Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

PROPOSAL FORM

FIFTH CALL FOR PROPOSALS

Scaling up and Enhancement of the National Tuberculosis, Malaria and HIV/AIDS Programs in the Philippines

TB Component

The Global Fund to Fight AIDS, Tuberculosis and Malaria is issuing its Fifth Call for Proposals for grant funding. This proposal form should be used to submit proposals to the Global Fund. Please read the accompanying Guidelines for Proposals carefully, before filling out the proposal form.

Timetable: Fifth Round

Deadline for submission of proposals	June 10, 2005
Board consideration of recommended proposals	September 28 – 30, 2005

Resources available: Fifth Round

As of the date of the Fifth Call for Proposals, US$ 300 million is available for commitment for the Fifth Call for Proposals. It is anticipated that additional resources will become available prior to the Board consideration of proposals. The amount available will be updated regularly on the Global Fund's website. Any information submitted to the Global Fund may be made publicly available.

Geneva, 17 March 2005

Notes:

How to use this form:

1 Ensure that you have all the documents that accompany this form—the Guidelines for Proposals, and Annexes A and B to this proposal form.

2 Please read ALL questions carefully. Specific instructions for answering the questions are provided.

3 Where appropriate, indications are given as to the approximate length of the answer to be provided. Please try to respect these indications.

4 To tick any of the boxes in the form, move the cursor to the textbox, right click and choose 'properties', then 'default value' 'checked'.

5 To avoid duplication of effort, we urge you to make maximum use of existing information (e.g., program documents written for other donors/funding agencies).

6 Instructions and guidelines are printed in blue

Annexes:

Annex A: Impact and Coverage Indicators (incl. glossary of terms)
Annex B: Green Light Committee Applications

1 Eligibility

Proposal title	The Philippine Country Coordinating Mechanism
Name of applicant	Scaling up and Enhancement of the National Tuberculosis, Malaria and HIV/AIDS Programs in the Philippines
Country/countries	Philippines

Type of application:

- ☒ National Country Coordinating Mechanism
- ☐ Sub-National Country Coordinating Mechanism
- ☐ Regional Coordinating Mechanism (including Small Island Developing States)
- ☐ Regional Organization
- ☐ Non-Country Coordinating Mechanism

[Please tick one of the boxes to categorize your application type; refer to Guidelines for Proposals, section II, paragraphs C1 to C4.]

Proposal components

- ☐ HIV/AIDS[1]
- ☒ Tuberculosis[2]
- ☐ Malaria
- ☐ Health system strengthening

[Please tick the appropriate box or boxes for your proposal target; refer to Guidelines for Proposals, section III, A.]

Currency in which the Proposal is submitted

- ☐ US$
- ☒ Euro

[Please tick the appropriate box. Please note that all financial amounts appearing in the proposal should be denominated in the selected currency only.]

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[1] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

[2] In contexts where HIV/AIDS is driving the tuberculosis epidemic, tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

1 Eligibility

[Countries classified as "lower-middle-income" or "upper-middle-income" by the World Bank are eligible to apply only if they meet additional requirements (see the Guidelines for Proposals, section II.A.).]

Country/countries	Philippines

☐ Low-income
☒ Lower-middle-income [see paragraph 1.1 below]
☐ Upper-middle-income [see paragraph 1.1 below]

[See the Guidelines for Proposals, Annex 1. For proposals from multiple countries, complete the above referenced information separately for each country.]

1.1 Lower-middle-income and upper-middle-income country

[Sections 1.1.1 and 1.1.2 must be filled out for these two categories; without this information, this proposal will not be considered for financing.]

1.1.1 Counterpart financing and greater reliance on domestic resources

[For definitions and details of counterpart financing requirements, see the Guidelines for Proposals, section II.A.
The field "Total requested from the Global Fund" in the table below should match the request in sections 5.1]

Table 1.1.1 – Counterpart Financing and Greater Reliance on Domestic Resources

Financing sources	**In Euro / US$**				
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**
Total requested from the Global Fund (A) [from Table 5.1]	**4,742,680**	**6,966,754**	**9,295,954**	**9,702,643**	**7,050,083**
Counterpart financing (B) [linked to the interventions for which funds are requested under (A)]	**6,000,000**	**6,300,000**	**6,615,000**	**6,946,000**	**7,293,000**
Counterpart financing as a percentage of: B/A x 100 = %	**126.51%**	**90.43%**	**71.16%**	**71.59%**	**103.45%**

1.1.2 Poor or vulnerable populations

Describe how these populations have been identified, and how they will be involved in planning and implementing the proposal (2–3 paragraphs).

Patients under treatment and those who have completed treatment were interviewed. The patients who have limited access to TB services were identified as the vulnerable population. The results of the interviews revealed the following barriers to access to TB services, which also serve as the major classification to identify the vulnerable populations:

1. Geographical barriers: These refer to hard to reach rural areas in mountains and isolated islands affecting mostly indigenous populations who have limited contact with health service providers.

2. Economic barrier: This includes scarcity of resources to pay for transportation, consultation, and purchase of health services and medications for TB affecting both urban and rural poor population, labor force, including factory workers and teachers, who expose co-workers or students if not properly treated.

3. Socio-cultural barrier: This refers to stigmatization, especially of TB patients co-infected with HIV, and MDR-TB patients thus unwilling to seek health services

4. Population in prisons: This includes inmates in local jails and in national penitentiaries not properly equipped to provide TB services for DOTS and DOTS-Plus.

5. Health system perceived to be non-responsive to people's health needs: People are distrustful of the public health system because of previous experiences of poor service delivery such as absence of personnel in clinics, unavailable TB medicines. The health personnel are not patient-centered and their actions do not encourage patients to seek their services.

Several Focus Group Discussions (Annex 1) and individual interviews were done among members of the vulnerable populations (including those living with the disease, urban poor population and those in the penal colonies). Findings and implications of the FGD were discussed during a GF TB Technical Working Group meeting. Officers of an existing organization of people living with TB (Samahang Ligtas Baga) participated in the deliberation activities prior to and during the proposal writing.

TB patients, especially the members of the two existing TB patient associations may be trained and encouraged to function as advocates of TB control and prevention, as facilitators of peer support groups, as DOT partners, and as defaulter tracers. Likewise, existing grassroot organizations may be employed as project partners.

1 Eligibility

1.2 CCM functioning - eligibility criteria

[To be eligible for funding National/Sub-National/Regional (C)CM applications have to meet the requirements outlined in 1.2.1 to 1.2.3.][Question not applicable for Non-CCM applications.]

1.2.1	Demonstrate CCM membership of people living with and /or affected by the diseases. *[This may be done by demonstrating corresponding CCM membership composition in section 3.6.3 'Membership Information.']*
	People living with and/or affected by disease is currently represented by Positive Action Foundation Philippines, Inc. (PAFPI) which is an organization of patients living with HIV/AIDS. During the 1st Forum of the Philippine Partnership to fight Tuberculosis, Malaria and AIDS, 3 more associations, 1 from HIV/AIDS and 2 from TB participated (Annex 2). The People Living with the Disease (PLWD) sector confirmed the membership of PAFPI to the CCM to represent HIV/AIDS PLWD and nominated Samahan ng Lusog Baga to represent TB PLWD to the CCM.

1.2.2	Provide evidence that CCM members representing the non-governmental sectors have been selected by their own sector(s) based on a documented, transparent process developed within each sector. *[Please summarize the process and attach documentation as an annex.]*
	The 1st Forum of the Philippine Partnership to Fight Tuberculosis, Malaria and AIDS was held on June 4, 2005. A broad spectrum of stakeholders in the civil society and various governmental agencies responsible for implementing the programs for the three diseases were invited (Annex 2). During the forum, the stakeholders were divided into 9 sectors with the government public health agencies further subdivided into national, regional, and local levels as follows: 1. Governmental public health agencies o National agency (DOH) o Regional agencies (CHD) o Implementing local agencies (PHO, CHO, MHO) 2. Other governmental agencies/corporations including those involved in economic policy 3. Academe 4. NGOs/Community-based organizations 5. People living with HIV/AIDS, TB and/or malaria 6. Private sector and professional organizations 7. Religious/Faith-based organizations 8. Public-Private coalitions 9. Multilateral and bilateral development partners Each of these sectors selected among themselves the nominees for membership in the Country Coordinating Mechanism (CCM). During the forum, the nominees for the faith-based organization and for PLWD were considered and will be eligible for election to CCM membership in the forthcoming CCM meeting. The nominees in the other sectors shall be considered for election as members of the CCM once current members` terms expire by which time the CCM membership will represent true sectoral representation chosen by their respective constituents.

1 Eligibility

1.2.3 Describe and provide evidence of a documented and transparent process to:
a) Solicit submissions for possible integration into the proposal *[please summarize and attach documentation as an annex.]*
A call for proposals was published April 1, 2005 in a daily newspaper of national circulation announcing the call for the 5th round proposal by the GF and inviting all interested stakeholders to submit concept proposals on any of the three disease components and health system strengthening (Annex 3).
b) Review submissions for possible integration into the proposal *[please summarize and attach documentation as an annex.]*
On April 29, 2005, concept proposals were screened for consistency with the national health plan by a CCM sub-committee. The sub-committee is headed by the National Center for Disease Prevention and Control, Infectious Disease Office-Department of Health with members from the World Health Organization Country Office, the Philippine Coalition Against Tuberculosis, the UN HIV/AIDS Program, USAID, and the National Economic Development Agency of the Philippines. A report of the result of the screening process was submitted to the CCM. Proponents of appropriate concept proposals were then invited to participate in the writing committee of each project component. (Annex 4)
c) Nominate (the) Principal Recipient(s) and oversee program implementation *[please summarize and attach documentation as an annex.]*
The Tropical Disease Foundation was nominated as PR for TB and HIV/AIDS components and the Pilipinas Shell Foundation Inc. was nominated as PR for the Malaria component. By election of the CCM members present, the TDF was elected as PR for TB and HIV/AIDS and Pilipinas Shell Foundation as PR for malaria. (Annexes 5 and 6).

2 Executive Summary

2.1 Executive Summary

[Please include quantitative information, where possible (4–6 paragraphs total):]

2.1.1	Briefly describe the (national) disease context, existing control strategies and programs as well as program and funding gaps. Explain how the proposed interventions complement existing strategies and programs, particularly where funding from the Global Fund has been received or approved.
2.1.2	Describe the overall strategy by referring to the goals, objectives and service delivery areas for each component, including expected results and associated timeframes. Specify for each component the beneficiaries and expected benefits (including target populations and their estimated number).
2.1.3	If there are several components, describe any synergies expected from the combination of different components—for example, TB/HIV collaborative activities (by synergies, we mean the added value that the different components bring to each other, or how the combination of these components may have broader impact).
2.1.4	Indicate whether the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal.

The Philippines is 9th among the 22 high-burden countries for TB with an estimated incidence of smear (+) TB cases of 133/100,000 population. The problem is worse in the urban poor settlements where the annual risk of infection is 6.5% compared to 2.3% in the general population. The Department of Health implemented the DOTS strategy in 1996 and has achieved a case detection rate of 68% in 2003. Treatment success rate has been 88% for the past three years. The strength of the National TB Control Program (NTP) is solid public-private collaboration as manifested by the establishment of public-private mix DOTS (PPMD) units in different parts of the country, 28 of which have already been installed with GF support from Round 2. Another strong feature of the Philippine NTP is the implementation of the first Green Light Committee (GLC)-approved DOTS-Plus project which started as a pilot in a PPMD unit in Metro Manila and is now in the expansion phase. This project was found feasible and cost-effective in the Philippine setting according to an economic analysis conducted by the WHO. The estimated incidence of MDR-TB patients in the country is 7,000 in 2000 based on mathematical modeling. The first nationwide Drug Resistance Survey (DRS) is still being completed. Both the PPMD and the DOTS-Plus initiatives have been evaluated recently by external teams with excellent findings. Scale-up is intended to make PPMD and DOTS-Plus services more accessible to the rest of the country, taking advantage of the experiences gained by the recent achievements, for which funding is inadequate. Through this proposal, an additional 27,435 new smear-positive TB cases are anticipated to be detected through the existing and new PPMD units installed, and an additional 2,500 MDRTB cases will be treated though the existing and new DOTS-Plus treatment sites in strategic areas.

To achieve the NTP goal to reduce the prevalence and mortality of TB by 50% in 2010 in support of the Millennium Development Goals for poverty alleviation, the current activities of GF Round 2 need to be enhanced and scaled up. This proposal has five objectives. Objective 1a aims to enhance the quality of DOTS implementation in the public sector through improvement in service provision and increase in access to DOTS services through health systems strengthening in public-public collaboration, DOTS certification and accreditation, strengthened data management by utilizing the Electronic TB register nationwide, timely detection and quality treatment of cases, control of drug resistance, and operational research. Convergence with the malaria projects through the engagement of the barangay (village) microscopists in the provision of DOTS services in hard to reach rural areas is an added value to the TB and malaria projects. Objective 1b aims to increase the demand for DOTS services in the public and private DOTS facilities by

removing barriers to access through social mobilization and social marketing for underserved populations and patient empowerment. Social mobilization and social marketing activities will converge with PPMD activities in areas where units have already been installed. Urban poor populations will be a special focus for social mobilization and accordingly, DOTS-Plus services may then be community-based in these areas leading to an added value of community mobilization to the DOTS, PPMD, and DOTS-Plus strategies.

Objective 2 aims to scale up PPMD activities in GF Round 2 and to ensure access to quality DOTS services by unreached and underserved populations through the a) the installation of 70 public-initiated and 30 private-initiated PPMD units including industrial clinics to ensure DOTS access to the labor force, school clinics for teachers and students, etc., b) enhancement of the existing 116 PPMD units, c) regular supervision and monitoring, and d) assurance of sustainability beyond project life of all the 216 PPMD units, including those established through other initiatives. Capacity building in the regional level through Regional Coordinating Committees will enhance the monitoring and supervision capacity for public health center DOTS and PPMD units. Synergies between DOTS, PPMD, community mobilization and DOTS-Plus are described elsewhere in this summary.

Objective 3 aims to scale up DOTS-Plus and mainstream it in the existing DOTS infrastructure in Metro Manila and outside Metro Manila for the treatment of at least 2,500 MDR-TB cases. GF resources will support health system strengthening through human resource development in the NTP central, regional and peripheral health centers, infrastructure development to strengthen laboratory capacity in the National TB Reference Laboratory for DST and the regional culture centers that have been equipped during the recent DRS, and the establishment of treatment centers in strategic areas. Implementation of DOTS-Plus in installed PPMD units promotes synergy between PPMD and DOTS-Plus. Additionality from other agencies includes funding from the USAID through a cooperative agreement with the CDC, and from the Lilly Foundation in the establishment of a proposed WHO Collaborating Regional Training Center in DOTS-Plus, and from the National Institute of Allergy and Infectious Diseases (NIAID), National Institutes of Health (NIH), USA through the Tuberculosis Research Unit (TBRU) in the Case Western Reserve University by participating in clinical trials. Efforts will be done to employ a community-based approach to MDR-TB treatment through social mobilization strategies and patient empowerment employing best practices identified in the current community mobilization activities under GF Round 2 and other previous projects, representing synergy with objective 1b. HIV surveillance among MDRTB patients is a new activity using anonymous unlinked samples from stored sera routinely collected for DOTS-Plus patients and is an added value for DOTS-Plus and HIV/TB. Another new activity is the conduct of a DRS in the urban poor population, an expected hot spot for MDR-TB that may be missed in a nationwide DRS, and repeated 4 years later to assess DOTS and DOTS-Plus program effectiveness and to predict trends.

Objective 4 is a new activity and aims to establish a strong TB and HIV collaboration in an epidemiologic scenario of high TB and low HIV prevalence. Collaborative mechanisms will include setting up of a coordinating body for TB/HIV activities and carrying out of joint TB/HIV planning, and conducting HIV surveillance of TB patients in 11 HIV sentinel sites of the GF round 3 and the 10 USAID-funded AIDS surveillance and education project (ASEP) sites, and among MDRTB patients in DOTS-Plus. A cross-referral system between the NTP and National AIDS Program (NAP) will be established to decrease the burden of TB in HIV/AIDS by ensuring access of all HIV patients to TB DOTS services, the provision of isoniazid preventive therapy for latent TB; and to decrease the burden of HIV in TB patients by ensuring proper referral of TB patients with high-risk behavior to HIV sentinel sites for voluntary counseling and testing, and ensuring anti-retroviral treatment where necessary. These activities are all in synergy with GF round 3 HIV/AIDS project, DOTS and DOTS-Plus activities in GF Round 2 and 5.

In addition, the present proposed TB component has significant health system strengthening components and synergizes with the programs for Malaria and HIV/AIDS

through joint monitoring and program reviews, and through the strengthening of the overall data management capacity of the DOH and the local government units.

2.2 Component and Funding Summary

Table 2.2 – Total Funding Summary

	Total funds requested in Euro					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
HIV/AIDS						
Tuberculosis	4,742,680	6,966,754	9,259,954	9,702,643	7,050,083	37,758,114
Malaria						
Health systems strengthening						
Total	4,742,680	6,966,754	9,259,954	9,702,643	7,050,083	37,758,114

3 Type of Application

Table 3 – Type of Application

Type of application:		
☒	National Country Coordinating Mechanism	➔ *go to section 3.1*
☐	Sub-National Country Coordinating Mechanism	➔ *go to section 3.2*
☐	Regional Coordinating Mechanism (including Small Island States)	➔ *go to section 3.3*
☐	Regional Organization	➔ *go to section 3.4*
☐	Non-Country Coordinating Mechanism	➔ *go to section 3.5*

[Complete section 3 as appropriate. Please note that - without these details, and in particular the information requested in section3.6 the proposal cannot be reviewed.]

3.1 National Country Coordinating Mechanism

Table 3.1 – National CCM: Basic Information

Name of National CCM	Date of Composition
The Philippine Country Coordinating Mechanism	March 5, 2002

3.1.1	Describe how the National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including non-governmental organizations, the private sector and academic institutions, and how it coordinates its activities with other national structures (such as National AIDS Councils) (2 paragraphs). *[For example, decision-making mechanisms, constituency consultation processes, structure of subcommittees, frequency of meetings, implementation oversight, etc. Provide statutes of the organization, organizational diagram and terms of reference as attachments.]*

Partnership: The Philippines has organized the Philippine Partnership to fight TB, Malaria, and HIV/AIDS which met in a forum to discuss the health and economic burden from TB, Malaria, and HIV/AIDS. The partnership is composed of a wide range of stakeholders in the civil society and the government involved in health (Department of Health, Department of Interior and Local Government, Local Government Unit) as well as other government agencies involved in economic policy, practice and poverty alleviation. Members to be elected in the CCM were nominated by their constituency during the forum according to the following sectoral representations:

1. Public Health Sector: National, Regional, Local
2. Other government sectors
3. Academe
4. Private Public Coalitions
5. Community-Based Organizations/ NGOs
6. People living with HIV/AIDS, TB &/or Malaria
7. Private Sector
8. Religious/Faith-Based Organizations
9. Public-private coalitions

CCM: Country Coordinating Mechanism is a multi-sectoral membership fostering partnership among all stake holders including those from the civil society, the private sector, non-government organizations, public sector, faith based organizations, representatives of people living with the disease, international

multi-lateral and bi-lateral agencies. This is the clearinghouse of all GF applications. CCM also oversees the implementation of the program in the country.

CCM is broadly representative of all national stakeholders in the fight against AIDS, TB and Malaria. Half of the CCM member organization representatives are women. The CCM is as inclusive as possible and seeks representation at the highest possible level of various sectors.

i) The constituent members elect a Chair and a co-chair.
ii) The CCM appoints an Executive Committee and other CCM committees as required.
iii) The CCM establishes a Secretariat, and selects an Executive Secretary to lead the Secretariat
iv) The hierarchy of authority is as follows:
    1. CCM
    2. Executive Committee
    3. Chair
    4. Executive Secretary.
v) Within the hierarchy, any party can be over-ruled by any higher party

Technical Working Group (TWG) for each component assists the CCM by providing the programmatic and scientific direction of the Projects. The TWG is headed by the Director of the Infectious Disease Office (IDO). Included in the TWG for the TB component are the Partners who are the implementers; National TB Control Program (NTP), Philippine Coalition Against TB (PhilCAT), World Vision Development Foundation (WVDF), Tropical Disease Foundation (TDF), IDO, the National TB Reference Laboratory (NTRL, RITM), Project Assistance to Control TB (PACT) represented by the WHO Adviser on TB, and a representative of the PR.

Operational guidelines of the CCM:

1. **Meetings and Decision-making by the CCM**
Meetings are held at least twice in a quarter and ad hoc pursuant to request submitted to the CCM Secretariat by at least 25% of the CCM members. CCM meetings are made as informative as possible to allow for the informed participation of all members of the CCM in decision making. Accordingly, a one-day meeting of the CCM at least once a quarter, specifically on the first month of the quarter is organized. During this meeting, each membership sector breaks up into small workgroups to deliberate on administrative and operational issues of the CCM. Breakout group discussions into the three disease component projects are also done during the one-day meeting to allow for the CCM members to review reports of the implementers and to deliberate on the project implementation and results obtained utilizing process, input, output, coverage and impact indicators, when applicable. During the plenary meeting, reports of the three disease component projects are presented by the PR to the CCM. A second meeting of the quarter in the second month takes place to deliberate on the quarterly report of the disease component projects and approve it for submission to the GF by the PR through the LFA. The CCM forwards to the Global Fund minutes of their meetings as related to Global Fund issues and information on membership changes.

Decision making of CCM: Reports will first be discussed with the TWG and the recommendations will be submitted to the CCM for their approval prior to submission to the GF. Decisions will be arrived at by balloting if necessary or through consensus. Any major dissents to decisions taken will be reflected in the minutes for transparency.

