DOH for scale-up considerations.
Amount requested	USD 818,002
Expected outcome	<ul style="list-style-type: none"> • Better PhilHealth packages for TB, HIV, and Malaria (across the care cascade) and inclusion in the PhilHealth Comprehensive Outpatient Benefit Package. • Increased reimbursement and utilization of PhilHealth benefits packages • Policy recommendations on various social contracting schemes.
Module #10	RSSH: Health Products Management Systems

Intervention(s)	Policy, strategy, and governance <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
	Storage and distribution capacity, design, and operations: <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
	Regulatory/Quality Assurance Support: <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
	Supply Chain Information System: <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
Population, geographies, and barriers addressed	<p>Population: 120 LGUs (UHC implementation sites)</p> <p>Geography: Nationwide, high-burden sites</p> <p>Barriers: With the full devolution of health services mandated by the UHC law, LGUs are expected to manage the PSCM cascade for health products and equipment, particularly individual-based services. However, the majority of the LGUs have limited capacity on PSCM.</p>

List of activities	<p>The ongoing GF TB grant 2021-2023 funds the TOT and rollout of the eLMIS (co-developed by USAID MTAPS and DOH), which will be completed by the end of 2023. The direct result will be a pool of eLMIS trainers at the CHDs, who will download the training to LGUs in 2024.</p> <p>For 2024-2026, the TB program will be considered a population-based service; as such, procurement of TB commodities will be through the DOH. Strengthening LGUs on PSCM as part of the FR is to prepare for the eventual transfer of the TB program into an individual-based service, in addition to several individual-based services that already started the devolution transition in 2022. In addition, the DOH-SCMO needs TA support to enhance its operations further to deliver its mandate.</p> <p><u>Policy, strategy, and governance:</u></p> <ul style="list-style-type: none"> • LGU Level: Training for LGUs on P/SCM systems & processes and their link to central and regional warehouses. • National Level: Expert deployment to DOH-SCMU to improve logistics management of population-based services. <p><u>Storage and distribution capacity, design, and operations:</u></p> <ul style="list-style-type: none"> • LGU Level: Development and dissemination of a P/SCM handbook for LGUs. • National Guideline: Expert deployment to support policy and guidelines development on P/SCM. <p><u>Regulatory/Quality Assurance Support:</u></p> <ul style="list-style-type: none"> • Establishment of a quality assurance/quality control system for LGU-procured health products and equipment aligned with Food and Drug Administration policies and guidelines. <p><u>Supply Chain Information System:</u></p> <ul style="list-style-type: none"> • Provide coaching and mentoring support to LGUs via CHDs (trained regional pharmacists) to operationalize the eLMIS at the LGU facilities.
Amount requested	USD 808,821
Expected outcome	<ul style="list-style-type: none"> • 120 LGUs with SCM systems in place, supported by an operational QC/QA system and functional eLMIS. • Improved DOH-SCMU services to its clients. • LGU PSCM Handbook
Module #11	RSSH/PP: Human Resources for Health (HRH) and Quality of Care

Intervention(s)	RSSH/PP: HRH planning, management, and governance, including for community health workers (CHWs) <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
Population, geographies, and barriers addressed	Population: 120 LGUs Geography: Nationwide Barriers: As part of the devolution transition of the health system, LGUs are required to manage their HRH fully. During the LGU consultation in preparing the FR, LGUs requested TA to localize the DOH HRH masterplan.
List of Activities	<ul style="list-style-type: none"> Deployment of consultants to support 120 LGUs in preparing their HRH master plans for 2024-2026. <p>*To date, other donors have no commitments to support the localization of the DOH HRH Masterplan.</p>
Amount Requested	USD 376,778
Expected Outcome	<ul style="list-style-type: none"> 120 LGUs with localized HRH masterplan, which means that LGUs will be able to determine their HRH requirements (quantify HRH needs, allocate HRH funding, perform recruitment and personnel management, and performance management systems)
Module #12	RSSH/PP: Laboratory Systems
Intervention(s)	Specimen referral and transport system: <input type="checkbox"/> New, <input checked="" type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
Population, geographies, and barriers addressed	Population: All TB and HIV facilities Geography: Nationwide Barriers: Access to RDTs for TB diagnosis and HIV rHIVda remains limited. Interrupted supply of drugs and commodities are experienced, and proximal facilities can share stocks to mitigate such incidence but have no budget for moving small quantities of commodities.

List of activities	<p>The ongoing GFTB grant supports the deployment of 370 specimen and commodity transport riders (STRIDERS). Their scope of work has already been expanded to support the HIV program since 2020. Some CHDs and LGUs already hired their STRIDERS in 2022 and 2023. More robust advocacy is necessary for LGUs to carry on the hiring of STRIDERS for their areas of jurisdiction in the long run.</p> <ul style="list-style-type: none"> • Deployment of 400 STRIDERS for 2024-2026 to service TB and HIV facilities, both public and private. • LGU advocacy for absorption of STRIDERS as part of their primary care network. <p><i>Details on the WHO assessment of the STRIDERS mechanism, including their catchment areas and recent accomplishments, are attached as Annex 25.</i></p>
Amount requested	USD 3,888,389
Expected outcome	<ul style="list-style-type: none"> • At least 85% functionality of RDTs (GeneXpert Modules). • Optimization of RDTs for multi-disease use, particularly TB diagnosis and HIV viral load testing • Ensure uninterrupted supply of drugs and commodities through redistribution.
Module #13	RSSH: Monitoring & Evaluation Systems
Intervention(s)	<p>Routine Reporting: <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down</p> <p>Surveys: <input checked="" type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down</p>
Population, geographies, and barriers addressed	<p>Population: All facilities (clinics and laboratories) using the ITIS and ITIS lite</p> <p>Geography: Nationwide</p> <p>Barriers: Country TB data is managed through the Integrated TB Information System (ITIS), a stand-alone system. With the plan of the DOH to have a single HIMS, ITIS needs to be integrated into the DOH HIMS.</p>

List of activities	<p>ITIS is currently stand-alone and is fully supported by the ongoing GFTB grant. The DOH is developing its HIMS with plans to integrate all disease-specific information systems.</p> <p>Considering the time required to design, test, and implement the envisioned DOH enterprise architecture, the integration will likely happen after 2026.</p> <p><u>Routine Reporting:</u></p> <ul style="list-style-type: none"> • Maintenance of the ITIS while the DOH HIMS is being developed. • Address interoperability of ITIS with related IS to include, but not limited to, QuanTB, eLMIS, PhilHeath IS, Gx Alter, EMR, etc. • Pursue ongoing work towards integrating DAT into ITIS. Current thinking to be explored is either adding a DAT module in ITIS or bridging ITIS to the DTA platform. • Expand the use of ITIS lite for TB mandatory case notification and treatment outcome reporting alongside the increase in the private care providers supporting the NTP/ included in the primary care provider network. • Deploy an expert to DOH to support the design of the DOH HIMS and how to integrate ITIS, OHASIS, and OLMIS into the new enterprise architecture. • USAID is providing experts to support the improvement of ITIS components. • Conduct TB care cascade analysis annually as part of the annual USAID/Philippines TB roadmap development, including yearly program implementation reviews for this FR. • DOH-led TB-HIV-HSS Joint Program Review in 2025, with support from various stakeholders. • Conduct of rGLC missions supported by this FR. • Deployment of ITIS project associates (71 in 2024, 67 in 2025, and 2026). <p><u>Surveys:</u></p> <ul style="list-style-type: none"> • 2024 Inventory Study • 2024 Clinical Diagnosis Study • 2025 Catastrophic Cost Study
Amount requested	USD 3,300,276

Expected outcome	<ul style="list-style-type: none"> • 100% of reporting units that digitally enter and submit data at the reporting unit level using the electronic information system. • Integration plan of ITIS in the DOH HIMS • Evidence generated from studies to support decision-making and implementation of adaptive management actions.
Module #14	Program Management
Intervention(s)	Grant Management: <input type="checkbox"/> New, <input type="checkbox"/> Scale-up, <input checked="" type="checkbox"/> Continuation, or <input type="checkbox"/> Scale-down
Population, geographies, and barriers addressed	<p>Population: PR personnel</p> <p>Geography: Nationwide</p> <p>Barriers: PBSP requires funding support to perform PR functions as needed for the grant.</p>
List of activities	<ul style="list-style-type: none"> • Development and submission of quality grant documents • Oversight and technical assistance related to effective and efficient GF grant implementation and management • Supervision of SRs and service contractors. • Human resource planning and management. • Operational costs. • Coordination with national and local authorities, including PCCM and community representatives. • Mobilizing leaders to support implementation and sustainability. • Address all contractual obligations with The Global Fund.
Amount requested	USD 15,731,201 [11% of the FR]
Expected outcome	<ul style="list-style-type: none"> • High client satisfaction rating from the country team, PCCM, and all grant stakeholders.

B. If you use a Payment for Results modality, provide information on the proposed performance indicators/milestones, targets, and amounts.

Performance indicator or milestone	Target				Rationale for selection of the indicator/milestone	Amount requested	Expected outcome	Specify how the accuracy and reliability of the reported results will be ensured.
	Baseline	Y1	Y2	Y3				
TBDT-3a Percentage of notified patients with all forms of TB (i.e., bacteriologically confirmed + clinically diagnosed) contributed by non-national TB program providers-private/non-governmental facilities; *includes only those with new and relapse TB	21% (99,240/470,754)	25% (131,009/524,036)	25% (139,723/558,890)	25% (148,928/595,711)	The indicator directly reflects the results from the RXPASS and Incentive Scheme Mechanism that will be employed in increasing private sector engagement.	USD 3,038,501	<ul style="list-style-type: none"> Increased TB case notification Increased use of RDT Reduction of clinical Increased TSR in the private sector 	The report will be collected from the ITIS. The full description of the RxPASS mechanism, including data validation, is detailed in Annex 23 .
TBC-1 Treatment Success Rate in the private sector: Percentage of TB patients (all forms) bacteriologically confirmed plus clinically diagnosed, successfully treated in the private sector	22.94% (12,935/56,377)	55% (66,273/120,497)	65% (85,156/131,009)	75% (104,792/139,723)	The indicator directly reflects the results from the RXPASS and Incentive Scheme Mechanism that will be employed in increasing private sector engagement.			
KVP-2 Number of people with TB (all forms) notified among key affected populations/high-risk groups (other than prisoners); *includes only those with new and relapse	31,689	32,880	34,380	35,880		USD 22,967,941	<ul style="list-style-type: none"> Increase Tb case notification among KVPs 	The report for KVP (disaggregated) will be generated from the ACF event registries and reports from jails. The PR and the LFA will validate this.
KVP-1 Number of people with TB (all forms) notified among prisoners; *includes only those with new and relapse TB	4,186	5,000	4,600	4,000		USD 3,780,378	<ul style="list-style-type: none"> Increase Tb case notification among KVPs 	These results will be achieved through the ACF Contractors Mechanism. The validation guidelines are detailed in Annex 27 .
<i>Add rows as relevant.</i>								

Countries should discuss with their country teams if they are considering using a Payment for Results modality as the basis of the funding request.

1.2 Rationale

A. Overall approach for selection and prioritization of requested interventions.

The country employed the people-centered framework in the TB program evaluation and analysis to inform this funding request. It anchors on reviewing the TB epidemiological data trend, analyzing surrounding issues among key and vulnerable populations driving the epidemic, and understanding the health systems gaps that impede access to quality TB care.

