The Global Fund to Fight AIDS, Tuberculosis and Malaria

Geneva, July 2002

For the use of the Global Fund Secretariat:
Date Received:
ID No:

PROPOSAL FORM

Before starting to fill out this proposal form, please read the *Guidelines for Proposals* carefully*.* When completing each question in the proposal form, please note the reference given to the corresponding section of the guidelines.

<u>This form is divided into 4 main parts</u>:

SECTION I is an executive summary of the proposal and *should be filled out only AFTER the rest of the form has been completed*.

SECTION II asks for information on the applicant.

SECTION III seeks summary information on the country setting.

SECTIONS IV to VIII seek details on the content of the proposal by different components.

<u>How to use this form</u>:

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

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

3. **All answers, unless specified otherwise, should be provided in the form**. If submitting additional pages, please mark clearly on the pages which section and numbered question this relates to.

4. To avoid duplication of efforts, we urge you to **make maximum use of existing information** (e.g., from programme documents written for other donors/funding agencies).

5. When **using tables**, all cells are automatically expanded as you write in them. Should you wish to **add a new row**, place the cursor on the outside of the cell at the bottom right-hand corner of the table and press ENTER.

   To copy tables, select all cells in the table and press CTRL+C. Place cursor where you would like the new table to begin and press CTRL+V.

   Please DO NOT fill in shaded cells.

SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund.

TO BE COMPLETED AFTER THE OTHER SECTIONS HAVE BEEN FILLED OUT

General information: *Table I.a*

Proposal title (Title should reflect scope of proposal)**:**	Accelerating the Response to HIV/AIDS, Tuberculosis and Malaria in the Philippines			
Country or region covered:	The Philippines			
Name of applicant:	The Country Coordinating Mechanism (CCM) of the Philippines			
Constituencies represented in CCM (write the number of members from each Category)**:**	**1**	**Government – Health ministry**	**2**	**UN/Multilateral agency**
	7	**Government – Other ministries**	**3**	**Bilateral agency**
	2	**NGO/Community-based organizations**	**1**	**Academic/Educational Organizations**
	4	**Private Sector**		**Religious/Faith groups**
	1	**People living with HIV/TB/Malaria***	**3**	**Other** (please specify): Public-Private Collaborations
If the proposal is NOT submitted through a CCM, briefly state why:				

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund:** *Table I.b*

			Amount requested from the GF (USD thousands)					
			Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Component(s) (mark with X)**:**		**HIV/AIDS**	2,452	2,779	2,837	2,813	2,906	**13,787**
		Tuberculosis	1,527	1,908	2,954	2,626	2,424	**11,438**
		Malaria	2,766	4,072	1,762	1,990	832	**11,424**
		Total	**6,745**	**8,759**	**7,553**	**7,429**	**6,162**	**36,649**
Total funds from other sources for activities related to proposal			**5,111**	**3,701**	**3,520**	**1,601**	**1,761**	**15,694**

* Includes Global Drug Facility for TB (Annex 10) – $ US 745,000 year 1, $ US 169,000 year 2, $ US 500,000 year 3

Please specify how you would like your proposal to be evaluated** (mark with X):

The Proposal should be evaluated as a whole	
The Proposal should be evaluated as separate components	**X**

* According to national epidemiological profile/characteristics

** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

*** This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

Brief proposal summary **(1 page)(please include quantitative information where possible)**:

- **Describe the overall goals, objectives and broad activities per component, including expected results and timeframe for achieving these results:**

The overall goal of the TB component in this proposal is:

- To halve the prevalence, incidence and mortality of tuberculosis by 2010 in concordance with the National Tuberculosis Control Program Plan (2001-2005).

There are two objectives defined in this component that are expected by the end of 2007:

Objective 1: Detect 85% TB cases and cure at least 85% of them. This objective covers three broad activities:

Activity 1: *Nationwide establishment of Public-Private Mix (PPMD) DOTS.* About one-third of TB patients are diagnosed and treated in the private sector in the Philippines, outside the technical guidance and monitoring of the National Tuberculosis Programme (NTP). This activity is expected to achieve 20% detection of TB cases from the private sector and this will contribute to reaching the overall target of the National Tuberculosis Programme (NTP) of achieving a case detection rate of 85%. Operational research on PPMD, through the joint effort of the Government and the Philippine Coalition Against TB (PhilCAT), has resulted in the development of protocols that will be the framework for the nationwide establishment of PPMD. With variation in the participation of the private sector on DOTS implementation in different areas, there is a need to establish specific PPMD models that are tailored to suit such variations. The establishment of PPMD sites requires 1) setting-up an operational structure, 2) installing the PPMD package to raise awareness on the need for PPMD among private practitioners and 3) monitoring/evaluation to oversee the quality of PPMD implementation.

Activity 2: Enhancement of DOTS in the Public Sector. This activity is expected to increase the case detection rate in the public sector to 65% and cure rate to 85%. The aim is to improve both the "service" and the "demand" side of TB control to broaden DOTS implementation in the public sector. This involves improving the quality of DOTS implementation to strengthen public service delivery and creating social demand for DOTS services. Social demand will be stimulated through social marketing, advocacy, community empowerment, peer support group and promotion of new and innovative approaches.

Activity 3: Analysis of national TB epidemiology. It is proposed to conduct a national epidemiological study starting in 2005 to determine the situation and trends in tuberculosis epidemiology in the Philippines.

Objective 2: To utilize the Green Light Committee approved DOTS – Plus project in addressing Multi-drug Resistant TB cases (MDR-TB). This activity will support the on-going DOTS-Plus Project at the Makati Medical Center, Manila. This project has been fully approved by the Green Light Committee to receive second–line anti-tuberculosis drugs at concessional prices. This activity will enable 750 multi-drug resistant TB cases (MDR) to undertake supervised treatment at an affordable cost.

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):

The main beneficiaries are the Filipino people afflicted with TB and multi-drug resistant TB, who would not otherwise have received treatment and who can be cured from their illness. Through this proposal, these people will have the potential to escape from the viscous cycle of poverty, as cure will allow them to return to their productive employment. This improved socio-economic status will extend to the whole family of TB patients.

Direct beneficiaries will also include the participating private doctors and nurses who are involved in TB control and health staff working in tuberculosis at various levels of the public sector. The former activity will contribute to increase the number of detected cases while the latter activity will ensure the delivery of quality TB services. The PPMD Staff (a nurse) is a beneficiary in terms of enriching his/her coordination & liaison capabilities between the private and the public sectors. As a conduit or a "go-between", he/she ensures the dynamic interaction and communication between these two sectors for effective PPMD implementation. There are 1,050 doctors whose capacity will be developed on PPMD.

If there are several components, describe the synergies, if any, expected from the combination of different components (By *synergies*, we mean the added value the different components bring to each other, or how the combination of these components may have effects beyond each individual component:

Involvement and active participation of the private sector in PPMD will facilitate referral of cases of TB - HIV co-infection to appropriate TB and HIV services respectively and allow the most efficient use of limited services and resources.
Involvement of the private sector working in PPMD will contribute to data collection and analysis under the nationwide health information system needed for monitoring of communicable diseases, including HIV-AIDS.
Delivery of quality services and creation of social demand to increase public awareness of TB will foster positive behavior among TB patients, by improving their health-seeking attitudes towards health-care.
With improved laboratory services, malaria diagnostics may be coordinated with TB microscopy work, as diagnosis for both diseases, at the Rural Health Unit Level (municipal) is often done by the same medical technologist.
The principles of DOTS strategy of TB, proven to have prevented drug resistance, may also be applied as a case holding mechanism for malaria to retard the development of resistance to anti-malarial drugs.

SECTION II: Information about the applicant

Table IIa serves to help you know which questions you should answer in this Section, reflecting the different types of application mechanisms and proposals.

For further guidance on who can apply, refer to Guidelines para. II.8–33

Table IIa

Application mechanism	Type of proposal	Questions to answer
National CCM	Country-wide proposal *(Guidelines para. 14–15)*	1–9
Regional CCM	Coordinated Regional proposal from multiple countries reflecting national CCM composition *(Guidelines para. 24–25)*	1–9 and 10
	Small Island States proposal with representation from all participating countries but without need for national CCM *(Guidelines para. 24 and 26)*	
Sub-national CCM	Sub-national proposal *(Guidelines para. 27)*	1–9 and 11
Non-CCM	In-country proposal *(Guidelines para. 28–30)*	12 – 16
Regional Non-CCM	Regional proposal *(Guidelines para. 31)*	12 – 15 and 17
Proposals from countries in complex emergencies will be dealt with on a case-by-case basis (Guidelines para. 32)		

Country Coordinating Mechanism (CCM), (Refer to *Guidelines paragraph 72–78)*

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	Yes
c). If composition of CCM has changed, briefly outline changes (e.g., list of new members or sector representatives)**:** The committee has included the following new members: ▪ Canadian International Development Agency ▪ World Vision Development Foundation, Inc. ▪ Philippine Society for Microbiology and Infectious Diseases ▪ Philippine Business for Social Progress ▪ Philippine Rural Reconstruction Movement ▪ Department of Education ▪ Department of National Defense ▪ National Commission for Indigenous People	

1. **Name of CCM** (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):
   The Country Coordinating Mechanism for HIV/AIDS, TB and Malaria of the Philippines.

2. **Date of constitution of the current CCM** (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses existing processes – which is encouraged – please explain this in Question 3)**:**

   March 5, 2002

3. **Describe the background and the process of forming the CCM** (including whether the CCM is an entirely new mechanism or building on existing bodies, how the other partners were contacted and chosen, etc.), (1 paragraph):

The membership of the National Infectious Disease Advisory Council (NIDAC) was expanded to form the CCM on February 5, 2002. The CCM is a multi-sectoral body with authority and responsibility to recommend operational strategies and policies, which can improve implementation of infectious disease prevention and control programs at the primary, secondary and tertiary levels of the health system. On March 5, 2002, an administrative order was issued as an amendment to the roles and functions of NIDAC. The council has since then extended its function as the CCM.