2. CCM Secretariat

A CCM Secretariat will be established by the Chairperson and will be located within the DOH premises and headed by the Executive Secretary and will report directly to the Chairperson. Permanent staff to the secretariat will be hired to coordinate and conduct the following administrative work associated with running a CCM:

· Coordinating the meetings of the CCM and its committees, including preparing

draft, agendas, issuing meeting reminders, making transportation arrangement to bring CCM members to meeting, preparing draft minutes, and distributing the minutes.

- Distributing GF guidelines and other documents
- Distributing drafts of proposals and other relevant documents
- Maintaining and updating distribution lists
- Maintaining the records of the CCM
- Issuing public announcements of calls for proposals
- Preparing and submitting reports to the Global Fund
- Responding to enquiries from the GF
- Responding to inquiries from other people and organizations.

The Secretariat under the guidance of the Chairperson shall convene the CCM as and when required.

3. CCM Executive Group

A select group of CCM members will form a core executive group in the CCM and will carry out selected tasks as and when delegated to them by the CCM. This five-member group will be selected by the CCM and will represent the core constituents (mentioned above). The members should not have any conflict of interest and should be technically competent to assess and take independent decisions.

4. Conflict of Interest policy

Election of the chairperson and co-chairperson should take place every anniversary of the creation of the CCM which is March 2002. The two should be elected by close balloting of the constituent members of the CCM. The chair and co-chair should come from different sectors.

The PR cannot be the chairman or co-chairman of the CCM to avoid conflict of interest. The PR must not participate in CCM decision making where results may impact on the PR monetarily or programmatically (see Annex 2).

3 Type of Application

3.2 Sub-National Coordinating Mechanism

Table 3.2 – Sub-National CCM: Basic Information

Name of Sub-National CCM	Date of Composition

3.2.1	Describe how the Sub-National CCM operates—in particular, the extent to which the CCM acts as a partnership between government and other actors in civil society, including NGOs, the private sector and academic institutions, and how it coordinates its activities with other national structures (e.g., National AIDS Councils) *(2 paragraphs). [For example, decision-making mechanisms, constituency consultation processes, structure of subcommittees, frequency of meetings, implementation oversight, etc. Provide statutes of the organization and organizational diagram as attachments.]*

3.2.2	Explain why a Sub-National CCM has been chosen *[1 paragraph].*

3.2.3	Describe how this proposal is consistent with and complements national strategies and/or the National CCM plans *[1 paragraph].*

3 Type of Application

3.3 Regional Coordinating Mechanism (including Small Island Developing States)

Table 3.3 – Regional Coordinating Mechanism: Basic Information

Name of Regional CM	Date of Composition

3.3.1	Explain why a Regional Coordinating Mechanism has been chosen *[1 paragraph].*

3.3.2	Describe how this proposal is consistent with and complements national strategies and/or the Regional Coordinating Mechanism plans. Provide details of how it would achieve outcomes that would not be possible with only national approaches *[1 paragraph].*

3.4 Regional Organizations

Table 3.4 – Regional Organization: Basic Information

Name of Regional Organization

3.4.1	Rationale Describe how this regional proposal complements the national plans of each country involved and how it would achieve outcomes that would not be possible with only national approaches.

3 Type of Application

3.5 Non-Country Coordinating Mechanism

Table 3.5 – Non-CCM Applicant: Basic Information

Name of Non-CCM applicant

3.5.1 Indicate the type of your sector (tick appropriate box):

- ☐ Academic/educational sector
- ☐ Government
- ☐ NGOs/community-based organizations
- ☐ People living with HIV/AIDS, tuberculosis and/or malaria
- ☐ Private sector
- ☐ Religious/faith-based organization
- ☐ Multilateral and bi-lateral development partners in country
- ☐ Other (please specify):

3.5.2 Rationale for applying outside an existing CCM

Non-CCM proposals are not eligible unless they satisfactorily explain that they originate from one of the following:

1. *Countries without legitimate governments;*
2. *Countries in conflict, facing natural disasters, or in complex emergency situations (which will be identified by the Global Fund through reference to international declarations such as those of the United Nations Office for the Coordination of Humanitarian Affairs [OCHA]); or*
3. *Countries that suppress or have not established partnerships with civil society and NGOs.*

3.5.2.1 Describe which of the above conditions apply to this proposal *(3–4 paragraphs)*.

3.5.2.2 Describe any attempts to contact the CCM and provide documentary evidence as an annex *(2 paragraphs)*.

3.5.2.3 Non-CCM proposals from countries in which no CCM exists
[Describe how the proposal is consistent with, and complements, national policies and strategies (or, if appropriate, why this proposal is not consistent with national policy) (3–4 paragraphs). Provide evidence (e.g., letters of support) from relevant national authorities in an annex.]

3.5.3 All non-CCM proposals should include as annexes additional documentation describing the organization, such as:

- statutes of organization (official registration papers);
- a summary of the organization, including background and history, scope of work, past and current activities;
- reference letter(s);
- main sources of funding.

3 Type of Application

3.6 Proposal Endorsement and Membership Section

3.6.1 Representation

Table 3.6.1 – National/Sub-National/Regional (C)CM Leadership Information
(not applicable to Non-CCM and Regional Organization applications)

	Chairperson	Vice Chairperson
Name	Dr. Ethelyn P. Nieto, MD, MPH	Ms. Marvi Rebueno Trudeau
Title	Undersecretary of Health for Health Operations	Pilipinas Shell Foundation
Mailing address	Department of Health San Lazaro Compound, Sta. Cruz Manila 1003, Philippines	Asturias Hotel Puerto Prinsesa Palawan, Philippines
Telephone	+63711-6067	+6348-434-5203
Fax	+63712-5866	+6348-434-5202
E-mail address	epnieto@co.doh.gov	aiohi@mozcom.com

3.6.2 Contact information

[Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication.]

Table 3.6.2 – Non-CCM Applicants and Regional Organizations: contact information
(not applicable to National/Sub-National/Regional (C)CM applications)

	Primary contact	Secondary contact
Name		
Title		
Organization		
Mailing address		
Telephone		
Fax		
E-mail address		

3 Type of Application

3.6.3 Membership information

[Applicable to submissions from National/Sub-National/Regional (C)CMs. Not applicable to Non-CCM Applicants and Regional Organization applications. One of the tables below must be completed for each national/Sub-National/Regional (C)CM member.]
[To be eligible for funding National/Sub-National/Regional (C)CMs must demonstrate evidence of membership of people living with and /or affected by the diseases.]

Table 3.6.3 – National/Sub-National/Regional (C)CM Member Information

National/Sub-National/Regional (C)CM member details			
Member 1			
Agency/organization	Canadian International Development Agency	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Multi/bilateral development partner	Sector represented	Multi/bilateral development partner
Name of representative	Ms. Myrna Jarillas	CCM member since	July 2003
Title in agency	Senior Program Officer	Fax	63(2)810-5142
E-mail address	Myrna.jarillas@dfait-maeci.gc.ca	Telephone	63(2)857-9139
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Proposal Review Panel	Mailing address	7th Floor, Tower II RCBC Building Makati City
Member 2…			
Agency/organization	Department of Education - Health and Nutrition Center	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government	Sector represented	Government
Name of representative	Dr. Thelma Navarrez	CCM member since	July 2003
Title in agency	Director II	Fax	63(2)687-2520
E-mail address	trnavarrez@deped.gov.ph	Telephone	63(2)687-2520

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Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Proposal Review Panel	Mailing address	5th Floor, Mabini Building Meralco Avenue Pasig City
Member 3…			
Agency/organization	Department of National Defense	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government	Sector represented	Government
Name of representative	Dr. Peter G. Galvez	CCM member since	July 2003
Title in agency	Medical Consultant	Fax	63(2)911-4552
E-mail address	pgalvez@dnd.gov.ph	Telephone	63(2)911-1651
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Proposal Review Panel	Mailing address	Office of the Undersecretary for Policy, Plans and Special Concerns Department of National Defense Camp Aguinaldo, Quezon City
Member 4…			
Agency/organization	European Commission	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Multi-/bilateral development partner	Sector represented	Multi-/bilateral development partner
Name of representative	Dr. Fabrice Sergent	CCM member since	October 2003
Title in agency	Individual Expert for Health	Fax	63(2)812-6686
E-mail address	Fabrice.Sergent@cec.eu.int	Telephone	63(2)812-6421

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Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Proposal Review Panel	Mailing address	7th Floor, Salustiana Ty Tower Perea St. cor. Paseo de Roxas St. Makati City
Member 5…			
Agency/organization	Deustsche Gesellschaft für Technische Zusammenarbeit (GTZ)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Multi-/bilateral development partner	Sector represented	Multi-/bilateral development partner
Name of representative	Dr. Claude Bodart	CCM member since	October 2003
Title in agency	Program Manager	Fax	63(2)812-6686
E-mail address	gtz.healthpro@pacific.net.ph	Telephone	63(2)812-6421
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Proposal Review Panel	Mailing address	9th Floor, PDCP Bank Center Herrera cor. Leviste Salcedo Village Makati City
Member 6…			
Agency/organization	Japan International Cooperation Agency (JICA)	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Multi-/bilateral development partner	Sector represented	Multi-/bilateral development partner
Name of representative	Dr. Masachi Suchi	CCM member since	July 2003
Title in agency	Chief Advisor	Fax	63(2)7722-063
E-mail address	qtbcp@meridian.ph	Telephone	63(2)7722-063
Main role in the	Proposal Review Panel	Mailing	Ground Floor, RITM

Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*		address	FCC Alabang Muntinlupa
Member 7…			
Agency/organization	Kilusan Ligtas Malaria	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Non-Government Organization	Sector represented	Non-Government Organization
Name of representative	Ray Angluben	CCM member since	September 2002
Title in agency	Project Director	Fax	63(48)434-5202
E-mail address	ray_angluben@hotmail.com	Telephone	63(48)434-6346
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Proposal Review Panel	Mailing address	KLM PRIMM Bldg. PED Cpd. Bgy. Bancao-Bancao Puerto Princesa City, Palawan Phil.
Member 8…			
Agency/organization	Apayao Provincial Health Office	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Local Government	Sector represented	Government
Name of representative	Dr. Thelma Dangao	CCM member since	September 2002
Title in agency	Provincial Health Officer II	Fax	63(78)501-1028
E-mail address		Telephone	63(78)983-1052
Main role in the Coordinating Mechanism and the	Proposal Review Panel	Mailing address	Provincial Health Office Apayao

proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*			
Member 9…			
Agency/organization	National Council for Indigenous People	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government	Sector represented	Government
Name of representative	Dr. Ricardo Sakai Jr.	CCM member since	September 2002
Title in agency	Medical Officer V	Fax	63(2)373-9534
E-mail address	rsakai@ncip.gov.ph	Telephone	63(2)374-5554
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component coordinator, financial input, review, other)*	Proposal Review Panel	Mailing address	2nd Flr, Dela Merced Bldg. West Ave. cor. Quezon Ave Quezon City, MM
Member 10…			
Agency/organization	National Economic Development Authority	Website	
Type *(academic/educational sector; government; nongovernmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; multi-/bilateral development partners)*	Government	Sector represented	Government
Name of representative	Ms. Arlene Ruiz	CCM member since	September 2002
Title in agency	Chief, HNPD	Fax	63(2)631-3758
E-mail address	asruiz@neda.gov.ph	Telephone	63(2)631-5435
Main role in the Coordinating Mechanism and the proposal development *(proposal preparation, technical input, component*	Proposal Review Panel	Mailing address	12 St. Jose Maria Escriva Drive Ortigas Center Pasig City, MM

coordinator, financial input, review, other)			
Member			
Agency/organization	University of the Philippines National Institute for Health	**Website**	
Type	Academic/Educational Partner	**Mailing address**	Rm 101, NIH Bldg. P. Gil St. Ermita, Manila
Sector Represented	Academic/Educational Partner	**E-mail address**	galveztan@mail.upm.edu.ph
Name of representative	Dr. Jaime Galvez-Tan	**CCM member since**	September 2002
Title in agency	Executive Director	**Fax**	63(2)525-0395
Role in CCM	Proposal Review Panel	**Telephone**	63(2)525-0395
Member			
Agency/organization		**Website**	
Type	Positive Action Foundation Philippines, Inc.	**Mailing address**	2361 Dian St. Malate, 1004 Manila, MM
Sector Represented	People living with HIV/AIDS	**E-mail address**	pafpi@edsamail.com.ph
Name of representative	Mr. Joshua Formentera	**CCM member since**	Review Panel
Title in agency	President	**Fax**	63(2)404-2911
Role in CCM	Proposal Review Panel	**Telephone**	63(2)832-6239
Member			
Agency/organization	Philippines Business for Social Progress	**Website**	
Type	Private Sector	**Mailing address**	Center for Corporate Citizenship Grd Floor, PSDC Bldg., Magallanes cor. Real 1002 Intramuros, Manila
Sector Represented	Private Sector	**E-mail address**	pbsp@pbsp.org.ph
Name of representative	Ms. Jazmin Gutierrez	**CCM member since**	September 2002
Title in agency	Asst. Director for Training and Consulting	**Fax**	63(2)527-3743
Role in CCM	Proposal Review Panel	**Telephone**	63(2)527-7741
Member			
Agency/organization	Philippine Coalition Against Tuberculosis	**Website**	
Type	Non-Government Organization	**Mailing address**	Ground Floor, RTC Bldg. QI Compound E. Rodriquez Sr. Ave. Quezon City
Sector Represented	Non-Government Organization	**E-mail address**	philcat@pacific.net.ph
Name of representative	Dr. Jennifer Ann Mendoza-Wi	**CCM member since**	September 2002

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Title in agency	Chairperson	**Fax**	63(2)749-8990
Role in CCM	Proposal Preparation	**Telephone**	63(2)781-9536
Member			
Agency/organization	Philippine National AIDS Council	**Website**	
Type	Government	**Mailing address**	3rd Floor, Bldg. 12 Department of Health San Lazaro Compound, Sta. Cruz, Manila
Sector Represented	Government	**E-mail address**	pnac_sec@yahoo.com
Name of representative	Dir. Remedios Paulino	**CCM member since**	September 2002
Title in agency	Director IV	**Fax**	63(2)743-0512
Role in CCM	Proposal Preparation	**Telephone**	63(2)743-0512
Member			
Agency/organization	Philippine NGO Council	**Website**	
Type	Non Government Organization	**Mailing address**	38-A San Luis St. Pasay City, Manila
Sector Represented	Non Government Organization	**E-mail address**	erdivinagracia@pngoc.com
Name of representative	Ms. Eden Divinagracia	**CCM member since**	March 2004
Title in agency	Executive Director	**Fax**	63(2)834-5008
Role in CCM	Proposal Review Panel	**Telephone**	63(2)834-5007
Member			
Agency/organization	Philippine Rural Reconstruction Movement	**Website**	
Type	Non Government Organization	**Mailing address**	56 Mo. Ignacia St., Bgy. Paligsahan Quezon City, MM
Sector Represented	Non Government Organization	**E-mail address**	prrmi@cal.com.ph
Name of representative	Dr. Luz Escubil	**CCM member since**	September 2002
Title in agency	Program Manager	**Fax**	63(2)372-4995
Role in CCM	Proposal Review Panel	**Telephone**	63(2)372-4992
Member			
Agency/organization	Philippine Tuberculosis Society, Inc	**Website**	
Type	Non Government Organization	**Mailing address**	E. Rodriguez Sr. Ave. España Ext., Quezon City
Sector Represented	Non Government Organization	**E-mail address**	butch_barrera@yahoo.com
Name of representative	Dr. Felix Barrera	**CCM member since**	September 2002
Title in agency	Chief Operating Officer	**Fax**	63(2)781-3752
Role in CCM	Proposal Review Panel	**Telephone**	63(2)781-3752

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Member			
Agency/organization	Research Institute for Tropical Medicine	**Website**	
Type	Government	**Mailing address**	Research Institute for Tropical Medicine FICC Alabang Muntinlupa City
Sector Represented	Government	**E-mail address**	rolveda@ritm.gov.ph
Name of representative	Dr. Remigio Olveda	**CCM member since**	September 2002
Title in agency	Director	**Fax**	63(2)842-2245
Role in CCM	Proposal Review Panel	**Telephone**	63(2)807-2628
Member			
Agency/organization	Tropical Disease Foundation, Inc	**Website**	
Type	Non Government Organization	**Mailing address**	Rm 2002 Medical Plaza Bldg. Amorsolo St. cor. Dela Rosa, Makati City
Sector Represented	Non Government Organization	**E-mail address**	tetupasi@yahoo.com
Name of representative	Dr. Thelma Tupasi	**CCM member since**	September 2002
Title in agency	President	**Fax**	63(2)888-9044
Role in CCM	Proposal Preparation	**Telephone**	63(2)840-2178
Member			
Agency/organization	United States Agency for International Development	**Website**	
Type	Multi-/bilateral development partner	**Mailing address**	8th Flr PNB Financial Center Roxas Blvd, Pasay City, MM
Sector Represented	Multi-/bilateral development partner	**E-mail address**	cfischer@usaid.org
Name of representative	Ms. Catherine Fischer	**CCM member since**	September 2002
Title in agency	Senior Technical Adviser	**Fax**	63(2)552-9800
Role in CCM	Proposal Review Panel	**Telephone**	63(2)552-9869
Member			
Agency/organization	World Health Organization - Philippines	**Website**	
Type	International Organization	**Mailing address**	2nd Floor, Bldg. 9 DOH Compound, Tayuman, Sta. Cruz, Manila
Sector Represented	International Organization	**E-mail address**	who@phl.wpro.who.int.

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Name of representative	Dr. Jean Marc Olivé	**CCM member since**	September 2002
Title in agency	Country Representative	**Fax**	63(2)731-3914
Role in CCM	Technical input	**Telephone**	63(2)528-9761
Member			
Agency/organization	World Vision Development Foundation, Inc	**Website**	
Type	Non Government Organization	**Mailing address**	883 Quezon Avenue Quezon City
Sector Represented	Non Government Organization	**E-mail address**	melvin_magno@wvi.org.
Name of representative	Dr. Melvin Magno	**CCM member since**	September 2002
Title in agency	National Health Advisor	**Fax**	63(2)374-7618
Role in CCM	Proposal preparation	**Telephone**	63(2)372-7777
Member			
Agency/organization	United Nations Program on HIV/AIDS (UNAIDS)	**Website**	
Type	International Organization	**Mailing address**	31st Floor RCBC Plaza Ayala Avenue Makati City
Sector Represented	International Organization	**E-mail address**	ma.elena.borromeo@undp.org.
Name of representative	Dr. Ma. Elena Borromeo	**CCM member since**	September 2002
Title in agency	Country Coordinator	**Fax**	63(2)840-0732
Role in CCM	Proposal Review Panel	**Telephone**	63(2)901-0411
Member			
Agency/organization	Department of Interior and Local Government	**Website**	
Type	Government	**Mailing address**	EDSA cor. Mapagmahal St., Quezon City, MM
Sector Represented	Government	**E-mail address**	Cesar25@yahoo.com
Name of representative	Hon. Austere Panadero	**CCM member since**	February 2005
Title in agency	Assistant Secretary	**Fax**	63(2)925-0361
Role in CCM	Proposal Review Panel	**Telephone**	63(2)925-0361
Member			
Agency/organization	University of the Philippines-College of Public Health	**Website**	
Type	Government/academe	**Mailing address**	625 P. Gil St. Ermita, Paco, Manila
Sector Represented	Academic/educational sector	**E-mail**	caancheta@yahoo.co

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		address	m
Name of representative	Dr. Caridad Ancheta	**CCM member since**	February 2005
Title in agency	Dean	**Fax**	63(2)524-2703
Role in CCM	Proposal Review Panel	**Telephone**	63(2)521-1394
Member			
Agency/organization	Department of Labor and Employment - Occupational Safety and Health Center	**Website**	
Type	Government	**Mailing address**	North Avenue cor. Agham Diliman, Quezon City
Sector Represented	Government	**E-mail address**	oshccenter@osch.dole.gov.ph
Name of representative	Dr. Dulce Estrella-Gust	**CCM member since**	February 2005
Title in agency	Executive Director	**Fax**	63(2)928-6728
Role in CCM	Proposal Review Panel	**Telephone**	63(2)928-6690
Member			
Agency/organization	United Nations International Children's Emergency Fund	**Website**	
Type	Multi/bilateral Development partners	**Mailing address**	31st Floor, Yuchengco Tower RCBC Plaza 6819 Ayala Avenue, Makati City
Sector Represented	Multi/bilateral Development partners	**E-mail address**	
Name of representative	Dr. Nicholas K. Alipui	**CCM member since**	February 2005
Title in agency	Representative	**Fax**	None
Role in CCM	Proposal Review Panel	**Telephone**	63(2)901-0170
Member			
Agency/organization	Philippine Council for Health Research and Development	**Website**	
Type	Research	**Mailing address**	3rd Flr. DOST Bldg. Taguig, Bicutan, MM
Sector Represented	Government	**E-mail address**	fabie@ehealth.ph
Name of representative	Ms. Merlita Opeña	**CCM member since**	September 2002
Title in agency	OIC – Executive Director	**Fax**	63(2)837-2924
Role in CCM	Proposal Review Panel	**Telephone**	63(2)837-2942

3 Type of Application

Member			
Agency/organization	Department of Health – Center for Health Development – Cordillera Administrative Region	**Website**	
Type	Health - Regional Level	**Mailing address**	CHD CAR, Baguio City
Sector Represented	Government	**E-mail address**	mccabotaje@yahoo.com
Name of representative	Dr. Myrna C. Cabotaje	**CCM member since**	September 2002
Title in agency	Director IV	**Fax**	63(74)442-8098
Role in CCM	Proposal Review Panel	**Telephone**	63(74)442-8097

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3.6.4. National/Sub-National/Regional (C)CM Endorsement of Proposal

[Please note: The entire proposal, including the signature page, must be received by the Global Fund Secretariat before the deadline for submitting proposals. The minutes of the CCM meetings at which the proposal was developed and endorsed must be attached as an annex to this proposal.]