The Philippine CCM appointed a task force to prepare separate funding requests for TB, HIV, and Malaria. The TB FR development process was led by the DOH-Disease Prevention and Control Bureau, representatives from TB KAP, PR technical team, WHO Philippines, and several experts from ongoing USAID health projects in the country.

The FR is rooted in the findings and recommendations from a robust gap analysis conducted through the Department of Health National Perspective Situational Assessment (NPSA) and Joint Program Review (See Annex 1) undertaken in 2022; and several stakeholder consultations¹ to prioritize the strategies and interventions.

Preparing the programmatic gap tables and reviewing successful and promising interventions guided the selection of interventions. Much consideration was also placed on the aligned expressed needs of the key affected population participating in the various consultation sessions.

The WHO-coordinated peer review was also participated in by the Philippines FR writing teams in February 2023, which enriched the contents of the FR for HIV, TB, and Malaria. The participants and the organizers commended all draft FRs presented by the Philippines delegation.

The FR development process was conscious of aligning and complementing with the Philippine Health Sector Agenda (Annex 2) and the DOH Primary Care Strategy (Annex 3) for 2023-2028.

Key operational recommendations from the regional Green Light Committee (rGLC) mission conducted in December 2022 were adopted in 2023, and recommendations for systems improvement were considered in preparing this FR. (Annex 4)

The TB-HIV co-financing plan outlines the TB and HIV program’s targets, strategies, and interventions for 2024 to 2026. This FR is a subset of this document.

In the end, the priority investment being solicited from The Global Fund Grant cycle 2024-2026 focuses on the following:

- 1. Scaling up DRTB diagnosis, treatment using new regimens, and care using patient-centered care-focused innovations.

1 Multi-stakeholder consultations conducted among implementing partners (December 6-7, 2022), key affected population (Luzon-December 13-15, 2022 and Visayas/Mindanao-January 23, 2023), local government units (January 12, 2023), other DOH central offices (January 17, 2023) and the private sector (January 31, 2023).

2. Scaling up successful interventions in finding and treating all people with TB.
3. Scaling up contact investigation and TB preventive therapy.
4. Scaling up initiatives to scale up the active engagement of community-based organizations and the private sector across the TB care cascade.
5. Implementing systems strengthening interventions to accelerate efforts towards universal health care, benefitting TB and other disease programs.

B. Decision Process for interventions selected for allocation versus those included in the PAAR

Specific for RSSH in support of the ongoing healthcare system transition towards implementation of the provisions of the universal healthcare law, interventions were prioritized based on critical gaps identified from analyzing government commitments vis-à-vis other donors (Annex 5) and those that the ongoing GFTB grant, the C19RM, and forecasted loans and cooperative agreements can cover.

Considering the high investment required to address TB in the Philippines, moderate domestic investment, and TGF allocation for this grant cycle, several excellent and promising interventions were scaled down and included as part of PAAR. This includes:


- Procurement of additional X-ray machines for multi-disease use
- Procurement of additional RDTs (Xpert, IGRA kits, Trunat) for multi-disease use
- Procurement of additional shorter TPT regimen for a more extensive scale of implementation
- Procurement of additional mobile vans to reach more KVPs
- Procurement of ultraportable X-ray machines for ACF in isolated areas
- Support the conduct of the 2026 NTPS.
- Support the conduct of a National TB Stigma Baseline Assessment

Furthermore, critical interventions to support the ongoing health systems changes in the central and regional offices of the DOH vis-à-vis the implementation of the UHC law provisions were also prioritized to be included in the PAAR as follows:

- HRH augmentation to the planned Philippine CDC.
- Capacity strengthening for CHDs on patient navigation and referral.
- Technical assistance to the development of the Laboratory Development Plan.
- Capacity building for UHC IS and non-UHC IS in implementing telemedicine services.

1.3 Context

The Philippine Health Care System

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The observed outcomes must be contextualized wherein the Philippine healthcare system is undergoing challenging reforms towards attaining UHC, encountering challenges with the onset of the COVID-19 pandemic, barely a year from the legislation of the UHC Act of 2019. (See Annex 6)

Health Outcomes

The Philippine health outcomes have continuously improved, but more is needed to attain the targets. It was envisioned back in 2016 for Filipinos to be among the healthiest in Southeast Asia. There is a slow decline in the maternal mortality ratio, 105 in 2020, versus a target of 90 per 100,000 population by 2022. There is a slow decline in infant mortality, with 21 in 2017 versus a target of 15 per 1000 live births by 2022. There is a slow decline in Tuberculosis incidence, with 539 in 2020 versus a target of 427 per 100,000 population in 2022. There is a slow decline in stunting among children, with 28.8% in 2019 versus a target mark of 21.4% among children under five in 2022. The country's health outcomes are among the poorest in Southeast Asia, and health outcomes are worse among vulnerable groups. However, life expectancy at birth is now 72, the country's target for 2022. In 2021, TB incidence was estimated to go upward due to the impact of COVID-19.

Health Reforms

The Philippine Development Plan 2023-2028 (See Annex 7) is the country's blueprint for development planning for the next six years. Health is part of promoting human and social development with "Boost Health" as a strategy, which highlights (1) addressing social determinants of health, (2) increasing health literacy and promoting appropriate health-seeking behavior, (3) improving access to quality and efficient health care, and (4) health systems strengthening. It also underlines harnessing private sector engagement, integrated and innovative healthcare delivery systems, interoperable health information systems, and evidence-informed policy development. The DOH strategy, targets, and interventions to support the PDP are outlined in the Philippines Health Sector Strategy for 2023 to 2028 and the Primary Care Strategy for 2023-2028.

Health Governance

As provided by the local government code of 1991, local government units are responsible for the devolved healthcare system, with DOH setting the national policies and standards. DOH also provided technical and financial assistance to LGU through its regional offices and the Centers for Health Development (CHD). The DOH also manages more than 70 specialized and end-referral hospitals nationwide.

The UHC Law, passed in 2019, further advanced the devolution, transferring 70% of the annual DOH budget to LGUs beginning in 2023 from 30% prior. This is coupled with the increase in national tax allocation to LGUs which started in 2022, resulting from EO No. 138 (See Annex 8), which fully devolves the delivery of essential services to LGUs. A Joint Department of Health -National Nutrition Council Devolution Transition Plan for 2022-2024 (Annex 9) was published to set the strategic direction, functions, standards, support to LGUs, performance matrix, and schedules towards full devolution.

The LGUs are underway in developing policies and mechanisms for technical, managerial, and financial integration. Models for local health systems integration are currently being designed and tested at varying levels of success.

The JPR 2022 found that across all LGUs visited, technical assistance is needed to develop systems and capacities to operate a fully devolved healthcare system—more expertise in CHDs to provide these required TA support services to LGUs. Preliminary feedback from the ongoing organizational development assessment of DOH and the CHDs by the World Bank is reporting similar findings.

Health Financing

Health financing in the country involves four sources, namely: (1) national and local government, (2) government and private insurance, (3) user fees, and (4) donors.

Based on the 2020 Philippine National Health Accounts, among the types of revenues of health financing schemes, other domestic revenues, which consist of revenues from households and corporations, accounted for 46% percent of the current health expenditure (CHE). This was followed by transfers from domestic government revenue (allocated to health purposes) with 38.9% of the CHE. Meanwhile, voluntary prepayment and social insurance contributions shared 8.9% and 5.5%, respectively. Transfers distributed by the government from foreign origins recorded the lowest revenues, about 0.8%.

The total CHE for the same year reached PHP 895.88 billion, 12.6% higher than in 2019. Health spending financed through government schemes and compulsory contributions to health insurance was recorded as the country's largest source of health financing, with a 45.7% share. Household out-of-pocket came second with 44.7% share, followed by voluntary health contributions with 9.6%.

Among healthcare providers, the bulk of spending was spent on hospitals (43.8%), followed by pharmacies (28.2%) and preventive care providers. Regarding health care functions, curative care received the most significant amount of CHE with 51.6%, followed by medical goods at 28.2%. Among income quintiles, health spending in the fifth quintile (top quintile) was the highest, with a 34.8% share. Infectious and parasitic diseases contributed 30.9% of disease groups, followed by noncommunicable diseases with a 30.5% share. The female population accounted for more than half (54.3%) of CHE. Population ages 65 and over shared 14% - the highest health care spending.

For the National TB Program, the national; government funds 100% of the anti-TB drugs for DS TB, TB in children, and TPT. In 2022, the government procured 100% of the GeneXpert cartridge requirement. For 2023, the government procured Bedaquiline for 22% of the requirements to achieve the country's target. X-ray is included in the PhilHealth Konsulta package beginning in 2022, thus accessible for all Filipinos; however, knowledge of this benefit could be better. Access to X-rays is limited just because the country does not have enough X-ray machines to cover the population. The 2017 NTPS reports poor health-seeking behavior² and PhilHealth is not actively promoting its benefit packages to the general public.

² Only 6% of those interviewed has symptoms suggestive of TB at the time of the survey. 41% of those with symptoms did not take action, while 40% self-medicated. Only 19% consulted a health care worker, mostly from the public sector (67%).

In addition to the Konsulta package, PhilHealth maintains the Out-patient TB Benefit Package from PhilHealth. However, the JPR 2022 found that most TB care facilities are no longer submitting reimbursements due to the lack of workforce to handle the cumbersome reimbursement process and the non-transparent utilization of reimbursements in the past.

Health Service Delivery

To realize the envisioned service delivery model provided by the UHC Law, the DOH has published the Philippine Health Facility Development Plan for 2020-2040 (Annex 10) and the Human Resources for Health Masterplan for 2020-2040 (Annex 11).

Implementing the DOH Primary Care Strategy for 2023-2028 is anchored on omnibus health guidelines and relevant clinical practice guidelines across the life stages.

Health data recording and reporting are moving into electronic platforms but must be more cohesive and vertical. DOH is working on setting up an integrated primary healthcare information management system to address this fragmentation.

The procurement and supply chain management system for health products and commodities at the national and local levels has much room for improvement. With the full devolution of health services, capacity strengthening is needed by LGUs for health-related procurement. An electronic logistics management information system (eLMIS) has been established, and a training pool for the CHDs are being organized to be entirely trained by the end of 2023 to support the eLMIS rollout to LGUs in 2024.

TB Policy and Practice

The National TB Program (NTP) is anchored on Republic Act No. 10767, entitled the “Comprehensive Tuberculosis Elimination Plan Act,” or the TB Law (See Annex 12). The critical approaches and strategies are provided in Updated Philippines Strategic TB Elimination Plan Phase 1 for 2020-2023. The new strategy, targets, and interventions to support the TB program are reflected in the TB-HIV Co-financing plan for 2024-2026.

The operational policies and procedures are provided in the 6th edition of the NTP manual of procedures (MOP) released in 2020 (See Annex 13). The MOP focuses on a technical approach to the TB care cascade while emphasizing the patient-centered care (PCC) approach. It provides detailed policies and procedures for frontline healthcare workers managing drug-susceptible tuberculosis (DS-TB) and drug-resistant tuberculosis (DR-TB).

Case-finding strategies include systematic screening in all health facilities, active case-finding in targeted communities, workplaces, and congregate settings, and contact tracing. All healthcare workers are also targeted for regular TB screening.