3.1. If the CCM is or includes an already existing body, briefly describe the work previously done, programmes implemented and results achieved (1 paragraph):

For the past eight months, NIDAC has looked into the operational problems of TB control implementation, particularly on the drug procurement issue, for which the council has proposed short- and lone-term solutions to the Secretary of Health.

In addition, NIDAC has been a venue for strengthening of private-public partnerships in health care delivery in accordance with its specific functions as follows:

- To commission evidence-based review on the implementation of policies, standards, and guidelines for specific infectious diseases.
- To prepare improvement strategies and develop policies to address the current program issues and recommend these to the Secretary of Health for official issuance to all concerned.
- To advocate for compliance to policy, standards and guidelines at various levels of the health system.
- To provide technical advice to all stakeholders involved in infectious diseases.
- To provide recommendations regarding financing of infectious disease programs.

4. **Describe the organizational processes** (e.g., secretariat, sub-committee, stand-alone; describe the decision-making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):

The CCM is a stand-alone organization. Headed by the Undersecretary of Health, it now has 24 members representing international agencies, private and public sectors, as well as organizations involved in public-private collaborations. Nominations of agencies for inclusion were made by the existing members of the original NIDAC and were voted upon. Invitations to the nominated agencies were thence sent for their acceptance.

- The United Nations and bilateral agencies represent the international affiliates.
- The private sector includes NGOs, research agencies, and people living with AIDS (PLWA).
- The public sector, headed by the lead agency, the Department of Health, has representations from the National Economic Development Agency, additional new members including Department of Education, Department of National Defense, and the National Commission for Indigenous Peoples.
- Finally, the organizations working on private-public mix (PPM) have representatives working on the three disease components.

5. **Describe the mode of operation of the CCM (**e.g., frequency of meetings, functions and responsibilities of the CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):

The CCM holds monthly meetings and has the following terms of reference:

- To consult on technical aspects of proposal development related to HIV/AIDS, tuberculosis, and malaria, as well as other infectious diseases.
- To finalize proposals and submit them to the Global Fund to fight AIDS, TB and Malaria (GF) on behalf of the country.
- To designate a competent trustee in charge of the overall financial accountability of the program. The trustee will ensure proper utilization of funds for their intended purpose; it will facilitate efficient and transparent disbursement of funds to partner agencies.
- To ensure quality implementation and monitoring of the fund's program.
- To ensure independent evaluation of the program's outputs.

6. Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required (1 paragraph):

The Infectious Disease Office (IDO) of the Department of Health now functions as the secretariat of the CCM. It has three working groups on each of the three program components: HIV/AIDS, Malaria, and Tuberculosis. It will coordinate with implementing partners and proponents to further strengthen the committee. It has also established its technical subcommittee, which will function as the secretariat for the GF-Philippines. The CCM plans to form its subcommittee on finance and audit in the next 12 months.

7. Members of the CCM (*Guidelines para. II.16 – 22)*:

Please note: <u>All</u> representatives of organizations included in the CCM must sign this page to be included in the original, hard-copy proposal sent to the Secretariat. The signatures must reach the Secretariat before the deadline for submitting proposals.

Please print additional pages if necessary, including the following statement:

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/ Organization	Name of Representative	Title	Date	Signature
Department of Health (DOH)	Dr. Jaime Lagahid	Medical Officer VII		
Main role in CCM				
To provide a link between the fund's project and the country's health policies, particularly on HIV/AIDS, tuberculosis and malaria. To lead the CCM technical subcommittee.				

Agency/ Organization	Name of Representative	Title	Date	``Signature
Department of Health (DOH)	Dr. Ernesto Villalon	Medical Specialist II		
Main role in CCM				
To lead the working group on HIV/AIDS component of the Global Fund; To participate in the CCM technical subcommittee.				

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Agency/ Organization	Name of Representative	Title	Date	Signature
Department of Health (DOH)	Dr. Rosalind Vianzon	Medical Specialist IV		
Main role in CCM				
To lead the working group on tuberculosis component of the Global Fund; To participate in the CCM technical subcommittee.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Department of Health (DOH)	Ms. Cecilia Hugo	Senior Health Program Officer		
Main role in CCM				
To lead the working group on malaria component of the Global Fund.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Research Institute of Tropical Medicine (RITM)	Dr. Remigio Olveda	Director		
Main role in CCM				
To lead the conduct of research and training on HIV/AIDS, tuberculosis and malaria.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Philippine Council for Health Research and Development (PCHRD)	Dr. Gemiliano Aligui	Executive Director		
Main role in CCM				
To lead the coordination and monitoring of research activities at the level of policy-makers and health program implementers, particularly on HIV/AIDS, tuberculosis and malaria.				

Agency/ Organization	Name of Representative	Title	Date	Signature
University of the Philippines - National Institute of Health UP-NIH)	Dr. Mario Festin	Vice Chancellor		
Main role in CCM				
To lead the coordination and monitoring of research activities at the academic level, particularly on HIV/AIDS, tuberculosis and malaria.				

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Agency/ Organization	Name of Representative	Title	Date	Signature
National Economic and Development Authority (NEDA)	Ms. Arlene Ruiz	Chief, Health, Nutrition and Family Planning Division		
Main role in CCM				
To provide a link between the fund's project and the country's plan and policies for social and economic development; To participate in the CCM technical subcommittee.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Department of Education (DepEd)	Dr. Thelma Navarez	Assistant Director		
Main role in CCM				
To provide a link between the fund's project and the country's educational plan and policies, as well as with the agency's health programs for teachers and students, particularly on HIV/AIDS, tuberculosis and malaria.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Department of National Defense (DND)	Dr. Peter Galvez	Medical Officer		
Main role in CCM				
To provide a link between the fund's project and DND's health programs for military members, veterans, and their family, particularly on HIV/AIDS, tuberculosis and malaria.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Local Government Unit / Provincial Health Office (LGU/PHO)	Dr. Roy Gavino	Provincial Health Officer		
Main role in CCM				
To provide a link between the fund's project and the implementation of health programs on HIV/AIDS, tuberculosis and malaria.				

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Agency/ Organization	Name of Representative	Title	Date	Signature
National Commission on Indigenous Peoples (NCIP)	Dr. Ricardo Sakai, Jr.	Medical Officer V		
Main role in CCM				
To provide a link between the fund's project and programs on HIV/AIDS, tuberculosis and malaria that involve indigenous people.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Philippine Tuberculosis Society, Inc. (PTSI)	Dr. Ernesto M. Molina	Medical Director of the Quezon Institute		
Main role in CCM				
To provide a link between the fund's project and the implementation of PTSI's activities on tuberculosis control and prevention in the community as well as in hospitals.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Tropical Disease Foundation, Inc (TDF)	Dr. Thelma Tupasi	President		
Main role in CCM				
To provide a link between the fund's project and the implementation of TDF's activities on tuberculosis control and prevention, particularly on the DOTS-Plus pilot project, as well as in training and research on tropical diseases.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Positive Action Foundation of the Philippines (PAFP)	Mr. Joshua Formentera	President		
Main role in CCM				
To provide a link between the fund's project and the activities of the foundation that involve people living with HIV/AIDS (PLWA) and affected families.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Philippine Business for Social Progress (PBSP)	Ms. Elvie Grace Ganchero	Manager		
Main role in CCM				
To link the fund's project with the promotion of education/prevention and advocacy for "HIV/AIDS in the Workplace" program, as an expression of corporate social responsibility.				

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Agency/ Organization	Name of Representative	Title	Date	Signature
Philippine Society for Microbiology and Infectious Diseases (PSMID)	Dr. Rodrigo Romulo	Member Representa-tive		
Main role in CCM				
To represent the society in the provision of technical expertise in infectious diseases.				

Agency/ Organization	Name of Representative	Title	Date	Signature
World Vision Development Foundation, Inc. (WVDF)	Dr. Melvin Magno	National *Kusog-Baga* Project Coordinator		
Main role in CCM				
To provide a link between the fund's project and WVDF's planned activities on tuberculosis in the Philippines.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Philippine Rural Reconstruction Movement (PRRM)	Mr. Conrado Navarro	Senior Assistant to the President		
Main role in CCM				
To represent the "lead support agency" for malaria component of the Global Fund, for project management and implementation and any other support as requested by the CCM.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Philippine Coalition Against Tuberculosis (PhilCAT)	Dr. Charles Yu	Chairman		
Main role in CCM				
To represent the "lead private-public mix agency" for the tuberculosis component of the Global Fund, and to undertake any other support as requested by the CCM.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Philippine National AIDS Council (PNAC)	Dr. Loreto Roquero	Director		
Main role in CCM				
To represent the "lead support agency" for HIV/AIDS component of the Global Fund, to support the preparation of proposals and undertake any other support as requested by the CCM.				

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Agency/ Organization	Name of Representative	Title	Date	Signature
Kilusan Ligtas Malaria (KLM)	Mr. Ray Angluben	Project Director		
Main role in CCM				
To provide a link between the fund's project and its activities to control and eliminate malaria in the province of Palawan.				

Agency/ Organization	Name of Representative	Title	Date	Signature
World Health Organization (WHO)	Dr. Jean-Marc Olive	WHO Representative to the Philippines		
Main role in CCM				
To provide a link between the fund's project and WHO's planned activities on HIV/AIDS, tuberculosis and malaria in the Philippines.				