Table 3.6.4 – National CCM Endorsement

Agency/Organization	Name of representative	Title	Date	Signature
Department of Health	Ethelyn P. Nieto, MD	Undersecretary DOH	6/07/05	
Department of Health	Myrna C. Cabotaje, MD	Director IV, CHD CAR	6/3/05	
Pilipinas Shell Foundation, Inc.	Marvi Trudeau	Program Manager	6/2/05	
Research Institute of Tropical Medicine	Remigio Olveda, MD	Director	6/2/05	
University of the Philippines Manila	Jaime Galvez Tan , M D	Executive Director	6/2/05	
National Economic Development Authority	Arlene Ruiz, MPH	Chief, Health Nutrition and Family Planning Division	6/06/05	
Department of Education	Thelma Narvarrez, MD	Director III	6/6/05	
Department of National Defense	Peter Galvez, MD	Medical Consultant	6-2-05	
Local Government Unit/Provincial Health Office	Thelma Dangao, MD	Provincial Health Officer	6/2/05	
National Commission on Indigenous Peoples	Ricardo Sakai, MD	Medical Officer V	6/2/05	
Philippine Tuberculosis Society, Inc	Felix Barrera, MD	Chief Operating Officer	6/2/05	
Tropical Disease Foundation, Inc.	Thelma E. Tupasi, MD	President	2 June 2005	
Positive Action Foundation of the Philippines, Inc.	Joshua Formentera	President	6/2/05	
Philippine Business for Social Progress	Jazmin Gutierrez	Assistant Director for Training and Consulting	6/2/05	
World Vision Development Foundation, Inc	Melvin Magno, MD	National Health Advisor	6/2/05	
Philippine Rural Reconstruction Movement	Luz Escubil, MD	Program Manager	6/04/05	
Philippine Coalition Against Tuberculosis	Jennifer Ann Mendoza-Wi, MD	Chairperson	6/04/05	
Philippine National AIDS Council	Remedios Paulino	Director IV	6/2/05	
Kilusan Ligtas Malaria	Ray Angluben	Project Director	6/2/05	

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World Health Organization	Jean-Marc Olivé	WHO Representative to the Philippines	8/6/05
United States Assistance for International Development	~~Catherine Fischer~~ CORAZON R. MANALOTO, MD	Senior Technical Adviser	7 June, 05
Japan International Cooperation Agency	Masachi Suchi, MD	Chief Advisor	7 June/05
Joint United National Programme on HIV/AIDS	Ma. Elena Borromeo, MD	Country Coordinator	7 June 05
Canadian International Development Agency	Myrna Jarillas	Senior Program Officer	3 June 2005
GTZ	Claude Bodart, MD	Program Manager	June 7, 2005
European Commission	Fabrice Sergent, ~~MD~~ PhD	Individual Expert for Health	02/06
Philippine NGO Council	Eden Divinagracia	Executive Director	2/6/05
Department of Interior and Local Government	Austere Panadero	Assistant Secretary	6/4/05
University of the Philippines - College of Public Health	Caridad Ancheta	Dean	2 June/05
Department of Labor and Employment - Occupational Safety and Health Center	Dulce Estrella-Gust, MD	Executive Director	
United Nations International Children Education Fund	Nicholas Alipui	Representative	6 June 05
Philippine Council for Health Research and Development	Ms. Merlita Opeña	OIC - Executive Director	6/2/05

3.6.5 CCM Endorsement Details for Applications from Regional Organizations:

[Regional Organizations must receive the agreement of the full CCM membership of each country in which they wish to work.]

List below each of the CCMs that have agreed to this proposal and provide in annexes the minutes of CCM meetings in which the proposal was approved. (If no CCM exists in a country included in the proposal, include evidence of support from relevant national authorities.)

Table 3.6.5 – Regional Organization Endorsement

Names of CCM	Country	Attachment number

4 Components Section

*[**PLEASE NOTE THAT THIS SECTION AND THE NEXT MUST BE COMPLETED FOR EACH COMPONENT.** Thus, for example, if the proposal targets three components, sections 4 and 5 must be completed three times.]*

4.1 Identify the Component Addressed in this Section

☐ HIV/AIDS[3]
☒ Tuberculosis[4]
☐ Malaria
☐ Health system strengthening

4.1.1 Indicate the Estimated Start Time and Duration of the Component

[Please take note of the timing of proposal approval by the Board of the Global Fund (described on the cover page of the proposal form), as well as the fact that generally, disbursement of funds does not occur for a minimum of two months following Board approval. Approved proposals must have a start date within 12 months of proposal approval.]

Table 4.1.1 – Proposal Start Time and Duration

	From	To
Month and year:	Nov-2005	Oct-2010

4.2 Contact Persons for Questions Regarding this Component

[Please provide full contact details for two persons; this is necessary to ensure fast and responsive communication. These persons need to be readily accessible for technical or administrative clarification purposes.]

Table 4.2 – Component contact persons

	Primary contact	Secondary contact
Name	Jaime Lagahid, MD	Thelma E. Tupasi, MD
Title	Director III	Program Director
Organization	Infectious Disease Office, National Center for Disease Prevention and Control	Tropical Disease Foundation
Mailing address	Infectious Disease Office, National Center for Disease Prevention and Control, Department of Health, San Lazaro Compound, Sta. Cruz, Manila	Tropical Disease Foundation Suite 2002 Medical Plaza Amorsolo cor de la Rosa Sts., Makati City 1229, Philippines
Telephone	632-711-6806	632-888-9044
Fax	632-711-6808	632-840-2178
E-mail address	ccmsecretariatphil@yahoo.com	tetupasi@yahoo.com

[3] In contexts where HIV/AIDS is driving the tuberculosis epidemic, HIV/AIDS components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

[4] In contexts where HIV/AIDS is driving the tuberculosis epidemic, tuberculosis components should include collaborative tuberculosis/HIV activities. Different tuberculosis and HIV/AIDS activities are recommended for different epidemic states; for further information see the 'WHO Interim policy on collaborative TB/HIV activities,' available at http://www.who.int/tb/publications/tbhiv_interim_policy/en/.

4 Components Section

4.3 National Program Context and Gap Analysis for this Component

[The context in which proposed interventions will be implemented provides the basis for reviewing this proposal. Therefore, historical, current and projected data on the epidemiological situation, disease-control strategies, broader development frameworks, and resource availability and gaps need to be clearly documented.]

4.3.1 Epidemiological and Disease-Specific Background

Describe, and provide the latest data on, the stage and type of epidemic and its dynamics (including breakdown by age, gender, population group and geographical location, wherever possible), the most affected population groups, and data on drug resistance, where relevant. (Information on drug resistance is of specific relevance if the proposal includes anti-malarial drugs or insecticides. In the case of TB components, indicate, in addition, the treatment regimes in use or to be used and the reasons for their use.)

The Philippines is hyperendemic for tuberculosis (TB) with a prevalence of smear (+) TB of 3.1 per thousand (1997 National TB Prevalence Survey, Tupasi et al., 1999). In 1997, the annual risk of infection (ARI) was 2.3% nationwide. TB was substantially higher in urban poor settlements with an ARI of 6.5% (Tupasi et al., 2000, Tupasi et al., 2000a). Data from the clinic of the DOTS-Plus project in Manila showed that 59% of 144 cases enrolled MDR-TB cases with data on family income were unemployed and 19% had family incomes below minimum wage level (Tupasi et al., 2003). Seventy-eight percent of smear-positive cases were between 15-54 years (the economically productive age group), and 69% were male. As of 2003, TB all cases was 296 per 100,000, and new smear (+) cases was 133 per 100,000; the estimated prevalence was 458 per 100,000; the mortality rate of TB is 49 per 100,000. The Philippines now ranks 9th among the 22 high-burden countries globally. The prevalence of HIV in TB is 0.1% in adults aged 15-49 and new cases of multidrug resistant TB is 3.2% (WHO/HTM/TB/2005.349).

The regimens used by the NTP under the DOTS strategy are as follows: Category I: 2HRZE/4HR; Category II: 2HRZES/1HRZE/5HRE; Category III: 2HRZE/4HR. All regimens are supervised with daily DOT through both intensive and maintenance phases. These regimens have been proven effective giving a treatment success rate among new smear-positive cases of 88% and a failure rate of 1%.

MDR-TB among new TB patients was 1.5% and 14.3% in previously treated patients with a combined rate of 4.3% (Rivera, et al., 1999). Based on a mathematical model, the estimated number of new MDR TB cases was 7,742 with an estimated 3.2% new cases in 2000 (Dye et al., 2002) and an estimated prevalence of MDR TB around 26,000 cases (Tupasi et al., 2003). Preliminary results of a nationwide drug resistance survey conducted in 2004 show a rate of 4.5% among new cases and 21% in previously treated cases. Data collected from the MMC DOTS Clinic which routinely performs culture showed that 3.9% of the new cases and 35.5% of the re-treatment cases failed DOTS treatment, and that all these failure cases had MDR (MID Quelapio, abstract for review, 36th IUATLD Conference, Paris, 2005).

Of 313 MDR-TB patients currently enrolled, 62% are males. Majority (77%) of patients belong to the economically productive age groups between 25-54 years. In terms of geographical location, 74% are from Metro Manila (MM) where the diagnostic and treatment services for DOTS-Plus are available; the remaining 26% come from outlying provinces requiring relocation to MM. Among 177 patients, 48% had resistance to the four first line agents, isoniazid (H), rifampicin (R), Ethambutol (E) and Streptomycin (S).

The treatment regimens being used at the DOTS-plus project are as follows:

1. HR-resistance: ZESFqPr (Cs to replace Fq if resistant)
2. HRE-resistance: ZSFqPrCs (PAS to replace Fq if resistant)
3. HRZE-resistance: SFqPrCsPAS (K or Cap to replace S or K, respectively, if resistant)
4. HRZES-resistance: KFqPrCsPAS (Cap to replace K if resistant; Cla to replace Fq if resistant)

Acronyms: Z=pyrazinamide; Fq=fluoroquinolone; Pr=Prothionamide; Cs=Cycloserine; PAS = para-aminosalicylic acid; K=Kanamycin; cap=Capreomycin, Cla= Clarithromycin)

Regimens are individualized and given for a minimum of 18 months. These regimens gave a cure rate of 61% in a cohort prior to the GF with a 6-month conversion rate of 82% among GF patients. The following principles of treatment are being followed: a) the use of first-line agents whenever possible as they are the most potent, effective, cheapest and best tolerated, b) the use of injectables in the intensive phase, with the following priority for use: streptomycin, kanamycin then capreomycin because of their bactericidal action, c) the use of fluoroquinolones where possible being the only bactericidal oral second-line agents, d) use of at least 4 drugs certain to be effective and more than 4 drugs if susceptibility to some of the drugs is uncertain for a total duration of at least 18 months, e) not adding a single drug to a failing regimen. In the Philippines, the resistance to Ofloxacin and Ciprofloxacin was noted to be 51.4% among MDR-TB cases (Grimaldo, et. al., 2001) and, therefore, cannot be relied upon for empiric use in the majority of the patients, in which case the other oral second-line agents will be employed. In cases where the Fqs are still deemed effective, the priority of usage will be Ofloxacin, Ciprofloxacin, then Moxifloxacin. Clarithromycin, a reinforcer with fewer side effects, will be used for those needing an additional drug.

4.3.2 Health Systems, Disease-Control Initiatives and Broader Development Frameworks

[Proposals to the Global Fund should be developed based on a comprehensive review of the capacity of health systems, disease-specific national strategies and plans, and broader development frameworks. This context should help determine how successful programs can be scaled up to achieve impact against the three diseases.]

a) Describe the (national) health system, including both the public and private sectors, as relevant to fighting the disease in question.

The Department of Health (DOH) directs the country's health policy. It maintains specialty hospitals and medical centers. The DOH has extension centers called the Centers of Development (CHD) in the 17 regions of the country. The CHDs provide technical assistance and resources to the Local Government Units (LGUs) for delivery of health services. Within the CHDs are the provincial health teams made up of representatives to the local health boards. The LGUs are tasked with the implementation of national health policies and programs. The provincial and district hospitals are under the provincial government while the municipal government manages the rural health units and the barangay (village) health stations. In every province, city or municipality, there is a local health board chaired by the local chief executive. The board serves as advisory body to the local legislative council on health-related matters. To improve the effectiveness and efficiency of the health services, the Health Sector Reform was introduced in 1999 which looked into the five pillars of health services namely 1) local health systems development, 2) public health programs, 3) health regulations, 4) hospital systems, and 5) health financing.

The private sector's involvement in maintaining the health of the people is extensive. This includes provision of health services in the clinics, hospitals, health insurance, manufacturing of drugs, medicines, vaccines, medical supplies, equipment and other health and nutrition products, research and development, human resource development and other health–related services. Access to these services is limited, especially for the poor mainly due to high cost and socio-cultural barriers.

TB control is through the National TB Program (NTP) which is represented by the Infectious Disease Office, the National Center for Disease Prevention and Control (NCDPC) – DOH which is the policy-making body and provides standards and guidelines on TB control. It is responsible for supervision and monitoring of the DOTS strategy of the TB program through the NTP central office as well as through the regional offices at the CHDs through the TB coordinators. The implementation of the TB program is done by the LGU health offices at the city and municipal levels. They are provided technical support by the NTP and the CHD through the regional TB coordinators.

Management of TB patients by the private practitioners is largely unregulated. In the past five years, there have been several initiatives of private-public collaboration in TB control. More recently, the NTP, with support from a local coalition (the Philippine Coalition Against Tuberculosis - PhilCAT), engaged private practitioners in TB control through the Public Private Mix DOTS (PPMD) program. This is currently being pursued through the GF round 2 project, other DOH partners and some self-installed initiatives. All PPMDs are supported with free drugs by the DOH.

Management of MDR-TB started in a PPMD unit at the Makati Medical Center administered by the Tropical Disease Foundation (TDF) in collaboration with the NTP in 1999. This received GLC approval as the first pilot project in 2000 and Global Fund support starting in 2003 for expansion of cohort. Mainstreaming of DOTS-Plus into DOTS is being pursued as services have started to be decentralized into satellite centers both in the public sector through the Lung Center of the Philippines (LCP), selected public health centers, and the private sector through a treatment center with both in-house and out-patient DOTS-Plus services.

b) Describe comprehensively the current disease-control strategies and programs aimed at the target disease, including all relevant goals and objectives with regard to addressing the disease. (Include both existing Global Fund-financed programs and other programs currently implemented or planned by all stakeholders and existing and planned commitments to major international initiatives and partnerships).

1. Expansion of DOTS Strategy of NTP

The goal of the NTP is to reduce the TB prevalence, incidence and mortality by half in 2010 compared to baseline data of 2000 (which is in line with the Millennium Development Goals). The objectives are: (1) to increase the case detection rate of the estimated TB cases from 68% in 2003 to 85% in 2007 through identification of infectious cases and other cases by improving the quality of DOTS in the public sector, engaging the private sector, increasing community awareness and demand for TB services; and (2) to further improve or at least maintain the high treatment success rate.

In 1996, the National TB Program (NTP) launched DOTS, attaining almost 100% DOTS coverage in the public sector in 2003. Case detection rate for smear-positive cases was 68% in 2003 (WHO/HTM/TB/2004.349). Treatment outcome for the whole country is 88% treatment success in new smear-positive cases for each of the last three years (WHO/HTM/TB/2004.349). The average DOTS failure rate is 1% nationwide and 1.6% in Metro Manila among new smear-positive cases (2003 NTP Report). No data are available for previously treated cases except in Metro Manila where treatment failure rate is 7% for previously treated cases (5% for relapse and 13% for failure cases).

A joint program review in 2002 by external evaluators (Annex 7) led by the WHO-HQ, including KNCV, JICA, CIDA, WHO-WPRO, Centers for Disease Control, Atlanta showed good quality DOTS services which should be sustained by strengthening monitoring and supervision and capacity development in program and laboratory management. It also recommended that further DOTS expansion be pursued by adopting the PPMD strategy.

More recently, Fixed Dose Combination (FDC) drugs with the support of a GDF grant and direct sales procurement by the government were adopted to improve treatment compliance and logistics management. Training courses on the used of FDCs have been undertaken with support from GF Round 2.

The following co-operations/projects were the cornerstone in the rapid expansion of DOTS in the public health sector:

a. Quality TB Control Project: DOH-JICA project for Quality TB Control Program (QTBCP) cooperation started in 1992. The current project, initiated in 2002, gives technical assistance, capacity development (e.g. training for health workers), support for monitoring and supervision, equipment (e.g. microscopes). The focus of the project is on quality DOTS implementation through the upgrading of laboratories for improved microscopy services (basic and advanced microscopy courses). Another activity is the external quality assurance (EQA) of microscopy has been implemented by the National TB Reference Laboratory (NTRL) with strong support from JICA, WHO and GF Round 2 proposal. A manual for quality assurance of sputum smear microscopy has been

developed, published, and disseminated in 2004.

A nationwide Drug Resistance Survey (DRS) has been undertaken in 2004 with the support of WHO and JICA by the NTRL with the establishment of culture centers in 5 regions of the country.

b. DOH-World Vision "Kusog Baga" Project: "Kusog Baga" ("Healthy Lungs") project is a TB control project of the World Vision Development Foundation, in collaboration with the DOH, supported by CIDA from 1998 to 2004. It increased demand for DOTS through community enhancement and social mobilization and contributed to more community-based DOTS. A key part of supporting the DOTS services of the NTP was intensive training activities.

The "Kusog Baga" project also contributed several "added-value" components, such as: capacity building, community-based DOTS and the development of a Regional TB Learning Center (in the Visayas). Advocacy and community mobilization efforts led to the development of so-called community task forces in selected barangays. These multi-sectoral people's groups were formed to empower people in the community to participate in the tuberculosis program. They serve to increase awareness of the disease, to encourage patient referral and to advocate for resources from the LGU. Final project evaluation led by IUATLD (Annex 8), in collaboration with WHO, DOH, JICA, PRRM (a Philippine NGO) and external developmental consultants showed:

- Strong partnership and coordination between the "Kusog Baga" Project and DOH at all levels throughout the project
- Strong political commitment at all levels
- Strong and improved laboratory services in most areas
- Knowledgeable and motivated health staff at all levels
- Increase of case detection rate from 35% to 67% in 3 years
- Treatment success rate was maintained at 85%
- Public-private partnerships were developed and strengthened in most areas
- Strong advocacy initiatives at all levels
- Successful community mobilizing efforts with specific focus on TB has led to the formation of community-based support groups and task forces.

c. Medicos del Mundo TB Control Project:

This international NGO supported by the Spanish government has been providing in collaboration with the NTP capacity building for laboratory (including equipment) and health workers, monitoring support, and support to two DOTS facilities in the private sector since 2001.

d. Local Enhancement and Development Project (LEAD)

This project, established in 2004 and funded by USAID, focuses on strengthening local governance in rural poor areas including the Autonomous Region in Muslim Mindanao (ARMM) through program management through capacity building in managerial and technical aspects. TB control is one of the components of the LEAD project.

2. Public-Private Mix DOTS (PPMD): Engaging the private sector in DOTS

In view of the major role of the private sector in TB treatment (Tupasi et al., 2000b, Auer et al., 2000), a number of private initiatives on public private mix DOTS (PPMD) have been undertaken. PPMD units numbering 25 have been self-installed since 1995. The Philippine Coalition Against Tuberculosis (PhilCAT) has piloted five models with Centers for Disease Control and Prevention (CDC) support. The Philippine Tuberculosis Initiatives for Private Sector (PhilTIPS) project has set up 20 units with USAID support. In 2003, PPMD became a major strategy for DOTS expansion with GF Round 2 support (see also #5 below).

In January 2005, an external evaluation of the GF supported PPMD sites showed that there was substantial additionality in case detection and very satisfactory case holding (Annex 9).

3. GLC approved DOTS-Plus pilot project for the management of MDR-TB

In August 2000, the MMC DOTS Clinic, a PPMD unit established in 1999, became the first DOTS-Plus pilot project approved by the Green Light Committee (GLC) making the

Philippines one of the few high burden countries with a DOTS-Plus GLC-approved pilot project. Around three quarters of the MDR-TB patients reside in Metro Manila; the remaining patients come from provinces requiring relocation to Metro Manila. An economic analysis in 2004 of the first cohort of MDR-TB patients before Global Fund support showed a cure rate of 61% and found the pilot project to be feasible and cost-effective (Annex 10). Clinic data show that among 177 patients, 48% had resistance to the four first-line agents isoniazid, rifampicin, ethambutol, and streptomycin, and resistance to Ofloxacin and Ciprofloxacin was noted in 51.4% of MDR-TB cases (Grimaldo et al., 2001). Thus, substantial use of various second-line drugs is needed, resulting in expensive drug regimens. (See also #5 below: Global Fund Round 2.) As of December 2004, the GLC has already performed six site monitoring visits (Annex 11).

4. Partnerships and Coalitions

a. Project Assistance to Control TB (PACT): a coordinating body composed of various partner agencies working with the DOH on TB control. It was established to coordinate efforts on a national scale towards a more effective and efficient implementation of the national TB control program. Its members include the DOH as chair, JICA, USAID, CIDA, World Vision Development Foundation, World Bank, Medicos del Mundo, WHO, NEDA (National Economic Development Authority), and BIHC-DOH (Bureau of International Health Cooperation of the DOH)

b. Philippine Coalition Against Tuberculosis (PhilCAT): launched in 1994, it is multi-sectoral, comprising at present 61 member organizations, including professional societies, government agencies, local and international NGOs, private for profit corporations, partners and individual TB advocates. Eleven local coalitions e.g. CCCAT, DACICAT, have also been established.

c. Comprehensive Unified Policy (CUP) in TB control: launched in March 2003 under Executive Order 187 (Annex 12) to foster partnership between and amongst public and private institutions including the academe and financial institutions in the government. This is a government initiative with strong partnership with PhilCAT.

d. PhilHealth: The Philippine Health Insurance Corporation outpatient TB benefit package, initiated by the governmental insurance agency PhilHealth, provides support for accredited DOTS units to provide quality DOTS services for qualified PhilHealth members and their dependents. This mechanism serves as a financial scheme to sustain PPMD implementation (Annex 13). It also provides PhilHealth TB Benefit Package for poor patients through its indigency program in partnership with the local government units and philanthropic organizations.