Presumptive TB cases are diagnosed using a rapid diagnostic test, such as GeneXpert MTB/RIF, as the primary diagnostic test for pulmonary and extrapulmonary TB in adults and children. TB LAMP shall be the alternative diagnostic test, especially when processing large sample loads, like active case-finding activities. Tuberculin skin test (TST) shall only be used as an adjuvant when in doubt about making a clinical diagnosis of TB in children. A TB Medical Advisory Committee (TB MAC) established for every region shall support clinical diagnosis for difficult DS-TB and DR-TB cases.

Based on client eligibility, DS-TB cases follow the standard treatment regimen (2HRZE/4HR for PTB or 2HRZE/10HR for TB in CNS & bones/joints). They are monitored through follow-up

smear microscopy and clinical assessment. PCC supports treatment adherence approaches, tapping healthcare workers, community volunteers, and family members.

Multidrug-resistant tuberculosis (MDR-TB) and rifampicin-resistant tuberculosis (RR-TB) cases follow standard treatment regimens based on patient eligibility and exclusion criteria. Beginning July 2023, BPaL and BPaLM are the standard regimens for eligible clients. The first- and second-line genotypic DST, either Line Probe Assay (LPA) or Xpert MTB/RIF and Xpert MTB/XDR, are done before MDR-TB, RR-TB, pre-XDR-TB, and XDR-TB treatment. In addition to the PCC approaches to support treatment adherence, patients are provided with patient enablers like transportation allowances and conditional cash transfers. Treatment monitoring includes clinical, microbiologic, and laboratory investigations.

For all TB cases, adverse drug reactions are reported using the Food and Drug Administration (FDA) ADR reporting, while writing for programmatic aDSM (active Drug Safety Monitoring and Management) is through the Pharmacovigilance Monitoring System (PViMS). All TB patients aged 15 years and above are offered provider-initiated HIV counseling and testing (PICT), and all patients aged 25 and above are screened for diabetes.

Tuberculosis preventive treatment (TPT) is offered to TB contacts, people living with HIV (PLHIV), and TB risk groups. Before TPT, TST is required except for PLHIV, children under five years old who are household contacts of a bacteriologically confirmed PTB case, and children aged five years old and above who are household contacts of a bacteriologically confirmed PTB patient and with other TB risk factors. The shorter regimen (3HP and 3HR) for TPT was introduced in 2023.

TB data are managed using the NTP recording and reporting forms with the utmost confidentiality. The Integrated TB Information System (ITIS) is the official TB electronic system, bearing the official TB register and TPT register to be maintained in all health facilities.

TB health promotion at the national and local levels is currently being done as part of the DOH's *Healthy Pilipinas* campaign. Chest X-ray screening is an out-of-pocket expense, but the DOH and TGFATM grant support Chest X-ray vouchers for systematic and active TB case finding. TB diagnosis using GeneXpert MTB/Rif is accessible in public and TGFATM grant-supported private facilities. First and second-line DST is also free and is provided by one LPA laboratory and five Xpert XDR laboratories. DS-TB standard regimens for adults and children, including TST, are free, procured by the DOH, and augmented by the LGUs, as needed. DR-TB regimens and ancillary medicines are also free but almost entirely funded by the TGFATM grant. DR-TB patients are provided enablers from the TGFATM grant, and some LGUs have adopted the practice to prevent catastrophic patient costs. TPT is also free but with a meager coverage rate.

The NTP Laboratory Network comprises 961 GeneXpert MTB/Rif machines operating in 872 rapid TB diagnostic laboratories (RTDL), eight phenotypic drug susceptibility testing laboratories, one LPA, 29 TB culture centers, and five operational Xpert XDR sites. As of February 2023, an additional five Xpert XDR sites are being set up, and 10 are ongoing procurement. Additional 100 Xpert machines capable of XDR TB testing were approved under C19RM and will be operational by the end of 2023.

There are also 300 x-ray voucher service providers contracted through the ongoing GFTB grant. The WHO is conducting an optimization study for GeneXpert and X-ray multi-disease use to determine the total need for the country. Results will be completed by the end of 2023.

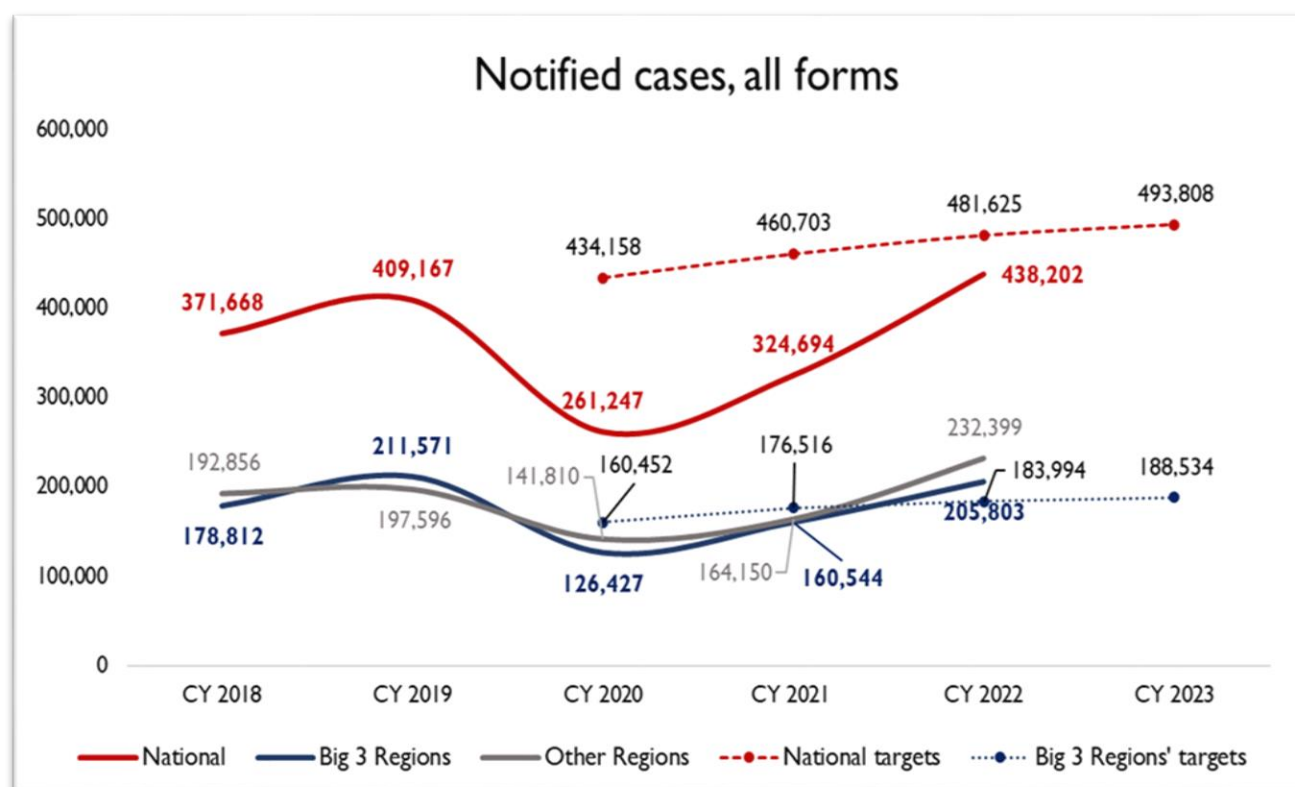
There are 3,300 TB DOTS facilities, of which 2,331 are health centers. There are 198 satellite and treatment centers nationwide supporting DR-TB patients. This will be reduced in 2024, resulting from iDOTS Phase 2 implementation, whereby 17 regional TB MAC will be optimized. By the end of 2023, all TB-DOTS facilities will provide TB-HIV services.

TB Epidemiology

The DOH-Epidemiology Bureau May 2022 Field Health Surveillance Information System (FHSIS) preliminary data identifies Tuberculosis (all forms) as the 8th leading cause of morbidity for 2021. The World Health Organization (WHO) Global TB Report reflects that in 2020, the country's TB incidence rate was highest in Southeast Asia (539 per 100,000) and is four times the global TB incidence (127 per 100,000). The TB incidence was reduced by 9% between 2018 to 2020. However, the estimated TB incidence rate for the Philippines in 2021 increased again to 650/100,000 due to the disruption in TB services during the COVID-19 pandemic. The WHO also conducted a TB Epidemiologic review in 2022 which showed that a more significant number of cases were missed among males compared to females (with 59% of estimated male TB cases missed in 2021) and that the case detection gap was huge among 0-14-year-old children of both sexes, with more than 70% missed in 2021.

The latest WHO estimates for RR/MDRTB is 19 per 100,000 population (WHO GTBR 2022). The epidemiologic review showed an increasing trend in the proportion of newly diagnosed patients among DR-TB cases, from 17% in 2018 to 36% in 2021, indicating improved programmatic performance, particularly in detecting DR-TB by scaling up Xpert usage among new cases.

Case Notification Rates



DS and DR TB notifications have recovered from the drop observed in 2020 during the mandatory lockdowns alongside the COVID-19 pandemic. In 2022, the Philippines met 80% of the national target for TB notifications (all forms), and 70% of the national target for DR TB case notifications.

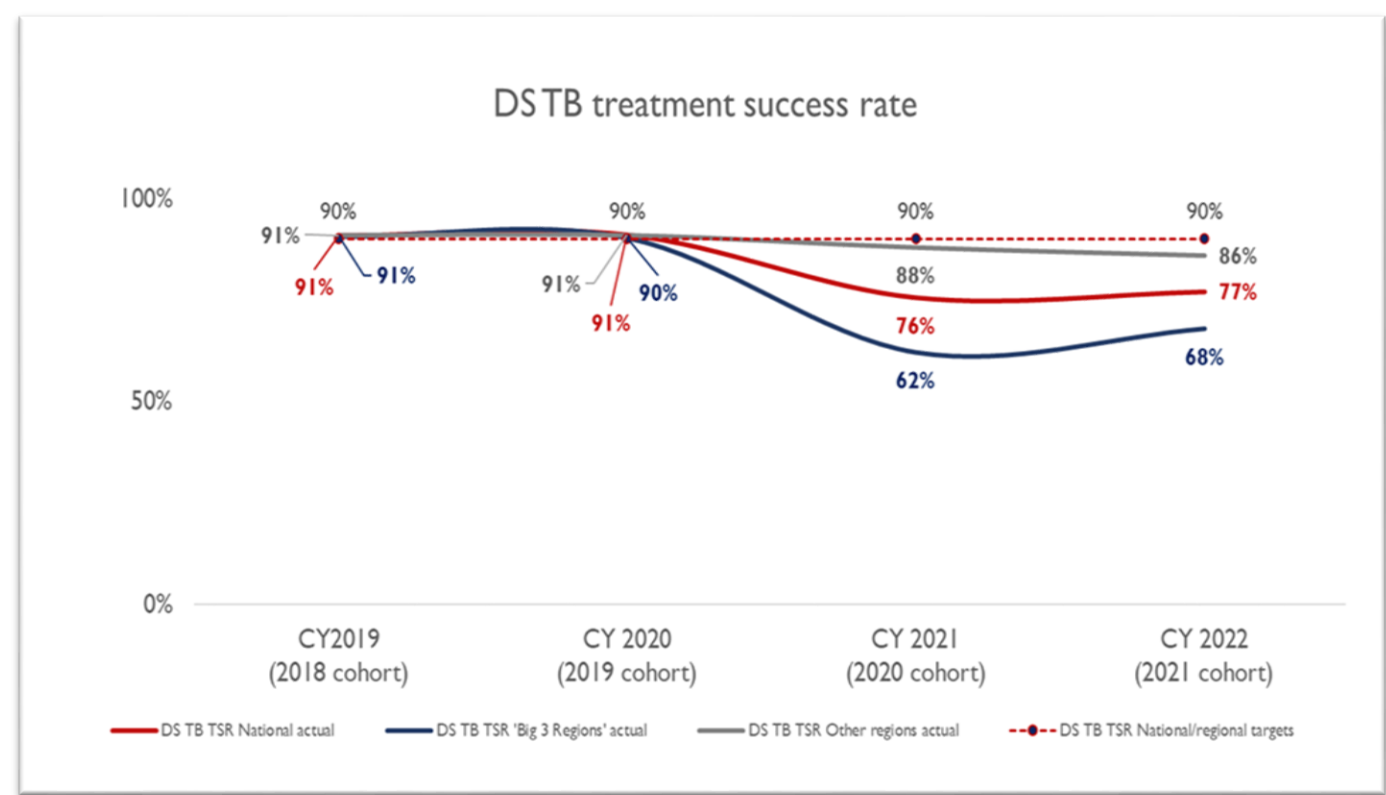
In 2022, 476,754 new and relapse TB cases were notified for a case notification rate of 427 per 100,000 (pop. 111,572,254). Mandatory notified cases are 21% (99,340) of notified TB cases (new and Relapse,) and children were at 8% (37,260).