Agency/ Organization	Name of Representative	Title	Date	Signature
United States Assistance for International Development (USAID)-Manila	Mr. Jed Meline	Deputy Chief, OPHN		
Main role in CCM				
To provide a link between the fund's project and USAID's planned activities on HIV/AIDS, tuberculosis and malaria in the Philippines.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Japan International Cooperation Agency (JICA)	Dr. Seiya Kato	Chief Adviser		
Main role in CCM				
To provide a link between the fund's project and JICA's planned activities on quality tuberculosis control in the Philippines.				

Agency/ Organization	Name of Representative	Title	Date	Signature
Joint United Nations Programme on HIV/AIDS (UNAIDS)	Dr. Arthur Jaucian	Country Program Adviser		
Main role in CCM				
To provide a link between the fund's project and UNAIDS' planned activities on HIV/AIDS in the Philippines.				

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Agency/ Organization	Name of Representative	Title	Date	Signature
Canadian International Development Agency (CIDA)	Ms. Myrna Jarillas	Senior Program Officer		
Main role in CCM				
To provide a link between the fund's project and CIDA's planned activities on HIV/AIDS, tuberculosis and malaria in the Philippines.				

7.1 Attached herewith are the following documents from private sector and civil society CCM members (PhilCAT, PTSI, TDF, PSMID, PBSP, WVDF, PRRM, PAFP, KLM):

- **Statutes of organization (official registration papers)**
- **A presentation of the organization, including background and history,scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

7.2 If a CCM member is representing a broader constituency, please provide a list of other groups represented.

8. Chair of the CCM and alternate Chair or Vice-Chair

	Chair of CCM	Alternate Chair / Vice-Chair	Alternate Chair / Vice-Chair
Name	Dr. Antonio S. Lopez	Dr. Thelma Tupasi	Dr. Myrna C. Cabotaje
Title	Undersecretary of Health	President	Director IV
Address	Department of Health, Bldg. 1, San Lazaro Compound, Rizal Avenue, Sta. Cruz, Manila, Philippines	Tropical Disease Foundation, Inc (TDF), Makati Medical Center, #2 Amorsolo St., Makati City 1229, Philippines	Department of Health, Bldg. 13, San Lazaro Compound, Rizal Avenue, Sta. Cruz, Manila, Philippines
Telephone	(+632) 7116075	(+632) 8936066	(+632) 7117846
Fax	(+632) 7116075	(+632) 8102874	(+632) 7117846
Email	useclopez@yahoo.com	drcramos@info.com.ph	mccabotaje@co.doh.gov.ph
Signature			

9. **Contact persons for questions regarding this proposal** (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

	Primary Contact	Second Contact
Name	Dr. Ernesto Villalon	Ms. Cecilia Hugo
Title	Medical Specialist II	Senior Health Program Officer
Address	Department of Health, Bldg. 13, San Lazaro Compound, Rizal Avenue, Sta. Cruz, Manila, Philippines	Department of Health, Bldg. 13, San Lazaro Compound, Rizal Avenue, Sta. Cruz, Manila, Philippines
Telephone	(+632) 7116808	(+632) 7116808
Fax	(+632) 7116808	(+632) 7116808
Email	eris.usa@yahoo.com eris.usa@hotmail.com	cecille.hugo@hotmail.com cecilth@hotmail.com
Signature		

(N.B. : SECTIONS 10 to 17 are not applicable to the current proposal.)

10. **For coordinated regional proposals and Small Island States proposals describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve** *(Guidelines para. II.24),* (1 paragraph):

10.1. For coordinated regional proposals, provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment (e.g, letter of endorsement from Chair/Alternate of CCM or equivalent documentation).

11. **Sub-national Proposal from Large Countries**

11.1. Explain why a sub-national CCM mechanism has been chosen(1 paragraph):

11.2. Describe how this proposal is consistent and fits with nationally formulated policies and/or how it fits with the national CCM plans *(Guidelines para. II.27),* (1 paragraph):

11.3. Provide evidence of support from the national CCM or, if there is none, from other relevant national authority as attachment *(Guidelines para. II.27),* (e.g, letter of endorsement or equivalent documentation).

Non-CCM applicant

12. Name of applicant:

13. Representative of organization applying:

Table II.13

	Representative	**Alternate**
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

14. Contact persons for questions regarding this proposal (please provide full contact details for two persons – this is necessary to ensure expedient and responsive communications):

Please note: The persons below need to be readily accessible for technical or administrative clarification purposes by the Secretariat or the TRP members.

Table II.14

	Primary contact	**Secondary contact**
Name		
Title		
Address		
Telephone		
Fax		
E-mail		

15. Description of applying organization

15.1. Indicate what type of organization the applicant is (mark with X):

Table II.15.1

	Non-Governmental Organization (NGO) or network of NGOs
	Community based Organization (CBO) or network of CBOs
	Private Sector
	Academic/ Educational Sector
	Faith-based Organization
	Regional Organization
	Other (please specify):

15.2. Provide as attachment the following documentation:

- **Statutes of organization** (official registration papers)
- **A presentation of the organization, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

16.Justification for applying outside the CCM

16.1. Indicate reasons for not applying through the CCM (Explain clearly the circumstances, conditions and reasons; *Guidelines para. II.28–29*), (1–2 paragraphs):

16.2. Have you been in contact with the CCM in your country or other relevant governmental agencies (e.g. Ministry of Health, National AIDS Council)**? If so, what was the outcome? If not, why?**

16.3 Include letters from supporting organizations (e.g. human rights groups, NGO networks, bilateral or multilateral organizations, etc) supporting your reasons for not applying through a CCM as attachment.

17. For regional proposals from Regional Organizations or International Non Governmental Organizations, describe how submitting this regional proposal adds value beyond the national level / what a national proposal could achieve *(Guidelines para. II.24),* (1 paragraph):

17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment.

17.1. Provide signed letters of endorsement from the national CCMs or, if there is none, from other relevant national authority for the countries covered by the proposal as attachment.

SECTION III: General information about the country setting

*Please note: For **regional proposals**, the information requested in this section should reflect the situation in all countries involved, either in an aggregated form or by individual country.*
*For **sub-national proposals**, the information requested should reflect the situation in the particular sub-national area within the overall country context.*

18.Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria: (Describe current epidemiological data on prevalence, incidence or magnitude of the epidemics; its current status or stage of the epidemics; major trends of the epidemics disaggregated by geographical locations and population groups, where this data is available and/or relevant; *Guidelines para. III.37 – 38),* (1 – 2 paragraphs per disease covered in proposal):

Tuberculosis (TB) is still a major public health issue in the Philippines; 75 Filipinos die daily from TB. The majority of those infected are the in economically productive group (aged 20-60 yeas old) who comprise the major labor force of the nation. The World Health Organization has included the Philippines among the 23 high TB burden countries globally, and ranked the Philippines 2nd to China in the Western Pacific Region in terms of case notification rate *(WHO Report 2002 – Attachment 2).* The prevalence of highly infectious, or sputum (+) cases, is about three times more common in the urban-poor than in other areas. The population is mainly comprised of the urban poor *(NPS, 1997 – Annex 3).*

19.Describe the current economic and poverty situation (Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases; *Guidelines para. III.39),* (1–2 paragraphs):

In 2001, the country's GNP grew 3.7% (GNP per capita: 13,088 pesos) while GDP increased 3.4% (GDP per capita 12,317 pesos). The agriculture and service sectors were the major sources of growth. Data for the second quarter of 2002 indicate that GNP growth is at 5.2% while GDP growth is at 4.5%. With regard to the share of health expenditure to GNP, this stood at 3.43% in 1999, which is still below the 5% standard by WHO for developing countries. Of total national government budget in 2001, around 2% was allocated for health. In terms of human development index (HDI), the Philippines ranked 77 out of 173 countries and 23rd among countries with medium human development. In 2000, the country's HDI was 0.754.

As to poverty incidence, 44.2% of the total number of families in 1985 can be considered poor but this declined to 31.8% in 1997. The decline, however, slowed down with the onset of the onset of the Asian financial crisis in the second half of 1997. This was aggravated by the widespread drought experienced in 1998. Consequently, poverty incidence increased to 33.7% in 2000. The decline in poverty incidence has been faster in the urban areas such that, as of 2000, only one out of five Filipinos living in these areas was considered poor. Meanwhile poverty in the rural areas barely improved. In addition, while the proportion of poor families has declined over time, the actual number of poor families has gone up due to the increase in population. At present, the population growth rate is posted at 2.36.

20. Describe the current political commitment in responding to the diseases (indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.; *Guidelines para. III.40),* (1–2 paragraphs):

In 1996, when the DOTS strategy was piloted and first introduced, Proclamation Order No. 840 was signed by then Pres. Fidel V. Ramos citing every August 19 as the National TB Day. This event is commemorated nationwide as an annual advocacy strategy for TB control. Similarly, in 1998, Memorandum Circular No. 98 -155 was signed by then Pres. Joseph Estrada (also then concurrently Secretary of Interior and Local Government), mandating the Local Government Units (LGUs) to adopt DOTS as a local strategy for TB control. It also included the provision of anti -TB drugs to augment national drug supply. The successful

expansion DOTS was largely due to the government's budget allocation. Under Pres. Gloria Macapagal Arroyo's administration, TB is one of the priority health programs and it is assured that anti-TB drugs is available at all government health centres. DOTS expansion has been expedited over the past five years to cover 100% of the population.

The current Secretary of Health, Hon. Manuel M. Dayrit, has prioritised TB as one of six flagship programs. Funding of drugs in government health centres is totally supported by the national and local governments. Aside from the strong political support, NTP is backed-up by international partners that give support to supplies, equipment and activities other than drugs, e.g., training, microscopes. They also constitute the high-level coordinating body known as Project Assistance to Control TB (PACT) that assist the DOH in advising on decisions pertinent to technical and managerial program issues.