5. Global Fund Round 2

The Global Fund Round 2 supports TB projects with the amount of $11.4 M. The four implementers are: (1) NTP-DOH to strengthen quality DOTS; (2) World Vision Development Foundation, Inc. to raise demand for DOTS; (3) PhilCAT to expand PPMD; and (4) Tropical Disease Foundation (TDF) to manage MDR-TB cases.

The main thrust of the NTP is to ensure quality DOTS services in the public sector. Training on FDC and EQA for laboratory and hospital DOTS were supported by GF Round 2 project. The World Vision Development Foundation was responsible for the activities to increase the demand for DOTS through community organization and social mobilization which showed a substantial increase (average of 40% additionality) in case detection through the TB Task Forces (Annex 14).

The NTP in collaboration with PhilCAT has received GF support to set up 71 PPMD units (28 units have been established as of May 31, 2005). After 18 months of implementation, an external evaluation by WHO (see Annex 9) in January 2005 found the following:

1. The collaborative structure for coordination between stakeholders involved in the GF-supported project seemed to be solid after a relatively short implementation period, largely due to the involvement of committed partners from both the public and private sector and the efficient work of PhilCAT.
2. The potential of Regional Coordinating Committees as an intermediary for communication between private providers and some public providers has yet to be maximized.
3. GF-supported PPMD units have contributed substantially to increased case detection. All except one site with GF-supported PPMD units have reached the 70% case detection

target.
4. While it is too early to analyze treatment outcome data, the observed high sputum smear conversion rates provide an indication of good quality services.
5. There is some concern with the tendency in some areas to depend on family members for DOT.
6. The sustainability of PPMD can be assured by an efficient certification, accreditation and administration of the PhilHealth TB package.

The MMC DOTS clinic, run by the TDF, expanded the GLC-approved DOTS-Plus pilot project for the management of MDR-TB. The GLC external evaluation in December 2004 (Annex 11) showed considerable progress achieved, with strong commitment of the implementer, and clear support from the NTP and local health authorities and that this project is very close to becoming a world-wide centre of excellence in the management of MDR-TB. A total of 352 MDR-TB patients have been enrolled including 165 patients prior to GF Round 2 support. The project has been designated to be one of two WHO collaborating training centers in the Western Pacific Region. This will be co-funded by the Lilly Foundation and by USAID through a Cooperative Agreement with the CDC. Capacity building of health personnel has been accomplished in accordance with 5th GLC visit recommendation, allowing the decentralization of DOTS-Plus to the public sector through the Lung Center of the Philippines, a public-initiated PPMD unit, and selected health centers in 7 out of 17 cities and municipalities in Metro Manila and including a provincial site outside Metro Manila. A satellite DOTS-Plus treatment center with both a housing facility and an out-patient DOTS-Plus service within Metro Manila has been established through support from the Philippine Amusement and Gaming Corporation, a government agency. During the 6th GLC monitoring visit, there was consensus in the need to take advantage of the momentum created by the success of the DOTS-Plus project, the support from GF, the expansion of the DOTS strategy, and the progress in the PPMD approach to make the management of MDR-TB an integral component of the NTP in the Philippines.

Stepwise mainstreaming of DOTS-Plus into DOTS in both public health centers and PPMD units as well as conducting HIV surveillance in MDR-TB as recommended by the GLC are components of this proposal.

c) Describe the role of AIDS-, tuberculosis- and/or malaria-control efforts in broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative, the Millennium Development Goals or sector-wide approaches. Outline any links to international initiatives such as the WHO/UNAIDS '3-by-5 Initiative' or the Global Plan to Stop TB or the Roll Back Malaria Initiative.

The TB program of the NTP is linked with the Global Plan to Stop TB. PhilCAT is a member of the STOP TB Partnership. The Philippines is also part of the WHO DOTS Expansion Working Group, the PPMD Sub-Group and the DOTS-Plus Working Group.

Country targets regarding TB have been set in line with the Millennium Development Goals and the WHO Western Pacific Regional TB control targets.

The Philippines regards TB control as a priority program in line with poverty reduction. This is shown by the sustained political and financial commitment of the government. Access to TB treatment is enhanced through DOTS expansion, both geographically in terms of coverage of all DOTS centers in the public health system and in service provision such as engagement of the private sector through PPMD. The DOTS-Plus program for the management of MDR-TB is consistent with STAG decision of 2004 recognizing Cat 4 regimens as the standard of care for MDR-TB and the EB Resolution 114.R1 which will be adopted the WHA 2005 "encouraging all member states to "ensure access to the universal standard of care that is based on the proper diagnostics, treatment, and reporting. Furthermore, the DOTS-Plus principles in the management of MDR-TB is consistent with the recommendations in the "International Standard of Care for TB" proposed by the WHO and the American Thoracic Society.

4 Components Section

4.3.3 Financial and Programmatic Gap Analysis

[Interventions included in the proposal should be identified through an analysis of the gaps in the financing and programmatic coverage of existing programs. Global Fund financing must be additional to existing efforts, rather than replacing them, and efforts to ensure this additionality should be described Use Table 4.3.3.a to provide in summarized form all the figures used in sections 4.3.3.1 to 4.3.3.3.]. [For health systems strengthening components the financial and programmatic gap analysis needs to provide information relevant to the proposed health systems strengthening intervention(s).]

4.3.3.1 Detail current and planned expenditures from all relevant sources, whether domestic, external or from debt relief, including previous grants from the Global Fund.

[List the financial contributions dedicated to the fight against this disease by all domestic and external sources. Indicate duration and amount, and ensure that the amount for domestic sources is consistent with Table 1.1.1]

Annual domestic resources for the National TB program are from 13-14 million USD. This includes other domestic resources including contributions from the local government units (LGUs). This is utilized primarily for first line anti-TB drugs, laboratory supplies and other needs. External resources include those from JICA through the QTBCP project, USAID through the PhilTIPS project and LEAD, Medicos del Mundo, also from the GF round 2 approved grant and from the WHO.

4.3.3.2 Provide an estimate of the costs of meeting overall (national) goals and objectives and provide information about how this costing has been developed (e.g., costed national strategies).

To achieve the goals of the NTP of 50% reduction in incidence and mortality from tuberculosis by 2010, we need to strengthen current initiatives in the public sector with expansion to other stakeholders (public and private) as well as ensuring quality care to patients. It also includes adapting new strategies (DOTS Plus) and the involvement of the community. All these activities will ensure achieving the MDG targets. The resources necessary to support the current initiatives for the next 5 years is estimated at 128 Million USD. This estimate is based on the proportion of current expenditures and the total budget needed for meeting the national targets through the identified activities.

4.3.3.3 Provide a calculation of the gaps between the estimated costs and current and planned expenditures.

Total gap in terms of resources to implement the National TB program for the next 5 years (in line with the GF Round 5 implementation) is about 128 Million USD. With the available domestic and external resources currently available to the NTP, the unmet gap would be 50 million USD or 30% of the total need.

Table 4.3.3 - Financial Contributions to National Response

	Financial contributions in Euro / US$						
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Domestic (A)	10,605,496	10,605,496	10,605,496	10,605,496	10,605,496	11,200,000	11,200,000
External (B)	6,787,517	2,495,131	1,899,749	1,745,288	1,802,934	1,792,000	1,680,000
External source 1 (to be named)							
External source 2 (to be named)							
Total resources available (A+B)	12,144,204	13,100,627	12,505,245	12,350,784	12,408,430	12,992,000	12,880,000
Total need (C)	16,010,275	18,334,673	19,217,879	20,403,634	20,669,570	21,436,800	21,252,000
Unmet need (C)-(A+B)	3,866,071	5,234,046	6,712,634	8,052,850	8,261,139	8,444,800	8,372,000

4.3.4	Confirm that Global Fund resources received will be additional to existing and planned resources, and will not substitute for such sources, and explain plans to ensure that this is the case.

At present, the government of the Philippines (GOP) covers the salaries of TB staff and the LGU program implementers while the NTP provides for the drug needs of all DOTS implementing facilities including existing PPMD units. The budget allocation from the GOP will continue during the GF financing. Funds received from funding agencies such as the GF and partner agencies have always been additional and are monitored through the Bureau of International Health Cooperation of the DOH to avoid redundancy or overlapping of resources.

In a recent pronouncement by the highest authority in government in line with the signing of the VAT measure, some P80 billion will be added to the government's revenues and boost the Bureau of Internal Revenue's April collection by P62.9 billion. The President said more investments will be poured into job creation, expanded educational opportunities and better health care for all Filipinos since "all these are at the core of our 10-point agenda."

In addition, the new secretary of health has also declared in his first official public act as health secretary during his address in the 1st Forum for the Philippine Partnership to fight TB, malaria and AIDS that the three diseases are his priorities and that the government sector will continue and expand its support for their control. Accordingly, the budget for TB control is assured and is estimated based on the expected number of cases detected and treated.

GF support will be utilized for health system strengthening and facility development to increase the absorptive capacity of the public sector to undertake monitoring/supervision, advocacy & social mobilization. The adequate training of health workers from the public sector and the PPMD units will enable them to deliver quality DOTS services and DOTS-Plus. Advocacy, as a strategy of NTP will encourage active and greater participation of TB stakeholders and increase awareness in the community to improve health seeking behavior and improve productivity of the patient in particular and the community in general.

GF resources intended to scale up the DOTS-Plus pilot project will definitely fill in an important gap in the TB control program and will be complementary to the NTP budget which supplies the 1st line anti-TB. With the treatment of infectious MDR-TB cases, transmission of MDR-TB will be halted and with DOTS implementation, the generation of new MDR-TB will be minimized so that the burden of MDR-TB will diminish through the GF project years to a level that may be manageable with local resources including subsidy from partners such as the Philippine Charity Sweepstakes Office, a government fund-raising agency to support health programs. In addition, the National Health Insurance Program has committed 2 billion Phlippine Pesos to support the PhilHealth TB Outpatient Package for accredited DOTS units which will ensure the sustainability of the gains attained with the GF Rounds 2 and 5 projects.

4 Components Section

4.4 Component Strategy

4.4.1 Description and justification of the program strategy

[This section must be supported by a summary of the Program Strategy section in tabular form.

- *Tables 4.4a and b (following section 4.4.1) are designed to help applicants clearly summarize the strategy and rationale behind this proposal. For definitions of the terms used in the tables, see Annex A. (See Guidelines for Proposals, section V.B.2, for more information.)*
- *In addition, please also provide a detailed quarterly work plan for the first 12 months and an indicative work plan for the second year. These should be attached as an annex to the proposal form.]*

Narrative information in section 4.4.1 should refer to Tables 4.4a and 4.4b, but should not consist merely of a description of the tables.]

4 Components Section

Table 4.4a. Goals and Impact Indicators over Life of Program

Goal No.	Goals over five years
# 1	Reduction of the prevalence and mortality due to tuberculosis by 50% in 2010 in support of the Millennium Development Goals for poverty alleviation.

Goal No.	Impact indicator	Baseline			Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Source and comments
		Value	Year	Source						
1	Reduced prevalence of TB all cases per 100,000 population	458	2002	WHO, 2003 Report	N/A	N/A	N/A	N/A	229	
1	Reduced incidence of PTB sm(+) per 100,000 population	133	2003	WHO, 2005 Report	N/A	N/A	N/A	N/A	72	
1	Reduced TB mortality rate per 100,000 population	49	2003	WHO, 2005 Report	44	40	36	32	29	
1	Increased Case detection rate (in percent)	68	2003	WHO, 2005 Report	70	74	78	80	85	CDR in all cases
1	Maintained Treatment success rate (in percent)	88	2003	WHO, 2005 Report	88	≥ 88	≥ 88	≥ 88	≥ 88	
1	Increased treatment success rate of MDR-TB (in percent)	61	2004	MMC DOTS-Plus pilot project	65	67	68	70	72	

[Impact indicators are not normally measured every year, and values for targets do not need to be entered for every year. It is advisable to refer to the list of coverage indicators provided in Annex A.]

4 Components Section

3.6 4.3 Component Strategy

3.6.1 4.3.1 Description and justification of the program strategy

[This section must be supported by a summary of the Program Strategy section in tabular form.
1 Tables 4.4a and b (following section 4.4.1) are designed to help applicants clearly summarize the strategy and rationale behind this proposal. For definitions of the terms used in the tables, see Annex A. (See Guidelines for Proposals, section V.B.2, for more information.)
2 In addition, please also provide a detailed quarterly work plan for the first 12 months and an indicative work plan for the second year. These should be attached as an annex to the proposal form.]

Narrative information in section 4.4.1 should refer to Tables 4.4a and 4.4b, but should not consist merely of a description of the tables.]

Table 4.4a. Goals and Impact Indicators over Life of Program

Program objectives over five years		
Objective No.	**Objective description**	**Link to goal by number**
# 1A	To enhance quality of DOTS implementation in the public sector through improvement in service provision and increase in access to DOTS services	**#**
# 1B	To increase the demand for DOTS services in the public and private DOTS facilities by removing barriers to access through social mobilization and social marketing for underserved populations (urban poor).	
# 2	To ensure access to quality DOTS services by the unreached and underserved populations through (a) scaling –up of PPMD with the installation of 100 PPMD units (b) enhancement of the existing PPMD units (c) regular supervision and monitoring and (d) assurance of sustainability of all GF PPMD units beyond project life	
# 3	To integrate DOTS-Plus in the existing DOTS infrastructure in Metro Manila and selected high MDR-TB prevalence areas outside Metro-Manila. Treatment of MDR-TB cases is the main focus of this objective, including human resource development, laboratory capacity building, health infrastructure development, and patient empowerment and community mobilization.	**#**
# 4	To establish and strengthen TB and HIV collaboration in an epidemiologic scenario where the TB prevalence is high and HIV burden is low	

4 Components Section

				Baseline		Year 1 target	Year 2 target	Year 3 target	Year 4 target	Year 5 target	Frequency of data collection
				Value	Year						
# 1A	**SDA 1A.1 Health Systems Strengthening**										
# 1A			Level 1. No. of physicians and nurses who undergo strengthening capacity through DOTS boosting courses	0	2004	680 pax	680 pax	680 pax	680 pax	680 pax	quarterly
# 1A			Level 1. No. of Midwives and BHWs who undergo strengthening capacity through DOTS boosting courses	130	2004	680 pax	1360 pax	1360 pax	680 pax	680 pax	quarterly
# 1A			Level 1. No. of medtechs who undergo strengthening capacity through DOTS boosting courses	0	2004	255	255	255	255	255	quarterly
# 1A			Level 1. No of hospital coordinators trained on DOTS referral	44	2004	18	34	68	20	14	quarterly
# 1A			Level 1. No of hospital coordinators who undergo DOTS Providers training course for hospital staff	44	2004	12	20	34	24	12	quarterly
# 1A			Level 1. No of hospital coordinators who undergo Microscopy training	0	2004	6	10	17	12	6	quarterly

# 1A			Level 2 no. of other key government agencies working for the urban poor oriented on Public-Public Mix DOTS implementation	0	2004	1	2	0	0	0	quarterly
# 1A			Level 1 No. of NTP Coordinators oriented on outside-the-country situations through international technical exchange	0	2004	10	10	10	10	10	quarterly
# 1A			Level 1 No. of staff hired to augment human resource complement at central level	0	2004	3	0	0	0	0	quarterly
# 1A			Level 1 No of equipment for technical assistance procured	0	2004	4	0	0	0	0	quarterly
# 1A			Level 1 No of equipment for technical assistance procured	1	2004	2	0	0	0	0	quarterly
# 1A			Level 2 no. of areas visited under joint Central/CHD/Provincial monitoring to low performing province/cities and catchment RHUs	10	2004	12	12	12	12	12	quarterly
# 1A			Level 2 no. of visits conducted as support to joint routine Regional (CHD)/provincial NTP monitoring activities to RHUs	32	2004	100	100	100	100	100	quarterly

# 1A			Level 2 no. of visits conducted under Joint monitoring with NTRL on lab status of TB Reference laboratories	0	2004	32	32	32	32	32	quarterly
# 1A			Level 1 No. of Yearend National Consultative Workshop for NTP coordinators	0	2004	1	1	1	1	1	quarterly
# 1A			Level 1 No. of Yearend National Consultative Workshop for Laboratory Managers conducted	0	2004	1	1	1	1	1	quarterly
# 1A			Level 3 Follow-through on the 2007 3rd NPS for the urban poor population conducted	0	2004		1				annual
# 1A	**SDA 1A. 2. Partnership and Coordination Development**										
# 1A			Level 2 No. of public hospitals referring to DOTS facilities through strengthening of service linkage between public health units and public hospitals through Public-Public Mix DOTS	0	2004	9	17	34	10	7	quarterly
# 1A			Level 2 No. of hospitals as DOTS providers through Strengthening the service linkage between public health	3	2004	3	14	17	10	7	quarterly

			units and public hospitals through Public-Public Mix DOTS								
# 1A			Level 2 No. of symposium on Public-Public Mix DOTS implementation for the urban poor conducted	0	2004	1	0	0	0	0	annual
# 1A			Level 2 No. of key partners attending the symposium on Public-Public Mix DOTS implementation for the urban poor	0	2004	10	0	0	0	0	annual
# 1A			Level 2 No. of CUP public members engaged through strengthened coordination of C.U.P. members involve with urban poor for Public-Public Mix DOTS implementation	0	2004	3	0	0	0	0	annual
# 1A	**SDA 1.A.3. DOTS Certification and Accreditation**										
# 1A			Level 2 No. of public facilities certified on quality DOTS services	118	2004	85	85	85	85	85	Quarterly
# 1A			Level 2 No. of public facilities recommended for PhilHealth accreditation	52	2004	85	85	85	85	85	Quarterly
# 1A	**SDA 1A.4. Data Enhancement**										

# 1A			Level 1 No. of staff assigned/Hired for the electronic TB register (ETR) (Type and number of Staff assigned/hired for the ETR	0	2004	10	31	104	78	0	quarterly
# 1A			Level 1 No. of trained central/CHD/ provincial/city Staff on the use of the (ETR)	0	2004	34	42	484	400	0	quarterly
# 1A			Level 2 Equip the provincial, city, CHDs and central (NEC) health offices with appropriate hardware support (No. of health facilities/offices equipped to provide immediate access to NTP data)	0	2004	10	27	66	131	0	quarterly
# 1A	**SDA 1A.5. Identification and treatment of cases for specific group (urban poor)**										
# 1A			Level 3 Population of 3 urban poor areas in Metro Manila with improved access to quality DOTS services	0	2004	30,000	30,000	30,000	30,000	30,000	quarterly
# 1A			Level 3 No. of TB symptomatics from the 3 urban poor areas who were referred by key agencies engaged in	0	2004	100	200	600	600	600	quarterly

			DOTS implementation								
# 1A			Level 3 No. of TB cases from the 3 urban poor areas who were referred by key agencies engaged in DOTS implementation	0	2004	15	30	90	90	90	quarterly
# 1A	**SDA 1A.6. Control of Drug Resistance**		Level 3 percentage of new smear positive pulmonary TB cases that remain smear positive after 5 months or more (failure rate)	<2%	2003	<2%	<2%	<2%	<2%	<2%	annual
# 1A	**SDA 1A.7 Operational Research**										
# 1A			Level 1 No. of OR (eg. Rapid survey among defaulters in Metro Manila) conducted	0	2004	1	0	0	0	0	annual
# 1B	**Capacity building and Human Resource**		**Level 1:** Number of community-based TB support group members trained on DOTS	N/A	2004	473	428	855	255	0	Quarterly
# 1B			**Level 1:** Number of community-based TB support group (Task Force) members trained on health education and counseling	137	2005	289	289	289	289	0	Quarterly
# 1B	**Behavioral Change Communication**		**Level 2:** Number of IEC materials produced	0	2004	1 flipchart, 1	1 radio infomercial, 1	1 poster, 1	1 comics	0	Quarterly

						poster, 1 brochure, 1 sticker	documentary video, 1 billboard, 1 brochure, 1 comics	sticker			
# 1B			**Level 2:** Number of community TB education Classes conducted by organized community-based TB support groups	0	2004	0	84	132	402	268	Quarterly
# 1B			**Level 3:** Percent of the target population aware on the signs and symptoms of TB, available DOTS services and where these are available	30%	2003	30%	30%	40%	50%	60%	Annually (Y3 & Y5)
# 1B			**Level 3:** Percent of the target population able to recall at least 3 signs and symptoms of TB, available DOTS services and where these services are available.	30%	2003	30%	30%	40%	50%	60%	Annually (Y3 & Y5)

# 1B			**Level 3:** Percent of the target population who sought DOTS services	30%	2003	30%	30%	50%	60%	70%	Annually (Y3 & Y5)
# 1B	**Coordination and Partnership Development**		**Level 1:** Number of public health workers trained on community organizing	0	2004	138	138	138	138	0	Quarterly
# 1B			**Level 2:** Number of community-based TB support groups (Task Forces) organized	0	2004	0	42	24	68	0	Quarterly
# 1B	**Monitoring and Evaluation**		**Level 1:** Number of supervisory visits conducted by public health workers to organized community-based TB support groups	0	2004	22	84	48	136	68	Quarterly
# 1B	**Identification of infectious cases of TB**		Level 3: Number of TB symptomatics referred by community-based support groups (Task Forces), other than those identified by public health facilities, seeking health services at public and private DOTS facilities	0	2004	0	6,216	13,729	33,443	34,279	Quarterly