Total TB cases (all types) were at 486,064, of which 86% were new (420,082) and 14% were retreatment (65,982), including relapse. Among all pulmonary TB cases, 46% (220,605/ 476,768) were bacteriologically confirmed.

TB Law mandates notification of TB cases, and implementation is guided by the DOH DM 2023-70. These policies will be critical to scaling up mandatory case notification and treatment outcome reporting in the country among non-NTP providers.

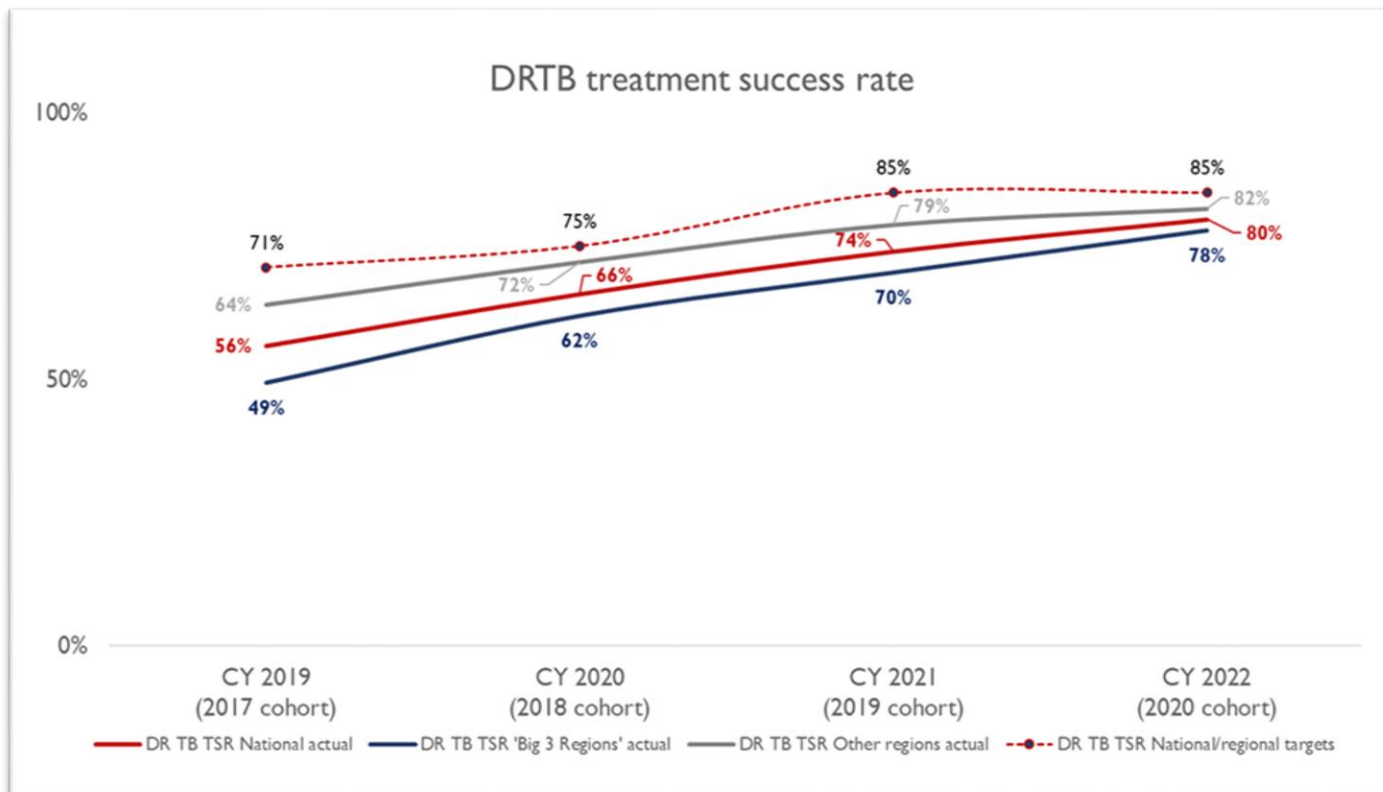
In 2022, the annual laboratory report showed RRTB rates among new TB cases were 2% (3,923/ 196,105) and 15% (4,314/ 28,811) among retreatment cases. The number of TB cases with RR-TB or MDR TB notified in 2022 is 8,166/10,655 (78%).

Treatment Success Rate



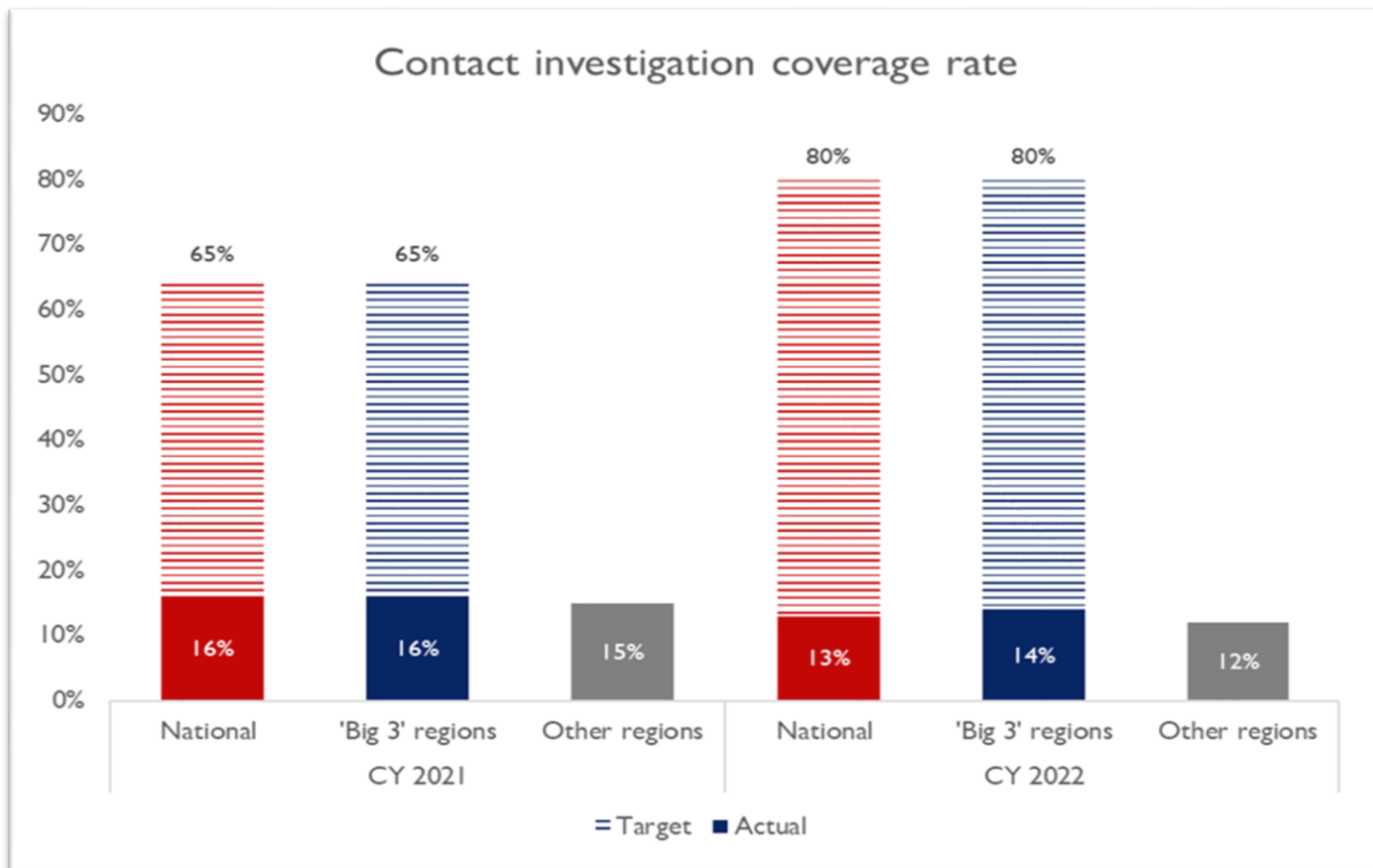
The figure above shows that the DS TB TSR for the 2021 treatment cohort met 85% of the target—an increase of 1 percentage point from the 2020 cohort.

The figure below shows that the DR TB TSR for the 2020 treatment cohort met 94% of the target, which is an improvement of 6 percentage points from the 2020 treatment cohort.

