The Global Fund
To Fight AIDS, Tuberculosis and Malaria

Concept Note for Early Applicants

This concept note template is to be completed by early applicants invited to request funding from the Global Fund in 2013 during the transition to the new funding model. For more information on how to complete this template, please refer to the Concept Note Instructions.

The funding request details the applicant's request for Global Fund resources in a disease area (and/or health systems strengthening). Referring as appropriate to relevant sections of the national health sector strategic plan, national disease strategic plans and other appropriate documentation, the funding request allows a country to articulate an ambitious and strategic funding request that will achieve maximum impact.

The sections of the concept note are:

Section 1: Summary information about the request.

Section 2: The application development process and compliance with CCM Eligibility Requirements.

Section 3: The description of the country's epidemiological situation, the national health and disease strategic plans' response, and the community systems and human rights context.

Section 4: The funding request, including a programmatic gap analysis, budget description and rationale, counterpart financing and focus of the funding request requirement.

Section 5: Implementation arrangements, including PR minimum standards.

Section 6: List of abbreviations and acronyms; list of annexes.

This concept note template is specifically designed for early applicants. It does not represent the final template to be used for the full roll out of the new funding model, and will be revised to reflect feedback received during the transition phase.

SECTION 1: SUMMARY INFORMATION			
1.1 Applicant Information			
Country	**Philippines**		
Applicant Type	**CCM**	**Component**	**TB**
Funding Request Start Date	**1 January 2014**	**Funding Request End Date**	**31 December 2016**

1.2 Summary Budget

Currency of Funding Request			USD		
Dates	A=Existing (GF Grant)	B= Indicative Funding Request (Incremental)	A+B= Existing plus Indicative Funding Request	C= Above Indicative Funding Request	A+B+C = Full Request
2014			22,877,031	6,311,074	29,188,105
2015			23,809,739	7,048,302	30,858,041
2016			25,493,230	8,121,846	33,615,076
Years 1-3 TOTAL			72,180,000	21,481,222	93,661,222

NOTE: The country has an ongoing/existing TGF Grant for TB (PHL-210-G11-T) that covers 2012-2014. This is not reflected in column "A" because the approved budget for 2014 was reprogrammed as part of the NFM early application for TB. Moreover, this concept note contains activities based on reprogramming and "Enhanced" National Strategic Plan for TB Control in the Philippines (Enhanced PhilPACT).

1.3 Confirmation of Program Split for Indicative Funding

During country dialogue, the applicant will propose how best to distribute indicative funding across relevant disease programs and cross-cutting health systems strengthening (HSS). Please provide the original indicative program split as communicated by the Global Fund, and, if relevant, the split approved by the Global Fund following country dialogue.

Program	Original Indicative Program Split Amount (USD)	Approved Program Split Amount (USD)	
HIV		HIV	
		Cross-cutting HSS	
Malaria		Malaria	
		Cross-cutting HSS	
Tuberculosis	**34,000,000**	Tuberculosis	**39,380,000**
		Cross-cutting HSS	
Total Indicative Funding	**34,000,000**	**Disease components**	**39,380,000**
		Cross-cutting HSS	**0**

SECTION 2: CCM ELIGIBILITY REQUIREMENTS AND DUAL TRACK FINANCING

Two of the six CCM Eligibility Requirements relate to development of the funding request and Principal Recipient (PR) selection processes and will be assessed as part of the funding request:

a. **Requirement 1 –** Funding request development process

b. **Requirement 2** - The Principal Recipient(s) selection process.

For each requirement, applicants must provide evidence of compliance and attach relevant supporting documentation. Please also fill in the **CCM Endorsement (Attachment 1)**.

2.1 Funding Request Development Process (Requirement 1)

Describe:

a. The **documented and transparent process** undertaken by the CCM to engage a broad range of stakeholders, including non-CCM members, in the funding request development process.

b. The efforts made to engage **key populations,** including most-at-risk populations, as active participants in the country dialogue and funding request development process. In your response, please be specific on who has participated.

In February 2013, The Global Fund (TGF) launched their New Funding Model (NFM) and invited the Philippines to be an early applicant for TB under the NFM. The Philippine Country Coordinating Mechanism (PCCM) accepted the invitation and initiated the formation of a special task force (CN Task Force) with supervision from the National TB Technical Working Group (TB TWG) to work toward the development and submission of the GF-NFM Concept Note (CN) for TB. The task force was comprised of selected members of the TB TWG, particularly representatives from the (a) Department of Health-Infectious Disease Office – National TB Control Program (DOH-IDO-NTP), (b) Lung Center of the Philippines (LCP), (c) National TB Reference Laboratory (NTRL), (d) Center for Health Development – National Capital Region (CHD-NCR), (e) United States Agency for International Development (USAID), and (f) WHO Philippines. The Philippine Business for Social Progress (PBSP) was also part of the task force, being the incumbent PR for the ongoing GFTB Phase 2 Project.

The National TB Program targeted to conduct a Joint Program Review (JPR) on the NTP in 2013, which is essentially a mid- implementation assessment of its 6-year strategy to control TB (Philippine Plan of

Action to Control TB or PhilPACT 2010-2016). As early as 2012, sub-assessments have been conducted on 4 key program elements: 1) National Health Systems Strengthening (NHSS), 2) Programmatic Management of Drug-Resistant TB (PMDT), 3) Laboratory Network, and 4) TB-HIV Collaboration. All of which resulted to the development of PhilPACT draft sub-plans. The development process and the sub plans for all 4 key program elements are detailed in Annex 2.1A, 2.1B, 2.1C, and 2.1D respectively. *All of the sub-plans were developed in consultation with key population groups (TB Patients, TB Patient Groups, PLHIV, PLHIV Support Groups and non-CCM members) and representatives from national/local government units, public/ private health care providers, Civil Society Organizations (NGOs, CBOs, Academe, Professional Groups), Donor groups, other government agencies and the private sector.*

The figure below represents the summary of the development process of the GF-NFM CN for TB. Each process was conducted with constant consultation with PCCM to fit the requirements stated in the application guideline for NFM. Also, recommendations from the TGF Philippine Country Team were acknowledged and considered during the agreement for process.

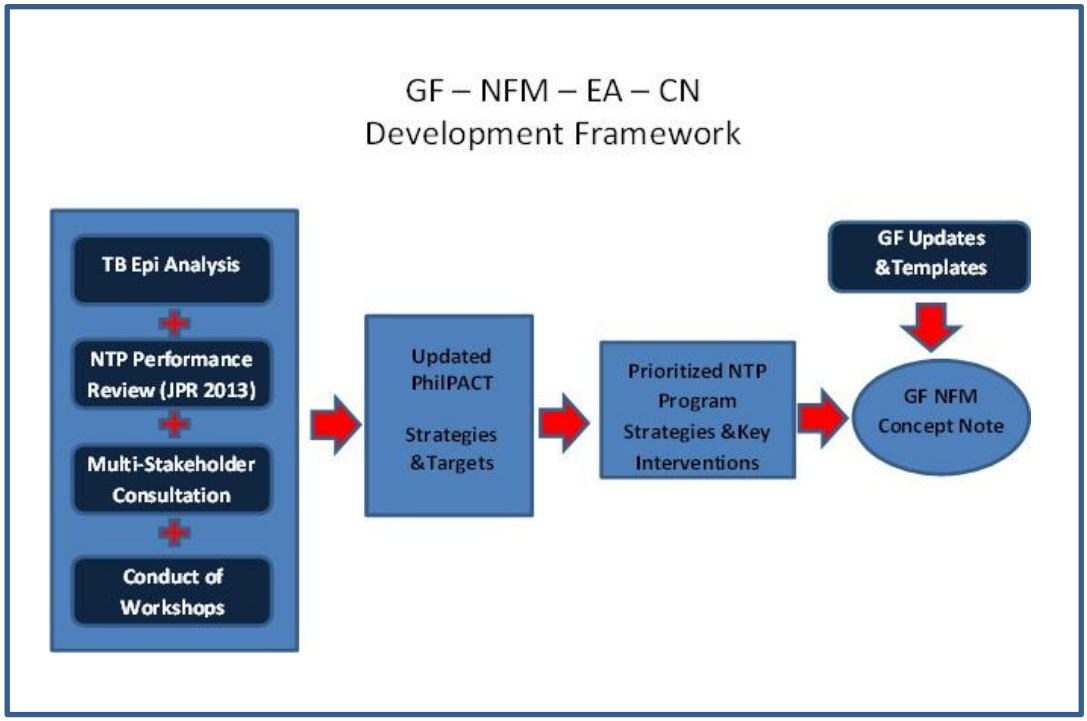


Figure 1. GF-NFM concept note process development summary

The NTP with support from the WHO Western Pacific Regional Office (WPRO), commissioned both international and local epidemiologists namely Dr. Norio Yamada (Japan/Research Institute of Tuberculosis) and Professor Maridel Borja (Manila/University of the Philippines – College of Public Health) to conduct the TB epidemiologic review for the Philippines which is also part of the JPR *(see detailed epidemiological review results in Annex 2.1 E)*. Another assessment review was commissioned by NTP with the support of PBSP through the current GFTB Phase 2 grant. The focus of this assessment is to review the Organizational Development (OD) component of NTP wherein a local OD consultant, Ms. Ramonesa Ricardo (Development Academy of the Philippines), was hired and conducted the OD assessment study *(see detailed OD assessment findings in Annex 2.1F).*

The findings and analysis from both epidemiological and OD assessment review provided the country with the most up-to-date TB disease trend and program management performance which served as key references in preparation for the review of the NTP performance.

The CCM through the CN Task Force initiated the discussions on the process for updating the PhilPACT and developing a draft CN in May 2013 *(See Annex 2.1G for the documentation on the PhilPACT steering committee and CN Task Force meeting).*

The 1st workshop for the review and updating of the PhilPACT was conducted during the 1st week of June *(See Annex 2.1H for Activity Report).* The workshop culminated with a multi-stakeholder consultation wherein comments regarding the enhanced PhilPACT targets and interventions, and the possible components of the CN for TB would be discussed further.

On the 3rd week of June, consolidated comments on the enhanced PhilPACT and data for the CN components were presented to develop the Draft CN for TB using the GF modular template *(See Annex 2.1 I for the Activity Report).* Part of the workshop includes discussion and agreements for the interventions to be proposed in the CN which was also anchored on a mapping and analysis of available/committed resources (funding landscape) for TB Control in the country. The said workshop was attended by the Task Force, CCM representatives and the GF Philippine Country team. The financial section of the CN was finalized and completed on the 26th of June *(See Annex 2.1J for the Activity Report).*

Recognizing the critical role of the different Local Government Units (LGUs) in the implementation of TB control programs, representatives from LGUs were invited to solicit comments and feedback from them regarding the full draft concept note. In the event, the task force received positive responses from the representatives *(See Annex 2.1K).*

The enhanced PhilPACT and the draft concept note were also presented to the CCM via a special session on 27th of June *(See Annex 2.1L for Minutes of Meeting)* then comments and recommendations from the consultations done were considered during a separate session for the CN peer review and finalization among the Task Force on the 2nd of July *(See Annex2.1M)*. Incorporating all final comments, the completed Draft CN was presented to the CCM on the 7th of July *(See Annex 2.1N for Minutes of Meeting).*

A copy of the Draft CN was also shared to the GF country team who coordinated an early TRP review in 15 July 2013, as part of their technical assistance support for the early applicants. Both the GF country team and the TRP provided several feedback/questions on the draft CN submitted. Responses to these comments were prepared and are already integrated into the various sections of this CN. Thus, a summary of the questions and answers is submitted herein as *Annex 2.1O.*

On 23 August – 6 September 2013, the JPR 2013 was conducted and key findings from the preliminary report validated the internal assessment findings (achievements, challenges and recommended action) of the NTP. The key JPR findings and recommendations have been greatly taken into account in the development of the enhanced PhilPACT and related sub-plans, including the eventual finalization of the GF NFM CN for TB early application *(this document)*. The presentation on the summary findings and recommendations from the JPR 2013 presented in the high-level debriefing is attached as *Annex 2.1P.* Full report is expected to be completed by end of September 2013. The insights from the JPR are also detailed in the CN under Section 3.