21. Financial context

21.1. Indicate the percentage of the total government budget allocated to health*:

Of the total national government budget in 2001, around 2% was allocated for health.

21.2. Indicate national health spending for 2001, or latest year available, in the Table III.21.2*:

Table III.21.2

	Total national health spending Specify year: **2000** (USD)	**Spending per capita** (USD)
Public	488,000,000	Not available
Private	1,782,000,000	Not available
Total	2,270,000,000	8.8**
From total, how much is from external donors?	79,800,000	

* from *"Highlights of the 1999 and 2000 Philippine National Health Accounts"*
** in real terms, based on the current value of the USD

21.3. Specify in Table III.21.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors)**:

Table III.21.3

Total earmarked expenditures from government, external donors, etc. Specify Year:	**In US dollars:**
HIV/AIDS	1,090,000
Tuberculosis	3,500,000
Malaria	1,180,000
Total	5,770,000

21.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives*, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria? (1–2 paragraphs)**:

The Philippines does not benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives or Sector – Wide Approaches.

* HIPC is a debt-relief initiative for highly indebted poor countries through the World Bank
** Optional for NGOs

22.National programmatic context

22.1. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB and/or Malaria (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.), (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

The Government sector is largely responsible for the implementation of the National Tuberculosis Programme (NTP) in the country. TB control activities are undertaken at different levels, including: central – region – province/city – municipality – barangay (village) levels. The NTP works under a devolved system in which the implementers are autonomous from the national government (DOH). The National Tuberculosis Control Program of the Department of Health (NTP) is responsible for the policy and standard development and technical support as well as drug procurement. The Regional Health Office provide technical assistance through the TB Coordinators, while the Local Government Units (LGUs), under the Dept of Interior and Local Government are partners serving as the implementing arm of the NTP at the community level.

Provincial/city TB coordinators conduct supervision of the municipal and the city level respectively. Diagnostic (microscopy) services are available at the Rural Health Units (RHUs) (numbering about 2,000), and treatment is provided to the Barangay Health Station (village level). Supervised treatment is given through "treatment partners", mostly the volunteer health workers or barangay officials, supervised by the barangay midwife. DOH-retained hospitals act as referral for complicated and problematic cases. Funds received from some partner agencies are sometimes placed in a "trust fund" of the finance unit of the DOH so that its use is properly ensured and monitored.

Comprehensive and integrated TB control policy guidelines, for both the governmental and private sectors, is being finalized and will be presented at a TB Summit involving both sectors by the end of 2003.

22.2. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes[**]:

Table III. 22.2

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget** (Specify time period)
1. World Vision Development Foundation (Philippines)	NGO	"Kusog Baga" Project (DOTS Expansion)	Phase I: US $ 1,200,000 Phase II: US $ 3,400,000
2. JICA	Bilateral Agency (Japan)	DOH-JICA TB Control Project (DOTS Expansion Project with Nat'l TB Reference Lab. (NTRL)	US $ 2,000,000 (2002 – 2007)
3. Medicus del Mundos	International NGO (Spain)	DOTS Expansion	Phase I: US $ 327,000 (1998 – 2001) Phase II: US $ 146,000 (2002 - 2004) Phase III: US $ 1,167,000 (2005 – 2007)
4. USAID	Bilateral Agency	Infectious Disease Surveillance / DOTS Expansion	US $ 1,200,000
5. World Health Organization	Multilateral Agency	DOTS Expansion	US $ 160,000
6. Tropical Disease Foundation	Private Agency	DOTS-Plus Project	US $ 200,000

Note
Budget support shown above is for technical support only (not for drugs), and includes activities such as training, fellowships and consultants

22.3. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB and/or Malaria (*Guidelines para. III.41 – 42*), (2–3 paragraphs):

DOTS has been expanded countrywide by the NTP in the public sector. However, it is known that more than one third of TB cases in the Philippines are diagnosed and treated in the public sector, outside the technical guidance and monitoring of the NTP. Therefore, a Public-Private Mix (PPM) approach will address the relatively low case finding and cure rates of the NTP. PPM is a mechanism where all stakeholders, public and the private, can improve case detection and can maintain quality DOTS implementation. There is a major programme intervention gap in this area and the additional requirements/costs of PPM cannot be covered by government budget because of limited resources. Expansion into PPM activities means an increase in the existing activities that cannot be covered by the private sector.

In addition, the Green Light Committee approved DOTS-Plus Project of the Makati Medical Center faces ongoing budget shortages in its treatment of multi-drug resistant TB cases. The Project receives support from private donors and resource constraints currently limit expansion of the project. It is proposed that the GF will be utilized to support initiatives for the gaps in TB control, especially in the private sector.

[**] For NGOs, specify here your own partner organizations

SECTIONS IV – VIII: Detailed information on each component of the proposal

PLEASE COMPLETE THE FOLLOWING SECTIONS FOR EACH COMPONENT
Please copy sections IV – VIII as many times as there are components

Please note: a component refers to a disease, i.e. your proposal will have more than one component only if it covers more than one disease. There should only be 1 component per disease.

If there are any objectives or broad activities within a particular component that are of a system-wide/cross-cutting nature such as capacity building or infrastructure development that may go beyond the scope of that particular component, please indicate those aspects clearly and specify how they would relate to other components of the proposal when detailing them in Question 27. (Guidelines para. IV.47 – 49)

If this is a fully integrated proposal, where two or more components are linked in such a way which would not make it realistic or feasible to separate, mark the boxes in Table IV.23 to identify all diseases which would be directly affected by this integrated component. (Guidelines para. 50)

SECTION IV – Scope of proposal

23. Identify the component that is detailed in this section (mark with X):

Table IV.23

Component (mark with X)**:**		**HIV/AIDS**
	X	**Tuberculosis**
		Malaria
		HIV/TB

24. Provide a brief summary of the component *(Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved)(2–3paragraphs):*

Tuberculosis is a major health problem in the Philippines. About 75 Filipinos die of tuberculosis everyday. The Philippines is one of the 23 high-burdened countries with TB globally and 2nd after China in the Western Pacific Region in terms of case notification rate *(WHO Report, 2002*). It affects predominantly the economically productive age (20-60 years old) group. The prevalence of smear positive cases is about three times higher among the urban-poor than the general population *(National Prevalence Survey, 1997 – Annexes 3 and 4)*. As a result, TB has been given high priority by the Department of Health (DOH).

DOTS was introduced in late 1996. It was expanded rapidly and covered about 95% of the population by 2001. The recent *Joint Program Review of the NTP (Attachment 3*) validated the quality of DOTS implementation of the Philippines, however the review team noted that the case detection rate (CDR) is relatively low at 60% (*WHO Report, 2002 – Attachment 2*). There is now a need to accelerate and expand the TB program in all sectors, public and private, to identify and treat the remaining 40% of unidentified smear positive cases occurring in the community.

Two interventions were recommended by the Joint Review: 1) partnership with the private sector through nationwide establishment of Public-Private Mix DOTS (PPMD) and 2) enhancement of DOTS in the public sector through improvement of quality service and creation of social demand for DOTS. It is planned to analyze the national TB epidemiology from 2005 to 2007, to monitor the overall situation and trend of TB epidemiology in the Philippines. In addition, the program review team recommended that multi-drug resistant

(MDR) cases be diagnosed and treated in an expanded strategy in coordination with the Green-Light Committee approved DOTS-Plus Project in Makati to minimize the emerging threat of MDR – TB to TB control in the Philippines.

GOAL: To reduce the prevalence, incidence and mortality due to tuberculosis by half in 2010

Objectives: By the end of 2007, the National TB Program is able to:

1. *Increase the case detection rate for the estimated TB cases (all types) from 58% in 2003 to 85% in 2007 and cure at least 85% of them.*

Under Objective 1, there are three (3) broad activities:

Activity 1. Nationwide establishment of Private-Public Mix DOTS (PPMD). This activity aims at detection of TB cases through PPMD centers. This will require 1) set-up of an operational structure for PPMD, 2) installation of the PPMD package and 3) monitoring and evaluation of PPMD implementation. The activity is to be organized in collaboration with the Philippine Coalition Against Tuberculosis (PhilCAT), a coalition of about 52 members, composed of governmental (DOH) and private practitioners, medical specialty societies, academes, civil society groups and NGOs, all involved in TB work.

Activity 2. Enhancement of DOTS in the public sector. This involves improving both the "service" and the "demand" side of the NTP to identify the 70% TB symptomatics in the community who take no action for their TB symptoms (*National Prevalence Survey, 1997 Annex 3*). Improvement in the quality of health services will require 1) boosting the knowledge of public health staff, 2) upgrading TB laboratory services and 3) equipping other government health facilities to fully implement the DOTS strategy. In creating social demand, advocacy and social marketing, empowerment of the community through community organization, promotion of new and innovative approaches and peer support groups will be used to heighten the public awareness. Expertise of NGO TB partners, including World Vision – Philippines in collaboration with the National Center for Health Promotion - DOH and the media will be used for implementation of this activity.

Activity 3. Analysis of national TB epidemiology. To monitor and document the epidemiological situation of TB in the Philippines, there is a need to measure the status and trends of the disease. Such analysis will also monitor and evaluate the impact of the DOTS strategy on the country's health indices. This activity is planned for 2005-2006 after DOTS was started in late 1996 and reached 95% coverage in 2001.

Activity 2. Utilize the Green-Light Committee approved DOTS–Plus Project in addressing MDR cases.

DOTS has been expanded nationwide by 2002. A DOTS-Plus Project at the Makati Medical Center DOTS Plus Clinic, approved by the Green Light Committee (GLC) to manage MDR cases has been established. Having satisfactorily achieved the prerequisite for managing cases of MDR TB through the GLC, this activity may now be conducted in coordination with the Makati Medical Center (private sector) as a synergistic "add-on" feature to the current activities of the NTP. The prevalence of MDR TB in the Philippines is about 4% *(National Prevalence Survey, 1997 – Annex 3)* and the activities of the Makati Medical Center are directly complementary to those of the NTP.