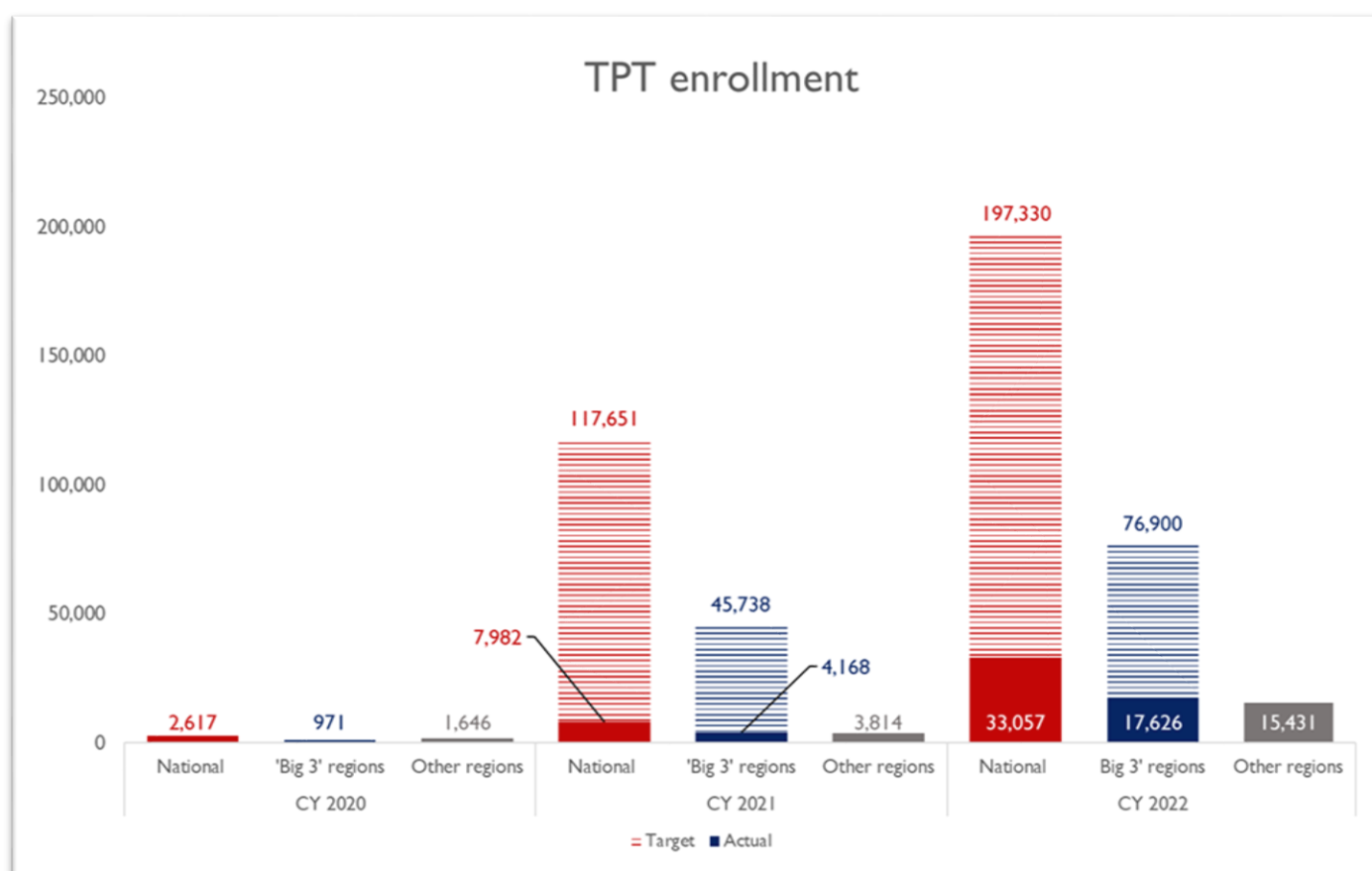


In 2022, treatment coverage was 66% (at the estimated incidence of 650), and all forms' success rate for the 2021 cohort was 79% (243,270/ 309,181) versus the 90% target. The low TSR directly results from increased mandatory notifications from non-NTP providers that also failed to report treatment outcomes, wherein TSR for MN cases was only 22% (15,560/ 71,182). The ITIS lite was operational to capture treatment outcomes reporting from mandatory case notifications in January 2022.

Contact Investigation and TPT



TB investigation among contacts of bacteriologically confirmed TB cases is not captured in the Integrated TB Information System (ITIS). In 2022, only 13% were reported to be evaluated for TB, which is far below the national target of 80%. In absolute values, a 400% increase was seen in 2022 (49,558) versus 2021 (8,830).



Under reporting in contact investigation probably contributes to low enrollment to TPT among the eligible population. The JPR 2022 reports that a contributing factor for TPT uptake is the low acceptance of health care workers and eligible population to take TPT. In 2022, TPT enrollment is only 17% of the national target.

TB-HIV Co-infection

PICT is offered to all TB patients. In 2022, 79% of TB patients had HIV results (0.85% positivity rate), 96% of TB with HIV were enrolled in ART, and 75% of PLHIV on ART were given TPT.

Among PLHIV, TPT is provided to 72% of PLHIVs in 2022. Default regimen is isoniazid which has a high refusal rate due to adverse drug reactions.

Key and Vulnerable Population

The NTP identifies the KVPs as TB contacts, urban and rural poor, elderly, children, people deprived of liberty, PLHIVs, and people with comorbidities.

Contact tracing/investigation is done among TB contacts. Systematic screening is done for poor communities, the elderly, and children. All jails and prisons have TB programs in place, with varying levels of implementation. TB & Diabetes programs are implemented in some hospitals.

Inequities and Barriers

The Philippines, an archipelago of more than 7000 islands, makes accessing TB screening and diagnosis difficult. Geographically Isolated and Depressed Areas (GIDA) are also present in big cities and provinces.

TB care models for increased access among males are available but must be scaled up.

The CLM system and redress mechanism for TB are being tested in six regions and will be evaluated by the end of 2023. Part of the FR is scaling-up enhanced models from 2024 to 2026 nationwide.

In 2023, NTP providers will be upskilled in the conduct of gender analysis and the use of gender data in health planning.

COVID-19 Impact

The onset of the COVID-19 pandemic in 2020 and the concomitant mobility restrictions hampered the implementation of the NTP. The 2020-2021 performance set back the country by one year and recovered to pre-pandemic performance levels by the end of 2022.

The NTP Adaptive Plan developed in 2020, which provided measures for TB care delivery while complementing the ongoing COVID-19 response, served as the implementation roadmap for the fast recovery of the program.

Status update on actions to address TRP comments on the GF TB Grant 2021-2023

1. The ITIS can provide sex-disaggregation data for analysis. A comprehensive TB-Gender integration plan is being implemented. Interventions to increase access to TB care among males are ongoing, particularly by setting up TB programs in male-dominated formal and informal workplaces. HRG learning sessions have been developed and provided to healthcare workers, media professionals, and correction officers. Skills building among NTP managers is also being provided on how to conduct gender analysis and use gender data for planning.
2. Private sector engagement has been a priority in the current grant by implementing mandatory case notification among private providers (hospital-based and standalone physicians) using molecular diagnosis for TB. ITIS lite has been developed for this purpose and is the current platform for private-sector reporting. Specimen transport riders have been scaled up to increase private sector access to RDTs. Incentives are being provided for mandatory case notification and treatment outcome reporting. Case notification officers were deployed to support NTP MOP 6th edition adoption among private care providers. In this FR, additional interventions focus on supporting the accreditation of private care providers to become part of the primary care network to access free anti-TB medicines and commodities and be able to reimburse from the PhilHealth comprehensive outpatient benefit packages for TB.
3. No focused studies have been conducted to analyze the drivers for DR TB cases. Due to the pandemic, the focus in 2021 was the COVID-19 emergency response, and in 2022 & 2023, catching up to bring the TB program performance back to pre-pandemic levels and beyond.
4. The electronic Logistics Information Management (eLMIS) has been completed. By the end of 2023, all regions would have trained eLMIS trainers. Rollout to LGUs will begin in

2024. The FDA already has an operational online drug registration system to reduce turnaround time. The ongoing GF Grant has augmented the FDA common service laboratory with two High-Performance Liquid Chromatography machines. USAID continuously supported the DOH (particularly the SCM office) on product selection, registration, quantification, budget allocation, and piloting various procurement options. With the devolution-transition plan underway, this FR focuses on capacity building for LGUs to manage their PSCM systems since the function will be fully devolved beginning 2024 for individual-based services.

5. The focus of the DOH in the last three years was responding to COVID-19, and everything else took a back seat, including the development of the health information system. With the UHC Law and the implementation of EO 138, DOH central and regional offices are undergoing major structural, and systems changes as part of the devolution transition. Concrete plans to review and revise the DOH enterprise architecture are currently being discussed. In addition, the law to establish a Philippine CDC is about to be approved. It will have a health epidemiology and surveillance center and should be considered in the plans. In this FR, support is to maintain the ITIS and support the designing of the DOH enterprise architecture to leverage the ITIS and other functioning information systems. On a related note, several digital solutions were tested and mainstreamed in the NTP including: CureAI, Everwell Hub smart pillbox, and one Impact App. Support for these are included in this FR.

1.4 Lessons Learned

1. USAID TB Innovations & Health Systems Strengthening Project conducted an independent analysis of selected case-finding models in 2021 for the Philippines NTP (Annex 14) with the recommendations for specific scenarios as detailed below.
 - a. For all jails/prisons, institutionalize TB active case finding, testing, and treatment as part of inmates' routine health care packages. **[Adopted in Module 4: KVP]**
 - b. For public and private TB care facilities, integrate the CXR voucher system to improve case finding. **[Adopted in Module 3: CWOPS]**
 - c. For workplaces, focus only on active case finding in industries with a workforce at high risk of TB infection (miners, asbestos handlers, health care workers, etc.)
 - d. For high-risk groups, pursue a one-stop-shop model in settings where they congregate. **[Adopted in Module 5: TB/HIV]**
 - e. For high-population density communities & GIDA areas, pursue one-stop-shop models, practically bringing the TB service package to their doorstep. **[Adopted in Module 4:KVP]**
2. USAID CLAIHealth Project conducted a study in 2022 to determine the cost-effectiveness of CXR with AI-Powered Computer-Aided Detection (Annex 15). The result supports AI for CXR screening for TB is encouraged primarily because it is relatively cheaper and faster. However, financing for initial investment and determining acceptability among practitioners should be considered. **[Adopted in Modules 3 and 4]**

3. The WHO Philippines reviewed the specimen and commodity transport riders (STRIDERS) and reported that it significantly increased access to RDT for TB (Annex 16). [\[Adopted in Module 12: RSSH/PP Laboratory Systems\]](#)
4. Findings from the BPAL operational research (Annex 17) confirm that patients' shorter treatment regimen for DRTB has been well received, resulting in an improved treatment success rate of 76% in 2021. [\[Adopted in Module 1: DRTB DTS\]](#)
5. The 1st monitoring mission on the implementation of iDOTS Phase 2 confirm that DR TB care can be integrated with DS Tb care in primary care facilities. [\[Adopted in Module 1: DRTB DTS\]](#)
6. KNCV implemented the Adherence Support Coalition to End TB (ASCENT) project to facilitate the global uptake of digital adherence tools (DAT) and generate evidence for optimal use and scale-up. For the Philippines, DAT implementation is patient-friendly and feasible to scale up. (Annex 18) [\[Adopted in Module 1: DRTB DTS\]](#)
7. The WHO recommends adoption of shorter TB preventive Therapy and initial implementation in 2022 showed better acceptance of 3HP among target clients. [\[Adopted in Module 2: TB/DR TB Prevention\]](#)
8. The WHO recommends the introduction of IGRA and TruNat. [\[PAAR\]](#)
9. The rGLC recommended scale up mandatory case notification and outcome reporting in their 2022 mission. [\[Adopted in Module 3: CWOPS-Private Sector\]](#)
10. The JPR 2022 recommended increasing private sector access to RDTs for TB diagnosis. This recommendation also responds to address high proportion of clinically diagnosed TB cases among notified cases from the private sector. [\[Adopted in Module 3: CWOPS-Private Sector\]](#)

1.5 Focus of Application Requirements

The FR is consistent with GF's new strategy for TB. Specifically, the TB FR for 2024-2026 will focus on the following:

- Increasing TB screening among KVPs by improving access to free X-rays and the use of CAD
- Scaling up access to RDT for primary TB diagnosis among public and private TB care providers.
- Mainstreaming shorter all-oral regimen for DR TB treatment and DAT for better treatment adherence.
- Addressing bottlenecks to increase TPT uptake for prevention, including mainstreaming the use of 3HP.
- Stronger engagement of CBOs and CSOs in health governance & planning, advocacy & communication, reducing HRG barriers, and being part of the primary care service delivery network.