The final version of the GF NFM CN for TB early application of the Philippines was presented in full to the CCM on 12 September 2013 and was endorsed for submission to the GF *(See Annex 2.1Q).*

2.2 Principal Recipient (PR) Nomination and Selection Process (Requirement 2)

Describe:

a. The documented and transparent **process and criteria** used to nominate any new or continuing PR(s).

b. How any **potential conflict of interest** that may have affected the PR(s) nomination process was **managed**.

Selection of the Principal Recipient for the TB project was listed as Agenda No. 7 in the 4th regular meeting of the PCCM, held at One Tagaytay Hotel, Tagaytay City on April18, 2013.

In the same meeting, the Technical Working Group for TB , strongly recommended to retain Philippine Business for Social Progress (PBSP), the current PR for the GF TB Phase 2 Grant for TB in the Philippines (2012-2014) based on the following:

1. **on the aspect of developing a good harmonized rationally written plan, the best partner would be the current PR;**
2. **satisfactory performance and the need to consolidate the grant as part of the GF NFM; and**
3. **on the aspect of urgency to meet the GF timeline.**

At the level of PCCM, there was no formal announcement made neither written nor verbal invite sent out to interested parties to submit Expression of Interest for the TB – PR because of limitations in time. The PCCM understood that the Philippines is one of the countries invited by GF to participate in the Early Application Process under the NFM and PCCM is fully aware that such invitation entails specific requirements such as having a qualified PR who can work with the program in the development of the concept note or proposal. This prompted the discussion to whether open the PR position to other interested parties or retain the current TB PR which is the PBSP. In this context, voting ensued. Voting method was through show of hands whereby 8 members were in favor of the decision to retain PBSP as PR and 4 voted against.

The PCCM body as per majority votes, decided PBSP to be the PR for the GF NFM – TB Grant in the Philippines for 2014 -2016 ***(See Annex 2.2).***

2.3 Dual-track Financing

Dual-track financing refers to a proposed implementation arrangement that involves both government and non-government sector PRs. If this funding request does not reflect dual-track financing, please explain why. **If this funding request includes a dual-track financing arrangement do not complete this section**.

This proposal will NOT take on dual track financing. It was decided by PCCM that non-DOH PR will be engaged to perform the function since the country has a rich pool of institutions qualified to perform the required functions of PR under the GF NFM.

The GF NFM Grant for TB will be managed by PBSP, an NGO who is currently managing the GF-TB Phase 2 Grant for TB in the Philippines (PHL-210-G11-T).

The Philippine DOH by mandate is the lead agency of the government for its Universal Health Care (UHC). The agency also sits as chair of the CCM Secretariat and chair of the TB TWG. Critical in its mandate is to oversee and coordinate all related efforts for TB, both funded by both public and private sectors (including all foreign assisted projects and those funded by private philanthropists). Considering this major role and anchored on best practice in program management and implementation, it is deemed more appropriate for DOH to focus on its leadership and oversight functions, including policy and regulation functions rather than placing extra burden with responsibilities on focused management and implementation of the GF grant. This is also aligned with the Conflict of Interest (COI) policy of the CCM, which recognizes the same rationale.

SECTION 3: COUNTRY CONTEXT

3.1 Country Disease and Health Systems Context

Explain the current and evolving epidemiology of the disease and relevant health system constraints in the country. Refer to the Performance and Impact Profile (PIP) provided by the Global Fund, and provide additional information to highlight the concentration of burden among specific population groups, age groups, gender and/or geographic regions, and any recent disease pattern changes (incidence or prevalence). Describe:

a. **The epidemiological situation and the key populations** that are epidemiologically important, and may have disproportionately low access to prevention and treatment (and for HIV and TB, the availability of care and support services).

b. Factors that may cause **inequity in access to services** for treatment and prevention, such as gender norms and practices, poverty, geography, conflict and natural disasters.

The Philippines and its Health System:

The Philippines, an archipelago of 7,100 islands, is located in the Southeast Asia. It has an estimated 97.5 million population in 2012. Population annual growth rate is 1.9%. They are distributed in 17 administrative regions (one is an autonomous region), 82 provinces and 135 cities of which 35 are highly urbanized. Functional literacy rate is 88.7% among females and 84.2% among males. It is a lower middle-income country with gross national income per capita of $4,160. Poverty incidence in 2012 is 22.3%. The top 3 regions in poverty incidence are ARMM, Region 5 and 12. The Philippines is one the growing economies in Asia with a GDP growth rate of 6% in 2012; however, un-employment rate is still high.

Health system is decentralized since early 1990s with the Department of Health (DOH) retained the mandate of health regulation, policy development, and promotion through the 16 regional health offices called the "Center for Health Development (CHD)" and the Autonomous Region of Muslim Mindanao (ARMM). Basic integrated health services are provided through the 2,314 health centers (HCs)/rural health units (RHUs) of the municipalities and cities. All of the 2,314 health centers nationwide are DOTS providers. These health facilities are under the administrative control of the local government units (LGUs) headed by a Mayor. Technical oversight by DOH is through the provincial/city health offices (PHO/CHO) of the LGU headed by Governor or City Mayor. Private sector also provides health goods and services through private hospitals and clinics, laboratories and drug stores. Public-private collaboration is a national policy. As of December 2012, there are 126 private hospitals, 162 public hospitals providing DOTS services. Under the GFTB Project, 8513 private health care workers were trained on DOTS. It is estimated that case detected through private 6% of the country's case detection rate in 2011.

The Infectious Disease Office (IDO) of the National Center for Disease Prevention and Control (NDCPC-DOH) exercises the over-all management of the National TB Control Program (NTP). Different DOH offices support IDO. National TB Reference Laboratory (NTRL) of the Research Institute of Tropical Medicine (RITM) manages TB laboratory network while the Programmatic Management of Drug Resistant TB (PMDT) is handled by the Lung Center of the Philippines (LCP). The National Epidemiology Center (NEC) and Information Management Service (IMS) are responsible for the health information system; the Procurement & Logistics Service (PLS) oversees the DOH procurement and supply system and manpower development by the Health Human Resource Development Bureau (HHRDB).

TB Disease Trend

The Philippines remains to be one of the 22 high burden countries in the world. The World Health Organization (WHO) in its 2012 Global TB Report *(Annex 3.1A)* has estimated that the country's TB incidence declined from 393/100,000 in 1990 to 270/1000 in 2011 (31.3% reduction); mortality rate from 58/100,000 in 1990 to 29/100,000 in 201 (50% reduction); and TB prevalence rate from 1,000/100,000 in 1990 to 484/100,000 in 2011 (51.6% reduction). To date, the country has achieved MDG targets and given the annual rate of decline, the magnitude of TB will be further reduced in 2016 as shown in Figure 2.

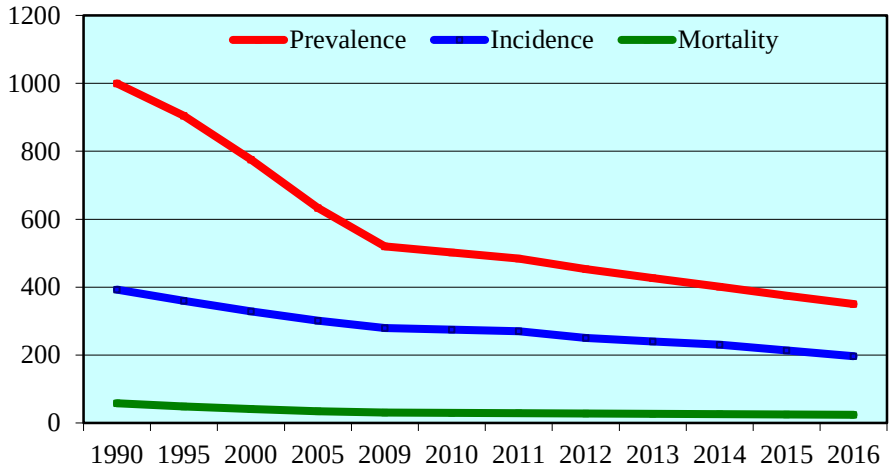


Figure 2. Trend of TB incidence, mortality and prevalence rate,1990 - 2016

The 2010 Philippine Health Statistics *(See Annex 3.1B)* reported that TB is the 6th cause of mortality in the country with a rate of 26.3/100,000 *(lower than WHO estimate)*. TB deaths are 5.1% of the total deaths. The rate is slightly lower than the five-year average of 28.6/100,000. In terms of TB mortality, a decreasing trend in TB mortality rate was noted wherein more deaths among males (17,103) was observed compared to deaths among females (7,611). However, the rate varied by geographical areas. Per cent of deaths without medical attendance range from 24% (Region 8) to 54% (NCR).

Based on the three (3) National TB prevalence surveys *(Annex 3.1C)* done in 1982, 1997 and 2007, the country had shown a continuous reduction of prevalence of smear and culture positive TB cases. However, there was an increase in the prevalence of those with chest x-ray findings suggestive of TB from 1997 to 2007. The proportion of those with symptoms suggestive of TB also decreased from 1997 to 2007.

Table I. National TB Prevalence Survey Summary of Findings

Indicator	NPS 1981 -82	NPS 1997	NPS 2007
Prevalence of culture positive TB	8.6/1,000	8.1/1,000	4.7/1,000
Prevalence of sputum smear-positive TB	6.6. / 1,000	3.1/1,000	2.0/1,000
Prevalence of those with x-ray findings suggestive of TB	4.2%	4.2%	6.3%
Percent of TB symptomatics	17.0%	18.4%	13.5%

In 2007, prevalence of smear positive was higher among males compared to females with rates of 3.5/1000 versus 1.9/1000 during their productive years. Prevalence was also higher among the malnourished and diabetics and prevalence increased with age. In addition, The 1997 NPS revealed that TB prevalence is twice among the urban poor than the general population.

Except for the urban poor which showed a TB prevalence *(per 1997 NPS)* twice that of the general population, the country has no regional nor provincial data on TB prevalence or incidence, thus disease burden per area could not be presented. The DOH-issued Philippine Health Statistics contains the TB mortality rate by region (which has limitations when comparing among areas due to varying quality of vital registration system), that varies from 2 per 100,000 (ARMM) to 43 peer 100,000 (Region 6). It is however estimated that TB prevalence will be higher among the regions and provinces with high incidence of poverty rate, geographically inaccessible, those regularly affected by man-made (armed conflicts) and natural disasters and with inadequate health service delivery network. Generally, these factors affected the NTP performance in these regions. Based on these characteristics *(Annex 3.1D),* the Autonomous Region of Muslim Mindanao (ARMM) fits into most of these situations followed by Region IV-A. The ratio of health facility workers and volunteers per population is grossly deficient in these areas.