# 1B			**Level 3:** Number of new smear positive cases referred by community-based TB support groups (Task Forces), other than those identified by public health facilities	0	2004	0	622	1,373	3,344	3,428	Quarterly
# 1B	**Quality treatment of infectious cases of TB**		**Level 3:** Number of new smear positive cases identified through and supervised by Task Force members (exclusive of those identified by public health facilities)	0	2004	0	435	961	2,341	2,400	Quarterly
# 1B			**Level 3:** Number of new smear positive cases identified through and supervised by Task Force members that were cured plus the number that completed treatment (treatment success rate). (This is exclusive of those identified by public health facilities)	0	2004	0	370	817	1,990	2,040	Quarterly
# 2	Health Systems Strengthening: Human Resources		Level 1: Number of service deliverers from existing and newly installed PPMD units trained on business and financial planning	N/A	N/A	0	0	432 (244 public, 188 private)	0	0	Annually

# 2			Level 1: Number of private service deliverers with enhanced training through technical exchange	N/A	N/A	10	10	10	10	10	Annually
# 2	Health Systems Strengthening: M and E		Level 1: Number of personnel trained on M and E and DOTS	N/A	N/A	20	0	0	0	0	Annually
# 2	Health Systems Strengthening: Health Infrastructure Development		Level 2: Number of service delivery points supported, both public and private	28	2005	50 (35 public, 15 private)	50 (35 public, 15 private)	0	0	0	Quarterly
# 2	Tuberculosis Prevention: Identification of Infectious Cases		Level 1: Number of service deliverers trained in sputum microscopy, both public and private	15	2005	32 (17 public, 15 private)	32 (17 public, 15 private)	0	0	0	Quarterly
# 2			Level 1: Number of service deliverers from existing PPMD units retrained on sputum microscopy, both public and private	N/A	N/A	0	116 (64 public, 52 private)	0	0	0	Quarterly
# 2			Level 2: Number of service delivery points for sputum microscopy, both public and private	28	2005	50 (35 public, 15 private)	50 (35 public, 15 private)	0	0	0	Quarterly
# 2			Level 3: Number of new smear positive TB cases detected under DOTS	328	04/05	325	2250	2600	2600	2600	Quarterly
# 2	Tuberculosis Treatment: Timely Detection and Quality Treatment of Cases		Level 1: Number of service deliverers trained in DOTS, both public and private	27	2005	65 (35 public, 30 private)	65 (35 public, 30 private)	0	0	0	Quarterly
# 2			Level 1: Number of private referring	374	04/05	500	500	0	0	0	Quarterly

			physicians trained in DOTS								
# 2			Level 1: Number of TB Diagnostic Committees trained	N/A	N/A	50	50	0	0	0	Annually
# 2			Level 1: Number of service deliverers from existing PPMD units retrained on DOTS, both public and private	N/A	N/A	0	232 (128 public, 104 private)	0	0	0	Quarterly
# 2			Level 2: Number of service delivery points for DOTS services, both public and private	28	2005	50 (35 public, 15 private)	50 (35 public, 15 private)	0	0	0	Quarterly
# 2			Level 3: Number and percentage of new smear positive TB cases registered under DOTS who smear converted at the end of the initial phase of treatment	N/A	N/A	292 (90%)	2025 (90%)	2340 (90%)	2340 (90%)	2340 (90%)	Quarterly
# 2			Level 3: Number and percentage of new smear positive TB cases registered in a specified period that were cured plus the number that completed treatment (Treatment Success Rate)	58	04/05	276 (85%)	1912 (85%)	2210 (85%)	2210 (85%)	2210 (85%)	Quarterly
# 3	Health System Strengthening		No of Trainers Trained in DOTS Plus	4	2005	20	0	0	0	0	Quarterly
# 3	1. Human Resource Development		Level 0: National Training Program for DOTS Plus	none	2005	yes	yes	yes	yes	yes	Once only

# 3			Level 1: No. of staff in the public and private centers who have received DOTS Plus training	372	2005	28	366	366	91	0	Quarterly
# 3			Level 1: No of treatment partners oriented in DOTS Plus		2005	950	1090	1113	329	114	Quarterly
# 3			Level 2:No of sites with regular supervision	3	2005	4	6	8	8	8	cumulative
# 3			Level 2: No. of communities mobilized for providing DOTS Plus treatment partners	0	2005	12	27	57	89	98	Quarterly
# 3	**2. Monitoring and evaluation (and supervision)**		Level 0:Existence of National an M and E Plan for DOTS Plus	none	2005	yes	yes	yes	yes	yes	Once only
# 3			Level 0:No of impact and outcome surveys related to DOTS plus conducted reported and disseminated	6	2005	1	1	1	1	1	annually
# 3			Level 1: Number of people trained in M and E, statistics and data management	13	2005	4	4	4	4	4	quarterly
# 3			Level 2. Number and percentage of service delivery points submitting accurate, complete and timely reports	2	2005	4	6	8	8	8	quarterly
# 3	**3.Health Infrastructure development**		Level 2:No of Treatment centers established	3	2005	4	6	8	8	8	quarterly (cumulative)

# 3			Level 2:No. Of OPD DOTS Centers providing DOTS Plus Services	29	2005	10	30	50	70	0	Quarterly (cumulative)
# 3			Level 2:No of Quality assured culture laboratory established	1	2005	1	2	3	4	5	Annually (cumulative)
# 3			Level 2. No of Laboratory that is quality assured by a supranational laboratory for DST	2	2005	2	2	2	2	2	Annually (cumulative)
# 3	**4. Procurement and Supply Management**		Level 1. No of People trained in Procurement and Management Supply	4	2005	6	7	8	9	10	Annually (cumulative)
# 3			Level 2:No. and percentage of sites reporting no stock outs of second line drugs	100%	2005	100%	100%	100%	100%	100%	quarterly
# 3			Level 2:No. and percentage of sites reporting no stock outs of laboratory supplies	100%	2005	100%	100%	100%	100%	100%	quarterly
# 3			Level 2:No. and percentage of sites reporting non functioning equipment	0	2005	4	6	8	8	8	Quarterly
# 3			Level 2: No of sites applying national rules and regulations regarding procurement and supply management	0	2005	1	0	0	0	0	quarterly
# 3	**5.Operational Research**		Level 0: Existence of a Protocol for operational research on DOTS Plus	1	2005	1	1	1	1	1	quarterly

# 3			Level 0; Operational Research used to inform policy and updating of treatment guidelines	3	2005	5	7	8	9	10	Annually (cumulative)
# 3			Level 1: No. of people trained in research methods	15	2005	17	19	21	23	25	Annually (cumulative)
# 3	**6.Treatment of Multidrug resistant TB**		Level 1: No. of service deliverers trained in MDR-TB	372	2005	288	366	366	91	0	Quarterly
# 3			Level2: No. of TB facilities delivering treatment for MDR-TB	32	2005	10	30	50	60	70	Quarterly (cumulative)
# 3			Level 3: No and percentage of MDR-TB tested with DST	219 (51%)	2005	209 (51%)	418 (51%)	861 (51%)	1009 (51%)	578 (51%)	quarterly
# 3			Level 3: No and percentage of MDR-TB suspects confirmed with MDR-TB	193 (45%)	2005	185 (45%)	369 (45%)	759 (45%)	889 (45%)	510 (45%)	quarterly
# 3			Level 3: No and percentage of MDR-TB patients enrolled among confirmed MDR-TB patients	178 (92%)	2005	170 (92%)	340 (92%)	700 (92%)	820 (92%)	470 (92%)	quarterly
# 3			Level 3: Percentage of MDR-TB patients who are culture negative by six months of treatment	80%	2004	81%	82%	83%	84%	85%	quarterly
# 3			Level 3: Percentage of MDR-TB patients enrolled who were cured plus the number of patients who completed treatment after 36 months after	61%	2004	65%	67%%	68%%	70%	72%	annually

			enrollment								
# 3			Level 3: Number and percentage of MDR-TB patients registered in a specified period that interrupted for more than 2 consecutive months after 36 months after enrollment	14%	2005	12%	10%	9%	8%	8%	Annually
#4	**SDA 4.1 Health Systems Strengthening**										
#4			Level 0 Number of TB/HIV meetings conducted	0	2004	6	6	6	6	6	quarterly
#4			Level 0 Number of TB/HIV policies/guidelines developed	0	2004	1	0	0	0	0	quarterly
#4			Level 0Number of sites supported	0	2004	1	0	0	0	0	quarterly
#4			Level 1 Number of service deliverers trained	0	2004	28	26	26	14	0	quarterly
#4			Level 2 Number of monitoring visits conducted	0	2004	0	22	40	58	62	quarterly
#4			Level 0 Number of Evaluation workshops conducted	0	2004	0	1	2	3	3	quarterly
#4			Level 2 Number of laboratory facilities upgraded	0	2004	4	1	1	0	0	quarterly

#4	**SDA 4.2 Surveillance of HIV among TB cases**										
#4			Level 0 Number of MOA signed	0	2004	0	7	8	8	2	quarterly
#4			Level 1 Number of staff trained on TB/HIV Surveillance	0	2004	0	50	50	50	15	quarterly
#4			Level 2 Number of sites conducting HIV surveillance on TB patients	0	2004	7	15	23	25	25	Quarterly (cumulative)
#4			Level 3 proportion of blood samples screened for HIV	0	2004	90	90	90	90	90	quarterly
#4			Level 2 Number of sites given equipment support	0	2004	1	0	0	0	0	quarterly
#4	**SDA 4.3. Improve the quality of life of people co-infected with TB-HIV/AIDS**										
#4			Level 1 Number of service deliverers trained	0	2004	30	45	15	0	0	quarterly
#4			Level 3 Proportion of HIV patients screened and treated for TB	0	2004	95	95	95	95	95	quarterly
#4			Level 3 % of HIV patients with TB given ARV if indicated	0	2004	95	95	95	95	95	quarterly

4.4.1.1 Provide a clear description of the program's goal(s), objectives and service delivery areas (provide quantitative information, where possible).

The goal of the National Tuberculosis Program is to reduce the prevalence and mortality due to tuberculosis by 50% in 2010 in support of the MDGs for poverty alleviation.

Overall Objective: To increase and maintain cure rate to at least 85% and case detection rate to at least 70% of infectious cases through DOTS

Objective 1a: To enhance the quality of DOTS implementation in the public sector through improvement in service provision and increase in access to DOTS services through:

• SDA 1a.1 Health System Strengthening in the areas of:
  o Human resource and capacity building– this includes the enhancement of more than 6,000 service providers in 5 years in terms of their technical and managerial capacity to provide quality DOTS services at all times. This also includes manpower augmentation at the central level through hiring of 3 staff who will be assigned task-specific roles.
  o Health Infrastructure Development – this includes equipment support (notebook computer, LCD projector, tape recorder and others) to enhance the training and advocacy functions of the central staff.
  o Monitoring and Evaluation of DOTS implementation in more than 500 areas in 5 years to oversee and assess the quality of DOTS services. This will be conducted through joint Central/CHD/provincial to DOTS facilities monitoring, through routine CHD/provincial to DOTS facilities monitoring and through annual national evaluation workshops for coordinators
• SDA 1a.2 Partnership and Coordination Development –strengthening the partnerships amongst public agencies through Public-Public Mix DOTS with 128 public hospitals and other key government agencies, particularly NAPC, DILG and DSWD which works with the urban poor.
• SDA 1a.3 DOTS Certification and Accreditation – To ensure provision of quality services of 425 public DOTS facilities and to ensure sustainability through the PhilHealth OPD TB Benefit Package, a government social financing scheme.
• SDA 1a.4 Strengthened Data Management –To provide timely and relevant NTP data for monitoring and program management by establishing a nationwide electronic TB register (ETR) system in 5 years.
• SDA 1a.5 Timely Detection and Quality Treatment of Cases – To increase case detection and improve case management in 3 urban poor areas.
• SDA 1a.6 Control of Drug Resistance – To control failure rate among new smear positive cases through regular recording and reporting of TB cases utilizing the regular TB information network.
• SDA 1a.7 Operational Research – To field test a rapid assessment tool to determine factors for treatment default in TB patients in Metro Manila as basis for the subsequent development of interventional strategies to reduce treatment default.

Objective 1b aims to increase the demand for DOTS services in the public and private DOTS facilities by removing barriers to access through social mobilization and social marketing for underserved populations (urban poor).In this proposal we will scale up social mobilization and social marketing activities to converge with PPMD activities in areas where these have already been installed.

- **SDA 1b.1. Health System Strengthening through:**
  - Capability building on community organization for 553 public health workers.
  - Capability building on DOTS for 2,010 members of community-based TB task forces.
  - Capability building for BCC for 1,156 public health workers and

community-based TB support group members.

- **SDA 1b.2. Behavioral Change Communications (BCC):** development and distribution of various BCC materials to increase community awareness on TB and promote available public and private DOTS services in 11 target populations and evaluate their impact on health seeking behavior in years 3 and 5.
- **SDA 1b.3. Coordination and Partnership Development** of at least 134 community-based TB support groups (TB Task Force) that will identify infectious cases and act as treatment partners.
- **SDA 1b.4. Monitoring and Evaluation** through regular visits of public health workers to organized community-based TB support groups (TB Task Forces) and annual assessment workshops to assess the contributions of the TB task forces and the functionality of the referral system between the TB Task Forces and DOTS facilities (public and private).
- **SDA 1b.5.** Identification of at least 8,767 infectious cases of TB through the referral of TB symptomatics by the TB Task Forces to DOTS facilities (public and private).
- **SDA 1b.6.** Caseholding of at least 6,137 infectious TB cases, including MDR-TB cases, through provision of DOT and default tracing by members of TB Task Forces.

Objective 2 aims to ensure access to quality DOTS services by the unreached and underserved populations through (a) scaling-up of PPMD with the installation of 70 public-initiated and 30 private-initiated PPMD units, (b) enhancement of the existing 116 PPMD units, (c) regular supervision and monitoring and (d) assurance of sustainability of all the 216 PPMD units beyond project life.

SDA 2.1: Health System Strengthening through human capacity building activities to ensure sustainability beyond project life.

SDA 2.2: Monitoring and Evaluation to ensure (a) observance of the installation process described in the Operational Guidelines for PPMD in the Philippines, (b) sustained provision of quality DOTS services in all PPMD units and (c) achievement of the desired targets and outcomes.

SDA 2.3: Health Infrastructure Development for PPMD Units through the PhilCAT – DOH DOTS Certification Standards and the PhilHealth Accreditation Requirements. Compliance to these two standards will ensure sustainability beyond project life.

SDA 2.4: Identification of Infectious Cases will be ensured through the provision of quality sputum microscopy services by trained medical technologists or microscopists to all TB suspects in the 100 new PPMD units and in the 116 existing PPMD units; at least 27,435 new sputum positive cases to be detected, of which 10,375 will be coming from the newly installed 100 PPMD units, over 5 years.

SDA 2.5: Timely Detection and Quality Treatment of Cases in all PPMD units.

SDA 2.6: Advocacy Initiatives by NCC – PPMD and RCC – PPMD to ensure multisectoral participation in DOTS/PPMD implementation.

Objective 3: To integrate DOTS-Plus in the existing DOTS infrastructure in Metro Manila and in at least one selected high MDR-TB prevalence area outside Metro-Manila for the treatment of 2,500 MDR-TB cases.

SDA 3.1. Health System Strengthening to enhance the absorptive capacity of the health sector to implement DOTS-Plus through:

- Human resource development at various levels of at least 77 health personnel for 8 DOTS-Plus treatment centers and 3,600 public health workers from referring DOTS units.

- Health infrastructure development for:
  - a laboratory network capable of providing quality assured DST in at least one central laboratory such as the National TB Reference Laboratory (NTRL) and quality assured cultures in at least 5 culture centers in the regional level previously developed for the drug resistance survey (DRS)
  - an infection-control-assured hospital facility in at least the Quezon Institute for DOTS-Plus
  - 8 infection-control-assured DOTS-Plus treatment centers.
- Enhanced procurement and supply management to provide a storage facility in a central warehouse for drugs and other health commodities to ensure uninterrupted supply of quality assured SLDs, drugs for adverse reaction, laboratory supplies and equipment, laboratory reagents and glassware, with rational distribution system
- Enhanced monitoring, supervision, and evaluation to provide:
  - at least monthly supervisory visits in each treatment center in the first year of operation, and reduced to quarterly visits after satisfactory performance and
  - an annual evaluation to assess impact.
- Strengthening operational research to undertake at least 5 studies, including treatment adherence, treatment delay, and others.
- Empowerment of at least 216 community workers including cured TB patients in Metro Manila and a selected area outside Metro Manila
- Community mobilization in 98 selected areas for peer support, DOT, and default tracing in line with Objective 1b.

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SDA 3.2. Diagnosis and Treatment of 2,500 MDR-TB patients from at least 6,000 cases screened through:

- Quality-assured culture and DST
- case holding through
  - DOT using quality-assured SLDs
  - provision of ancillary drugs for co-morbidity and drugs for adverse drug reaction
  - provision of psychosocial support through peer support groups and enablers
- provision of skills training and educational benefits to patients to improve their economic productivity in line with poverty alleviation
- household contact tracing for early diagnosis and treatment of MDR-TB.

SDA 3.3. Monitoring and Control of Drug Resistance through

- culture and DST of 850 DOTS failures with persistent smear positive sputum 5 months or more after initiating treatment.

- at least two drug resistance surveys (DRS) in an urban setting.

Objective 4: To establish and strengthen TB and HIV collaboration in an epidemiologic scenario where the TB prevalence is high and HIV burden is low.

SDA 4.1. Health Systems Strengthening through:

- The establishment of a cross referral system between the NTP and National AIDS Program (NAP)
- The creation of a TB/HIV committee to develop policies and guidelines relevant to TB/HIV

SDA 4.2. Surveillance of HIV in TB patients

- to estimate prevalence and trends over time by utilizing TB patients as one sentinel group in the HIV sentinel surveillance sites in collaboration with the AIDS Surveillance Education Project (ASEP) and the new GF sentinel sites
- unlinked anonymous HIV testing in archived blood samples from 2500 MDR-TB patients.

SDA 4.3. Improve the quality of life of people co-infected with TB-HIV/AIDS through:

- the cross-referral of cases in the HUB and in the community to the NTP for smear and culture for TB diagnosis and provision of DOTS in those with TB disease
- prevention of TB disease in HIV+ patients through INH treatment for latent TB infection
- develop mechanisms for VCT among TB patients at risk for HIV
- provide ARV treatment for TB patients with HIV

4.4.1.2 Describe how these goals and objectives are linked to the key problems and gaps arising from the description of the national context. Demonstrate clearly how the proposed goals fit within the overall (national) strategy and how the proposed objectives and service delivery areas relate to the goals and to each other.

The overall framework of the national TB program, which targets national coverage, detection of at least 70% of smear positive TB cases and the curing of at least 85% of those detected depends greatly on the existing health infrastructure network and services, and the availability of financial and technical resources. The current situation in the country, whereby gaps related to delivery and access to quality services is still great, is indicative of a triangulated situational problem of public awareness, service delivery and availability of facility/logistics that leads to a more serious existing problem of rising complications, resistance to drugs, increase of cases and out of hand situations because of untracked cases. Reduction of TB prevalence and mortality therefore requires a multi-angular approach to address all the identified problems at the same time frame. The objective of ensuring the delivery of quality DOTS implementation will take on enhancing capacities of implementers in delivering services. Considering the limited financial capacity of the country, the number of health staff will not change significantly over the next few years, but what the individual workforce can do and the formal structures within which they work can be modified and altered to meet new needs. A continuous process of development and training of human resources will address these changing demands in the health workforce. This however will have to be complemented through hiring and training of new staff, social mobilization and community participation to increase demand for DOTS services and strengthening the public health information system to support data management for planning and action. With improved information system, program planners and decision makers will be able to address issues of maldistribution of personnel and services more effectively.

A key problem and gap in the implementation of the NTP addressed by Objective 2 is low utilization of the DOTS strategy in the private sector. Despite earlier efforts to address this gap through various PPMD initiatives, there are still a significant number of private physicians who are not aware of the cost-effectiveness of the DOTS strategy. Moreover, infrastructure support for DOTS engagement of these physicians is also insufficient. Installation of 100 new PPMD units and the enhancement of the existing 116 units installed by several initiatives which include the 71 installed under GF Round 2 as proposed will result in the detection of additional 27,435 new smear (+) TB cases from referrals of private physicians over the five-year period increasing overall NTP case detection rate by 3.3% in Year 1, 4.9% in Year 2, 5.1% in Year 3, 5.0% in Year 4 and 5.1% in Year 5. Ensuring achievement of 85% treatment success rate among these patients through direct supervision of treatment, provision of free anti-TB drugs and regular monitoring will result in reduced TB mortality and prevention of multi-drug resistant TB.

The inclusion of DOTS-Plus (Objective 3) will address the gap in the NTP and will enhance DOTS. By enhancing laboratory services to include culture and DST, case finding will be improved. By providing quality DOTS and DOTS-Plus services, cure rate for all TB patients will increase. By DOTS enhancement the generation of new MDR-TB is prevented and by treating the existing MDR-TB cases hand-in-hand with DOTS, transmission of drug-resistance is diminished ensuring that the success in DOTS in the

NTP will be maintained for the new cases and improved in the previously treated cases.

The activities under Objective 4 will address this issue of TB and HIV coinfection. The identification of these activities was guided by the WHO interim policy and the Regional Framework for HIV-TB collaborative activities.

With all these areas covered successfully, detection and cure rates can reach the targets of 70% and 85% respectively, and subsequently lead to the reduction of TB prevalence and mortality.