- Strategic support for realizing the UHC law provisions at the local levels, particularly in strengthening local government units in health governance and planning, financial management, and PSCM.

1.6 Matching Funds (if applicable)

About **USD 14,154,968** will be invested, including the catalytic matching funds amounting to USD 4M for 2024-2026 for private sector and CSO/CBO engagement.

Private Sector Engagement

Private healthcare provider engagement aims to find and successfully treat the missing people with drug-susceptible and drug-resistant TB. More specifically, to increase TB case notification and treatment outcome reporting using GeneXpert as the primary diagnostic tool and WHO-recommended treatment regimen.

Under the ongoing GF TB grant (2021-2023), the Prescription for Patient's Access to Screening Services for TB (RXPASS) mechanism is implemented. The service package for private providers includes:

- *Deployment of case 210 notification officers to solicit participation among the private sector to use the ITIS lite for mandatory case notification & treatment outcome reporting.*
- *Provision of X-ray vouchers to clients of private providers.*
- *Optimization of 400 STRIDERS to provide private sector access to RDT sites.*
- *Provision of financial incentives for every case notified (PHP 250) and treatment outcome (PHP 750) provided quarterly.*

With the RXPASS mechanism implemented between April 2022 to December 2022, the proportion of mandatory TB case notifications tested with GeneXpert increased to 19% (from 4% in 2021). By the end of 2023, all high-burden sites with a high concentration of private providers would have been saturated.

From joint monitoring and assessment exercises with GF SI on the RXPASS mechanism, key recommendations for enhancements were proposed and are being adopted as part of the RxPASS service package under this FR:

- Scale-up advocacy to increase uptake of RxPASS, which includes better access to X-Ray vouchers and RDT sites (via STRIDERS).
- Scale up learning activities for the private sector on compliance with the NTP MOP.
- Enhance ITIS lite for increased mandatory case notification and treatment outcome reporting.
- An enhanced financial incentive scheme, increasing to PHP 500 for bacteriologically confirmed TB case notification and PHP 1000 for treatment outcomes that are cured.
- Non-financial incentives will be introduced through recognition events for private healthcare providers contributing to the NTP.
- Deployment of more Notification Officers to support (1) stand-alone physicians using the ITIS, (2) provide technical assistance to adopt WHO-recommended treatment regimens for

TB patients, and (3) technical assistance for accreditation as primary care facilities (iDOTS). This will enable private care providers to access government-funded RDTs, cartridges, anti-TB medicines for DS and DR TB, and TPT. Concomitantly, to access PhilHealth reimbursement for the TB outpatient benefit package.

With the enhanced RxPASS mechanism, the mandatory case notification target will be 25% across the years, and with interventions to support treatment outcome reporting, to be able to achieve 90% TSR for all forms of TB. And TSR among private providers increased from 22% in 2022 to 55% in 2024, 65% in 2025, and 75% in 2026.

It is critical to note that the priority function of the notification officers in 2024-2025 will be improving MN and Tx outcome reporting, but it will shift to technical assistance provision in 2025-2026 for MOP compliance and PhilHealth accreditation.

In the long term, the role of TB notification officers will be included in the role local surveillance officers as envisioned in the Philippine Centers for Disease Control – Center for Epidemiology and Surveillance. The plan is to deploy surveillance officers in all cities and municipalities nationwide by 2026.

The sustainability of STRIDERS is discussed under the RSSH modules (governance and human resources) and sustainability section of this FR.

Several private sector engagement models are also being implemented in the country, including:

- USAID TB Innovations and Health Systems Strengthening project has several initiatives:
 - Managing the TB Diagnostics Consortium, whereby pooled procurement of Xpert and Xpert cartridges is done among its private membership at a lowered cost. Members also agree to cap the service rates for Xpert testing in their facilities.
 - FAST Plus in private hospitals focused on improving access to X-ray and RDTs for Tb diagnosis and contributing to case notification.
- TB in the workplace programs is being scaled up to large companies USAID TB Innovations and Health Systems Strengthening project. At the same time, it is being installed in micro, small, and medium enterprises by the GF AccessTB project.
- Private PPM facilities are operational.
- In the past, Pharmacy DOTS initiatives were pursued, but not sustained.

CSO/CBO Engagement

For CSO and CBO engagement, capacity building will be provided to CSOs and CBOs already supporting the NTP to formalize their engagement as part of the primary care network. CSOs and CBOs with clinics will be provided technical assistance to be accredited by PHIC and/or by LGUs as local service providers to augment their healthcare system.

Technical assistance will also include helping CSOs and CBOs with operating clinics in marketing their services to LGUs.

Relatively, TB KAPs currently supporting the program will be upskilled to qualify as STRIDERS, Notification Officers, and Community Health Volunteers.

Section 2. Maximizing Impact

The strategy describes clear pathways for controlling and eliminating the three diseases globally. The [Review Criteria of the Technical Review Panel](#)³ will be used to help evaluate optimal program design.

2.1 Ending AIDS, TB, and Malaria

A. Primary Goal

The vision is for a TB-free Philippines by 2030, and by 2026, the FR will directly contribute to the following results:

- *Decrease TB deaths by 50% from 54 in 2021 to 27 in 2026,*
- *Reduce TB catastrophic cost from 42% in 2017 to 0% in 2026, and*
- *Achieve 90% patient satisfaction for TB services received.*

To ensure value for money, this FR highlights the following:

- *Active and intensified case finding among KVPs in high-burden sites.*
- *Increasing access to DR TB services by integrating it at the primary care level (iDOTS).*
- *Improving access to RDT for TB diagnosis and optimizing for multi-disease use, including HIV viral load testing and COVID-19 diagnosis.*
- *Adopting WHO recommendations by mainstreaming shorter treatment regimens for DR-TB*
- *Reducing potential TB disease management costs by scaling up systematic TPT among KVPs.*
- *Expanding the primary care provider network to include CBOs, CSOs, and the private sector.*
- *RSSH interventions are supportive of TB, HIV, Malaria, and other diseases (See Section 2.2)*

This FR builds on evidence and learning (See Section 1.4) by adopting and scaling up good and promising interventions that directly contribute to advancing the primary goal of ending TB. It addressed the KAP concerns as generated from the KAP consultations conducted (establishing CLM, redress mechanisms for TB, CSO, and CBO capacity building to be part of the primary care network, CSO and CBO capacity building to be part of health governance and planning, etc.), and aligns with the country's health care strategy on boosting primary care and realizing the provisions of the UHC law and full devolution (EO No. 138, s. 2021). All interventions will be implemented nationwide, ensuring all populations are included.

B. Program Essentials

With the increasing domestic investment and complementation with the grants from The Global Fund and other donors, all TB program essentials in the GF guidance will be fulfilled to a scale

³ Review Criteria of the Technical Review Panel - https://www.theglobalfund.org/media/3048/trp_technicalreviewpanel_tor_en.pdf#page=15

beyond current levels of implementation. These are all included in the Philippines NTP MOP 6th edition.

- For TB screening and diagnosis: (1) systematic screening with CXR +/- CAD is used for all active, enhanced, and intensified case-finding activities; (2) RDT has been adopted as the primary diagnostic tool for TB; (3) DST for all BC TB cases; and (4) operationalization of the TB Laboratory network.
- For TB treatment and care: Shorter all-oral regimen for DRTB will be fully adopted beginning July 2023, and iDOTS and DAT have been mainstreamed to support treatment adherence.
- For TB Prevention: TPT, including shorter TPT regimens, has already been adopted for eligible populations beginning in 2023 and will be scaled up in 2024. This includes social and behaviour change communication interventions for both providers and clients.
- For TB/HIV Collaborative Activities: All TB patients are provided PICT, and those confirmed with HIV are enrolled on ART. Similarly, All PHIV are regularly screened for TB, and those testing positive are enrolled in TB treatment.
- For crosscutting concerns: The ITIS is fully operational, providing real-time case-based TB surveillance. Mandatory case notification is being scaled up for private providers using the MN/RxPASS mechanism and ITIS lite. DS and DR TB care is already integrated at the primary care level (iDOTS) and ongoing implementation of key interventions outlined in the NTP Community Engagement, Human Rights, and Gender National Action Plan 2021-2023.

It is important to note that while shorter treatment regimens for DS TB and adopting child-friendly formulations are already part of the DOH guidelines, the adoption plan is still up for deliberation in 2023 for preparing the 2024 budget.

2.2 Resilient and Sustainable Systems for Health

The allocation letter highlights the Philippines as an RSSH-priority country and recommends support for Universal Health Care and pandemic preparedness. This FR accounts for the specific recommendations whereby:

- *Specimen and commodity transport mechanisms (STRIDERS) will be scaled-up to support TB and HIV programs to access RDT sites for laboratory services and enable commodity transport among proximal facilities to mitigate the incidence of interrupted drug supply.*
- *Roll out eLMIS training to 120 UHC implementation sites and provide coaching and mentoring to ensure operationalization.*
- *Strengthen the capacity of the DOH Supply Chain Management Unit to develop policies and improve the delivery of its mandate.*
- *Strengthen the capacity of LGUs in managing their procurement and supply chain management systems,*
- *Maintain the Integrated TB Information System while supporting its integration into the envisioned DOH health information management system for primary care.*

- *Support improvement of the PhilHealth comprehensive outpatient benefit package (particularly for TB, HIV, and Malaria), reimbursement policies & process, and utilization tracking mechanism. This will guarantee access for all Filipinos to free healthcare for primary care programs by reducing the catastrophic costs to affected populations, realizing UHC.*
- *Support developing and testing social contracting modalities necessary to operationalize primary care provider networks.*
- *Support localization and implementation of the DOH Human Resources for Health Masterplan at the LGU level.*
- *Scaling up private sector engagement as part of the primary care service delivery network (See Section 1.6)*

To ensure people-centered integrated systems for health are maximized, this FR includes:

- *Operationalizing nationwide community-led monitoring mechanism and redress mechanism for TB that will eventually integrate with HIV.*
- *Strengthening CSO and CBO representation and participation in the Local Health Boards for health governance and planning at the LGU level.*
- *Strengthening of CSOs and CBOs to be part of the primary care provider network*
- *Capacity building of TB champions to support advocacy and communication at all levels.*
- *Improve the capacity of local government units on data-driven planning and budgeting for health.*

2.3 Engagement and Leadership of Most Affected Communities

The most affected TB communities have been active in formulating this FR. KAP representatives were part of the Joint TB-HIV Program Review assessment teams. They were part of developing the Philippine TB-HIV Co-Financing Plan for 2024-2026. The KAP leaders facilitated two KAP consultations organized by the Philippine CCM to solicit feedback and recommendations. During the country dialogue, KAP leaders presented the KAP-recommended interventions to be included in the FR.