The case detection rate among the 17 regions ranges from 46% (Region 2) to 114% (Region 6) while the treatment success rate ranges from 87% to 94%. Three big regions namely Region IV-A, the National Capital Region (NCR) and Region 3 are estimated to contribute to the most number of TB cases based on the national TB incidence rate. However, Region 3 and IVA perform less than the expected target. ARMM is an autonomous region populated by Muslims, suffering from prolonged conflicts (political and personal), with widespread poverty, mostly geographically inaccessible and inadequate health service capacity while Region IVA is the biggest region, with high population/health worker or facility ration with weak regional TB control team.

NTP with the support of its partners, such as IMPACT and SIAPS, both being funded by USAID, had prioritized ARMM and the big regions – CALABARZON, NCR and Region 3 for technical assistance such as capability-building, monitoring and advocacy with the local government units. The NTP is addressing the needs of the rural and urban poor through the deployment of Health AIDERS that is being proposed under this grant. Improving the proportion of health workers to population is being addressed by the Department of Health (DOH) through the deployment of the 22,500 nurses and midwives to the health centers and hospitals for manpower augmentation. The Philippine government has implemented several poverty intervention, one of which is the conditional cash transfer to the first quintile (covering 4.8 million Filipinos).

The country also ranked 8th among the countries with high burden of MDR-TB. The 1st Philippine Drug Resistance Survey (DRS) conducted in 2003 revealed that the prevalence of MDR among new cases is 4% and 21% among re-treatment cases with a combined prevalence of 5%. Result of the 2nd DRS is expected to be delivered by the end of 2013.

According to the TB-HIV Performance Presentation Report in 2012, TB-HIV co-infection in the country remains low with 0.1 % of TB patients infected with HIV. However, more strategies to encourage HIV testing among TB patients should be implemented to improve testing rate of 2% among all TB cases to the desired rate of at least 80% among all TB cases.

<u>TB Notification Trend</u>

The DOTS strategy was expanded nationwide in 2003.

In 2012, there were 216,051 TB cases notified, all forms, which yields to a case detection rate (CDR), all forms, of 82% (regional range: 46% - 114%) and case notification (CNR) of 221/100,000 (regional range of 123 – 307). The top four performing regions are Western Visayas, Bicol, CARAGA and the National Capital Region (NCR). Among the total notified TB cases, 93,450 (43%) are new smear positive cases while 4,079 (1.9%) are relapse and extra-pulmonary (EP) is only 3,270 (1.5%) (NTP 2012 Performance Report). The remainder of 53.6% are smear negative cases. The low EP maybe due to non-involvement of most hospitals where EP are mostly found.

Figure 3 below shows an increasing trend of CDR of new smear positive and TB, all forms from 2000 to 2012. The faster increase of CDR, all forms, from 2009 to 2012 is attributed to the higher increase among the smear negative TB cases including children. Proportion of children among the total cases varied by region from 10% to 40% which may indicate an over diagnosis in some areas. Trend of notification rate of new smear positive cases by sex showed slight increase among males than females.

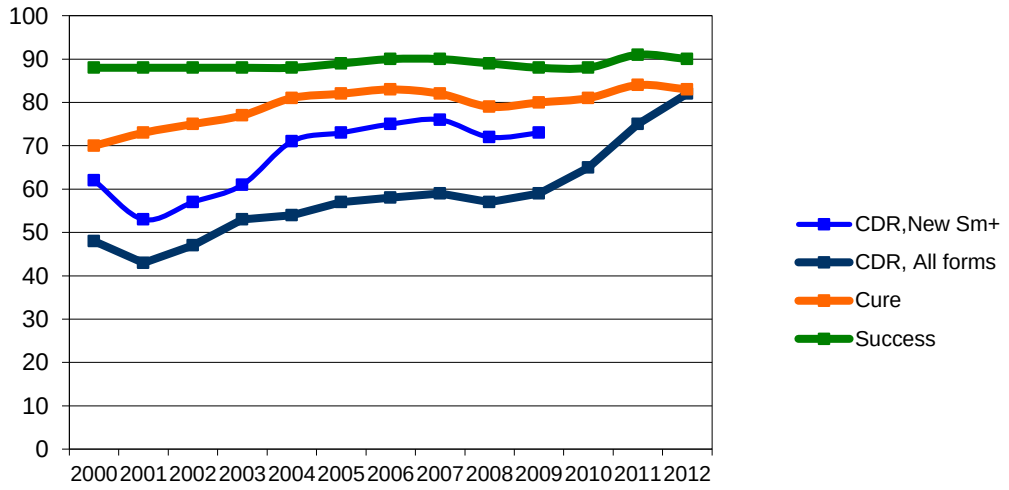


Fig. 3. Trend of CDR and treatment/cure rate, 2000 - 2012

There is a decrease in the smear positivity rate among TB symptomatic examined but overall smear positivity rate is still around 15%. This implies that case finding in general is not yet saturated.

The increasing trend of reported TB symptomatics and TB patients could be attributed to the (a) engagement of the non-NTP providers like the private practitioners, hospitals, drug stores and other government health facilities, (b) change in the major indicator being reported by NTP from CDR, NSP to CDR, all forms, and (c) improved reporting of children.

Treatment outcome, as shown above, is generally good with treatment success rate (TSR) of new smear positive cases is more than 85% since year 2000, the latest (2011 cohort) being 90%. Other outcomes are: death (2%), failed (1%), default (4%) and not evaluated (3%). However, there is variation among regions, provinces and cities. Default rate of more than 5% is registered by ARMM, CALABARZON and Southern Mindanao.

In 2012, the PMDT program has tested 17% of retreatment cases, and <1% of new cases. Around 1807 MDR-TB cases were diagnosed and 1799 were enrolled. Currently 2618 cases are undergoing anti-TB second-line treatment. The current program coverage is at 17% of the estimated annual MDR-TB cases in the Philippines. The country is embarking on rapid expansion of MDR services to increase coverage by 40% by 2016. Note that more details on the current implementation of PMDT in the country is discussed in the latter part of this section.

Based on the JPR initial findings from the TB Epidemiologic Review *(Annex 3.1E)* by Dr. Yamada and Prof. Borja, key findings related to the TB disease trend were raised:

1. **<u>Case Finding.</u> Since 2001, the ratio of diagnosed TB cases to the number of TB symptomatic increased. Alongside this is the decrease in smear positive cases and increase is in smear negative cases, which largely comprised of childhood TB cases. These findings are attributable to the NTP case finding expansion interventions to include policy focusing on smear positive cases, increasing coverage for childhood TB, increase in implementation of hospital-based DOTS and involvement**

of Public-Private Mixed DOTS. The over-all smear positivity rate is around 15%, which means case finding is generally not saturated.

2. **Treatment Outcomes. Treatment Outcomes are generally good while variation is present by areas. The proportion of re-treatment cases is stable and low. On the assumption that there is no significant number of primary defaulters, the overall treatment program quality is considered acceptable.**

3. **Impact of NTP on Trend of Mortality. Assuming TB mortality data is comparable over the time, it is observed that while TB CNR is increasing recently, TB deaths are decreasing. Decrease in TB deaths seems to be faster recently with increase in TB CNR. This may suggest that expanding quality DOTS has impact on the reduction of TB mortality. Although there might be several factors for mortality trend that needs to be taken into consideration. Further analysis is needed (by region, age group and sex) for better understanding of the situation.**

4. **Impact of NTP on Prevalence. Assuming results are comparable, the prevalence of both smear positive and culture positive TB case decreased between 1997 and 2007. This suggests that not only case finding and but also good treatment might have contributed to reduce prevalence of bacteriologically positive TB. The prevalence of CXR findings of TB increase may probably be due to TB survivors showing abnormal CXR shadows. While it is not possible to further investigate due to lack of data, there was a noted decrease in the prevalence of smear positive cases in females over males, while prevalence itself is lower in females. Note, however, that the difference between genders has been reduced.**

5. **Impact of NTP on Incidence. Source of infection in community has decreased because prevalence of bacteriologically positive cases decreased. This might contribute to reduction of TB incidence, which comes from recent infection. Overall impact needs further assessment.**

6. **MDR Trend. Until the 2nd DRS results are released, it is not possible to conclude. However, age pattern may indicate ongoing transmission of MRD TB among young age group is more likely to be from recent infection, than elderly patients are. If the observation is true, MDR is still transmitted in the community and that there may be regional differences. There is also no clear association between treatment outcome achievements and as such, MDR may be from TB treatment in non-NTP facilities. Acceleration of PMDT is necessary and situational analysis survey of TB treatment outside the NTP network may be required.**

7. **TB-HIV. Further information is required for non-NCR target areas. Prevalence of HIV among TB patients examined in NCR is less than 1%. According to NASPCP, TB prevalence among PLHIVs is around 54%. However, HIV incidence is increasing exponentially which merits strengthening surveillance and monitoring of co-infections owing to TB-HIV co-morbidity.**

Over-all, the NTP is performing toward the attainment of their vision for a TB –Free Philippines, however burden is still high and much effort needs to be taken into consideration to sustain/enhance and expand program coverage. While the TB disease indicators for the country are aligned with the global targets, significant variations are evident by region and among key population groups *(Annex 3.1F).*

These variations essentially reflects the inequities of health outcomes which are attributable to social determinants of poor health that generally influences TB epidemiology in the country:

1. **Poverty. It is an established fact that there is direct correlation of poverty and disease, like TB. Concomitant to poverty are malnutrition, illiteracy, crowding, poor population density, and poor access to care which increases vulnerability to TB transmission. While TB disease does**

discriminate, TB tends to be more prevalent in urban areas, with the highest incidence seen among the poorest and most crowded areas. More so, urban environments provide, as epicenters for the transmission of MDR-TB, allowing for interactions between various at-risk populations, like HIV infection and AIDS. As of 2012, 22% of the Filipinos have family income below the threshold. Furthermore, the poor have the greatest need for services; yet the non-poor have a greater access to services. The non-poor receives larger share of public subsidies compared to the very poor. Most services are available at the facility level, which the poor in GIDA could not access, thus, creating a low demand from the poor establishing inequities of health outcomes.