[For health systems strengthening components only:]

4.4.1.3 Describe in detail how the proposed objectives and service delivery areas are linked to the fight against the three diseases. In order to demonstrate this link, applicants should relate proposed health systems interventions to disease specific goals and their impact indicators. To demonstrate the contribution of the proposed health systems strengthening intervention(s) in fighting the disease(s) include at least three disease relevant indicators with a baseline and annual targets over the life of the program. *[This may be done in form of an annex based on the format of table 4.4.b.]*

Clearly explain why the proposed health systems strengthening activities are necessary to improve coverage in the fight against the three diseases. *[When completing this section, applicants should refer to the Guidelines for Proposals, section III.B.&F.]*

4.4.1.4 Provide a description of the target groups, and their inclusion during planning, implementation and evaluation of the proposal. Describe the impact that the project will have on these group(s).

The following are the target groups of this proposal:
• TB cases: all TB cases including MDR-TB and coinfected TB/HIV, particularly in vulnerable groups with barriers to access of TB services will benefit from quality DOTS and DOTS-Plus services with improved cure rates, reduced mortality, reduced transmission of TB and increased economic productivity.
• Objective 1a - Health workers: health workers include TB program coordinators and hospital staff in regional, provincial and city levels and program implementers including DOTS physicians, nurses and medical technologists, midwives, barangay health workers, and NTP hospital staff in the public sector. The project will improve their knowledge, skills and ability to deliver quality DOTS services to all TB patients.
• Objective 1b – Community leaders and volunteers and TB symptomatics: Community leaders and volunteers will increase access to quality DOTS services and provide patient-centered TB services. TB patients will be the main recipient and are expected to benefit from improved health seeking behavior, less stigma and more patient-friendly DOT.
• Objective 2 – Referring private physicians: private practitioners tapped to collaborate and participate in the TB program. TB symptomatics will be the main recipient and are expected to benefit from better access to DOTS, resulting in reduced health seeking delay and better treatment of TB.
• Objective 3 - Community health workers: this includes rural health physicians, nurses, midwives, medical technologists, barangay health workers and empowered cured TB patients who will assume responsibility in continuing the treatment regimen of MDR-TB cases, leading to higher cure rates, reduced default and mortality and transmission of MDR-TB.
• Objective 4 - Program Managers, NGOs and TB-HIV patients: program managers include coordinators of NTP and NAP at the central and regional levels. NGOs involved in TB control and HIV prevention working in the local community will be involved. This will result in reduction of morbidity and mortality from these two diseases, destigmatizing HIV/AIDS.

4 Components Section

All target groups were given consideration in the development of this proposal by inviting TB patients to participate in a TWG meeting concerned with the development of the proposal. Individual and focus group discussions were done among people living with the disease, among the urban poor and among prisoners to identify barriers in accessing health services. The experiences in program implementation of the health workers (private and public sector), NGOs, community task force members and officers and referring private physicians as well as the patients who received treatment were determined during consultation meetings and workshops. The identified barriers and the suggested ways to counter them suggested in these consultations were addressed in this proposal. Evaluation and verification of the proposal content were done during the CCM meeting where there was a wide range of representation from and among partners.

4.4.1.5 Provide estimates of how many of those reached are women, how many are youth, how many are living in rural areas. The estimates must be based on a serious assessment of each objective.

Table 4.4.1.5 Objectives

	Estimated percentage of people reached who are:		
	women	Youth	Living in rural areas
Objective 1a and b	50%	20%	50%
Objective 2	50%	20%	20%
Objective 3	40%	10%	30%
Objective 4	40%	5%	30%

4.4.1.6 Provide a clear and detailed description of the activities that will be implemented within each service delivery area for each objective. This should provide reviewers with a clear understanding of what activities are proposed, how these will be implemented, and by whom.

Objective 1a: To enhance the quality of DOTS implementation in the public sector through improvement in service provision and increase in access to DOTS services.

SDA 1a.1 Health Systems Strengthening in the area of:
o Human resource and capacity building - includes the enhancement of the service providers in terms of their technical and managerial capacities to provide quality DOTS services at all times; conducted by central, NTRL, CHD, CHD TB Reference Laboratories, province/city NTP Coordinators.
Main Activities:

- Strengthen capacity of Physicians and Nurses through boosting course on TB program management (3days x 40 pax/batch x 85 batches in 5 years)
- Strengthen capacity of Midwives and selected BHWs through boosting course on TB program management (3days x 40 pax/batch with 85 batches in 5 years)
- Strengthen capacity of Medtechs/NTP Microscopists through boosting course on TB laboratory management (5days x 15 pax/batch x 85 batches in 5 years)
- Train 154 NTP public hospital coordinators representing 77 public hospitals on DOTS referral for Public-Public Mix DOTS implementation
- Train 102 NTP public hospital coordinators in 51 public hospitals on DOTS service provision for Public-Public Mix DOTS implementation
- Train 51 NTP public hospital laboratory staff on basic microscopy for Public-Public Mix DOTS implementation
- Orient other key government agencies working for the urban poor on Public-Public Mix DOTS implementation (2days x 40pax/batch in 3 batches)
- Expose NTP Coordinators on outside-the-country situations through international technical exchange (1batch/year at 10pax/batch x 5 years)
- Augment human resource capacity at central level
    - o Hiring of Monitoring and Evaluation Officer (1 Staff)

o Hiring of Training Coordinator (1 Staff)
o Hiring of finance/administrative assistant (1 Staff)

SDA 1a.1 Health Systems Strengthening in the area of:
o Health Infrastructure Development –Includes provision of equipment to enhance the training and advocacy functions of the central staff.
Main Activities:

- Improve office support of NTP central Staff
  Equipment for technical assistance/training
  (LCD Projector, Laptop, Projector Screen)
- Equipment for advocacy, communications and documentation
  (Digital camera, Tape Recorder – 1 unit each)
- Communications support for daily NTP operations
  (1phone or cellcard/central Staff/month)

SDA 1a.1 Health System Strengthening in the area of:
Monitoring and Evaluation – pertains to the monitoring and evaluation of DOTS implementation in prioritized sites to oversee and assess the quality of DOTS implementation. Monitoring visits will be jointly undertaken but with various frequencies. The peripheral levels (CHD, province and city) will monitor more often.
Main Activities:

- Conduct 12 joint Central/CHD/Provincial monitoring visits in low performing areas with their catchment public DOTS centers
- Conduct and support CHD/provincial routine monitoring on NTP implementation in 102 areas/year
- Conduct yearend national consultative evaluation workshop for NTP Managers (3days for central and CHD NTP managers with invited guests/observers)
- Conduct Yearend national consultative evaluation workshop for NTP Laboratory Managers (3days for central, NTRL and CHD NTP Laboratory managers with invited guests/observers)
- Follow-through of the 2007 3rd NPS for the urban poor population (Joint undertaking of DOH, PhilCAT, TDFI in support of the 3rd NPS)

SDA 1a.2 Partnership and Coordination Development – consists of developing coordination and strengthening partnerships amongst vital public agencies concerned with the urban poor through Public-Public Mix DOTS strategy. The initiating agency will be the DOH central office, in partnership with PhilCAT as the co-convenor of the Comprehensive Unified Policies on TB Control (CUP). Coordination with public hospitals will also be enhanced for more synchronized management of TB cases. This will be initiated by the central office of DOH, in-partnership with the DOH National Center on Health Facilities. At the peripheral levels, the CHD and province/city NTP Coordinators will spearhead the process.
Main Activities:

- Strengthen the service linkage between public health units and public hospitals through Public-Public Mix DOTS strategy (77 public hospitals trained as DOTS referral centers in 5 years)
- Strengthen the service linkage between public health units and public hospitals through Public-Public Mix DOTS strategy (51 public hospitals trained as DOTS service providers in 5 years)
- Conduct symposium on Public-Public Mix DOTS for the urban poor
- Strengthen coordination of C.U.P. members involve with the urban poor for Public-Public Mix DOTS implementation

SDA 1a.3 DOTS Certification and Accreditation - to ensure quality of DOTS services, DOTS facilities undergo self-assessment, apply for certification and, externally assessed by the CHD certifiers upon compliance with a set of quality standards. If certified, the facility can apply for accreditation, through PhilHealth; enabling them to avail of the OPD TB Benefit Package, a social financing scheme that the facility can use in sustaining DOTS implementation.
Main Activities:

- Conduct DOTS certification (5 DOTS facilities/CHD/year) – this activity was initiated by NTP in 2003 and currently, there are 118 certified DOTS facilities (public and PPMDs). This is the initial step to avail of the PhilHealth OPD TB Benefit Package.
- Recommend for PhilHealth accreditation of all certified DOTS facilities – this step allows the access to the PhilHealth Package. A DOTS facility can apply for accreditation after being certified. There are 52 accredited DOTS facilities at present.

SDA 1a.4 Data Management – The ETR is an innovation for the NTP that allows immediate access to quality NTP data necessary for monitoring and program analysis. Inclusion of PPMD and MDR-TB data facilitates better coverage of NTP information. This can support the coordinators to appropriately utilize relevant NTP data and for immediate feedback to concerned health workers. Quality data, timeliness, increase coverage and rapidity in the transfer of information are features of ETR.

Main Activities:

- Assign/Hire staff for the ETR implementation. These consist of a Data Manager and ETR Coordinator assigned to the National Epidemiology Center (NEC) and Data Entry Clerks assigned to the different ETR workstations.
- Train Central/Centers for Health Development/Provincial/City Staff on the use of ETR. In this activity, 459 staff working in all regions, provinces and cities will be trained on ETR application. Initial training will be a Regional User's Training on the Electronic TB Register.
- Equipment support to the provincial, city, Centers for Health Development (CHDs) and Central ((NEC) offices with appropriate hardware support**.** This includes software enhancement for local adoption of the BOTUSA ETR software provided by the Centers for Disease Control (CDC) and all the necessary hardware support for the ETR workstations.

SDA 1a.5 Identification and Treatment of Cases for specific groups– this covers 3 urban poor areas in Metro Manila. Partner government agencies will be engaged and will support case finding and case holding activities through their network of offices/outposts located within the urban poor areas.

Main Activities:

- Conduct case finding activities. This will be conducted in 3 urban poor areas with an average population of 10,000 per area. With this activity, it is estimated that 200 symptomatics will be referred to a DOTS center per area per year.
- Treatment of identified cases. Among the TB symptomatics referred to the 3 urban poor areas, about 30 TB cases per area per year will be detected and enrolled to a DOTS center.

SDA 1a.6 Control of Drug Resistance – To control failure rate among new smear positive cases

Main Activities:

- Regular recording and reporting of TB cases utilizing the regular TB information network.

SDA 1a.7 Operational Research – To field test a rapid assessment tool to determine factors for treatment default in TB patients in Metro Manila as basis for the subsequent development of interventional strategies to reduce treatment default.

Main Activity:

- Conduct a rapid survey in a sample of TB patients residing in Metro Manila to identify factors among defaulters and to identify interventions that will reduce treatment default.

Objective 1.b aims to increase the demand for DOTS services in the public and private DOTS facilities by removing barriers to access through social mobilization and social marketing for underserved populations (urban poor).

SDA 1.b.1. Health System Strengthening through capability building for public health

workers and organized community-based TB support groups

Main Activities:

- **Training on DOTS** for community-based TB support groups (TB Task Forces) to equip at least 15 members per TB Task Force on DOTS to be able to identify TB symptomatics and act as treatment partners. A total of 2,010 TB Task Force members would be trained within 5 years.
- **Training on Community Organizing** for public health workers At least 553 (from Years 1 to 4) municipal and city TB Coordinators would be certified trainers on community organizing and advocacy. They would serve as facilitators in the formation of community-based TB support groups (TB Task Forces)
- **Training on health education and counseling** to equip TB Task Force members and health care workers to effectively provide information on TB prevention and control by conducting community TB classes and utilizing various BCC materials. A total of 1,156 Task Force members and health care workers would be trained within 5 years.

SDA 1.b.2. Behavioral Change Communications (BCC): Development and distribution of various BCC materials to increase awareness of the 11 target population and evaluate its impact on years 3 and 5 in their health seeking behavior. A total of 1 radio infomercial, 1 billboard, 1 documentary video, 1 flipchart, 2 posters, 2 stickers, 2 brochures and 2 comics design would be developed and distributed.

Main Activities:

- **Conduct of FGD and informal interviews with TB patients and other stakeholders.**
- **Distribution of IEC materials to covered areas, key stakeholders, other public and private facilities, and selected private institutions.**
- **Evaluation researches on Year 3 and 5 to measure the impact of existing BCC interventions to the awareness on TB and health seeking behavior of the target population.**

SDA 1.b.3. Coordination and Partnership Development of at least 134 community-based TB support groups (Task Force) that will identify infectious TB cases and act as treatment partners.

Main Activities:

- Conduct of baseline surveys.
- Consultation and planning meetings with local government executives, public health center and PPMD unit staff
- Conduct of needs assessment and organizational capacity building activities

SDA 1.b.4. Monitoring and Evaluation through regular monitoring visits to organized community-based TB support groups (Task Force) and conduct of annual assessment workshops.

Main Activities:

- Joint monitoring visits by TB Coordinators and implementers at the national, regional and municipal/city levels would be conducted to organized community-based TB support groups (Task Force) to assess the case finding and DOT activities of the TB Task Forces and provide technical assistance to further develop their organizational capacities. At least 336 monitoring visits would be conducted from Years 1 to 5 (Year 1 – 22, Year 2 – 84, Year 3 – 48, Year 4 - 136, and Year 5 – 68 monitoring visits).

- Annual Assessment Workshops would be conducted to assess contributions of the TB Task Forces and the functionality of the referral system between the TB Task Forces and DOTS facilities (public and private)

SDA 1.b.5. Identification of at least 8,767 Infectious Cases of TB **through the referral of**

TB symptomatics by the TB Task Forces to DOTS facilites (public and private),

SDA 1.2.6. Case holding of at least 6,137 infectious TB cases**, including MDR-TB cases, through provision of DOT and default tracing by members of TB Task Forces.**

Main Activities:

- Identification of at least 87,667 TB symptomatics and at least 8,768 new sputum smear positive TB cases.TB Task Force members would be supervising the treatment of at least 6,137 new sputum smear positive TB cases.

Objective 2 aims to ensure access to quality DOTS services by the unreached and underserved populations through (a) scaling-up of PPMD with the installation of 70 public-initiated and 30 private-initiated PPMD units, (b) enhancement of the existing 116 PPMD units, (c) regular supervision and monitoring and (d) assurance of sustainability of all the 216 PPMD units beyond project life.

SDA 2.1: Health System Strengthening through human capacity building activities to ensure sustainability beyond project life through:

Main Activities:

- **Training on Business and Financial Planning** in Year 3 for the 432 PPMD personnel coming from the 216 PPMD units; 188 of the 432 PPMD personnel are from the private-initiated PPMD units.
- **Technical Exchange Activities (Study Tours)** for selected 50 PPMD personnel from the private sector over the project duration.

SDA 2.2: Monitoring and Evaluation to ensure (a) observance of the installation process described in the Operational Guidelines for PPMD in the Philippines, (b) sustained provision of quality DOTS services in all PPMD units and (c) achievement of the desired targets and outcomes through:

Main Activities:

- **Training on Monitoring and Evaluation** for the 20 newly hired national and regional M and E personnel in Year 1.
- **Central Monitoring** by NCC-PPMD on a quarterly basis in the first 3 years and twice yearly in the last 2 years.
- **Regional Monitoring** by RCC–PPMD together with the provincial or city NTP coordinators on a quarterly basis for the first 3 years and twice yearly in the last 2 years.
- **Annual Program Implementation Reviews (PIR)** by the 17 RCC–PPMD with the participation of the PPMD units, PhilCAT and DOH – IDO over 5 years.

SDA 2.3: Health Infrastructure Development for PPMD Units through the PhilCAT – DOH DOTS Certification Standards and the PhilHealth Accreditation Requirements. Compliance to these two standards will ensure sustainability beyond project life through:

Main Activities:

- **PPMD Personnel Augmentation** through the provision of a 3-year personnel support for the 30 private-initiated PPMD units; 30 PPMD Nurses and 30 PPMD Medical Technologists for the first 3 years only. These manpower will be supported and sustained in the last 2 years through claims coming from the PhilHealth Outpatient Anti-TB DOTS Benefit Package and counterpart financing from the private-initiated PPMD units
- **Provision of $500.00 per PPMD Unit** for facility improvement with counterpart financing from the LGU for the 70 public-initiated PPMD units and from the hospital

or clinic management for the 30 private-initiated PPMD units. Equipment support will also be provided to all PPMD units to be installed.

SDA 2.4: Identification of Infectious Cases will be ensured through the provision of quality sputum microscopy services by trained medical technologists or microscopists to all TB suspects in the 100 new PPMD units and in the 116 existing PPMD units; at least 27,435 new sputum positive cases to be detected, of which 10,375 will be coming from the newly installed 100 PPMD units, over 5 years through:

Main Activities:

- **5-Day Training on Basic Sputum Microscopy** for 64 Medical Technologists and Micrsocopists, 30 of which will be from the private sector.
- **Launching of 100 PPMD Units**, that will serve as new service delivery points for sputum microscopy; 50 will be launched each year for the first 2 years (35 public-initiated and 15 private-initiated yearly).
- **3-Day Retraining on Basic Sputum Microscopy for 116** Medical Technologists and Microscopists from the 116 existing PPMD units; 52 of which will come from the private sector.

SDA 2.5: Timely Detection and Quality Treatment of Cases in all PPMD units through:

Main Activities:

- **3-Day DOTS Providers Training** on the NTP policies and procedures for 130 Physicians and Nurses (60 from the private initiated PPMD units) of the 100 PPMD units to be installed.
- **Half-day Orientation for 1,000 DOTS Referring Physicians** on the NTP policies, PPMD and the PhilHealth Outpatient Anti-TB DOTS Benefit Package over 2 years.
- **1-Day Training Workshop** for 100 TB Diagnostic Committees over 2 years.
- **Launching of 100 PPMD Units**, that will serve as new service delivery points for DOTS; 50 will be launched each year for the first 2 years (35 public-initiated and 15 private-initiated yearly).
- **2- or 3-Day Retraining for 232 PPMD Physicians and Nurses (104 from the private-initiated PPMD units) in Year 2.**
- **Provision of Free Anti-TB Drugs, procured through GDF, to 63,101 TB cases (**including 27435 new sputum smear positive cases) **for the 216 PPMD units over 5 years.**

SDA 2.6: Advocacy Initiatives by NCC – PPMD and RCC – PPMD to ensure multisectoral participation in DOTS/PPMD implementation through:

Main Activities:

- **Conduct of 100 Advocacy Symposia** at the local level where PPMD units are to be installed to promote NTP – DOTS to key players in the public and private sectors for the commitment of private physicians' involvement in NTP over two years.
- **Annual Support to the National Lung Month Activities,** which are spearheaded by DOH – IDO and supported by PhilCAT. This is an institutionalized campaign for increasing society's awareness on TB and other lung diseases in all regions.
- **Support to the Annual PhilCAT Convention**, an event organized and led by PhilCAT to promote NTP – DOTS in the private sector and update the coalition members and partners on TB prevention and control through local and international participation.
- **Annual Support to the World TB Day Activities**, which are jointly organized by PhilCAT, DOH – IDO, WHO and other local and international partners.

Objective 3 aims to mainstream and accelerate the on-going DOTS-Plus services into

DOTS activities in 5 treatment centers in Metro Manila and selected high MDR-TB prevalence areas outside Metro-Manila by 2010. This will be done through the following activities:

SDA 3.1. Health systems strengthening
Main Activities:

- This will start with **human resource development.** A Training of Trainers and development of training modules will be accomplished in the first year. A critical mass of health workers will be trained in the first year to allow for new treatment sites to be developed. This training will continue for the next four years to ensure replacement of attrition and development of new staff as the number of treatment sites also increase. Training on monitoring and evaluation will continue during the project implementation to ensure effective program management.
- **Monitoring and evaluation (and supervision)** of the DOTS-Plus program through site visits to satellites, regular consilium meetings, DOTS-Plus Task Force meetings and incorporating the recording and reporting of DOTS-Plus in the National TB registry. External monitoring and evaluation of DOTS-Plus program by GLC will continue.
- **Drug resistance surveillance**: This includes drug resistance surveillance to measure the magnitude of MDR-TB burden and to track trends to measure the effectiveness of the program and for development of appropriate treatment regimen.
- **Health infrastructure development**: Treatment centers will be organized in existing health facilities within Metro Manila in the initial phase, then at least one treatment center outside MM. Prior to engaging a center on DOTS-Plus, good DOTS shall be ensured and enhanced if necessary. Health centers around the treatment centers will be engaged to deliver facility-based DOT. Treatment centers will be linked to a culture center which will do the baseline and sputum monitoring. This structure will be patterned after the existing arrangement at the MMC DOTS-Plus, and the satellites in LCP and the Bahay in QI. Communities will be mobilized to provide community-based DOT for MDR-TB patients.
- **Laboratory Capacity building** will also be done through development of a laboratory network to provide services for culture and DST. This will involve the culture centers in the various regions that have been developed for the DRS and the NTRL for quality assured DST. These culture centers and the NTRL should be quality assured by a supranational laboratory.
- **Procurement and supply management** of 2nd line anti-TB drugs through the GLC mechanism.

SDA 3.2. Diagnosis and treatment of confirmed MDR-TB patients through DOTS-Plus service delivery focusing on strategies to enhance adherence such as the provision of enablers in the form of food, transportation reimbursement, drugs and management of adverse drug reactions. Housing in the treatment centers for patients living in far distances from the DOTS-Plus sites will be provided on a case to case basis.

Objective 4 aims to decrease the burden of TB in people living with HIV/AIDS in an epidemiologic scenario where the TB prevalence is high and the HIV burden is low through:

SDA 4.1. Health Systems Strengthening aims to establish a cross referral system between the NTP and National AIDS Program (NAP) through the creation of a TB/HIV committee to develop policies and development of guidelines relevant to TB/HIV and development of mechanisms for identification of HIV among TB cases.