This FR adopted TB KAP recommendations to include:

- *Establishment of a nationwide CLM and strengthening TB coalitions.*
- *Establishment of a nationwide redress mechanism.*
- *Capacity building of CSOs and CBOs to be part of the primary care network and support community-based health promotion activities and reproduction of IEC on differentiated care services.*
- *Capacity building of CSOs and CBOs on health governance and planning and better representation in the local health board.*
- *Capacity building of TB champions, including financial support for advocacy and communication activities.*
- *Continue ACF and Intensified Case Finding in GIDA using mobile vans and X-ray vouchers.*

- *Adoption of shorter treatment regimens.*
- *Enabler support for DR TB patients (medical, laboratory, psycho-social support)*
- *Synchronization of TB care in public and private facilities.*

One TB KAP recommendation not included in the FR is providing various enabler support for community reintegration. However, it will still be addressed through a study on the pipeline mapping social protection programs available in the Philippines for Filipinos before, during, and after treatment. The study will help optimize available resources (social protection support services from other national government agencies) and inform the development of additional missing and essential social protection programs.

2.4 Health Equity, Gender Equality, and Human Rights

Describe how the Global Fund-supported program(s) will maximize:

A. Health Equity

The FR focuses on finding people with TB among crucial and vulnerable populations nationwide. This includes TB contacts, urban and rural poor communities, people deprived of liberty, the elderly, children, and people with comorbidities, including PLHIV, diabetes, and smokers. DRTB diagnosis, treatment, and care are also being integrated into primary care facilities to reach all population groups nationwide. In addition, support to PhilHealth for better comprehensive outpatient benefit packages for TB will reduce catastrophic costs, and support to localizing the DOH masterplan will ensure adequate HRH for quality service delivery.

B. Gender Equality

The FR includes developing gender-sensitive IEC materials to support the scale-up of TPT among the eligible population. Upskilling of program managers on gender analysis and gender data utilization in health planning and implementation will be scaled up. In the ongoing grant, differentiated service deliveries are being established to increase male access to TB care, which will be carried on by NTP partners in 2024 and beyond. SOGIE orientation sessions will also be provided to all NTP public and private implementers.

C. Human Rights

The FR will scale up the initiatives of the ongoing GF TB grant. By the end of 2026, the CLM and redress mechanism will have nationwide coverage, and at least 34 TB champions will be actively engaged in local and national advocacy and communications. HRG training will also be provided to media professionals, correction officers, and health care providers.

Details on the interventions to address human rights and gender-related barriers to TB care are detailed in Section 1.1, Module 6. To emphasize, the Philippine NTP has a National Action Plan for Community Engagement, Human Rights, and Gender 2021-2023 (Annex 19). In 2023, this will be reviewed, and a new 3-year NAP will be developed and supported by the ongoing GF TB grant.

2.5 Sustainability, Domestic Financing, and Resource Mobilization

A. Describe the major challenges to the sustainability of the national response and efforts to address these challenges.

The full devolution-transition of healthcare services from DOH to LGUs, alongside the implementation of the UHC law provisions, is currently the major concern of the evolving Philippine healthcare system.

Critical organizational development changes are happening in the DOH and its regional offices for the devolution transition. In addition, work is being done to establish the Philippine Center for Disease Control and Virology Institute. At the LGU level, competencies must be developed and/or strengthened to implement full devolution.

For UHC law implementation, major changes are happening in PhilHealth to develop comprehensive primary care packages and establish provider-payment schemes. For LGUs, need to establish social contracting mechanisms in setting up their primary care provider networks.

Specific to the TB program, the table below identifies specific challenges to sustainability and the national response:

Challenges	National Response
1. HRH for DR TB clinical and laboratory services currently relies on the GF TB Grant, including hiring STRIDERS, notification officers, IT IS project associates, and community health volunteers.	<ul style="list-style-type: none">• The DOH HRH Master Plan 2023-2040 will be localized. Capacity-building support will be provided to LGUs to manage their own HRH based on their needs.• Full implementation of iDOTS will integrate DR and DS TB service to the primary care facility and RDT site, which will streamline manpower needs.• Advocacy to LGUs to absorb STRIDERS.• Support upskilling of the increasing number of DOH surveillance officers to take on the role of notification officers and ITIS project associates.• Capacity building and inclusion of CBOs into the primary care provider network to augment the public health sector's manpower. <p>See Annex 23 for specific actions on the HRH augmentation support from the FR.</p>

2. PhilHealth TB benefit package is underutilized.	<ul style="list-style-type: none"> To pursue discussions to rationalize the DOH budget for the TB program (free RDT and medicines) vis-à-vis the current PhilHealth TB outpatient benefit package and the envisioned comprehensive primary care benefit package. Engage expert to support improvements in the policies and process of PhilHealth in reimbursement, utilization tracking, and introduction of new social contracting mechanisms.
3. Full devolution expects LGUs to manage the Special Health Fund. Policies and capacities in setting up and managing the SHF are still under development.	<ul style="list-style-type: none"> Support LGUs in establishing systems to manage the Special Health Fund. Build capacities in health investment planning to consider funding requirements across the TB care cascade. Representation of CSOs and CBOs in the Local Health Boards should be strengthened. Capacity building on financial management and resource mobilization.
4. Full devolution will shift PSCM to LGU. Policies and systems are not in place.	<ul style="list-style-type: none"> Capacity building for LGUs in PSCM. Establishment of policies and systems for LGU PSCM. Operationalization of the eLMIS. Development and adoption of innovative procurement models, like pooled procurement and provider payment schemes. Development and adoption of social contracting models for the primary healthcare network
5. Eliminating TB requires addressing social determinants of Health.	<ul style="list-style-type: none"> Conduct of study to map out social protection packages available for Filipinos across the care continuum. This will optimize the use of available resources and will help determine gaps and serve as a basis for the development of relevant support packages.

B. Describe how co-financing commitments for the 2021-2023 allocation period have been realized.

The total domestic funding commitment for 2021 to 2023 is USD 176 million. While this consists of national government, social health insurance, and private sector commitment, the subsequent utilization data is available only for national and PhilHealth and none from the private sector. For 2021, the committed budget is USD 40 million, while the actual budget utilized is USD 24 million based on

actual national government disbursements and social health insurance reimbursements. While this includes the national government, social health insurance, and private sector commitment, the subsequent utilization data is available only for national and PhilHealth and none from the private sector. This results in a 59% actual-to-committed ratio for the 2021 TB budget. For 2022, the ratio of actual to committed budget is 53% for a budget difference of USD 33 million. The 2023 ongoing actual-to-committed ratio is 77% for the budget difference of USD 17 million.

Particulars	2021 (USD M)	2022 (USD M)	2023 (USD M)
Committed	40	62	74
Actual	24*	33*	57*
Ratio actual/committed	59%	53%	77%

*Based on 2021 national government TB budget disbursement, 2022-2023 national government TB budget allotment, and social health insurance reimbursements

C. Describe how co-financing will increase over the 2024-2026 allocation period, how these co-financing commitments will be tracked and reported, and planned actions to address remaining funding gaps.

The total funding requirement for fully implementing the TB sub-plan for three years is USD 619 million. This implies a year-on-year increase in funding requirement of 8% from 2024 to 2025 and 12% from 2025 to 2026. The total TB committed funding from all funding sources is USD 412 million. This leaves a total funding gap of USD 207 million (33%) to achieve the planned TB programs for the next three years. If the entire USAID funding is utilized to address the funding needs in the TB-HIV co-financing plan, the funding gap may be reduced to USD 181 million (29%).

Particulars	2024 (USD M)	2025 (USD M)	2026 (USD M)	TOTAL
Funding Requirement	188	203	227	619
Funding Commitment	122	133	157	412
National Government	54	65	81	200
PhilHealth	5	6	6	17
Local Government Unit	6	7	8	21
Foreign Assisted Projects: USAID*	11	8	12	31
Foreign Assisted Projects: TGF	45	46	49	140
Out of Pocket	1	1	1	4
Funding Gap	66	71	70	207

*Values correspond to activities in the TB-HIV co-financing plan that have clearly been identified as supported by USAID funding. However, the total USAID funding forecast is much higher at USD 9M per year for a total of USD 57M.

The DOH-Bureau for International Health Cooperation will consolidate reporting of annual TB-related expenditures of DOH, PhilHealth, and the Department of Labor and Employment to The Global Fund. In 2023, the Philippine CCM will design the mechanism and release the necessary resolutions. The DOH will also work with the Department of Interior and Local Government (DILG) or other appropriate offices to improve the recording and reporting of LGU's annual TB-related budget and expenditure reporting. Furthermore, DOH will work with the TB National Coordinating Council to establish the same reporting mechanism for the members of the TB NCC.

The national government and PhilHealth co-financing will be available annually through the DOH, and PhilHealth reports, respectively, while USAID expenditures annually can be provided by the USAID country mission. The next TB NCC meeting will discuss the feasibility of DOLE reporting on private financing for employment related CXR. A system for monitoring LGU expenditures for health will be set up alongside the systems to operate the Special Health Fund. For all available data, the DOH- Bureau for International Health Cooperation, as secretariat for the Philippine CCM, will consolidate the reports generated and submit them to TGF.

Increasing LGU investment and PhilHealth co-financing will be the two main interventions to address the funding gap. The government and other partners plan various interventions to build LGU capacity on UHC implementation and PhilHealth co-financing, including those proposed in this funding request.

D. If applicable, describe specific arrangements and modalities for innovative financing approaches linked to this funding request and the national response.

None for the National TB Program.

2.6 Pandemic Preparedness

Describe how the Global Fund-supported program(s) build capacities most critical to prevent, detect and respond to infectious disease outbreaks.

The C19RM grant supported the country's interventions in controlling and containing COVID-19 by improving laboratory and hospital patient management capacities. These include procurement of hospital, laboratory, and ICU equipment like RT-PCR machines, mechanical ventilators, non-invasive ventilators, pulse oximeters, high-flow nasal cannulas, and oxygen concentrators. The C19RM grant has also improved testing and treatment by procuring rapid antigen test kits and COVID-19 medicines.

Additional funding for C19RM under the Wave 1 activities was approved and is currently being carried out. Items included are the procurement of 50 portable x-rays and 100 GeneXpert machines (Gx4), and 300,000 Xpert MTB-Rif cartridges. Wave 1 approved activities also include TA support to EB Strategic Assessment and Road mapping of Public Health Surveillance Systems activities and Institutional Strengthening for Pandemic Resiliency which is for review and clearance by the GF Country team.

Final proposals from various DOH departments are expected to be submitted on March 13, 2023 for the C19RM Wave 2. It will be submitted to the Global Fund on March 20, 2023.

The country has yet to develop a robust pandemic preparedness plan. USAID has committed to support this process through its Global Health Security Project in the Philippines, which begins in March 2023. As mentioned, the DOH has expressed interest in submitting to the World Bank Pandemic Preparedness Fund.

One of the strategic thrusts of the Health Sector Strategy 2023-2028 is “**Protect from Health Risks.**” The primary interventions committed are to strengthen health systems structures which include:

- *Establishing the Philippine CDC and the Virology Institute,*
- *Improve local epidemiology and surveillance,*
- *Improving the laboratory health systems,*
- *Strengthening health emergency auxiliary response teams.*
- *Updating the pandemic preparedness plan*
- *Establishing standards and guidelines for diagnosis and management of disease outbreaks.*
- *Facilitate regulatory pathways for emergency medicines and technologies and implement risk-based regulation.*
- *Ensuring availability of mechanisms for self-sufficiency during emergencies.*
- *Build resilient facilities by securing capital assets and ensuring quality through local and international 3rd party accreditation.*

In the interim, the TB program will be guided by the DOH AO 2015-0039: Guidelines for Managing TB Control Program During Emergencies and Disasters (Annex 20) and the TB Adaptive Plan outlining the procedures for operating the program during a pandemic (Annex 21).