2. **Stigma & Poor Health Seeking Behavior. Stigma essentially roots from misinformation. The 1997 NPS showed that positive action behavior among those with TB is low- only 21% of TB symptomatics and 28% of TB patients consulted a health provider. Not much change has resulted since the 2007 NPS showed that 68% of TB symptomatic cases do not take any action and 43% of them self-medicate. The lack of a clear health communication plan/framework disables implementation of strategic interventions to address stigma and improve health-seeking behavior through information, education and communication and behavior change communication campaigns. While there is increasing participation among community-based groups and patient groups, these needs to be further expanded and strengthened to result to significant impact. In addition, poor households and communities have the potential to be producers of health & nutrition outcome, if they are equipped with the right knowledge, attitude and behavior. By addressing their health information needs, inequities of health outcomes can also be addressed.**

3. **Health System Barriers. Access to quality TB services is affected by weaknesses and deficiency in both the national and local levels of government. These are related to a) infrastructure (lack of and/or inequitable distribution of health facilities concentrated in urban areas), b) human resources (lack of health care providers, underpaid and overworked staff, inadequately trained, migration to other countries), c) financing (underfunded public health services, d) high out-of-pocket transaction costs, low population coverage and low availment of PhilHealth benefits, e) governance (corruption, health not a priority, health program implications of political dynasty), f) regulation (lack of institutional capability, weak implementation of drug regulation, strong commercialization of anti-TB drugs, weak regulation among private facilities), g) service delivery (inadequate linkage between public-public and public-private health facilities, geographical accessibility within and among regions, varying treatment protocols among private health care providers), and h) information (weak health promotion strategy, weak vital registration and manual data recording & consolidation).**

4. **Vulnerable Population Coverage. DOTS implementation is at 100% among all health facilities (local DOTS Centers) and yet the NTP has not reached saturation point for its key performance indicators. This supports the need for a more aggressive active case finding that will look into the vulnerable populations that are not reached by the current NTP infrastructure. This includes increasing participation of private health facilities into DOTS implementation (public/ private hospitals and clinics) and developing/implementing better interventions for DOTS service delivery among inmates, children, close contacts, urban poor, indigenous population, elderly, disabled, people in GIDA and those with TB co-morbidities (especially PLHIV and DM). Further discussion on this is detailed in Section 4.7.**

5. **Program Management & Administration. Contributing to the inequalities of health outcome can also be attributed to the lack of management skills and competencies among TB program managers at all levels of the NTP, which are generally comprised of clinicians. This limits their potential to strategically manage the program and address to health systems strengthening.**

3.2 National Health Sector and National Disease Strategic Plans

Describe the current national health sector strategic plan, as well as the relevant national disease strategic plan (and attach these documents), and the implementation of these plans to date, citing any recent evidence from relevant program reviews, evaluations, surveillance data or surveys.

Summarize for each plan:

a. The **key goals, objectives and priority program areas.**
b. The **key implementers** involved, and their main sources of funding.
c. **Main outcomes and impact** achieved to date, noting any limitations in **national data systems** to measure service delivery and/or demonstrate impact.
d. Country processes **for reviewing and revising** these plans. If valid for less than 18 months, explain the process and timeline for the development of a new plan.
e. **Constraints to implementation**, and **lessons learned** that will inform future implementation.

Also summarize:

f. The **main areas of linkage** between the plans, including how implementation of the national health sector strategic plan impacts on HIV, tuberculosis and malaria outcomes.
g. **Key human rights barriers** (including those relating to gender inequalities) that may impede access to health services, and existing programs that address these key constraints.
h. The **main community systems-related constraints** that challenge the achievement of planned outcomes, and existing programs that address these key constraints.

Philippine Universal Health Care Program

The National Health Strategic Plan is embodied in the Aquino Health Agenda *(Annex 3.2A)* through the Universal Health Care (UHC) or *Kalusugang Pangkalahatan* (KP). UHC seeks to "improve, streamline, and scale up the health reform strategies in order to address inequities in health outcomes by ensuring that all Filipinos, especially those belonging to the lowest two income quintiles, have equitable access to quality health care". The goals are (a) financial risk protection, (b) improved access to quality hospitals and health care facilities, and (c) attainment of the health-related MDGs. The National Health Insurance Program NHIP) of the Philippine Health Insurance Corporation (PhilHealth) is the prime mover to achieve these goals.

The following are the six (6) strategic instruments to achieve the AHA strategic thrusts- (a) health financing, (b) service delivery, (c) policy, standards and regulation, (f) governance for health, (e) human resources for health, and (f) health information. The National Objectives for Health (NOH) contains key health targets and strategies to address public health problems which include TB CDR and TSR that were adopted from the PhilPACT. These TB indicators are also included in measuring the health performance of the local government units (LGU) and the Centers for Health Development (CHD).

The country's strategic plan to control TB is contained in the 2010 – 2016 Philippine Plan of Action to Control TB or PhilPACT *(Annex 3.2B).* It was developed in 2009 by the writing groups headed by the NTP manager under the strategic guidance of the steering committee headed by the NCDPC director and underwent consultative process that involved stakeholders from the LGUs, other government agencies, private organizations, non-governmental organizations, TB patient organization and development

partners. It was issued by DOH through administrative order (AO) no. 2010-003. The vision is TB-free Philippines and the goal is to reduce TB mortality and morbidity by half compared to 1990 data by achieving the targets of CDR of 85% and TSR of 90% and detecting and treating at least 15,000 MDR TB patients.

The PhilPACT has four objectives that cover the six UHC strategic instruments, eight strategies and 30 performance targets as shown in table II. below:

Table II. PhilPACT Strategies and Performance Targets

PhilPACT Objectives vis-a-vis AHA/UHC	Strategies	No. of performance targets
Reduce local variation in TB control performance (*Governance and health information)*	1. Localize implementation of TB control 2. Monitor health system performance	5 3
Scale up and sustain coverage of DOTS implementation (*Health service delivery and human resource*)	3. Engage both public and private health care providers 4. Promote and strengthen positive behavior of communities 5. Address MDR-TB, TB/HIV, and needs of vulnerable population	3 3 6
Ensure provision of quality TB services *(Regulation)*	6. Regulate and make available quality TB diagnostic tests and drugs 7. Certify and accredit TB care providers	4 3
Reduce out-of-pocket expenses related to TB care *(Financing)*	8. Secure adequate funding and improve allocation and efficiency of fund utilization	4

The PhilPACT ensures that supply-side would be able to respond to the demand of the communities and patients by managing the six strategic instruments. Systems enhancement ensures that logistics are always available, human resources have the capability to provide the services and that progress is tracked through an enhanced information system. Engaging the non-NTP providers such as private practitioners, hospitals, other government health facilities such as prison clinics is necessary to find the missing TB cases. It also recognizes the need for appropriate approach to address needs of the vulnerable population, the MDR-TB patients and TB HIV co-infected patients.

The Joint Program Review (JPR 2013) for the National TB Program *(See detailed JPR information in Annex 2.1P)*

Mid-way of the implementation of the PhilPACT, the NTP and its key stakeholders conducted a Joint Program Review of the National TB Program aimed at assessing the over-all NTP progress within an integrated health system setting with reference from the PhilPACT strategies. The exercise looked into the implementation gaps among the thematic areas of assessment to include: (1) Local TB Epidemiology, (2) Basic DOTS implementation, (3) Laboratory Network Operations, (4) Public-Private Partnerships in DOTS, (5) Advocacy, Communication and Social Mobilization for DOTS, (6) Programmatic Management of Drug-

Resistant TB, (7) TB Drug and Commodities Supply Management, (8) Program-related Policy, Finance and Governance, and (9) NTP Organizational Systems and Capacity.

The JPR 2013 was conducted by around 80 individuals divided into 7 teams comprised of international and local consultants, including technical representatives from the DOH national and regional offices, LCP, NTRL, NGOs (PBSP, World Vision, PhilCAT), USAID Office of Health and its current projects (IMPACT, CHANGE, HPDP, SIAPS), Global Fund Secretariat, WHO (WHO Geneva, WEPRO, WHO Philippines), and RIT-JATA. The various teams covered 14 provinces and cities nationwide and conducted the JPR 2013 from 23 August up to 6 September 2013. Note that both the epidemiologic review (Yamada/Borja) and the OD assessment (Ricardo) are part of the JPR 2013 and were conducted before the JPR 2013 field visits.

The figure below presents the JPR 2013 process and methodology. The references used in this document are from the area reports, thematic reports and high-level findings presented in the JPR 2013 debriefing. The JPR 2013 full report will be available by end of September 2013.

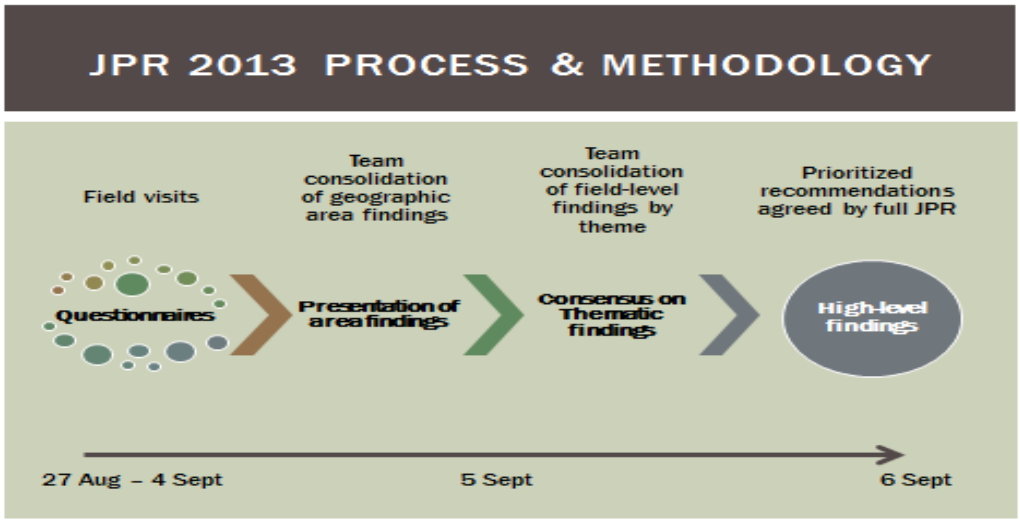


Figure 4. 2013 Joint Program Review Process and Methodology

Based on the preliminary report of the JPR 2013 *(Annex 2.1P),* The Philippine's NTP is a model program among the world's high-burden countries having been built with a solid foundation. However, there are several gaps that should be considered moving forward to better the NTP and achieve country committed targets.

JPR Findings: NTP Major Achievements

Since 1990, the Philippines made efforts in reducing the prevalence of and annual number of deaths due to TB by approximately 50%, ensuring the attainment of the country's commitment to control TB under the MDGs.

The Stop TB Strategy is implemented across the country, within an integrated health system and including the involvement of multi-sectoral stakeholders. The PhilPACT articulates a technically appropriate plan that expands the NTP's priorities beyond smear-positive cases, to include all forms of TB. Progress toward TB targets is monitored as one of the performance measures of Local Government Units (LGUs). All of the 2,300 Regional Health Units (RHUs) implement DOTS, with a network of barangay health workers extending case detection and treatment activities into communities. With over 200,000 cases diagnosed and initiated on treatment, the estimated case detection rate of all forms of TB was 82% in 2012. The

strategic expansion of Private sector and Public hospital engagement in DOTS (PPMD) has benefitted national case detection, contributing 24% of notified cases in 2012. Over half of inmates in jails and 83% of inmates in prisons are covered by the DOTS network. The treatment success rate in 2011 was 91%.

The NTP benefits from strong political commitment to health, in general, and TB specifically. The Department of Health's budget has shown continuous increase in the past 5 years. The government funds the central procurement of all of the required drugs for new and retreatment smear-positive patients. The increase in the health budget will enable the expansion of benefits and number of beneficiaries under the national health insurance plan, Philippine Health Insurance Corporation (PhilHealth), and infrastructure improvements. PhilHealth coverage for the management of drug-resistant TB is anticipated to begin in 2014.

The NTP has successfully secured and managed increasing levels of funding from external sources, enabling it to introduce newly available technologies for diagnosis and to initiate the Programmatic Management of Drug-Resistant Tuberculosis (PMDT). Forty-five PMDT treatment sites have been launched in 16 of the 17 regions, and the number of cases initiated on treatment for drug-resistant TB increased four-fold between 2009 and 2011.