25. Indicate the estimated duration of the component:

Table IV.25

From (month/year)**:**	2003	**To** (month/year)**:**	2007

26. Detailed description of the component for its FULL LIFE-CYCLE:

Please note: Each component should have ONE overall goal, which should translate into a series of specific objectives. In turn each specific objective should be broken-down into a set of broad activities necessary to achieve the specific objectives. While the activities should not be too detailed they should be sufficiently descriptive to understand how you aim to achieve your stated objectives.

***Indicators**: In addition to a brief narrative, for each level of expected result tied to the goal, objectives and activities, you will need to identify a set of indicators to measure expected result. Please refer to Guidelines paragraph VII.77 – 79 and Annex II for illustrative country level indicators.*

***Baseline data**: Baseline data should be given in absolute numbers (if possible) and/or percentage. If baseline data is not available, please refer to Guidelines paragraph VII.80. Baseline data should be from the latest year available, and the source must be specified.*

***Targets**: Clear targets should be provided in absolute numbers (if possible) and percentage.*

For each level of result, please specify data source, data collection methodologies and frequency of collection.

An example on how to fill out the tables in questions 26 and 27 is provided as Annex III in the Guidelines for Proposals

26.1. Goal and expected impact (Describe overall goal of component and what impact if applicable, is expected on the targeted populations, the burden of disease, etc.), (1–2 paragraphs):

Please note: the impact may be linked to broader national-level programmes within which this component falls. If that is the case, please ensure the impact indicators reflect the overall national programme and not just this component.

Please specify in Table IV.26.1 the baseline data. Targets to measure impact are only required for the end of the full award period.

Based on the National Tuberculosis Plan, the goal of the TB Control Program is to decrease the prevalence and incidence by half in 2010. In 2000, 67,056 Sputum (+) cases or 60% of the estimated incidence were discovered (*WHO, WPRO Report, 2002 – Attachment 2*). There are an estimated 40% of TB cases occurring in the community that remain unrecognized. Access to public sector sputum microscopy services by the private sector can contribute to the increase in the case detection of those cases. Currently, the drugs provided by the government can support the needs of the public sector. Provision of drugs from the Global Drug Facility (GDF) for 2003-2005 and from the GF for 2006-2007 will ensure completion of treatment and cure of these patients in both public and private sectors and other mechanisms, including PhilHealth (Philippine Health Insurance) are being explored to also cover these costs.

An improved and good quality service in the public sector is a motivating factor to increase the presentation of more TB symptomatics to treatment facilities the public sector. Communities will be empowered to detect cases and supervise treatment through community-based TB activities. Organized peer support groups can effectively encourage TB cases to seek diagnosis and treatment of their disease.

Early diagnosis and treatment of TB cases can cut the transmission of the disease and ultimately, decrease the prevalence and avert deaths due to TB.

Table IV.26.1

Goal:	To reduce the TB prevalence, incidence and mortality by half in 2010	
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline** **Year: 2000***	**Targets** **Year 5: 2007**
Reduce the prevalence of smear + cases from	**3.1 / 100,000 population**	1.9 / 100,000 population
Reduce the incidence of smear positive cases from	**130 / 100,000 population**	84 / 100,000 population
Reduce the TB mortality rate from	**36.1 / 100,000 population**	19.2 / 100,000 population

***This is based on the results of the National Prevalence Survey, 1997. Given that DOTS coverage has only recently reached 100%, 1997 data should be comparable to 200 figures.

27.Objectives and expected outcomes (Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal), (1 paragraph per specific objective):

Question 27 must be answered for each objective separately. Please copy Question 27 and 27.1 as many times as there are objectives.

Please note: the outcomes may be linked to broader programmes within which this component falls. If that is the case, please ensure the outcome/coverage indicators reflect the overall national programme and not just this component.

Specify in Table IV.27 the baseline data to measure outcome/coverage indicators. Targets are only required for Year 2 onwards.

Objective 1: Increase the case detection rate for the estimated TB cases (all types) from 58% in 2003 to 85% in 2007 and cure at least 85% of them. This can be achieved through a strategy involving collaboration between public and the private sectors. Overall case detection increases if the private can effectively detect TB cases. Combining the detected cases of both the public and private sectors could result in achieving the NTP target of 85% case detection by 2007. Likewise, the cure rate is expected to increase from 75% to 85%, or more, if the private sector also cures these TB cases.

Objective 1:	Increase in the case detection rate from 58% of estimated cases, all types, in 2003 to 85% in 2007 and to cure at least 85% of them				
Outcome/coverage indicators *(Refer to Annex II)*	**Baseline** **Year:**	**Targets** **Year 2:**	**Year 3:**	**Year 4:**	**Year 5:**
Increase in the case detection rate • Public sector • Private sector	 56% 2%	 59% 8%	 60% 20%	 62% 20%	 65% 20%
Total	**58%**	**67%**	**80%**	**82%**	**85%***
Increase in the cure rate of DOTS areas	75%	78%	82%	85% or more	85% or more

Notes:
a. The proportion of all treatment units implementing DOTS is already 100% (2002) in the public sector. As of now, it is not possible to determine the DOTS implementation in the private sector,
b. We are targeting 85% CDR that is higher than the global target of 70% because of the low case estimation based in the WHO Report, 2002 – Attachment 2: p.12.

27.1. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives) (1 short paragraph per broad activity):

Activity 1: Nationwide establishment of PPMD. Operational research on PPMD, through the joint efforts of the Philippine Coalition Against Tuberculosis (PhilCAT) and the USAID-CDC, with the technical collaboration of WHO, resulted in the formulation and development of protocols that can serve as guidelines for operate and expand PPMD nationwide. The establishment of PPMD requires 1) the setting-up of an operational structure for PPMD, 2) installing the PPMD package that consists of advocacy, training, and launching, that is highlighted by signing of the Memorandum of Understanding (MOU) among the participating health providers, and 3) monitoring and evaluation conducted in collaboration with other partners to assess PPMD implementation.

Objective 1:	**Increase the case detection rate for the estimated TB cases (all types) from 58% in 2003 to 85% and cure at least 85% of them**				
Broad activities	**Process/Output**	**Baseline**	**Targets**		**Implementing agencies**
Activity 1: Nationwide Establishment of PPMD	**indicators** (indicate one per activity) *(Refer to Annex II)*	**(Specify year)** **2002**	**Year 1** **2003**	**Year 2** **2004**	
Setup the operational structure of PPMD (first step)	Number of new PPMD units setup at:				PhilCAT, DOH, Regions
	Central level	-	1	0	
	Regional level	-	0	2	
	Province / city level	-	7	20	
Install PPMD package (second step) comprised of: - Symposia - Training - Launching / MOU signing	Number of PPMD packages installed		8	22	PhilCAT, DOH, Regions
Monitor and evaluate PPMD implementation	Proportion of planned monitoring visits actually conducted:				
	Central to Region	-	70%	80%	DOH, PhilCAT
	Region to Province/City	-	70%	80%	DOH, PhilCAT
	Province/City to PPMD implementing centres	-	70%	80%	Region, Provincial Health Office (PHO), City Health Office (CHO)

Activity 2: Enhancement of DOTS in the public sector. This consists of improving the service side and the demand side of TB control. To attract more patients seeking the services of the public sector, it will be aimed to deliver improved quality DOTS. The skills of health staff need to be boosted through training to improve proficiency and TB laboratories will be upgraded. It is proposed that the expertise of a major bilateral partner agency of the NTP, JICA, will be utilized for this purpose. For low performing areas, boosting or re-tooling courses can be conducted. Introduction of DOTS to other facilities e.g. hospitals, will also be undertaken.

Strengthening the TB Diagnostic Committees (committees of TB specialist and radiologists that review complicated TB cases, usually at the provincial level, and provide technical advice to the NTP), through updates, workshops and technical support, will be undertaken to ensure proper assessment of smear negative TB cases. Diagnostic committees are a unique feature of the NTP in the Philippines. Monitoring and evaluation will be conducted according to a systematic plan, especially for the low-performing sites. National program reviews will also be held in 2005 and 2007 to assess overall DOTS implementation.

Creation of social demand to encourage TB clients to consult DOTS services is another aspect in the public sector that can be strengthened. Expertise of World Vision-Philippines and the National Center for Health Promotion - DOH can be utilized for advocacy activities geared toward the improvement of health-seeking behavior, particularly among the non-action takers. Community organizations can build linkages through heightened community awareness while peer support groups can motivate and advocate other members of the community. Innovative promotional approaches to increase knowledge, attitude and practices of TB clients are encouraged and supported.

Objective 1:	Increase the case detection rate of the estimated TB cases (all types) from 58% in 2003 to 85% in 2007 and cure at least 85% of them				
Broad activities **Activity 2:** **Enhancement of DOTS in the Public Sector**	**Process/Output** **indicators** (indicate one per activity) *(Refer to Annex II)*	**Base-line** **2002**	**Targets** **Year 1** **2003**	**Year 2** **2004**	**Implementing Agencies**
1. Improve the quality of the DOTS service through:					
- Training	Proportion of planned training courses actually conducted	-	70%	80%	DOH, TB reference laboratories, Regional Health Offices, JICA
- Strengthening of TB diagnostic committees	Number of updates/workshops and technical support	0	2	1	DOH, Regional Health Offices
- Conduct of national programme reviews	Number of national programme reviews conducted	1	0	0	Planned for 2005 – 2007, DOH, partner agencies
2. Create social demand for DOTS services					
- Produce IEC materials (broadcast & print) (for details see tables of Annex 8)	Number of TV & radio commercials produced and aired No. of print materials developed/ produced				World Vision, Health Promotions Centre, DoH
- Organize communities: year 1 is the organizing phase, outputs begin in year 2	Number of communities organized	0	90	All municipalities per province or city have at least 1 organized barangay	World Vision, Region, LGU
- Organize peer support groups	Number of peer support groups organized at community level	0	90	All municipalities per province or city have at least 1 organized peer support groups	World Vision, Region, LGU
- Proposals for innovative promotional approaches	Number of provincial/city proposals implemented	0	3 provinces and 3 cities	All target provinces and cities	World Vision, Region, LGU

Activity 3: Analysis of national TB epidemiology. It is proposed to conduct an analysis of the TB situation and trends in the Philippines from 2005 to 2007. There is a need for periodic analysis of the country's TB situation to ascertain the outcomes of the control program to guide TB control policy development and implementation. All relevant NTP partners, especially the academic sector, will be invited to participate in this activity.