Section 3. Implementation

3.1 Implementation Arrangements

- A. Describe changes to implementation arrangements that will maximize implementation effectiveness and optimize efficiency.**

Program Management

The Philippine CCM endorsed the Philippine Business for Social Progress, Inc. (PBSP) as the principal recipient (PR) for the TGF TB grant cycle 2023-2026. PBSP is the PR for the TGF TB grant cycle 2021-2023.

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PBSP will directly administer the grant, and implementation will be through the DOH national and regional centers in coordination with the health facilities at the various LGUs.

The TB-HIV TWG will continue providing technical oversight for the grant and regularly report to the PCOC and the PCCM.

PBSP will maintain its current structure, organizing teams by geographical coverage. This allows for more integrated management of the grant, which proved to be more efficient considering the scale of operations.

WAMBO and GDF will be the international procurement channels that will be used. Local procurement will follow the PBSP procurement policy and guidelines. Noteworthy is the Bids and Awards Committee, PBSP Levels of Authority Manual, and a Fixed Assets Registry.

DRTB Diagnosis, Treatment, and Care Interventions

PBSP will directly manage this module. DOH will be the technical lead to provide guidelines. CHDs/PHOs/CHOs will supervise operations of iDOTS facilities and TB laboratories (RDT sites, TB culture centers, and DST Centers). CHDs will also manage about 120 PMDT specialists to provide technical assistance, coaching, and mentoring among all iDOTS facilities nationwide. The Lung Center of the Philippines remains as the training arm for PMDT and is responsible for the performance management of the 120 PMDT specialists. The CHD will directly manage the operations of regional TB MAC.

TB/DR Prevention Interventions

PBSP to procure PPD and TPT (3HP) and production of SBCC materials for health care workers and the general public. The CHDs will conduct TPT orientation sessions with support from PBSP. TPT provision will be through primary care centers. DOH-KMITS will enhance the ITIS to improve TPT recording and reporting functions. PBSP will directly engage 450 community volunteers (with preference for eligible KAP members) to perform contact investigation and TPT provision.

CWOPS Interventions

For the private sector engagement, PBSP will engage a sub-recipient to implement the TB Mn/RX Pass and other private-sector engagement interventions. PBSP will directly disburse incentives for eligible private care providers.

For CBO/CSO/KAP capacity building, a service contractor will be engaged in designing and implementing the identified interventions.

KVP Interventions

PBSP will directly operate four Konsutayo Vans (KV). CHDs/LGUs will operate 17 KVs. PBSP will maintain the 21 vans. PBSP will only support the manpower and operating expenses for the 17 KVs assigned to CHDs/LGUs for the first year. PBSP will also engage five private organizations as ACF contractors. PBSP will directly manage the X-ray voucher system. Community Health volunteers will also be tapped into ACF and ICF activities.

PBSP will directly conduct ACF in jails and prisons. TB-HIV services will be provided to PDLs.

TB/HIV Interventions

PBSP will engage 35 medical technologists and 10 nurses to support the provision of TB-HIV services nationwide. CHDs will conduct PICT training supported by the grant. Part of the FR is subsidizing EQAS registration for all laboratory-based HIV testing facilities. DOH will develop the guideline implementation tool for Urine LAM in 2023 and procurement for urine LAM is included in this FR. PBSP will also procure 3HP for PLHIV that will be administered by HIV facilities nationwide.

RHRGBR Interventions

In 2023, the TB and HIV programs will develop a common HRG module that will be disseminated to media professionals, healthcare workers, and correction officers. These will be rolled out in 2024-2026 through service contractors.

A service contractor will also be engaged to scale-up the redress mechanism to 11 regions based on learning from the ongoing establishment of a TB redress mechanism for 6 regions. The TB patient hotline is the platform for the TB redress mechanism. It includes links to retainer lawyers and psychologists for legal aid and mental health services, respectively. PBSP will engage consultants to support the development of the implementing rules and regulations of the amended TB Law.

RSSH Interventions

Considering the diverse expertise needed to provide technical assistance on the proposed RSSH interventions, PBSP will engage short-term consultants or service providers as applicable. PBSP will manage the contracts with appropriate DOH representatives to co-develop scopes of work and approve technical deliverables. PBSP will engage a program lead for RSSH who will ensure all interventions are implemented and will regularly coordinate/report progress to the DOH and the PCCM.

B. Describe the role that community-based and community-led organizations will have in implementing programs supported by the Global Fund.

Through patient empowerment and reducing stigma and discrimination, PBSP, through the NTP, will organize a TB Champions Pool to be capacitated to serve as advocacy champions at the national and local levels. The pool will be selected among the key affected population groups, including healthcare workers and community leaders, local chief executives, and critical personalities/influencers. They will be capacitated in public speaking and supported to participate in national and regional advocacy initiatives.

CLM and redress mechanisms will be scaled up nationwide. The end goal is to establish a multi-disease CLM. However, given that the CLM for TB is under development and the CLM for HIV is also changing, it is unlikely that the CLM for TB-HIV can be integrated within 2024-2026. The vision for integration is to have a CLM mechanism that will not be disease-specific, with standardized tools and common oversight bodies. The TB CLM mechanism will be engaging one CLM team per region. CLM activities will be done at the facility level. Using standardized tools, data will be regularly collected and reported to the DOH regional office for action. The DOH regional office will discuss and address concerns with the local government

units. For findings needing legal aid, the CLM teams will have access to retainer lawyers that are part of the redress mechanisms in place.

3.2 Key Risks and Mitigation Measures

In addition to the identified challenges and responses in Section 2.5 on sustainability, the following are other key risks and mitigating measures.

Key Implementation Risks	Corresponding Mitigation Measures	Entity Responsible
[Tax Return] The country will not be able to return tax being recovered by TGF. Risk Level: High Likelihood: High	A position paper is being finalized to discuss the measures that will be undertaken by the country on this issue. See Annex 22	DOH
[Governance] Delay in the implementation of UHC Provisions Risk Level: Medium Likelihood: Medium	Fast track EQUITY Project, UHC IS, and UHC CATCH to provide a full demonstration of technical, financial, and managerial integration to serve as the basis for scale-up	DOH, PHIC, and IPs
[CSS] CLM recommendations will not be recognized by the government. Risk Level: Medium Likelihood: Low	Strengthen the RCC and NCC as platforms for advocacy and communication.	IPs
[Financing] LGUs fail to manage the increased allocation for health from DOH. Risk Level: Medium Likelihood: Medium	Establish support channels for LGUs in optimizing health budgets for health programs. Establish emergency channels to support the health needs of poor municipalities	DOH (DPCB, BLHSD, FICT)
[HPMS] Stock out of Xpert cartridges, anti-TB medicines, and related commodities Risk Level: Medium Likelihood: Medium	For SLDs, to maintain buffer stock. For SLD and Xpert cartridges to be routinely monitored.	

<p>[HPMS] eLMIS cannot be operationalized at the LGU level</p> <p>Risk Level: Medium</p> <p>Likelihood: Medium</p>	<p>For FLDs, to maintain buffer stock. For SLDs and Xpert cartridges to be routinely monitored.</p>	<p>DOH (DPCB, SCMO & KMITS)</p>
<p>[HPMS] Delayed release by Bureau of Customs due to delayed DOH concurrence to consignments and related tax charging.</p> <p>Risk Level: High</p> <p>Likelihood: Low</p>	<p>For GF procured goods to be monitored closely, supporting DOH to process immediate release.</p>	<p>NTP, PR</p>
<p>[HRH] DOH has gradually reduced its HRH deployment program, and LGUs fail to engage the needed health workforce.</p> <p>Risk Level: Medium</p> <p>Likelihood: Low</p>	<p>Establish emergency channels to support the HRH requirements of poor municipalities.</p>	<p>DOH- HHRDB</p>
<p>[Program Management] Misuse of grant funds</p> <p>Risk Level: Medium</p> <p>Likelihood: Low</p>	<p>Conduct routine and special financial monitoring activities for all PR personnel, SRs, and service contractors involved in financial and procurement transactions. Ensure that the Enterprise Risk Management System is in place and operational.</p>	<p>PR</p>
<p>[Program Management] Loss, theft of non-financial assets</p> <p>Risk Level: Medium</p> <p>Likelihood: Low</p>	<p>Ensure the fixed assets registry is up to date and assets are covered by insurance. Ensure FAR is reconciled with expenditure reports. Ensure safety and security checks are made in all facilities with GF properties.</p>	<p>PR</p>
<p>[Disaster Risk] Program implementation Delays due to natural or man-made disasters, including epidemics.</p> <p>Risk Level: High</p> <p>Likelihood: High</p>	<p>Ensure all TB and HIV Care facilities have business continuity plans or facility emergency protocols.</p> <p>Insurance for fixed assets put in place and coverage of medical/accident and life insurance of personnel supporting the grant</p>	<p>DOH, PR</p>

Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

This checklist only applies to applicants requested to apply using the Full Review application approach.

Refer to the [Full Review Instructions](#)⁴ for details, applicability and resources.

Documents Reviewed by the Technical Review Panel

<input checked="" type="checkbox"/>	Funding Request Form
<input checked="" type="checkbox"/>	Performance Framework
<input checked="" type="checkbox"/>	Detailed Budget
<input checked="" type="checkbox"/>	Programmatic Gap Table(s)
<input checked="" type="checkbox"/>	Funding Landscape Table(s)
<input checked="" type="checkbox"/>	Prioritized Above Allocation Request (PAAR)
<input checked="" type="checkbox"/>	Health Product Management Template
<input checked="" type="checkbox"/>	Implementation Arrangement Map(s)
<input checked="" type="checkbox"/>	RSSH Gaps and Priorities Annex
<input checked="" type="checkbox"/>	Gender Assessment (see Annex 26)
<input checked="" type="checkbox"/>	Assessment of Human Rights-Related Barriers (see Annex 26)
<input checked="" type="checkbox"/>	Essential Data Table(s)
<input checked="" type="checkbox"/>	National Strategic Plans TB-HIV Co-Financing Plan for 2024-2026
<input type="checkbox"/>	Innovative Financing Documentation (if applicable)
<input type="checkbox"/>	Supporting Documentation Related to Sustainability and Transition (if available)
<input checked="" type="checkbox"/>	List of Abbreviations and Annexes

Documents Assessed by the Global Fund Secretariat

<input checked="" type="checkbox"/>	Funding Priorities from Civil Society and Communities Annex
<input checked="" type="checkbox"/>	Country Dialogue Narrative
<input checked="" type="checkbox"/>	CCM Endorsement of Funding Request
<input checked="" type="checkbox"/>	CCM Statement of Compliance
<input checked="" type="checkbox"/>	Additional documentation to support co-financing requirements
<input type="checkbox"/>	Sexual Exploitation, Abuse and Harassment (SEAH) Risk Assessment (optional)

⁴ Full Review Instructions - https://www.theglobalfund.org/media/5743/fundingrequest_fullreview_instructions_en.pdf