JPR Findings: NTP Challenges

Consolidating the JPR 2013 area and thematic reports in discussing the current challenges of the NTP has been categorized into 3 NTP service areas, namely: (A) Challenges in finding all TB cases; (2) Challenges in ensuring that all TB patients are cured and (3) Challenges in securing an enabling environment for quality TB control. Below are the major challenges identified:

A. ***Challenges in finding all TB cases.*** **Among TB patients who were actively seeking care through the formal health network, the review identified various missed opportunities for their identification as TB patients. The smear-positivity rate averaged over 20% in laboratories visited, suggesting that out-patient departments and general practice offices are not suspecting TB sufficiently to ensure that TB patients are not missed or their diagnosis delayed. Many retreatment cases were not screened for drug resistance, limiting timely detection of drug-resistant cases. A substantial proportion of rifampicin-resistant cases (34% in 2012) were not enrolled on treatment. The proportion of public and private hospitals, and private practitioners, engaged in DOTS remains relatively low given the magnitude of these sectors within the country. Finally, a high number of jails and prisons are not yet incorporated into the DOTS network and inmates have limited access to care.**

   There is evidence from past demographic health surveys to confirm the findings from patient and community-member interviews conducted during the JPR ,that many patients continue to face considerable barriers to seeking care. Most notable were lack of information at the community level about TB and the availability of free services. Given the lack of information, stigma remains high in some regions and patients fear the detection of TB. Transportation costs for facility visits and laboratory confirmation remain a barrier for many.

   Furthermore, the laboratory network lacks trained microscopists and quality assurance to monitor their performance was irregular. The use of the newly introduced Xpert MTB/Rif machines is not being adequately monitored.

B. ***Challenges in ensuring all TB cases are cured.*** **While the national treatment success rate is high, considerable variance was noted among and within regions. Where treatment success rates were low, the policy of directly observed treatment was commonly not followed. Referrals were not systematically done, leading to high default rates among some groups, such as migrant workers. The proportion of patients on treatment for drug-resistant TB who default is unacceptably high at**

more than 30% among patients who initiated treatment in 2009. The factors contributing to the high default rates are not fully understood. However, anecdotal evidence from some patients suggests that the centralized nature of treatment is overly burdensome for patients and their families as they incur high travel costs and extensive time away from work and home (financial limitations). Severe adverse reactions and long treatment duration were also reported as reasons for discontinuation of treatment.

While stock-outs of first line drugs were rarely reported and seemed only to stem from distribution delays, stock-outs of streptomycin and pediatric formulations were common. The overall drug supply management system is insufficient to ensure the uninterrupted supply of first-line drugs, with incomplete evidence for appropriate forecasting, inadequate buffer stocks, and limited tools for stock management. For the Second Line Drugs (SLD) however, no stock outs have been reported, but there has been overstock on PASER and Cs and packets of expired drugs. The overstock (of PASER and Cs) is very likely due to the ADRs which prompted adjustment in the treatment regimen. Overstock and expiration of some drugs are likely due to non-achievement of target for patient enrolment under PMDT since 2011. At that time, reference and basis for forecasting was the target for patient enrolment and non-achievement of the target means non-utilization of duly procured drugs. In this CN under the NFM, strategy to prevent further occurrence of overstock and expiration was considered and taken into consideration which includes new forecasting mechanism and strengthening DSM capacity of the NTP.

C. ***Securing an enabling environment for quality TB control.*** **While there is an allotted budget for TB control nationally through the Department of Health, the most fundamental risks to the sustainability of strong program performance and continued improvement in coverage of quality services are related to the system barriers for accessing this fund. The JPR identified two primary constraints to the timely availability of funding. The first relates to managerial capacity, particularly at LGU level, to comply with the planning and budgeting requirements to secure timely regional funding allocations. The second relates to the low level of reimbursements under PhilHealth, which severely limits the availability of funding to support supervisory activities, or local innovations in service delivery and patient support. The current reimbursement sharing schemes vary by LGU and may not benefit the health workers expected to file the claims resulting to lower motivation to process claim. Confirming patient eligibility under PhilHealth is cumbersome, given the lack of access by facilities to lists of eligible patients. The burden of documenting eligibility falls to the TB patients, who receive free TB treatment regardless of whether a claim is filed or not and therefore, are not motivated to assist the facility with filing a claim. The proportion of DOTS facilities that are PhilHealth accredited remains low.**

Given the breadth of activities required to implement quality patient-centered care, the complexities of coordinating multiple donor investments and significant government funds, and the magnitude of the coverage of the program, the availability of DOH-employed human resources is insufficient. The program has turned to externally funded, project-based staff who lose employment at the end of project cycles, and contractual workers in service delivery sites, to cover the gaps. Building and sustaining the capacity of these staff in the context of high turnover poses a challenge.

Monitoring, supervision, quality control and evaluation of program activities were insufficient at all levels of the system. The gaps are associated with the constraints highlighted above, namely the limited or delayed availability of funding for supervision and the shortage of human resources. Data reporting is often delayed. The new electronic data systems that may support more routine monitoring have not yet been operationalized, with limited availability of computers, internet connections or phone lines in RHUs.

The JPR identified constraints to the operationalization of the NTP's strategic expansion of programmatic priorities to include all forms of TB. Central financing and procurement is only guaranteed for drugs needed to treat categories 1 and 3, and for laboratory reagents to diagnose drug sensitive disease. Secondly, the rollout of PMDT has not yet been fully integrated within the DOTS network. Screening for drug resistance and diagnosis and treatment of MDR-TB are largely operating through a parallel system. Currently, nearly all operational costs and commodities for PMDT are provided by external donors.

Aligned to and in addition to the JPR 2013 findings, the NTP has determined key issues that should be addressed as the NTP Action Agenda to support successful TB Control implementation in the Philippines in the remainder of the PhilPACT implementation coverage (2014-2016):

1. **Lack of Manpower. One of the key JPR findings was the lack of DOH personnel (quantity and quality) to manage the implementation of the NTP at all levels. This is further complicated by the recent approval of the DOH Rationalization Plan resulting to reduction of DOH personnel at the regional levels by 50%. And despite the increasing budget allocation for TB Control, the high burden and large program coverage challenges greatly the implementation of the NTP due to the current lack of manpower and inevitable reductions in the coming months. This is further complicated by the inability of local government units (provinces and municipalities), who are poor and cannot afford hiring more personnel to support their local health delivery system.**

2. **Lack of access to affordable and quality TB diagnostic services. TB Laboratory services, particularly those using new diagnostic tools, are concentrated in highly populated areas to include key cities and provincial capitals. This contributes to lack of access among rural populations, particularly those in Geographically Isolated and Depressed Areas (GIDA). Furthermore, the program has much needed improvements in maintaining and ensuring the quality of TB diagnostics services for microscopy, culture, and DST across all providers.**

3. **Limited Case Finding. Since the DOT strategy was introduced in the Philippines, case finding has always been passive, which potentially supports the non-detection and non-reporting of cases to the NTP among patients detected by the non-NTP facilities. Furthermore, passive case finding is also an underlying factor supporting non detection of TB among high risk and vulnerable populations. While the PhilPACT committed to increase DOTS coverage among vulnerable populations, it was limited to pilot initiatives in selected sites for DOTS delivery for children, urban poor, PLWHA and inmates.**

4. **Many non-NTP providers still utilized by the TB patients.** All Health Centers/RHU in the country are **DOTS facilities, but majority of private hospitals and clinics and even public hospitals nationwide are not providing TB services in accordance with NTP protocol. This imposes a key limitation of the program as majority of people seeking medical help goes to private clinics and hospitals. Non-compliance to DOTS by private providers (hospitals and clinics) correlate to higher out-of-pocket expenditure that may lead to treatment interruption and default which may eventually lead to complicated cases of TB like MDR/XDR/TDR-TB.**

5. **Low detection and poor treatment outcome of the MDR-TB patients. By end of 2012, only 17% of estimated 11,469 MDR-TB patients had been detected and started treatment. The 2009 patient cohort shows treatment success rate of 56% and high defaulter rate of 33%. Consistent with the JPR 2013 findings, the main reason for low coverage and high default rate remains to be due to lack of access to PMDT services and the poor socio-economic status of patients that affects treatment adherence.**

6. **Weak TB and HIV collaboration. While a policy is in place for TB-HIV collaboration, its implementation has been constrained and limited in the past several years. The current TB-HIV collaboration is**

operational to date only in the National Capital Region. The protocol for co-infection management is yet to be developed, including capacity strengthening for both TB and HIV facilities on co-management. Referral systems also need to be established, including effective recording and reporting. There is also a need to expand area coverage, enhance collaboration between NTP and NSPCP and enhance collaboration of DOTS facilities and treatment hubs.

7. **Poor logistical management system. Incidence of stock-outs of Category 2 anti-TB drugs, overstocking of pediatric anti-TB drugs and lack of PPD in the DOTS facilities had been reported to NTP. As mentioned in the previous section, the 2013 JPR identified specific problems on the NTP drugs and commodities supply management, namely (a) lack of trained manpower and tool/system in forecasting of NTP logistics to be procured by DOH, (b) lack of buffer stocks, (c) inadequate storage space in the national, regional and provincial levels, (d) the National Online Stock Inventory Recording system (NOSIRS) that tracks the goods at different levels is not yet implemented nationwide and (d) lack of systematic monitoring and supervision.**

8. **Weak TB Information Management System. Over-all the NTP data management system is weak, complicated by the country's weak vital registry/surveillance systems. Since much data are manually prepared, there is poor data quality and delayed reporting—which defeats data purpose to help in management decision making and planning.**

   Before 2010, several information systems where being used for TB. It was in 2011 that the NTP pushed for the development of an integrated TB information System (IT IS). Due to the ongoing enhancement of the DOH enterprise architecture, the development of IT IS progressed slowly and to date, it is being piloted in selected regions nationwide. In its current state, enhancements particularly on the laboratory module are being done, including on-going efforts to link IT IS to DOH information systems such as NOSIRS (which captures DSM related data and variables) and ClinicSys (the DOH's official information system for all Health Centers)

9. **Weak Program Management and Financial Management Capacity. Based on the JPR findings, particularly on the OD assessment *(Annex 2.1F),* the NTP not only lacks manpower across all levels, but also the management and financial capacity to perform its function more efficiently. In its current set-up, the NTP is lodged under the DOH-NCDCP-IDO being managed by a full-time Program Manager and a technical officer shared by the IDO. At the regional levels, there NTP Medical and Nurse coordinators, but not true for all CHDs. Majority of the programmatic/technical, administrative and financial functions (core tasks) of the IDO for NTP are project-funded. On the other hand, based on the last 5 years, the NTP budget allocation has been increasing but utilization is seen to be low and slow. Another critical finding is on the NTRL being structurally lodged under RITM but whose work is almost all related to the NTP.**

10. **Underutilized Philhealth. The JPR found out that the PHIC is operational, having been able to release reimbursements to both public and private health DOTS facilities. However, it is challenged greatly as reach and utilization remains limited and low. Eligibility and benefits information is not available to all members which limits its use. Furthermore, there is a need to establish mechanisms to ensure funds reach the facilities, processes are streamlined and simplified and TB-related packages are enhanced and developed, especially for DR-TB cases. It is further noted that PHIC should be studied to be leveraged as a mechanism for quality control.**

NOTE: The JPR 2013 recommendations and planned action response, including the funding landscape and those action responses, which is included in this CN application is detailed in Section 4, on the discussion of the programmatic gap.

Enhancement of the PhilPACT

Anchored on the NTP internal assessment and as further validated by the JPR 2013 findings and recommendations, the NTP, in consultation with key stakeholders, worked on the updating and revision of the PhilPACT. The "Enhanced PhilPACT" *(Annex 3.2C)* served as reference in the development of this concept note. As discussed in Section 2.1 of this application, the enhanced PhilPACT is anchored on the most recent TB epidemiological data for the country and specific sub-plans of relating to priority program areas for the NTP (laboratory network, PMDT, TB HIV collaboration, and NTP health systems strengthening).