SDA 4.2. Surveillance of HIV in TB patients to determine prevalence and trends over time by utilizing the LQAS in DOTS facilities in selected sentinel surveillance sites in collaboration with the AIDS Surveillance Education Project (ASEP) and the new GF sentinel sites and unlinked and anonymous HIV testing in archived blood samples from MDR-TB patients.

SDA 4.3. Intensified case finding and treatment of TB in HIV/AIDS patients through the cross-referral of cases in the HUB and in the community to the NTP for smear and

culture for TB diagnosis and provision of DOTS in those with TB disease; prevention of TB disease in HIV+ patients through INH treatment for latent TB infection; develop mechanisms for VCT among high risk groups for HIV in TB patients.

4.4.1.7 Outline whether these are new interventions or existing interventions that are to be scaled up, and how they link to existing programs.

4.4.2 Describe how the activities initiated and/or expanded by this proposal will be sustained at the end of the Global Fund grant period.

As the overall structure evolves towards more local responsibility and with the emphasis on quality efforts, sustainability is ensured through community organization and patient empowerment. Patient empowerment means not only involving them in program implementation but also making them socio-economically productive members of the society. Training of trainers and community leaders, instead of merely training service deliverers will ensure continuous process of development even when the project ends. Building expertise among local health workers in treating and managing MDR-TB cases will ensure sustainability and mainstreaming of DOTS-Plus into DOTS implementation.

Social mobilization activities will pave way for enhancing the management capability and organizational skills of the community support groups (TB task forces). This will eventually train them to be independent in developing, managing and legitimizing their own organizations. Upon achieving such stability, they would be able to strengthen their link with the local government units enabling them to rally and raise their own funds in sustaining TB-related activities that have been initiated by this project. Furthermore, these organized task forces will be established in strategic areas. Their strategic location will facilitate easy transfer of skills and knowledge to neighboring villages thus, creating a ripple effect. The PhilHealth package (TB insurance scheme) of the government will also help in sustaining the efforts. PPMD activities will be sustained through the PhilHealth Outpatient TB Benefit Package where a reimbursement of about $75 for each eligible TB patient detected and treated under DOTS. This will go for the payment of the consultation fee of the physician, cost of diagnosis and maintenance of the PPMD operating cost. Provision of anti-TB drugs and monitoring will remain to be a commitment of the government. Financial returns is ensured through this package for DOTS implementing units which would enable the local health facilities to sustain their activities even when the project ends.

The DOH has a Medium Term Plan to meet the Millennium Development Goals which is supported by the GOP budget augmented by grants or loans from bilateral and multilateral developmental partners.

4.4.3 Describe gender inequities regarding program management and access to the services to be delivered and how this proposal will contribute to minimizing these gender inequities *(2 paragraphs)*.

In terms of the DOTS program which prioritizes smear positive over smear negative, females may be excluded from the provision of free medicines because of the socio-cultural inhibitions which make it more difficult for women to expel good quality sputum which is needed for proper diagnosis (Somma et al., 2004, WHO, 2002). Accordingly, the TB Diagnostic Committees (TBDC) is an appropriate mechanism to ensure that smear-negative patients receive quality diagnosis and treatment.

There are no studies to document gender inequities in the Philippines in terms of access to TB services. The National TB Program targets all cases of all ages regardless of gender. This proposal is designed to serve all cases in all possible areas where they can be served

through social mobilization and community participation. In most regions of the country, females are more health conscious than males, making them access health services more than males.

However, there are fewer females being treated for TB reflecting the demographic data of TB cases showing them to be 3 times less affected than males.

The efforts to make DOT more community-based may be of special benefit for patients with day-long jobs. This may be more relevant to men than women since especially among the urban poor, fully working men are more common than fully working women.

4.4.4 Describe how this proposal will contribute to reducing stigma and discrimination against people living with HIV/AIDS, tuberculosis and/or malaria, and other types of stigma and discrimination that facilitate the spread of these diseases *(1–2 paragraphs)*.

In the country, TB is commonly perceived as an incurable disease and a disease of poverty. This in part contributes to stigmatization and eventual discrimination of TB patients due to inadequacy in behavioral change communication. This proposal addresses the problem on TB stigma and discrimination through social marketing and social mobilization activities and BCC (cited under Objective 1b of this proposal). These activities will heighten awareness on TB among the general population which will eventually result in reducing TB stigma.

It is envisioned that in the near future, a TB champion who is a very important person in the government or in the civil society can come forward to be identified as having been cured of TB to de-stigmatize the disease. In addition with this de-stigmatization, cured TB patients can participate with community leaders and volunteers in identifying TB cases, serving as treatment partners and being advocates for TB treatment and management.

4.4.5 Describe how principles of equity will be ensured in the selection of patients to access services, particularly if the proposal includes services that will only reach a proportion of the population in need (e.g., some antiretroviral therapy programs) *(1–2 paragraphs).*

The plan of action of this proposal calls for ensuring delivery of free quality DOTS services for all TB patients, particularly the vulnerable and underserved population, following the international standard of care for TB (Objective 1a). As such, all health centers providing DOTS services will be provided refresher training courses, with emphasis on unprejudiced selection of TB cases as well as unbiased approach towards medical management of TB patients especially in ensuring complete treatment. Under objective 1b, social mobilization and community participation to increase demand for services will not only be limited to project sites because part of the strategy is to encourage community task forces to adopt other task forces in neighboring communities, which will create a ripple effect.

Scaling-up access to DOTS services, focusing on involving more private practitioners including traditional healers, pharmacists and private physicians will address the issue of equity through PPMD (objective 2). DOTS-Plus (objective 3) should be available for the management of all MDR-TB patients without bias to age, gender and socio-economic status. The TB/HIV collaboration aims to address co-infected patients for treatment of both TB and HIV/AIDS and measure trends of HIV among TB patients.

4.5 Program and financial management

[In this section, CCMs should describe their proposed implementation arrangements, including nominating Principal Recipient(s). See the Guidelines for Proposals; section V.B.3, for more

information. Where the applicant is a Regional Organization or a Non-CCM, the term 'Principal Recipient' should be read as implementing organization.]

4.5.1	Indicate whether implementation will be managed through a single Principal Recipient or multiple Principal Recipients.	☒ Single
		☐ Multiple

[Every component of your proposal can have one or several Principal Recipients. In Table 4.5.1 below, you must nominate the Principal Recipient(s).]

Table 4.5.1 – Implementation Responsibility

Responsibility for implementation			
Nominated Principal Recipient(s)	**Area of responsibility**	**Contact person**	**Address, telephone and fax numbers, e-mail address**
Tropical Disease Foundation	TB and HIV/AIDS Components	Thelma E. Tupasi, MD	TDF, Suite 2002 Medical Plaza, Amorsolo cor de la Rosa Sts., Makati City 1229 Philippines Tel: 632-8890489 Telefax: 632-8889044 tetupasi@yahoo.com

4.5.2 Describe the process by which the CCM, Sub-CCM or Regional CM nominated the Principal Recipient(s).

[Minutes of the CCM meeting at which the Principal Recipient(s) was/were nominated should be included as an annex to the proposal. If there are multiple Principal Recipients, questions 4.5.3 – 4.5.6 should be repeated for each one.] [Question not applicable to Non-CCM and regional Organization applications].

The Tropical Disease Foundation was nominated as PR for TB and HIV/AIDS components and the Pilipinas Shell Foundation Inc. was nominated as PR for the Malaria component. By election of the CCM members present, the TDF was elected as PR for TB and HIV/AIDS and Pilipinas Shell Foundation as PR for malaria. (see Annex 5 and 6).

4.5.3 Describe the relevant technical, managerial and financial capabilities for each nominated Principal Recipient.

[Please also discuss any anticipated shortcomings that these arrangements might have and how they will be addressed, please refer to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).]

Technical: The Tropical Disease Foundation (TDF), the PR, started TB work in the early 1990's with a laboratory performing TB diagnostic work such as culture and drug susceptibility testing. It then undertook the National TB Prevalence Survey (NTPS) in 1997 as commissioned by the Department of Health (DOH). In 1999, responding to the NTPS finding that there had been no significant change in the magnitude of the TB problem in the country, and that more patients consult private physicians, the TDF partnering with the Makati Medical Center (MMC), entered into a private-public collaboration with the DOH and the local government unit (Barangay San Lorenzo) to form the MMC DOTS Clinic which was the second private-public Mix DOTS (PPMD) unit in the Philippines. As capacity building of its DOTS staff, majority, if not all have undertaken the DOTS Training Course conducted by the NTP. Its laboratory staff likewise have participated in the NTP Basic Microscopy Training Course, with some who have attended advanced courses including Training on External Quality Assurance.

In 2000, the MMC DOTS Clinic was the first DOTS-Plus pilot project to be approved by the Green Light Committee (GLC) worldwide and has since been visited six times by the GLC for site monitoring and evaluation. The sixth GLC Site Visit Report is attached (Annex 10) which cited the impressive progress of the DOTS-Plus project since the last visit. Being one of the first five DOTS-Plus pilot projects, the MMC DOTS-Plus project has always been invited through its Program Director to attend the annual DOTS-Plus meetings. Moreover, the Program Director is a member of the Writing Committee of the DOTS-Plus Guidelines, and is currently the Chair of the DOTS-Plus Working Group in STOP TB. Staff of the DOTS-Plus project have undergone different forms of capacity building. The first training on DOTS-Plus was through a visit by an expert from Partners in Health implementing the Peru DOTS-Plus project where most of the basic principles of

DOTS-Plus were laid and are still being applied at present. A physician and nurse in the MMC clinic undertook a training course in DOTS-Plus in the State Agency for TB and Lung Disease in Riga, Latvia, now a WHO Collaborating Center. Another three staff in the DOTS-Plus project did an observation visit to Lima, Peru to gain insight in community-based DOTS-Plus. Recently, a staff was invited to participate in the First DOTS-Plus Consultants' Course in the WHO Collaborating Center in Latvia. At least two of its current laboratory staff have undergone extensive training in the Korea Institute of Tuberculosis (KIT), the supranational laboratory of the TDF Laboratory. Even prior to these bench trainings, the TDF laboratory has been visited several times by Dr. Sang Jae Kim, the former Director of the KIT, and by the current Director of the KIT, including one of his staff.

Managerial: The Philippine GF Program Director has managed the TDF as President of the Organization since it started as a science research agency in 1984, and has a Program Unit specifically for the GF project consisting of a team of TB program specialists handling the TB Component of Round 2 which recently received a grant rating of A and a board decision of "Go" for Phase 2. This team is composed of a TB Program Manager, a Deputy Program Manager, a TB Coordinator, who have been directly overseeing and supervising the implementation of the program according to GF requirements and in line with the existing NTP systems. A Program Assistant is in charge of filing and organizing the documents of the project. A Data Management Team composed of a Data Manager and a team of data encoders and programmers, a Human Resource (HR) Officer and an Information Technology (IT) Officer provide support in the overall management of program implementation.

Financial: The PR has an Administrative Unit which is composed of a Program Administrator, a Finance Officer and 2 Assistants, an Accounting Officer and 2 Assistants, a Procurement Officer and 2 assistants, and an Internal Auditor who have efficiently handled the fiscal aspect of GF Round 2.

4.5.4	Has the nominated Principal Recipient previously administered a Global Fund grant?	☒ Yes ☐ No

4.5.5 If yes, provide the total cost of the project and describe the performance of the nominated Principal Recipient in administering previous Global Fund grants *(1–2 paragraphs).*

The total cost of the:
TB project is US$ 11,438,064 of which amount disbursed is US$ 3,080,023.
Malaria project is US$ 11,829,545 of which amount disbursed is US$ 6,393,153.
HIV/AIDS is US$ 5,528,825 of which amount disbursed is US$ 1,745,114.
Total: US$ 28,796,434 of which amount disbursed is US$ 9,473,176.

The TDF has effectively functioned as the Principal Recipient for the GF Project in the Philippines. The initial Global Fund rating of TDF was: A2: Financial management systems, B1: Institutional and Programmatic, B1: Procurement and Supply Management, B2: Monitoring and Evaluation. The final grant rating was "A" with a Board decision of "Go" for Phase II.
In relation to the Phase II application for the TB project:

1. the CCM assessed the PR as A: Expected or exceeding expectations on disbursement to sub-recipients, in managing the grants, and in informing the CCM of its progress during implementation.
2. the LFA assessed the PR as having adequately disbursed to sub-recipients with respect to disbursements to sub-recipients, performed adequately in the management of the Phase 1 grant and that the phase 1 grant performance overall composite rating is B1: adequately met overall expectations.

4.5.6 Describe other relevant previous experience(s) that the nominated Principal Recipient has had:

[Please describe in broad terms the relevant programs, as well as their objectives, key implementation challenges and results (2–3 paragraphs).]

a) The TDF undertook the 1997 NTPS as authorized by the DOH. This survey was done 14 years after the first survey and served to reset the targets for the NTP in line with its findings. This survey garnered an Outstanding Operational Health Research Award given by the Philippine Council for Health Research Development (PCHRD).

b) The TDF initiated the private-public MMC DOTS clinic. A major challenge was the big and wide catchment area of the clinic. Patients came from all over Metro Manila to avail of this private sector services. This has been addressed through a referral network with other PPMDs and public DOTS health centers that are nearer to the patients' residence.

c) The MMC DOTS-Plus pilot project was the first approved GLC pilot project for MDR-TB in 2000. The major challenges at the beginning of implementation which have been resolved were the lack of support from partners to undertake the expensive and complex DOTS-Plus initiative, leading to lack of funds and lack of human resources to undertake the complicated strategy (prior to the GF). The geographical structure of the Philippines has always posed a challenge in the enrollment of patients to the centralized DOTS-Plus services of MMC, and in the same way, in the decentralization of services to the public health centers where DOTS is well-implemented. In response to this challenge, the TDF solicited funds from sources other than the GF for treatment centers to serve as satellites to the MMC DOTS-Plus clinic. The Philippine Amusement and Gaming Corporation (PAGCor) funded the renovation of a former Teachers' TB Pavilion while the Lung Center of the Philippines funded the building of another treatment center. In the GF proposal, budget for more human resource has been ensured. Data management was also a challenge but is now being addressed through collaboration with the Partners in Health using the Electronic Medical Record (EMR) of Peru.

d) The DOTS-Plus Economic Analysis was undertaken by WHO, Geneva partners led by Katherine Floyd with the MMC DOTS-Plus staff in 2002. This study meant to assess the feasibility, effectiveness, cost and cost-effectiveness of the DOTS-plus pilot project. Conclusions were: i) it is feasible to provide individualized treatment regimens including second-line drugs on an outpatient basis in a resource-poor setting (86% compliance with treatment); ii) DOTS-Plus can substantially improve treatment outcomes of MDR cases; iii) It is good value for money in relation to standard benchmarks for low and middle-income countries; and iv) efforts are needed to reduce patient and family costs (Annex 14) Need to insert the latest version of the Economic Analysis which is still with Katherine Floyd. .

e) The TDF is the third TB Research Unit (TBRU) of the NIH-funded clinical trial on TB Treatment Shortening with the Case Western Reserve University, Cleveland. The main challenge is patient recruitment considering the very strict inclusion criteria of the study. Currently, a two-way referral system has been established between TDF and the health centers of Makati City where patients identified in the public centers to be eligible for the study and for DOTS-Plus are referred to the MMC DOTS Clinic, and patients in the study are referred back to the health centers for treatment supervision, and defaulters in the Clinic are reported and located by the health centers.

f) It has partnered with the Mayo Clinic, Rochester, for its Contact Tracing Study among TB patients. Preliminary results showed that among 606 contacts, 83 (14%) were x-ray positive and among 14 patients who submitted sputum, 11 (79%) turned out to be bacillary TB (unpublished).

4.5.7 Describe the proposed management approach and explain the rationale behind the proposed arrangements.
[Outline management arrangements, roles and responsibilities between partners, the nominated Principal Recipient(s) and the CCM (2–3 paragraphs).]
The PR office shall be headed by the Program Director (PD). There shall be two divisions in the administrative organization of the PR: Program Management Division headed by the Program Managers (PMs) and a Financial Management Division headed by the Program Administrator (PA). A Management Team composed of the EA, PM, and the GA plus the officers of the TDF: Vice-president, Treasurer, and Secretary shall assist the PD. The Management Team shall assist through weekly meetings to assess the financial management of the program. The Internal Auditor shall report directly to the Program Director. A management information system under an IT Administrator shall provide support through regular updating and creation of computer programs that will be necessary for the PR to perform its tasks. To undertake the project, the two divisions shall have sections as follows: 1. Financial Management Division, under the Program Administrator has three sections. o The Finance Section responsible for funds management, funds accounting and reporting, and the disbursement of funds with a Finance Officer and an Accounting Officer o The Procurement and Supply Management Section, under the Procurement Officer: responsible for bulk procurement with the authorized procuring agency and in turn be responsible for ensuring quality and the best price for drugs and other supplies. It shall likewise be responsible for safeguarding the, warehousing and inventory of these supplies o The Logistics and Administrative Section under the Administrative Officer: responsible for hiring and monitoring of personnel. 2. The Program Management Division, under the Program Manager, shall be responsible for the day-to-day management of the field implementation of the Project. It has: The Data Management Section under the Data Manager shall provide support to the project implementation through services required in encoding and preparation of data and data analysis. The Monitoring and Evaluation Section, under the Program Coordinator shall take charge of periodic assessment of the program implementation through site visits with the program implementers and through External Evaluation Activities Relationships with Partners: A Technical Working Group (TWG) for each component shall assist the PR and provide the programmatic and scientific direction of the Program. The TWG shall be headed by the Director of the Infectious Disease Office (IDO). Included in the TWG for the TB component are the Partners who will be the implementers; National TB Control Program (NTP), Philippine Coalition against TB (PhilCAT), World Vision Development Foundation (WVDF), Tropical Disease Foundation (TDF), and IDO, the National TB Reference Laboratory (NTRL, RITM), Project Assistance to Control TB (PACT) represented by the WHO Adviser on TB, and a representative of the PR. a. Performance of tasks as Principal Recipient 1. Organization of meetings The PR shall recommend the conduct of meetings and their agenda to the CCM as necessary. Upon approval by the CCM to conduct the meeting, the CCM secretariat based in the IDO shall communicate with all the members of the CCM. The attendance of all the members shall be guaranteed by giving a written notification (with the meeting agenda) at least 2 weeks before the scheduled meeting and by constant follow-ups. The secretariat shall document and prepare the minutes of the meeting. All member organizations/agencies of the CCM shall be given a copy of the minutes. 2. Monitoring and Evaluation of program implementation Assisted by the sub-recipients, the PR shall be responsible for the monitoring and evaluation of the implementation of the program through site visit verifications and collation of implementers performance quarterly report on accomplishment of targets based on indicators identified according to the workplans. The findings from the sub-recipients' monitoring and evaluation shall be the bases for the PR's overall monitoring

and evaluation report to be submitted to the CCM for approval as a pre-requisite to the submission to the CCM
3. Management of GF funds
1. Receiving and disbursing of GF Funds:
All funds received from the GF shall be officially receipted by the TDF as the PR and shall be deposited in a separate bank account under the account name of the TDF for proper accounting and control.
Project funds shall be disbursed to the sub-recipients as cash advance based on the approved Memorandum of Agreement (MOA) entered into by the PR and the sub-recipients detailing the purpose of the agreement, the responsibilities of both parties, period covered, budgetary requirement and others.
2. Submission of financial reports
Monthly liquidation of funds must be submitted to the PR based on a Technical Agreement summarizing the disbursements for the period and the cumulative disbursements as of the end of the period. Request for cash replenishment must be results-based.
3. Overseeing and managing proposed procurements
All purchases of supplies, pharmaceutical or non-pharmaceutical, should be done in bulk to ensure lower cost using the approved procuring agent, which will be responsible for quality assurance of the purchased pharmaceutical supplies needed by the project. A Procurement and Supply Management System has been submitted and approved by the GF through the LFA. For this project, the supply and management office of the Western Pacific Regional Office of the WHO shall assist in the procurement utilizing their pre-qualified and accredited procuring agents through the reimbursable scheme for the Philippines. Pharmaceutical commodities shall be procured through the Global Drug Facility (GDF) or the International Dispensary Association (IDA) as appropriate.
4. Safekeeping of records and necessary data for audit
All documents and records on financial transactions for GF funds shall be kept intact in the Corporate Finance of the PR and shall be made available for audit upon request of the LFA.
4. Establishment and implementation of monitoring and evaluation systems.
The PR shall ensure that all activities approved for implementation shall be done according to the approved terms of reference. Monitoring and evaluation of progress of the implementers shall be the responsibility of the component TWG. The PR shall make field visits to the project sites for reports verification, in coordination with the NTP and partners.
An External Review Team composed of consultants with expertise on the specific disease component of the program from international and national development partners shall be organized to evaluate the project implementation on a yearly basis.
6. Preparation of Reports
In order to obtain adequate data/information on process/performance reports to the CCM and GF, the program implementers in each of the program components shall meet monthly with their respective TWG and Sub Recipient to prepare monthly reports by SR including programmatic activities and expenses as basis for disbursement by the PR. Each program component sub-recipient shall submit quarterly activity reports and to its respective TWG. The CCM shall meet twice in a quarter to review the progress of the program implementation based on the indicators/milestones agreed upon in the work plans prior at the start of implementation. The PR's report to the CCM shall be based on data obtained through TWGs' meeting.
The PR shall submit/present quarterly reports to the CCM and GF through the LFA on the financial and programmatic activity and progress reports of the respective components.