Objective 2: To utilize the Green Light Committee approved DOTS-Plus Project in addressing MDR cases.

The Green Light Committee (GLC) has approved the DOTS-Plus Project of Makati Medical Center (MMC) for the management of MDR-TB cases. Prior to the introduction of DOTS in

1996, treatment of TB was been largely unsupervised. The failure rate of the DOTS re-treatment regimen at the DOTS Clinic of MMC among previously unsupervised cases is 31% compared to 0% among new cases. All of the treatment failure cases were subsequently diagnosed with MDR-TB. In this setting, the need for DOTS-Plus becomes imperative. However, this Project has been hampered by lack of finds for second-line anti-TB drugs. GF funding is being requested to address this important emerging issue for the NTP.

Table IV.27

Objective:	**To utilize the Green Light Committee (GLC) approved DOTS – Plus Project to treat multidrug resistant (MDR) TB cases**				
Broad activities	**Process/Output indicators** (indicate one per activity) *(Refer to Annex II)*	**Baseline (Specify year)**	**Targets**		**Implementing Agencies**
			Year 1	**Year 2**	
- Enhance the capacity / expertise of staff of the DOTS – Plus project	Number of staff receiving enhanced training on management of cases under DOTS-Plus according to the standards of the GLC	50%	70%	80%	Tropical Disease Foundation (TDF) at the Makati Medical Center (MMC)
- Reapply to the GLC for enrollment of 750 cases in addition to the approved cohort of 200 cases	Proportion of targeted MDR-TB cases enrolled in DOTS-Plus	-	20%	40%	Tropical Disease Foundation (TDF) at the Makati Medical Center (MMC)
- Strengthening and forming linkages between public and private DOTS units	Proportion of DOTS sites in Makati, the project site, actively networking with the DOTS – Plus Project, referring cases and assisting in DOTS – Plus defaulter follow-up	5%	20%	50%	Tropical Disease Foundation (TDF) at the Makati Medical Center (MMC), Makati City Health Office, DOH

Please note: Process/output indicators for the broad activities should directly reflect the specified broad activities of THIS component.

Specify in Table IV.27.1 below the baseline data to measure process/output indicators. Targets need to be specified for the first two years of the component.

For each broad activity, specify in Table IV.27.1 who the implementing agency or agencies will be.

28. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.), (*Guidelines para. III.41 – 42*),(2–3 paragraphs):

1. Provision of drugs – drugs and other logistics are prerequisites for the DOTS strategy to succeed. Drugs from the GF would benefit the PPMD since the government's budget can

currently only support drugs for the public sector. In the long - term it is planned that government will cover drug costs. Provision of drugs to the private sector can address the poor compliance of their patients due to the high cost of drugs commercially bought by these patients. In this way, the GF complements the government's resources for drugs that eventually lead to better compliance and cure of more cases through the provision of the needed drug requirement. Likewise, such provision of drugs can help in the prevention of MDR TB even among the cases coming from the private sector.

2. Capacity building - a well-trained and knowledgeable health worker, both in the public and private sector, is important for quality implementation of DOTS services. Orientation of the private sector on the current NTP policies enables them to understand the thrusts of the Program and allows them to identify areas for complementation with the public sector. Implementers of both sectors need to be continuously harnessed and honed to sustain the quality of service delivery.

3. Advocacy – this is to improve the health-seeking behavior of the TB clients especially among those non-action takers. It also aims to disseminate and heighten the awareness on the key initiative of the Program particularly the PPMD. High profile personalities and TB champions can be encouraged to inspire the private sector to adopt the PPMD approach. On the other hand, communities can be mobilized to form community groups that can lobby for funding support, locally and internationally. They can also perform surveillance on TB in their respective locale. The cured TB patients can be organized as peer support groups who can act as motivators, advocates and as treatment partners. They are the appropriate groups to de-stigmatize the disease in their community.

4. Monitoring/supervision/evaluation – to support quality DOTS implementation, there is a need to strengthen program monitoring, supervision and evaluation. Supervision is an avenue to identify and recommend solutions to problems besetting the program. Through monitoring and supervision, especially during the initial phase, best practices gained from this approach can be valuable for replication in other PPMD areas. Review of program performances or evaluation can enable program managers and implementers to re-visit the plan and re-direct their succeeding activities as necessary. Lessons learnt during the evaluation can be applied to other TB endeavors and future undertakings. It can also forecast the Project's life for possible extension later.

29. Briefly describe how the component addresses the following issues (1 paragraph per item):

29.1. **The involvement of beneficiaries such as people living with HIV/AIDS:**

Beneficiaries, including TB patients themselves, can be utilized as motivators and advocates for the TB program. They can share their experiences through testimonies, being former TB patients. As treatment partners, they can relate themselves better with the TB patients. These patients may share their experiences with others to promote their treatment and cure.

29.2 **Community participation**:

Empowered communities can manage and sustain community-based TB programs. Community groups can influence partner agencies to provide financial support and resources for the TB program in their localities. They can also be utilized to undertake community-based surveillance. Peer support groups can act as treatment partners and as educators on TB.

29.3. **Gender equality issues** (*Guidelines paragraph IV.53*):

Equal opportunities for both sexes in terms of hiring, training and community participation on TB activities will be carried-out in implementation of this proposal. Another important gender – related issue is the fact that more than 50% of TB patients in the Philippines are males, who generate most of the income for families. If bread-winners are afflicted

with TB, families enter a vicious cycle of poverty. The activities of this proposal aim to improve the socioeconomic status of entire families through effective TB diagnosis and treatment.

29.4. **Social equality issues** (*Guidelines paragraph IV.53*):

Equal opportunities for TB diagnosis and treatment will be accorded to all municipalities, regardless of income, all ethnic groups and include other vulnerable groups, such as prisoners.

29.5. **Human Resource development**:

Capacity building of both the private and the public sector is necessary for quality DOTS implementation. This enables them to understand the Program thrusts and be able to properly position themselves as to what effective service they can extend to their TB patients. Speaker's bureau can be formed from the participating health workers of the public and the private to act as resource persons during training, fora and conventions.

29.6. **For components dealing with essential drugs and medicine, describe which products and treatment protocols will be used and how rational use will be ensured** (i.e. to maximize adherence and monitor resistance), *(Guidelines para. IV.55),* (1–2 paragraphs):

The current TB Program follows the treatment protocols of the WHO and the International Union Against Tuberculosis and Lung Disease (IUATLD) in the management of TB patients. DOTS is the key overall strategy of the Program.

SECTION V – Budget information

30. Indicate the summary of the financial resources requested from the Global Fund by year and budget category, (Refer to *Guidelines paragraph V.56 – 58*):

Table V.30

Resources needed (USD)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Human Resources	207636	236436	229236	288682	165432	1127423
Infrastructure/ Equipment	77112	108292	257215	230096	175100	847815
Training/ Planning	240968	427635	820614	425965	429735	2344917
Commodities/ Products	38854	103640	204046	37200	20000	403740
Drugs	280513	280513	280513	580513	580513	2002566
Monitoring and Evaluation	78035	151085	378075	255685	268685	1131565
Administrative Costs	355570	433690	577370	607370	557370	2531370
Other – office supplies (consumables)	248054	166454	206454	200054	227654	1048669
Total	**1,526,741**	**1,907,745**	**2,953,524**	**2,625,566**	**2,424,490**	**11,438,066**

The budget categories may include the following items:
Human Resources: *Consultants, recruitment, salaries of front-line workers, etc.*
Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bednets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *Overhead, programme management, audit costs, etc*
Other (please specify):

30.1. For drugs and commodities/products, specify in the table below the unit costs, volumes and total costs, for the ***FIRST YEAR ONLY***:

Table V.30.1

Item/unit	**Unit cost** (USD	**Volume** (specify measure)	**Total cost** (USD)
Second-line anti-TB drugs (MDR drugs) (Objective 2)			
- Ofloxacin 400 mg tab	1.09	88,452 tabs	96,957
- Prothionamide 250 mg tab	0.11	210,600 tabs	24,178
- PASER 4 gm sachet	1.46	77,922 sachets	113,571
- Cycloserine 250 mg cap	0.01	168,480 caps	1,231
- Kanamycin 1 gm vial	0.20	11,907 vials	2,436
- Capreomycin 1 gm vial	0.97	1,701 vials	1,647
- Clarithromycin 250 mg tab	0.96	42,120 tabs	40,491

30.2. In cases where Human Resources (HR) is an important share of the budget, explain to what extent HR 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 paragraph):

PPMD staff have both administrative and technical roles in the project. They will liaise between the public and the private physician to ensure compatibility and coordination of activities on TB diagnosis and treatment. Initially, this is to be funded by the GF. However, it is planned that this cost eventually absorbed by the private sector from the fourth year of implementation. The PhilHealth can also be tapped as the mechanism for absorption of PPMD costs. Staff for community organizations and staff for management of MDR TB are needed to facilitate the corresponding start-up activities. Part of their role will be to ensure sustainability of the activities that they have initiated within the overall health system.

31. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars (*Guidelines para. V.62*)**:**

Table V.31.1

	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
Domestic (public and private)							
External*					$745,000	$169,000	$500,000
Total					$745,000	$169,000	$500,00

* Global Drug Facility (Annex 10) – assumed $ USD 10 cost per course of treatment

Please note: The sum of yearly totals of Table V.31.1 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labeled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

*32.Provide a **full and detailed budget as attachment**, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate.*

Detailed budget tables are given in Annex 2.

33. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u> (Refer to *Guidelines para. V.63*):

Table V.33

Resource allocation to implementing partners* (%)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Government	21%	34%	50%	42%	45%	**41%**
NGOs / Community-Based Org.	38%	27%	16%	16%	19%	**21%**
Private Sector	40%	38%	32%	33%	35%	**35%**
People living with HIV/ TB/ malaria	0.4%	0.7%	1.0%	0.8%	0.8%	**0.8%**
Academic / Educational Organizations	0%	0%	0.6%	8%	0.3%	**2%**
Faith-based Organizations	–	–	–	–	–	–
Others *(please specify)*	–	–	–	–	–	–
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in USD	1,527,000	1,908,000	2,954,000	2,626,000	2,424,000	11,438,000

** If there is only one partner, please explain why.Please note: The following three sections (VI, VII and VII) are all related to proposal/component <u>implementation arrangements</u>.*

If these arrangements are the same for all components, you do not need to answer these questions for each component. If this is the case, please indicate clearly in which component the required information can be found.

<u>SECTION VI – Programmatic and Financial management information</u>

Please note: Detailed description of programmatic and financial management and arrangements are outlined in Guidelines para. VI. 61 – 73, including the main responsibilities and roles of the Principal Recipient (PR).

34. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations), *(Guidelines para. VI.64),*(1–2 paragraphs)**:**

Monetary Management system: The Principal Recipient (PR) shall be responsible for the local fiduciary arrangements. A system of financial controls following standard accounting and auditing policies and procedures shall be implemented. A Fund Manager shall be responsible for the overall financial operations. Each disease component of this programme shall have a sub-recipient to which the PR shall disburse funds in accordance with agreed upon progress accomplishments. A requisition for fund replenishment prepared by the sub-recipient and approved by the respective steering committee and the overall Programme Manager shall be submitted to the Fund Manager for fund allocation. Thence, it is submitted to the Treasurer for disbursement. The accountant shall act as the internal auditor and is responsible for over-seeing that

appropriate accounting procedures have been followed. An annual audited financial statement by an independent reputable external auditing firm shall be accomplished to ensure that sound accounting policies and procedures are implemented

Programmatic Management: An overall Programme Manager shall oversee the implementation of the project. A steering committee (SC) for each of the disease components shall be organized to comprise an external multi-sectoral board of consultants responsible for the technical and ethical review and monitoring of progress implementation of the programme as detailed in this proposal. These SCs shall report to the overall Programme Manager. Disbursement of funds shall be contingent upon agreed upon target accomplishment and submission of statement of expenses (SOE) by the sub-recipient.

34.1 Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement), (1 paragraph)**.**

This arrangement should ensure the timely attainment of goals and efficient and transparent management of funds so that the disbursements are according to the proposed budgets and that the funds are given to the intended beneficiaries.

35. Identify your first and second suggestions for the Principal Recipient(s) (Refer *to Guidelines para. VI.65–67)*:

Table VI.35

	First suggestion	**Second suggestion**
Name of PR	**Tropical Disease Foundation**	
Name of contact	**Thelma E. Tupasi, MD**	
Address	**C. P. Manahan Memorial Annex Makati Medical Center 2 Amorsolo St., Makati City 1200 Philippines**	
Telephone	**63 2 893 6066**	
Fax	**63 2 810 2874**	
E-mail	**tdf@info.com.ph**	

Please note: If you are suggesting to have several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organization(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc), *(Guidelines para. VI.66–67),* (1–2 paragraphs):

The Tropical Disease Foundation (TDF) is a private science foundation registered under the Securities and Exchange Commission, Philippines, and accredited by the Department of Science and Technology and the Philippine Council for NGO Certification as a DONEE Institute.

The TDF has technical expertise in tropical infectious diseases, including the three diseases covered in these proposals, and has a proven track record in transparent management of funds from its projects with U.S. National Academy of Sciences/Board on Science and Technology for International Development (NAS/BOSTID), the World Bank and the WHO/United Nations Health Programme/ Tropical Disease Research Programme – Research Capacity Strengthening Grant. It was commissioned by the DOH to conduct the 1997 Nationwide Tuberculosis Prevalence Survey that successfully documented the status of TB burden in the Philippines. The TDF is currently implementing the Green Light Committee-approved DOTS-Plus Project for treatment of Multi-drug resistant (MDR) TB cases. Accordingly, since private-public partnership is a very strong feature of this

proposal, the TDF, representing the private sector, is the most appropriate principal recipient for these proposals.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.), (1 paragraph)**:**

The PR is a member of the CCM to which it should report the progress of the programme and financial management prior to submission to the Global Fund. The Steering Committee (SC) of each of the disease components shall determine the timed target goals at the outset of the programme which shall be the basis for the disbursement plan of its component budget. Each SC shall meet bimonthly with the disease component implementors and do regular site visits to monitor the progress of the project. The SC and the sub-recipients shall report to the PR quarterly to provide the basis for fund replenishment. An audited financial statement shall be prepared by the PR for submission to the CCM and the Global Fund.

36. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity**, (1–2 paragraphs)**:**

Each disease component implementor shall prepare a bimonthly narrative report of its activities performed, problems encountered, and solutions implemented. These are submitted to the respective Steering Committees for discussion in their bimonthly meeting. A quarterly progress report is prepared by the disease component implementor, to be submitted and approved by its respective steering committee for submission to the PR. The sub-recipient of each disease component shall likewise prepare a quarterly summary of expenses with supporting documents to the Fund Manager to ensure the appropriate utilization of funds. An annual audited financial report shall be required of each disease component sub-recipient to serve as a basis for the externally audited programme financial report.

Additional resources required from Global Fund: To strengthen managerial capacities, an initial training and hiring of additional staff should be undertaken. Funds for the hiring and training of a management staff for financial and programme implementation would have to be requested from the Global Fund. Funds have to be made available to support workshop and training of the members of the steering committee on the standard method of monitoring and evaluation of the program, to adopt the appropriate and recommended indicators for programme implementation for each of the respective disease components. The Global Fund should also provide honoraria for these consultants.

SECTION VII – Monitoring and evaluation information

37. Outline the plan for conducting monitoring and evaluation including the following information, (1 paragraph per sub-question).

37.1. Outline of existing health information management systems and current or existing surveys providing relevant information (e.g., Demographic Health Surveys, Living Standard Measurement Surveys, etc.), (*Guidelines para. VII.76)***:**

With the adoption of the DOTS, the NTP has adopted a standardized quarterly reporting system of case detection and treatment outcomes. Data is initially generated from the implementing levels and forwarded to the provincial/city TB coordinators for consolidation and analysis. The consolidated report is then submitted to the regional TB Coordinators for processing into a regional report. This regional report is then forwarded to the central level to be concatenated with national TB data that is collected during national consultative workshops held twice a year. Likewise, a Field Health Service Information System (FHSIS) is utilized but only for limited indicators. A demographic

survey was conducted last 1997 that analyzed the knowledge, attitude and practices *(Demographic Health Survey, 1997, Philippines, - Annex 11)* of the population regarding the TB Program. Every ten years a national population census is undertaken in the country.

37.2. Suggested process, including data collection methodologies and frequency of data collection (e.g., routine health management information, population surveys, etc.)**:**

Regional TB data can be collected quarterly through e-mail using the DOTS reporting system. The FHSIS is now being revised to meet the information and reporting needs of the NTP. A TB information or a database for PPMD will be developed and integrated in the current TB recording and reporting system. Analysis of national TB epidemiology will be conducted at least every 5-10 years until the problem of tuberculosis is controlled. This study gives the epidemiological situation of the country from which estimates for planning can be derived. Demographic Health Surveys will also be used to supplement information on health practices and population surveys will also be used for planning and determination of recent health indices.

37.3. Timeline:

An analysis of the status and trend of national TB epidemiology is proposed for 2005, with implementation in 2006 and finalization in 2007. This process will include full documentation and publication of the epidemiological data collected. The implementing levels will conduct routine periodic reviews, at least quarterly, on activities undertaken.

37.4. Roles and responsibilities for collecting and analyzing data and information:

The TB coordinators at the provincial and regional shall be responsible in ensuring that records and reports are properly filled-up and sent to the different levels on time. Analysis is done at the provincial, regional and central levels. Feedback of findings on case detection and treatment outcomes will be provided to the implementing level for immediate and appropriate action.

37.5. Plan for involving target population in the process:

TB community and peer support groups can increase case detection in their communities. They can act as treatment partners who would supervise the daily intake of drugs. They can also help in the assessment and evaluation of the TB activities at the local level and can participate in problem-solving pertaining to TB control.

37.6. Strategy for quality control and validation of data:

Completion of patient records should be done fully and in a timely manner and new patients shall be entered in the TB register upon initiation of treatment at the peripheral level. This will be endured through a systematic plan of supervision and monitoring. Review of records and reports shall be undertaken during monitoring visits by the provincial and regional TB coordinators. Corrective measures and provision of feedback will be instituted to improve NTP implementation. Validation of reports will be undertaken during these visits.