Most of the changes reflected in the Enhanced PhilPACT aims to address the above-mentioned challenges and details of the strategies, interventions and new country TB control performance targets were based on these sub-plans:

- **The NTP health system strengthening (NHSS) sub-plan identified key areas that must be enhanced to support the scale-up of different NTP initiatives. These are in the area of program management strengthening, human resource augmentation, public-private engagement, and integrated TB information system expansion and logistics management improvement. *(Annex 2.1A)***

- **The PMDT sub-plan provides the roadmap for finding more drug-resistant TB cases by expanding the coverage through mainstreaming of PMDT services within the existing DOTS facilities and reducing poor treatment outcomes. *(Annex 2.1B)***

- **The laboratory sub-plan aims to expand access to quality laboratory diagnostic services both for susceptible and drug resistant TB cases. *(Annex 2.1C)***

- **The TB HIV sub-plan describes joint plan of the NTP and the NASPCP approaches to strengthen collaboration at the national/regional and service delivery levels to ensure that TB HIV patients are promptly and effectively attended to. *(Annex 2.1D)***

The Enhanced PhilPACT Operating Structure:

Organizational unit	Program areas	Coverage areas
Department of Health including its CHDs and hospitals	• Policy and standard development • Data management/ M&E • Logistics management • Hospitals provide TB services	Nationwide
Local government units through provincial and city health offices	• Formulation of local TB plan and policies • Provision of technical support • Monitoring and evaluation • Quality control of laboratory services	Nationwide
Local government units through the health centers, rural health units, barangay health stations	• Provision of TB diagnostic, treatment and counselling services • Referral • Data management • Logistics Management	Nationwide
Other government agencies	• Formulation of policies and guidelines for the sector they cover such as the inmates, labor, poor, indigenous people	Nationwide

Engaged Private sector	• Provision of TB services • Advocacy	Nationwide
Development partners	• Financial and technical support	USAID projects are in 43 provinces and cities; GF is nationwide, KOFIH in one province and RIT/JATA in 2 cities of Metro Manila
Communities	• Assist in TB symptomatic identification, doing DOT and TB education	Nationwide

Note: The detailed functions of the various organizations and institutions in the implementation of the PhilPACT can be seen in the NTP Manual of Procedures *(Annex 3.2D)* and the functional areas of the various Foreign Assisted Projects are seen in *Annex 3.2E*.

PhilPACT Current Outcomes and Impact

Suggested Revision: Results of the internal midterm review of the PhilPACT targets showed that TB mortality and TB prevalence of all forms were already achieved. It is also projected that CDR, all forms is likely to be achieved aligned with the MDG timeline. while the treatment success rate has already been achieved. Two key indicators: (1) detection of MDR- TB and (2) no. of children treated and given IPT, however, are currently not on track to be achieved by 2016. Table below provides a detailed presentation of the country performance and achievements:

TABLE III. PhilPACT Impact Targets and Country Performance

PHILPACT IMPACT TARGETS	ACHIEVEMENT	REMARKS
Reduce TB mortality from 87/100,000 to less than 44 per 100,000 in 2016 (recomputed: 58/100,000)	29 per 100,000 (2012 Global TB Report)	Achieved
Reduce prevalence of all forms of TB from 799 per 100,000 in 1990 to less than 400 per 100,000 in 2016. (Recomputed 1000/100000)	484 per 100,000 (2012 Global TB Report)	Achieved
OUTCOME TARGETS		
At least 85% of new smear positive TB cases are detected and at least 90% have successful treatment	CDR, all forms (2012)=82% Treatment success rate = 91%	On track to be achieved Achieved

At total of at least 15,000 MDR-TB cases have been detected and provided with quality-assured second line drugs	From 2010 – 2012, a total of 3,367 MDR-TB had been detected and initiated treatment (22% of total target)	Not on track
OUTPUTS / BENEFICIARIES by 2016		
5 million TB symptomatics examined	1,790,000 (36%)	On track to be achieved
1 million adult TB patients (all forms) provided with treatment	565,855 (57%)	On track to be achieved
730,000 children provided with treatment or preventive therapy	87,936 (12%)	Not on track
15,000 MDR-TB detected and provided with SLD	3,367 (22%)	Not on track
15,000 TB patients provided with HIV counselling and testing	8,623 (57%)	On track to be achieved

National Data System

Mortality statistics are collected by the National Statistics Office (NSO) through vital registration and analysed and published by the DOH through the annual Philippine Health Statistics. However, it is important to note that the quality of the data provided by NSO may not capture the overall TB mortality situation as it was documented that around 40% of the TB deaths were not medically attended. In order to address this gap, it was recommended that the country perform a TB mortality study.

The NTP through the GFTB Phase 2 Grant commissioned Dr. Anna Beirrenbach in 2011 to conduct a national level review of TB Mortality in the country. However, due to lack of data that will allow cross-referencing for analysis, a sub-national TB mortality was recommended. Preliminary results of data collected showed that a sub- national data analysis of TB mortality was also not feasible because of lack of data to be used for analysis. Dr. Beirrenbach provided key recommendations to help improve the country's data quality in preparation for a future TB Mortality Survey (Annex 3.2F).

The National Epidemiology Center (NEC) and NTP routinely collect TB morbidity data from the public health facilities as part of the Field Health Services Information System (FHSIS).

The National TB Prevalence Survey (NTPS or NPS) is performed in order to determine the present magnitude of the tuberculosis problem. The results of this survey will serve as the basis for the course of action that the NTP will take to control tuberculosis in the Philippines. The country has conducted the NTPS/ NPS from 1981, 1997 and 2007 (See Results on Annex 3.1C). A 4th NTPS/ NPS is slated on 2017.

The nationwide survey on drug resistance aims to determine the national prevalence of primary and acquired resistance to the four major anti- tuberculosis drugs. The Philippines conducted its 1st National Drug Resistance Survey (DRS) in 2003 – 2004, whereby the reported prevalence of the different forms of anti-TB drug resistance were high. Resistance to any drug was 20.4% in new TB cases and 38.8% in previously treated TB Case. Multi- drug resistant TB prevalence was 3.8% and 20.9% respectively. (See Results on Annex 3.2G). The 2nd DRS was conducted through the GFTB Phase 2 Grant in 2011-2012 and the final report is due by the end of 2013.

Data on health seeking behavior is also included in the 2008 National Demographic Health Survey (NDHS), in 2012 Family Health Survey and will be part of the 2013 NDHS.

The WHO uses these above-mentioned surveys to estimate the country's TB incidence, prevalence and mortality and number of people with MDR-TB disease.

Routine reporting of TB symptomatics and TB cases are performed by DOTS facilities to NTP by manually filled-up quarterly NTP reports that are submitted and consolidated by the provincial/city health offices (PHOs/CHOs) and CHDs. With this system, annual data is consolidated and officially reported every 2-3 quarters. In 2012, a Data Quality Audit (DQA) was externally commissioned by the NTP through the GFTB Phase 2 Grant and the study listed data quality issues particularly on data entry errors, delayed reporting and errors in data consolidation (Annex 3.2H).

Critical response to improve data quality was the development of a web-based, electronic NTP reporting system called the Integrated TB Information System (ITIS) supported under the GFTB Phase 1 and 2 grants. It is currently being rolled out for adoption nationwide by end of 2014. DQA is now routinely being done with the support of USAID IMPACT and SIAPS Projects. Part of the data management improvements for the NTP is the current initiative of the DOH-Information Management Service (IMS) to align ITIS to other DOH information systems such as the Clinic system that captures the basic information of patients consulting the HCs/RHUs, the Hospital Information System (HOMIS) used by public hospitals and the National Online Stock Inventory Registration System (NOSIRS) that tracks all DOH-procured and distributed health products including anti-TB drugs.

Country Planning Cycle

The country's health development agenda is part of the Philippine Medium Term Development Plan (2010-2016), particularly defined in the section on social development and termed as the Aquino Health Agenda (AHA) or the DOH-Universal Health Care (UHC), which has been described at the onset.

The AHA translates to development and implementation of Local Investment Plans for Health in all province and cities nationwide. And for the National TB Program, AHA instruments are embodied in the PhilPACT.

The NTP planning cycle is through the conduct of semi-annual assessment & planning sessions with CHD-NTP Program Managers who in turn, plan out NTP implementation with provincial/city and municipal health teams.

The DOH through the NTP chairs the National TB TWG that meets at least every quarter. The NTP also sits in various project/program steering committees, coalitions and similar bodies for co-ordination of efforts pursuant to the achievement of the NTP goals.

Since the PhilPACT is midway in its implementation, the NTP is undergoing an elaborate process of internal and external performance assessment. On the early part of 2013, NTP has initiated regional NTP performance assessment reviews and data consolidation & analysis of previous years. A Joint Program Review (JPR) has also been initiated that will peak between the 24th of August up to 6th of September as pre-selected international and local consultants, including donors and interest groups will look into the various components of the NTP vis-à-vis its PhilPACT commitments. The assessment of components, specifically the review of the current TB epidemiology of the country and Organizational Development Assessment of the NTP has been initiated and will be completed before the end of September 2013.

The results of the internal assessment exercises and the preliminary findings from the review of the TB Epidemiology has served as reference for the NTP to enhance the PhilPACT which served as reference for the development of this concept note, in consultation with multi-stakeholders, as previously described in Section 2.1.

Linkage of the AHA/DOH-UHC, PhilPACT and the GF NFM Early Grant Application for TB

The Universal Health Care (UHC) has three strategic thrusts, namely: (1) attainment of the health- related MDGs, particularly MDG 6 that covers performance targets for HIV-AIDS, Malaria, and TB; (2) financial protection through expanded coverage and benefits of PhilHealth; and (3)improve access to quality services from hospitals and other facilities.

To date, PhilHealth has developed and strengthened outpatient benefit packages for the three diseases including TB. Conditional Cash Transfers (CCT) was also implemented for the first quintile (about 4.8 poor households) that will be expanded to the 2nd quintile this year with DOH supporting through PhilHealth benefits and the Community Health Teams (CHT).

Health facilities such as hospitals and RHUs/HCs are being upgraded and frontline health workers are supplemented by the RN HEALS program (Registered Nurses for Health Enhancement and Local Service). These interventions positively affect the 3 diseases.

Table IV: Linkage of Global Fund support to PhilPACT and UHC

CN Module	Interventions for GF support	PhilPACT Strategy no.	PhilPACT Performance Target
DOTS package	*Increasing access to TB diagnostics*	*6*	*6.2 TB microscopy services are expanded to improve access* *6.3 Culture, DST and Rapid Diagnostic Centers are scaled-up*
	Engaging hospitals in TB control	*3*	*3.2 90% of public hospitals and 65% of private hospitals are participating in TB control either as DOTS provider or referring center*
	Health manpower supplementation in poor areas	*5*	*5.5 Policies, operational guidelines and models are developed, disseminated and locally adopted to address needs of vulnerable populations*
MDR-TB	*Mainstreaming PMDT*	*5*	*5.1 A total of 19,500 MDR-TB cases have been detected and provided with quality-assured second-line anti-TB drugs.* *5.2 At least 75% of MDRTB patients are successfully treated*
TB HIV collaboration	*Expanding TB HIV collaboration*	*5*	*5.3 At least 80% of enrolled TB cases in Category A and B areas and MDR-TB cases are provided with HIV counselling and testing*
M&E	*Monitoring and evaluation of interventions*	*2*	*2.3 TB information system integrated with national M&E system and with the Unified Health Management*

			Information System (UHMIS)
Program management		*1*	*1.4 At least 70% of national, regional and provincial/city teams have been trained and supported to manage TB control program*

Key Human Rights Barriers

The National TB Control Program recognizes that there are socio-cultural, geographic, financial and health system barriers in accessing TB care by the TB patients especially among the vulnerable population as shown by different studies and reported by the 2013 Joint Programmed Review (Annex 2.1P).