4.5.8	Are sub-recipients expected to play a role in the program?	☐ Yes ➔ go to.5.9 ☒ No ➔ go to 4.6

4.5.9 How many sub-recipients will be, or are expected to be, involved in the implementation?	☐ 1-5
	☐ 6-20
	☐ 21 – 50
	☐ more then 50

4.5.10 Have the sub-recipients already been identified?	☐ Yes ➔ go to 4.5.11 - 4.5.13
	☐ No ➔ go to 4.5.14 & 4.5.15

4.5.11 Describe the process by which sub-recipients were selected and the criteria that were applied in the selection process (e.g., open bid, restricted tender, etc.); *(2–3 paragraphs).*

4.5.12 Where sub-recipients applied to the CCM, but were not selected, provide the name and type of all organizations not selected, the proposed budget amount and reasons for non-selection in an annex to the proposal *(1–2 paragraphs)*.

4.5.13 Describe the relevant technical, managerial and financial capabilities of the sub-recipients.

[Describe anticipated shortcomings or challenges faced by sub-recipients and how they will be addressed (e.g., capacity-building, staffing and training requirements, etc.).]

4.5.14 Describe why sub-recipients were not selected prior to submission of the proposal.

4.5.15 Describe the process that will be used to select sub-recipients if the proposal is approved, including the criteria that will be applied in the selection process *(1–2 paragraphs).*

4.6 Monitoring and Evaluation (M&E)

[The Global Fund encourages the development of nationally owned monitoring and evaluation plans and M&E systems, and the use of these systems to report on grant program results. By answering the questions below, applicants should clarify how and in what way monitoring the implementation of the grant relates to existing data-collection efforts].

4.6.1	Describe how this proposal and its Monitoring and Evaluation plan complements or contributes towards existing efforts (including existing Global Fund programs) to strengthen the national Monitoring & Evaluation plan and/or relevant health information systems.

The Field Health Services Information System (FHSIS) is the system that provides the Department of Health (DOH) with field-based surveillance and program management information on selected public health programs. Operational since 1989, it provides the basic surveillance and service data needed to monitor disease morbidity and disease intervention activities in each of the programs on a routine basis (weekly, monthly, quarterly or annually). The FHSIS remains the only information system in the whole government machinery that is in place down to the barangay level. The system is being managed by the National Epidemiology Center, which is also the unit tasked to coordinate the M&E of the Global Fund Project.

Currently, the TB project under the GF uses various monitoring tools to keep track of the project accomplishments. NTP uses an excel-based report to monitor the progress of TB cases under treatment. Other partners/implementers also use other tools such as the Electronic TB Registry, a system developed by CDC for the BOTUSA project. DOTS-Plus project implementers also use another system, EMR, developed in collaboration with Partners in Health (PIH) through assistance provided by CDC/USAID. What this proposal covers is the integration of the existing M&E tools of the project with the information system of the national government. The GF proposal would, if approved, serve as the entry point for enhancing the national information system.

According to the proposed M&E plan, each project implementer will still do own monitoring activities to keep track of the project progress. Project implementers will focus on process evaluation. To complement this effort NEC will focus on outcome and impact evaluation. All data gathered during these M&E activities will be submitted to NEC for collation and data processing, which will eventually be shared with other partners during formal and informal meetings. This would ensure that all data obtained by the project implementers are being incorporated into the national system and will then be used for decision making.

For the GF project implementation the PR is responsible for regular monitoring of program implementation through field visits and collation and validation/verification of reports of sub-recipients.

External evaluation which is the responsibility of the PR shall be requested from technical partners such as the WHO that are partners knowledgeable about the project implementation to be conducted on an annual or bi-annual basis.

4.7 Procurement and Supply Management

[*In this section, applicants should describe the management structure and systems currently in place for the procurement and supply management (PSM) of drugs and health products in the country]. [When completing this section, applicants should refer to the Guidelines for Proposals, section V.B.5.]*

4.7.1	Briefly describe the organizational structure of the unit currently responsible for procurement and supply management of drugs and health products. Further indicate how it coordinates its activities with other entities such as National Drug Regulatory Authority (or quality assurance department), Ministry of Finance, Ministry of Health, distributors, etc.

Procurement of drugs and other medical commodities and equipment is centralized in the Principal Recipient. A department in the PR organization, the Procurement & Supply Department is dedicated in carrying out procurement functions. The Department has the

necessary systems and full manpower compliment to carry out its functions.

All procurement of imported drugs and commodities are done through WHO. WHO handles competitive bidding, quality assurance and securing tax-free clearance from the Finance Department. Importation of drugs is cleared with the Bureau of Drugs and Food Administration (BFAD).

Procurement plan development

The PR is responsible for procurement of drugs and commodities. It obtains product quantification and specifications for health-related products from the implementers. The timing for procurement and arrival of goods shall be considered in the work plan so that these will coincide with timely implementation of the activities.

Procurement systems

All purchases must be within the budgetary allocation. Once a need for a commodity has been identified, the Procurement Officer accomplishes a requisition form and forwards it to the Finance Officer to ascertain consistency with the procurement budgetary plan. An official pre-numbered purchase order form is accomplished and approved by the Program Administrator before ordering can be done. The procurement is done through the WHO-WPRO endorsed by the Bureau of International Health Cooperation utilizing the Reimbursable Procurement Scheme. All procurement for second-line anti-TB drugs are coursed through the WHO Procurement Office in WHO Headquarters and the GLC which negotiates with the IDA. For locally procured items, a canvass form at least three different suppliers is done by the Procurement Officer. The supplier with the lowest bid and offers the product with the correct specifications and of acceptable quality is chosen. For purchases exceeding Php 1,000,000, an invitation for bids is published in a local newspaper.

Quality assurance and quality control

All pharmaceutical commodities (second-line anti-TB drugs) are provided with quality assurance from the suppliers obtained through the procuring agent, the International Dispensary Association. Expiration date monitoring is done regularly by implementing the First-In-First-Out Policy to avoid drug wastage. The drug storage room is equipped with a thermo hygrometer scale which is checked by the warehouse custodian on a daily basis to ensure proper temperature and humidity control. Any spike in the temperature reading is immediately reported by the custodian to the service technician of the air conditioning unit.

National laws and international agreements

Procurement through the WHO WPRO is done to allow the waiver of taxes on duties on health-related commodities and exemptions of taxes and duties on local purchases is coursed if possible through WHO to obviate taxes and customs duties.

Distribution and inventory management

Distribution system for second-line anti-TB drugs is under the supervision of the PR. Stocks for distribution are withdrawn from the warehouse by the clinic pharmacist through the Warehouse Custodian. All commodities issued are checked for their correctness, quantity, expiration date and physical characteristics. The balance sheet is updated during every transaction. The inventory management is according to the existing procedures in place at the DOTS-Plus pilot project at the Makati Medical Center utilizing balance sheets to monitor stock movements.

4.7.2 Procurement Capacity

a) Will procurement and supply management of drugs and health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient or will sub-recipients also conduct procurement and supply management of these products?

- ☒ Principal Recipient only
- ☐ Sub-recipients only
- ☐ Both

b) For each organization involved in procurement, please provide the latest available annual data (in Euro/US$) of procurement of drugs and related medical supplies by that agency

PR procurement for Phase I of Round 2 GF are as follows:

Second-line anti-TB drugs	US$	451,582
Anti-malaria drugs and commodities	US$	1,994,500
Anti-HIV/STI drugs and commodities	US$	323,723
TOTAL	US$	2,769,805

4.7.3 Coordination

a) For the organizations involved in section 4.7.2.b, indicate in percentage terms, relative to total value, the various sources of funding for procurement, such as national programs, multilateral and bilateral donors, etc.

All drugs and commodities were procured utilizing GF resources.

b) Specify participation in any donation programs through which drugs or health products are currently being supplied (or have been applied for), including the Global Drug Facility for TB drugs and drug-donation programs of pharmaceutical companies, multilateral agencies and NGOs, relevant to this proposal *(1 paragraph)*.

4.7.4 Supply Management (Storage and Distribution)	
a) Has an organization already been nominated to provide the supply management function for this grant?	☐ Yes ➔ continue ☒ No ➔ go to 4.7.5
b) Indicate, which types of organizations will be involved in the supply management of drugs and health products. *[If more than one of these is ticked, describe the relationships between these entities (1 paragraph)]* ☐ National medical stores or equivalent ☐ Sub-contracted national organization(s) (specify which one[s]) ☐ Sub-contracted international organization(s) (specify which one[s]) ☐ Other (specify)	
c) Describe the organizations' current storage capacity for drugs and health products and indicate how the increased requirements will be managed.	
d) Describe the organizations' current distribution capacity for drugs and health products and indicate how the increased coverage will be managed. In addition, provide an indicative estimate of the percentage of the country and/or population covered in this proposal.	

[For tuberculosis and HIV/AIDS components only:]

4.7.5 Does the proposal request funding for the treatment of multi-drug-resistant TB?	☒ Yes ☐ No

[If yes, applicants should be aware that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Proposals must therefore indicate whether a successful application to the Committee has already been made. If not, a Green Light Committee application form must be completed and included with this proposal (see AnnexB).]

4.8 Technical Assistance and Capacity-Building

[Technical assistance and capacity-building can be requested for all stages of the program cycle, from the time of approval onwards, including Technical Review Panel Clarifications, development of M&E or Procurement Plans, etc.]

4.8.1 Describe capacity constraints that will be faced in implementing this proposal and the strategies that are planned to address these constraints. This description should outline the current gaps as well as the strategies that will be used to overcome these to further develop national capacity, capacity of principal recipients and sub-recipients, as well as any target group. Please ensure that these activities are included in the detailed budget.
There is a need to develop a computerized health information system within DOH at the National Epidemiology Center to facilitate collection of data for the Field Health Service Information System (FHSIS) to generate timely reports at the central level and provide feedback to the regional and local levels. The existing Health Information System does not provide timely data to address in full the needs of the NTP for program management and monitoring and evaluation. The monitoring and evaluation needs of the GF in TB as well as in the two other disease entities can be the entry point in enhancing the capacity

of the FHSIS of the Department of Health.

The electronic TB registry (ETR) developed by CDC has been made available to developing countries in Africa where it is now being used in five countries with very limited resources and low level of IT expertise. The CDC is offering the ETR for use in the Philippines. To be able to use the ETR, capacity building through facility development and office improvement with the installation of equipment and other hardware support down to the provincial level is essential. In addition, manpower development is necessary to implement the ETR. The adoption of the ETR builds upon the existing paper based TB reporting and recording system which is now in place at the most peripheral level. Patient based recording up to the level of the province for transmittal to the regional and national levels has to be devised to make it possible for data analysis at the central/regional levels to be disaggregated into gender, age, and other strata.

Because DOTS-Plus is a relatively new intervention, capacity is needed from experts and from experienced DOTS-Plus pilot project implementers all over the world. Indicators needed for the monitoring and evaluation of DOTS-Plus should ideally be agreed upon by the DOTS-Plus pilot projects and technical advisers. Training on what and how these indicators will be used by the sites should also be arranged such as to come up with a common set of terms and definitions.

Expanding the human resource capacity for DOTS-Plus is a challenge, mostly due to the fact that the great majority of health professionals is seeking to work abroad. To counter this, it is necessary to train non-health professionals and non-professionals with good interpersonal skills for responsibilities of TB care such as DOT, health education, defaulter tracing, and emotional support for patients.

5 Budget Section

[Please note that this section is to be completed for each component. Throughout, 'year' refers to the year of proposal implementation. For example, if Table 4.1.1 indicates that the proposal starts in June, year 1 would cover the period from June to the following May.

Financial information can be provided either in Euro or US$, but must be consistent throughout the proposal. Please clearly state denomination of currency.]

All budget breakdowns requested in the following sections are to be provided as an attachment to the hard and soft (electronic) copies of the proposal form.

5.1 Component Budget

[The budget should be broken down by year and budget category. The budget categories and allowable expenses within each category are defined in detail in the Guidelines for Proposal, section V.B.7. Costs that do not fall within the above-mentioned categories can be allocated under 'other' but must be specified. The total requested for each year, and for the program as a whole, must be consistent with the totals provided in sections 5.1.]

Table 5.1 – Funds Requested from the Global Fund in EURO

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Human resources	576,794	781,748	1,120,448	1,158,671	1,144,828	4,782,489
Infrastructure and equipment	376,840	368,800	185,636	176,740	70,563	1,178,579
Training	1,260,268	1,649,858	1,670,284	1,339,293	789,404	6,709,107
Commodities and products	332,439	661,119	1,311,061	1,616,750	1,090,475	5,011,844
Drugs	668,041	1,316,663	2,603,822	3,148,905	1,998,280	9,735,711
Planning and administration	906,708	1,188,577	1,298,282	1,380,979	1,140,342	5,914,888
Other (please specify):	621,590	999,989	1,106,421	881,305	816,191	4,425,496
Total funds requested from the Global Fund	4,742,680	6,966,754	9,295,954	9,702,643	7,050,083	37,758,114

The component budget must be accompanied by a detailed year 1 and indicative year 2 workplan and budget. This should reflect the main headings used in section 4.4. (component strategy) and should meet the following criteria, (Annexes 15-19 for detailed budget):

a) It should be structured along the same lines as the component strategy—i.e., reflect the same goals, objectives, service delivery areas and activities.
b) It should be detailed for year 1 and indicative for year 2, stating all key assumptions, including those relating to units and unit costs, and should be consistent with the assumptions and explanations included in section 5.2.
c) It should provide more summarized information and assumptions for the balance of the proposal period (year 3 through to conclusion of proposal term).
d) It should be integrated with a detailed workplan for year 1 and an indicative workplan for year 2.
e) It should be fully consistent with the summary budgets provided elsewhere in the proposal, including those in this section 5.

5.1.1 Breakdown by Functional Areas

[Provide the budgets for each of the following three functional areas—monitoring and evaluation; procurement and supply management; and technical assistance. In each case, these costs should already be included in Table 5.1. Therefore, the tables below should be subsets of the budget in Table 5.1., rather than being additional to it. For example, the costs for monitoring and evaluation

may be included within some of the line items in Table 5.1 above (e.g., human resources, infrastructure and equipment, training, etc.).]

Monitoring and evaluation:

[This includes: data collection, analysis, travel, field supervision visits, systems and software, consultant and human resources costs and any other costs associated with monitoring and evaluation.]

Table 5.1.1a – Costs for Monitoring and Evaluation in EURO

	Funds requested from the Global Fund for monitoring and evaluation					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Monitoring and evaluation	518,599	723,688	1,043,027	859,136	777,935	3,922,385

Procurement and supply management:

[This includes: consultant and human resources costs (including any technical assistance required for the development of the Procurement and Supply Management Plan), warehouse and office facilities, transportation and other logistics requirements, legal expertise, costs for quality assurance (including laboratory testing of samples), and any other costs associated with acquiring sufficient health products of assured quality, procured at the lowest price and in accordance with national laws and international agreements to the end user in a reliable and timely fashion; do not include drug costs.]

Table 5.1.1b – Costs for Procurement and Supply Management in EURO

	Funds requested from the Global Fund for procurement and supply management					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Procurement & supply management	43,843	87,759	177,590	215,745	135,001	659,938

Technical assistance:

[This includes: costs of consultant and other human resources that provide technical assistance on any part of the proposal—from the development of initial plans, through the course of implementation. This should include technical assistance costs related to planning, technical aspects of implementation, management, monitoring and evaluation and procurement and supply management.]

Table 5.1.1.c – Costs for Technical Assistance in EURO

	Funds requested from the Global Fund for Technical assistance					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Technical assistance	119,675	145,578	244,798	276,415	270,217	1056683

5 Budget Section

5.1.2 Breakdown by Service Delivery Area

[Please estimate the percentage allocation of the annual budget over service delivery areas. The objectives and service delivery areas listed should resemble, as closely as possible, those in Table 4.4b.]

Table 5.1.2: Estimated Budget Allocation by Service Delivery Area and Objective.

		Year 1	Year 2	Year 3	Year 4	Year 5	Total
Value per year							
Objectives	**Service delivery area**	**Estimated percentage of budget**					
Objective 1A	**Service delivery area 1**	8%	9%	5%	4%	6%	6%
	Service delivery area 2	0%	0%	0%	0%	0%	0%
	Service delivery area 3	0%	0%	0%	0%	0%	0%
	Service delivery area 4	3%	3%	9%	9%	4%	6%
	Service delivery area 5	0%	0%	0%	0%	0%	0%
	Service delivery area 6	0%	0%	0%	0%	0%	0%
	Service delivery area 7	1%	0%	0%	0%	0%	0%
Objective 1B	**Service delivery area 1**	2%	2%	2%	2%	1%	2%
	Service delivery area 2	1%	1%	1%	1%	1%	1%
	Service delivery area 3	3%	3%	3%	2%	2%	2%
	Service delivery area 4	2%	1%	1%	1%	1%	1%
	Service delivery area 5	2%	1%	1%	1%	1%	1%
	Service delivery area 6	4%	3%	2%	1%	1%	2%
Objective 2	**Service delivery area 1**	6%	5%	5%	3%	5%	5%
	Service delivery area 2	5%	5%	4%	4%	6%	5%
	Service delivery area 3	5%	4%	3%	3%	4%	4%
	Service delivery area 4	3%	5%	0%	0%	0%	1%
	Service delivery area 5	12%	10%	4%	4%	5%	6%
	Service delivery area 6	2%	2%	1%	1%	2%	1%
Objective 3	**Service delivery area 1**	2%	2%	1%	1%	1%	1%
	Service delivery area 2	1%	0%	3%	0%	0%	1%
	Service delivery area 3	7%	7%	4%	5%	7%	6%
	Service delivery area 4	0%	0%	0%	0%	0%	0%
	Service delivery area 5	0%	0%	0%	0%	0%	0%
	Service delivery area 6	18%	25%	40%	47%	40%	36%
Objective 4	**Service delivery area 1-3**	1%	1%	1%	2%	2%	1%

Program Management & Adm		10%	10%	10%	10%	10%	10%
Total:		100%	100%	100%	100%	100%	100 %

5.1.3 Breakdown by Partner Allocations

[Indicate in Table 5.1.3 below how the requested resources in Table 5.1 will, in percentage terms, be allocated among the following categories of implementing entities.]

Table 5.1.3 – Partner Allocations

	Fund allocation to implementing partners (in percentages)				
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
Academic/educational sector	**0%**	**0%**	**0%**	**0%**	**0%**
Government	**53%**	**56%**	**67%**	**70%**	**66%**
Nongovernmental/ community-based org.	**0%**	**0%**	**0%**	**0%**	**0%**
Organizations representing people living with HIV/AIDS, tuberculosis and/or malaria	**33%**	**31%**	**18%**	**15%**	**22%**
Private sector	**0%**	**0%**	**0%**	**0%**	**0%**
Religious/faith-based organizations	**0%**	**0%**	**0%**	**0%**	**0%**
Multi-/bilateral development partners	**14%**	**13%**	**15%**	**14%**	**12%**
Others (Government)	**0%**	**0%**	**0%**	**0%**	**0%**
Total	100%	100%	100%	100%	100%

5 Budget Section

Key Budget Assumptions for requests from The Global Fund
Without limiting the information required under section 5.1, please indicate budget assumptions for year 1and year 2 in relation to the following:

5.1.4 Drugs, commodities and products

[Unit costs and volumes must be fully consistent with the detailed budget. If prices from sources other than those specified below are used, a rationale must be included.]

a) Provide a list of anti-retroviral (ARVs), anti-tuberculosis and anti-malarial drugs to be used in the proposed program, together with average cost per person per year or average cost per treatment course. *(Annex 20)*.

b) Provide the total cost of drugs by therapeutic category for all other drugs to be used in the program. It is not necessary to itemize each product in the category. (Annex 21).

c) Provide a list of commodities and products by main categories e.g., bed nets, condoms, diagnostics, hospital and medical supplies, medical equipment. Include total costs, where appropriate unit costs. *(Annex 22).*

(For example: *Sources and Prices of Selected Drugs and Diagnostics for People Living with HIV/AIDS.* Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, June 2003, (http://www.who.int/medicines/organization/par/ipc/sources-prices.pdf); Market News Service, *Pharmaceutical Starting Materials and Essential Drugs*, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); *International Drug Price Indicator Guide on Finished Products of Essential Drugs,* Management Sciences for Health in Collaboration with WHO (published annually) (http://www.msh.org*); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (*http://www.stoptb.org/GDF/drugsupply/drugs.available.html*).)*

5.1.5 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first two years, to what extent human resources spending will strengthen health systems' capacity at the patient/target population level, and how these salaries will be sustained after the proposal period is over *(1–2 paragraphs). (Annex 23).*

Manpower augmentation is essential for the implementation of the TB component at this phase of the TB epidemic. GF supports the salaries during the project term and it is envisioned that the DOH and the LGUs will sustain the support beyond project life. Manpower for the Electronic TB Register implementation will be hired only for one year mainly to set up the capacity of the work station. PPMD manpower will be sustained through the DOTS PhilHealth outpatient package for TB. In addition, the Philippine President said more investments will be poured into job creation, expanded educational opportunities and better health care for all Filipinos since "all these are at the core of our 10-point agenda."
The MDR-TB burden at this time will need substantial increase in manpower. However, as quality DOTS is implemented, the generation of MDR-TB will be minimized and with the treatment of infectious MDR-TB with DOTS plus is undertaken, transmission will be halted, diminishing the burden of MDR-TB so that in the future, the manpower from new treatment sites may proportionately decrease to a level that will be absorbable within the resources of government. In addition, some of the DOTS-Plus manpower will be community partners and will need minimal support; however,

5.1.6 Other key expenditure items

Explain how other expenditure categories (e.g., infrastructure, equipment), which form an important share of the budget, have been budgeted for the first two years *(1–2 paragraphs).(Annex 24).*

Minimal infrastructure cost for the TB component is intended for the establishment of treatment sites for DOTS-Plus as they will be implemented in existing DOTS units and the existing laboratory network that the Department of Health has established will be strengthened to support the program.

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