37.7. Proposed use of M&E data:

Data obtained through monitoring and evaluation will be used to revise and update policy on TB control. The data will be used to determine whether revision of the overall strategic plan is required to reach the desired targets of the NTP. This can serve as basis in the formulation of future plans that are congruent with the objectives of the NTP.

38. Recognizing that there may be cases in which applicants may not currently have sufficient capacity to establish and maintain a system(s) to produce baseline data and M&E indicators, please specify, if required, activities, partners and resource requirements for strengthening M&E capacities.

Please note: As M&E activities may go beyond specific proposals funded by the Global Fund, please also include resources coming from other sources at the bottom of Table VII.38.
Examples of activities include collecting data, improving computer systems, analyzing data, preparing reports, etc.

Table VII.38

Activities (aimed at strengthening Monitoring and Evaluation Systems)	**Partners**	**Resources Required** (USD)					
		Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Monitoring and evaluation of establishment of PPMD		45,710	113,760	318,750	223.360	223,360	924,940
Monitoring and evaluation of the improvement in DOTS services in the public sector		0	0	27,000	0	8,000	35,000
Monitoring and evaluation of creation of social demand for DOTS services		0	5,000	0	0	5,000	10,000
Monitoring and evaluation of DOTS – Plus		32,325	32,325	32,325	32,325	32,325	161,625
Total requested from Global Fund		**78,035**	**151,085**	**378,075**	**255,685**	**268,685**	1,131,565
Total other resources available*		10,000	15,000	15,000	20,000	20,000	80,000

* Note: Approximate budget from DOH for monitoring and evaluation of DOTS services

SECTION VIII – Procurement and supply-chain management information

39. Describe the existing arrangements for procurement and supply chain management of public health products and equipment integral to this component's proposed disease interventions, including pharmaceutical products as well as equipment such as injections supplies, rapid diagnostics tests, and commodities such as micronutrient supplements, condoms and bed nets (Refer to *Guidelines paragraph VIII.86*)**.**

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified?	In order to participate in the DOH transactions, suppliers are required to be accredited following the strict criteria set by the accreditation committee of the Department, chaired by an Undersecretary to ensure that only capable and qualified suppliers may be used.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	Procurement in the DOH is generally conducted by bulk procurement through open competitive bidding locally for government funds and international competitive bidding (ICB) for loan proceeds from the World Bank (WB), following the procedures and guidelines of the WB. The bidding process is conducted by the Central Office Bid and Awards Committee (COBAC) chaired by an Assistant Secretary of the DOH
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	Mechanisms for quality assurance are being implemented through a Technical Committee that examines and evaluates the adherence to the specifications required of the products and testing the products, especially drugs/medicines at the Bureau of Food and Drugs (BFAD) e.g. for quality and bioavailability testing for rifampicin
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	The distribution system being implemented now is the Contract Distribution System whereby the DOH contracts to a private forwarder to handle the distribution and delivery of the drugs/medicines from the regional office to the municipality levels quarterly to replenish the actual consumption to maintain the required average level of stock in the municipality

For MDR drugs:

Table VIII.39

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified? For most of the second-line drugs, the GLC was responsible for the selection of these suppliers. For other drugs such as ciprofloxacin, ofloxacin, the supplier with the lowest price is selected.	As a GLC-approved project, most second line drugs are procured through the official agency, Medicines Sans Frontieres (MSF)/ transfer, delivered to the WHO – Western Pacific Regional Office and brought to the TDF through a forwarder.
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations?	Second – line TB drugs are procured at concessional prices as negotiated by the GLC. The GLC oversees procedures to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective?	The drugs are inspected as to the gross appearance and date of expiration. Drugs appearing to be substandard are returned to the procuring agency, transferred with replacement. Drugs requiring refrigeration are ensured in the cold chain during transport until upon arrival at the destination and during storage at the DOTS-Plus site.
What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply?	Second – line drugs are distributed directly to the DOTS – Plus Project from Customs directly, or from Customs via WHO. WHO, WPRO also provides assistance in supply through the reimbursable procurement scheme of WHO.

40.Describe the existing arrangements for procurement of <u>services</u> (e.g., hiring personnel, contracts, training programs, etc.), (1–2 paragraphs)**:**

Hiring personnel – A vacancy is posted in the Bulletin Board of the DOH and the post is advertised in the local media, setting the deadline for application and interview of applicants. The screening committee of the DOH then conducts the interview and makes a recommendation to the Head of the Agency for appointment of the accepted applicant.

Training Program – Training programs of the Department of Health are coordinating through the Human Resource Management Development Bureau (HRMDB) after assessing the training needs of the units and personnel.

41. Provide an overview of the additional resources (e.g., infrastructure, human resources) required to support the procurement and distribution of products and services to be used in this component, (2–3 paragraphs):

The DOH Procurement and Logistics Service, as the Secretariat of the Central Office Bid and Awards Committee (COBAC), is responsible for the preparation of the documents necessary to consummate the Contract of Goods and supervise the distribution and delivery through the Contract Distribution System (CDS)

42. Detail in the table below any additional sources from which the applicant plans to obtain products relevant to this component, whether additional requests have been requested or granted already. (For each source, indicate a contact person at the program in question, the volume of product in the request of grant, and the duration of support. Examples of such programmes are the Global TB Drug Facility or product donations from pharmaceutical manufacturers), (*Guidelines para. VIII.88*):

Table VIII.42

Programme name	Contact person (with telephone & email information)	Resources requested (R) or granted (G)	Timeframe and duration of request or grant
Global Drug Facility	Dr. Mario Raviglione e-mail: raviglionem@who.int	(G) approximately USD 1.5 million*	3 years (2003-2005)

*Annex 10

42.1. Explain how the resources requested from the Global Fund for the products relevant to this component will be complementary and not duplicative to the additional sources, if any, described above (1 paragraph):

Funds for drugs requested for 2006-2007 GF will cater to the TB patients diagnosed at the PPMD. The Government budget only provides sufficient resources for the TB patients seen in the public sector.

LIST OF ATTACHMENTS

Please note:
The list of attachments is divided into two parts: the first part lists the attachments requested by the Global Fund as support for Sections III and IV.
The second part is for applicants to list attachments related to other Sections such as the Information on applicants (Section II), Detailed Budget (Section IV), or other relevant information.

Please note which documents are being included with your proposal by indicating a document number.

General documentation:	**Attachment #**
1. Poverty Reduction Strategy Paper (PRSP)	_____
2. Medium Term Expenditure Framework	_____
3. Sector strategic plans	_____
4. Any reports on performance	_____
HIV/AIDS specific documentation:	**Attachment #**
5. Situation analysis	
6. Baseline data for tracking progress[1]	
7. National strategic plan for HIV/AIDS, with budget estimates	_____
8. Results-oriented plan, with budget and resource gap indication (where available)	
TB specific documentation:	**Attachment #**
9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control **(National TB Control Program Plan for 2001-2005)**	Attachment 1
10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents **(Manual of Procedures for the National TB Control Programme, 2001, Philippines)**	Attachment 4
11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form) **(Tuberculosis Control in the WHO Western Pacific Region, 2002 Report)**	Attachment 2
(2002 WHO TB Data Collection Form for the Philippines)	Attachment 5
12. Most recent independent assessment/review of national TB control activities **(Joint Tuberculosis Programme Review, The Philippines, July 2002)**	Attachment 3
Malaria specific documentation:	**Attachment #**
13. Situation analysis	_____
14. Baseline data for the tracking of progress	_____
15. Country strategic plan to Roll Back Malaria, with budget estimates	_____
16. Result oriented plan, with budget and resource gap indication (where available)	_____

[1] Where baselines are not available, plans to establish baselines should be included in the proposal.

General documentation:	**Attachment #**
17. CCM documents 17.1 Department of Health policies 17.1.1 Administrative Order # 76, s.2002 (February 5, 2002) 17.1.2 Department Order # 86-J, s. 2002 (March 4, 2002) 17.1.3 Administrative Order # 83-A, s. 2002 (March 5, 2002) 17.2 Minutes of Meeting 17.2.1 NIDAC meeting on February 15, 2002 17.2.2 NIDAC meeting on April 26, 2002 17.2.3 CCM meeting on August 30, 2002 17.3 Documents from CCM members 17.3.1 Philippine Coalition Against Tuberculosis 17.3.2 Philippine Tuberculosis Society, Inc. 17.3.3 Tropical Disease Foundation 17.3.4 Philippine Society for Microbiology and Infectious Diseases 17.3.5 Philippine Business for Social Progress 17.3.6 Philippine Rural Reconstruction Movement 17.3.7 Kilusan Ligtas Malaria 17.3.8 Philippine National AIDS Council	

TB specific documentation:	**Attachment**
Project Matrix for the TB Component of the GFATM Proposal	Annex 1
Detailed Budget for the TB Component of the GFATM Proposal	Annex 2
The 1997 Nationwide Tuberculosis Prevalence Survey in the Philippines	Annex 3
Tuberculosis in the Urban Poor Settlements in the Philippines	Annex 4
Proclamation No. 840 (Declaring August 19 as the National TB Day)	Annex 5
Memorandum Circular 98-155 (Local Government Tuberculosis Control Strategy)	Annex 6
Empowering the Private Sector in the Control of Tuberculosis in the Philippines in a Strengthened National TB Program	Annex 7
Nationwide Basic C.O. & Campaign Against TB	Annex 8
DOTS-Plus for MDR - TB in the Philippines: Global Assistance Urgently Needed	Annex 9
Application for Grant of Anti-TB Drugs from the Global TB Drug Facility	Annex 10
Demographic Health Survey, 1997, Philippines (Pages 151 to 153)	Annex 11
Project Assistant to Control Tuberculosis (PACT)	Annex 12
2000 Annual Report Tropical Disease Foundation	Annex 13

Malaria specific documentation:	**Attachment #**

Crosscutting documents/activities	**Attachment #**