Several local studies show that stigma against TB still exist in the communities that could lead to discriminatory practices and adversely affect health service utilization. The 2008 National Demographic Health Survey showed that stigma varied among regions. It is highest in the Autonomous Region of Muslim Mindanao (ARMM). A USAID-supported project, Communication for Health Advancement through Networking and Governance Enhancement (CHANGE), had assisted NTP develop a communication plan and campaign which started in August 2013 with the intent of reducing stigma to TB. Innovations and Multi-Sectoral Partnerships to Achieve Control of TB (IMPACT), another USAID project, has been conducting training of health care providers on interpersonal communication and counselling to provide effective advice to TB patients and their families.

The following are the initiatives done by NTP to address the barriers to TB care among the vulnerable populations:

- **In 2005, upon NTP's advocacy, the Department of Labor and Employment (DOLE) issued policies and guidelines regarding the management of TB patients in the workplace to prevent workers from being unnecessarily terminated or discriminated**

- **Since 2008, NTP has worked with the National AIDS and STI Prevention and Control Program (NASPCP) to implement collaborative actions to address the problem of TB HIV co-infection. Plan, policies and program had been developed and implemented to ensure that TB patients in high risk areas will be tested for IV while HIV patients will be tested for TB**

- **Since 2009, TB-DOTS program has been implemented in in the jails and prisons in coordination with the Department of Justice (DOJ) that manages the prisons, the Bureau of Jails and Penology Management (BJMP) who oversee the jails and the International Committee of Red Cross who provides support on health and justice. Currently, 83% of inmates has access to TB diagnostic and treatment services**

- **Three projects supported by Global Fund, RIT/JATA and WHO/CIDA have implemented strategies to improve access by the urban poor to TB care in Metro Manila**

- **Logistical, psychosocial and financial support are being provided to the drug-resistant TB patients to enable them to comply with their daily treatment**

- **Six Professional Medical Associations or specialty societies (PCCP, PPS, PCR, PAFP, PCP, and PSMID) helped in disseminating the International Standards of TB Care and the Patient Charter.**

Nonetheless, these initiatives have limited population coverage, are currently not yet institutionalized and have not systematically addressed the needs of other vulnerable groups that include the indigenous population, those in conflict situations, rural poor, those affected by natural calamities and others. IMPACT, a USAID project, has been conducting a systematic profiling of these vulnerable groups and collecting evidences of various interventions with the aim of helping NTP prioritize these sub-groups and institute effective strategies.

Community Systems-related Constraints

The Philippines has long history of nurturing community participation in health promotion, prevention and service provision. It started in the 1970s with the implementation of NGO-led community based health programs. Government's involvement in engaging communities was evident after the declaration of Alma Ata in 1978 and the scaling up of primary health care implementation in the 1980s. Thousands of community health volunteers called "Barangay Health Workers" (BHW) were trained and assisted the health center staff in the provision of wide range of health services including TB care. Some LGUs provided varying amounts of financial assistance to BHWs to enable them to perform their tasks. In 2012, under the UHC, thousands of Community Health Teams or CHTs were organized and capacitated to perform three functions: (1) as PhilHealth navigator, (2) as service provider or referral assistance and (3) as health educator.

Under the NTP, since 1990's NGOs had organized community volunteers into groups called TB Task Force, TB Patrol, etc. to help in TB symptomatic identification, TB counselling, performing DOT and contact investigation. World Vision Development Foundation Inc. (WVDFI) documented that around 5% of the total TB cases in their project sites were contributed by the community groups.

Based on these experiences, there are four major constraints in community engagement:

1. ***Difficulty of sustaining the active participation of the community volunteers through time;***
2. ***Weak community system that would ensure successful referral to health centers and getting feedback;***
3. ***Inadequate logistical support such as transportation and supplies to enable volunteers to perform their functions; and***
4. ***Lack of supportive supervision by the health center staff to ensure that procedures / services are done by volunteers within the health protocol.***

Some projects such as the one supported by Global Fund, USAID, WHO/CIDA, KOFIH and RIT/JATA projects had provided insights on how to strengthen community systems to reduce barrier to TB services. These include strengthening the community health referral system, developing community level information system, community-NGO-HC partnership and supportive supervision.

Briefer PMDT Implementation in the Philippines

The Philippines ranked 8th among the high MDR-TB burden countries. Based on the 2003-04 Drug-Resistance Survey (DRS), the estimated prevalence of multi-drug resistant tuberculosis among TB retreatment cases is 21% and among all the new cases is 4%, both smear positive and negative. In absolute figures, there are around 10,000 MDR-TB cases annually. The 2nd DRS is ongoing and preliminary results does not veer away from the results of the 1st DRS. This will be confirmed by the end of 2013.

Background

The management of DR TB in the Philippines started in 1999 in a private DOTS clinic – Makati Medical Center through Tropical Disease Foundation (TDF) and was the first Green Light Committee (GLC) approved pilot project in the world.

In 2003, the Philippines' grant proposal for Round 2 of Global Fund was approved and one of the components was to treat 500 cases of MDR- TB. Additional treatment centers were established at the Kabalikat sa Kalusugan (KASAKA) in Quezon Institute (2004), a private institution, and at the Lung Center of the Philippines (2005), the first public facility to be involved in MDR – TB services as a treatment center.

In 2006, Round 5 proposal of the country to the Global Fund was approved again and cohort of cases to be treated was expanded from 500 to 2,500 MDR – TB cases from 2006 to 2011. This development paved the way for the mainstreaming of MDR– TB services to the National TB Control Program notwithstanding the involvement of the public sector through the LCP, and the public health centers through decentralization (community TB care) of MDR – TB cases. More facilities in the public and private sectors were involved as treatment centers and the National TB Reference Laboratory (RITM- NTRL) were engaged to establish a laboratory network in the country.

In 2008, the implementing guidelines for Programmatic Management of Drug-resistant TB (PMDT) was signed by the Secretary of Health setting the mandate to support the treatment of MDR – TB in the country.

In 2009, the Department of Health (DOH) took the stewardship in implementing the Programmatic Management of Drug – resistant TB and designated the LCP as the implementing arm for PMDT. A transition plan was created with different partners with the objective of ensuring the continuity of quality services to drug-resistant TB patients, strengthening of DOH technical and managerial capacity of PMDT, and to prepare DOH/LCP in acquiring GLC approval.

In 2010, the DOH applied to GLC for approval to continue MDR– TB services after the TDF ceased operations on March 31, 2010. An interim approval to treat 400 patients was granted to DOH on February 24, 2010 and was expanded to 1,200 patients (including the 400 patients in the interim approval) on May 7, 2010.

In 2012, the second phase of the Rolling Continuing Channel (RCC) GFATM Grant was approved to support the NTP in treating 7,903 cases of MDR – TB until 2014.

In May 2012, a WHO GLC Mission was conducted, resulting to various recommendations for the NTP and specifically to PMDT (Annex 2.1I is the *Monitoring Mission Report of the GLC* and Annex 2.1J is a *matrix of the GLC recommendations and status of action response*). Over-all the GLC saw good progress in case finding and program scale-up and identified several challenges for the improvement of PMDT in the country. The discussion below already takes into account all GLC recommendations adopted by the country.

PMDT Implementing Structure

Under the National TB Control Program, there are four main DOH offices involved in implementing PMDT on a national level. LCP ensures the quality implementation of PMDT treatment guidelines for both case holding and case finding. It is also responsible for the scale-up of PMDT services to all regions to attain service accessibility. The National TB Reference Laboratory (NTRL) of the Research Institute of Tropical Medicine (RITM) supervises the laboratory network for the PMDT; it is also responsible for the scale up of the laboratories for prompt and efficient diagnosis, as well as bacteriological monitoring of patients. The Materials Management Division (MMD) is mainly in charge of the storage and distribution of second line drugs. The DOH – Information Management Service leads the development and training rollout of the Integrated TB Information System (ITIS) for data management. The figure below presents the structure:

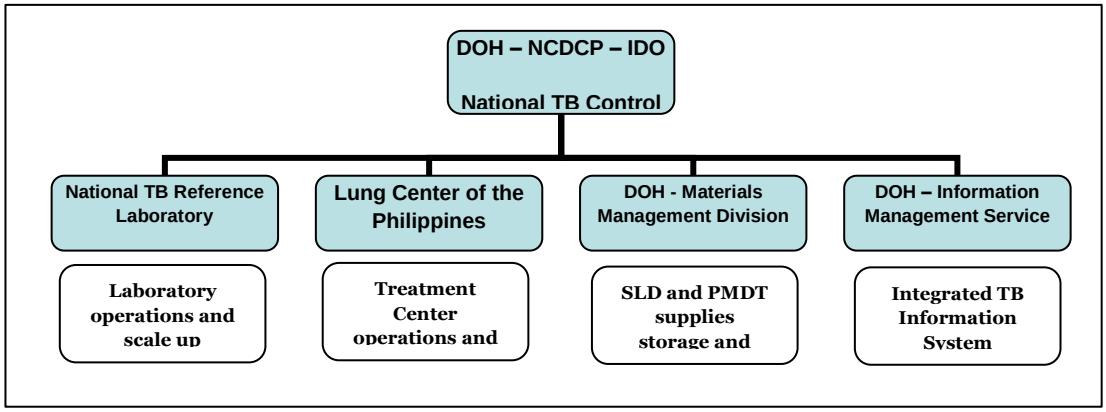


Figure 5. PMDT Implementing Structure

At the DOH-Regional levels, the Center for Health Development (CHD), otherwise known as the Regional DOH Centers oversees implementations and provides technical support to all facilities providing PMDT services.

PMDT Case Finding Mechanism

Both passive and intensified case finding are being implemented for PMDT. The following are presumptive DR-TB cases which are referred to PMDT treatment facilities for screening: (1) All retreatment cases including non-converter from Category 1 & 2; (2) New TB cases who are: (2.1) Contacts of confirmed DR-TB cases; (2.2) Non converter of Category I, (3) Persons living with HIV (PLHIV) who are presumptive TB cases and (4) high risk and vulnerable groups like inmates and children.

All presumptive DRTB cases from RHUs, Health Centers and Private Clinics and hospitals are referred to the nearest PMDT treatment facility for screening. The process, which usually lasts within 15-60 minutes, includes (1) patient interview for treatment history (2) physical assessment, (3) medical history, (4) sputum collection for DSSM / TB Culture/ Conventional DST and Xpert MTB/Rif MTB/Rif assay. At this stage, the health provider already explains the "Paunawa", wherein TB basic information are discussed to the patient, including the disease prognosis. All household contacts of diagnosed DRTB cases are also evaluated by screening for signs and symptoms and chest x-ray.

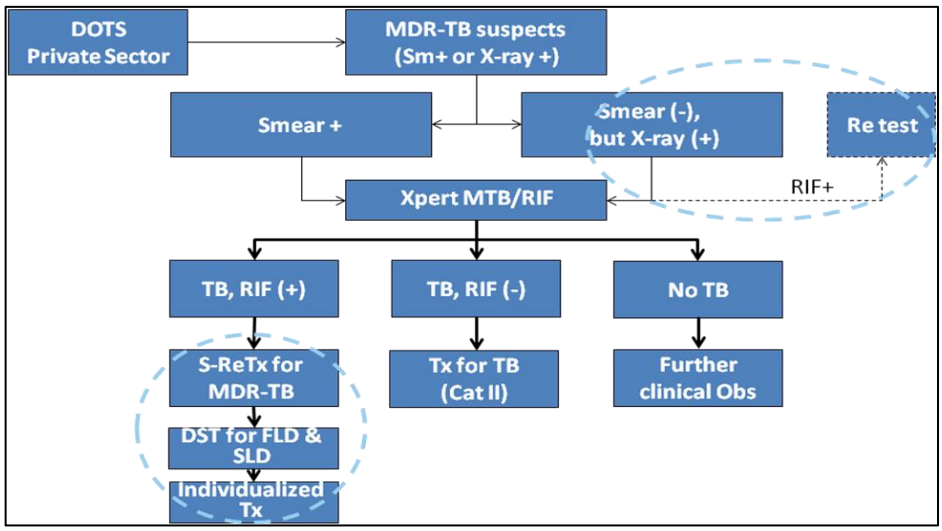


Figure 6. DRTB Case Finding Algorithm

PMDT Case Holding Mechanism

All cases diagnosed with resistance to Rifampicin through Xpert MTB/Rif MTB/Rif, are initiated on standard regimen for drug-resistant TB (SR-DR) as soon as possible. Once the GX results are ready (usually between 1-7 days depending on GX location), patients are informed of the result. For R-resistance GX confirmed cases, the PMDT health care provider calls the patient to inform them about the result and instructs them to prepare documentary requirements pre-requisite to treatment initiation. Patient is also advised to visit the TC as soon as possible. When the patient reports to the facility, preferably with a pre-identified treatment partner, the patient will be enrolled on CAT 4 treatment, followed by a counselling session focused: (1) on treatment regimen, (2) on what to expect out of treatment, (3) on the problems of not adhering to treatment and the possible adverse drug reactions, and (3) the enabler support packages. Before providing the 1st dose of treatment, an agreement between the patient and the provider called "Kasunduan" is signed, which essentially confirms the patient's willingness and commitment to undergo and complete the treatment. Within 7 days of treatment initiation, laboratory baseline tests are collected (DSSM, Culture, blood chemistry, X-ray and DST) for each enrolled patient.

The standardized regimen for confirmed DR-TB through Xpert MTB/Rif MTB/RIF testing Z-Km-Lfx-Pto-Cs. Intensive phase runs between 6 months or 4 months past culture conversion, whichever is longer and the continuation phase is for a minimum of 12 months. Individualized regimen (drug regimen revision/augmentation) is done once conventional DTS results are made available, decided upon by the PMDT consilium. Currently, there is a national and regional consilium.

For XDR-TB cases, an individualized regimen based on a quality assured first line and second line DST is prescribed for a minimum of 24 months. The regimen comprises of susceptible FQ, susceptible 2LI, all group 4 drugs plus two group 5 drugs and high dose of H. For MDR-TB cases suspected of XDR-TB, regimen includes unused FQ, unused 2LI and all group 4 drugs. Once the suspect shows resistance to both FQ and 2LI, XDR-TB regimen is used. For those cases showing resistance to other drugs other than R through conventional DST, individualized regimen is consistent with the WHO 2008 Emergency Guidelines and the Union DRTB Guidelines of 2013.

Each patient undergoes monthly monitoring of DSSM and culture during the intensive phase and during the continuation phase, DSSM monitoring is done monthly and culture every 2 months. For patients with age below 50, blood chemistry and x-ray monitoring are done every 6 months; and for patients with age 50 and above, this is done every 3 months.

The enable support package provided to a patient is dependent on the social case study and home verification report done by PMDT social health workers or nurses. Enablers are provided only to patients categorized as "Class C" based on the socio-economic classification of the Philippine Department of Social Welfare and Development (DSWD). Class C segment of the population are those who are poor, defined by combined family annual income and assets below the poverty threshold. The current enabler package includes transportation/meal allowances to support treatment adherence. Half-way houses are also made available to some patients who live far from the PMDT treatment facility. Other enabler support provided on a case-to-case basis includes special diagnostics for co-morbidity, special medical/surgical procedures and hospitalization.

Part of the DOT on the intensive phase is continuous patient assessment, ADR monitoring and inter-personal counselling. In case of treatment interruption, the health care provider immediately calls the patient to encourage treatment compliance. Default tracing, in cooperation with the RHU, is done weekly for patients who default within 3-5 continuous days.

Patient empowerment and holistic development is also part and parcel of the PMDT treatment package. Roving clinical psychologists are made available for psycho-social support, particularly in the National Capital Region (NCR). For non-NCR areas, services of psychologists are provided upon the clinic physician's discretion. Patients are also organized to participate in patient peer-support groups and related activities (facilitated group counselling, family counselling, and patient group general assemblies). Patients are also

equipped with livelihood trainings and skills development as part of the patient support package of PMDT.

Part of the PMDT protocol is decentralization, whereby patients completing the intensive phase with negative culture results are decentralized. There are cases however whereby patients are decentralized earlier, whenever their culture results turn out negative. The LCP ensures that the facility receiving the decentralized patients are trained and equipped in PMDT case management. Despite decentralization, the TC monitors patient progress through DOT every Saturday, including drug monitoring among the treatment sites.

For patients completing treatment (18 or 24 months), post-treatment follow-up is conducted every 6 months thereafter until 2 years using X-ray in the treatment centers. At any point in time that the patient shows signs and symptoms related to TB, the patient undergoes DSSM, Culture and DST. Depending on the result, treatment will be initiated.

Understanding the current PMDT Patient Decentralization

Diagnosed MDR-TB patients are managed by either the PMDT TC or STC during the intensive phase of treatment (1st six months). This depends on the proximity of the patient to the TC or STC. Patients under the intensive phase of treatment far from either the TC or STC housed in a PMDT halfway house. When DR-TB patients become culture negative, which is usually after 6 months, the patients begin the continuation phase of their treatment. It is at this time when patients are decentralized to the PMDT Treatment Site (TS).

Understanding the TC-STC and TS Dynamics for PMDT

Treatment Centers are public or private hospital-based/hospital-affiliated DOTS certified providers capacitated to give comprehensive PMDT services including management of complicated cases. Depending on their proximity to a public/private laboratory with Xpert MTB/Rif, they can directly provide Xpert MTB/Rif services to DR-TB suspects at the point of care. Satellite Treatment Centers (STCs) are DOTS-certified, LGU-managed health units (RHU/DOTS Facilities) capacitated to provide PMDT services. They do not provide Xpert MTB/Rif services.

Confirmed MDR-TB cases (via Xpert MTB/Rif) by the TC or Xpert MTB/Rif-capacitated laboratories are enrolled into PMDT treatment in the TC or STC, whichever is nearer to the patient's residence. Both the TC and STC manage DR-TB cases during the intensive phase of treatment. Both manage halfway houses, depending on patient load. Essentially, STCs are small TCs managing fewer MDR-TB patients.

The TS, on the other hand is like the STC, but smaller (scale of operations) and located nearer to the communities. They only manage DR-TB cases from among their covered geographical jurisdiction. Both the TC and STC transfer the management of MDR-TB cases to the TS once the patient converts to culture negative. They do not manage MDR- TB patients undergoing intensive phase of treatment.

PMDT Drugs and Supply Management

Forecasting and Procurement. **PMDT treatment facilities accomplish monthly report of Projected and Actual consumption of drugs and are submitted to LCP-PMO. These reports are used by the LCP in forecasting drugs (ancillary and SLD) and the procurement request will then be submitted to PR (PBSP). The procurement request is reviewed by DOH-IDO and USAID/SIAPS before PBSP initiates international procurement from the GDF via IDA.**

Requisition and Distribution. **Requisition of drugs and supplies is done by PMDT treatment facilities a month before the start of a specific quarter (e.g. 3rd quarter is July-September, requisitions were based from June DSM Reports and will be distributed to all facilities before the end of June). LCP consolidates all requests from the reports submitted and forwards the requests to the Central/Regional warehouse for repacking and distribution. Distribution of SLDs is done on a quarterly basis. On the other hand, ancillary**

medicines and medical supplies are distributed monthly.

***Monitoring and Reporting*. DSM reports accomplished by PMDT treatment facility staff are submitted to LCP – PMO on a monthly basis. This includes the actual consumption by all patients from the previous month. It also includes the current inventory of all SLDs, ancillary medicines and medical supplies, adverse drug reactions recorded, near-expiry/expired or damaged drugs, and drugs/supplies status. On-site drug monitoring in warehouses and treatment facilities is done by the CHD every month through the field coordinators and quarterly by LCP.**

Major Challenge in PMDT in the Philippines

As verified by the JPR 2013 and consistent with the GLC Mission recommendations in 2012, one of the major challenge faced by the PMDT in the country today is the high default among DR-TB cases. While there has been observable decline since 2012, this needs to be further mitigated. Several mechanisms (comprising the current Patient Enabler Package) are currently being employed to improve treatment adherence (and prevent default):

1. **Patient Decentralization. The lack of access to PMDT diagnostics and treatment facilities is one of the major reasons for default. Recognizing this, the program needs to bring treatment closer to the homes of the patients. Hence, there is a need to enhance/scale-up patient decentralization. Once a patient is decentralized, he/she will take all of his drugs at the treatment site but will need to visit the Treatment Center (TC) or Satellite Treatment Center (STC) every Saturday and other days that the treatment site is closed. All drugs, forms, entitlements and enablers that are given to patients will be continued as long as the patient is still taking his/her drugs.**

2. **Patient Psycho-social support. Continuous education and counseling (individual/group) is done in the treatment facilities. Counseling is readily available from trained facility personnel and roving psychologists. Furthermore, peer education and counseling sessions are being performed alongside organizing and empowering patient groups. Livelihood projects are also provided to patient groups to help them cope up and earn additional income to address their personal and family economic requirements.**

3. **Patient Housing Provision. Due to the limited PMDT facilities and in order to improve access to treatment, halfway houses are maintained by the treatment centers to accommodate patients who live far from the treatment facilities. Patients who avail of this provision stay during the intensive phase (up to 6 months) before decentralization.**

4. **Transportation/Meal Allowances. For patients who are not living far from the treatment facilities, but are financially constrained to travel daily for treatment, substantial amount is provided for transportation to and from the facility. For those patients who are decentralized, the allowance may be forfeited or converted into another form of support needed by the patient to continue treatment, which is usually meals/food supplementation.**

5. **Special Medical and Laboratory Support. Patient's experiencing co-morbidities and ADRs are provided with in-patient and out-patient subsidized medical (hospitalization/surgery/related expenses) and laboratory support (special diagnostics & procedures).**

6. **Default/Interrupter Tracing. Patients who are at high-risk of interruption are being tracked by the treatment facility staff to ensure they would not default. House visits are performed by the facility staff for patients who have incurred 8 absences in one month. Patients are counselled and reasons for interruption are identified and documented.**

7. **Community/Home-Based Treatment. This mechanism taps community health volunteers that are trained on how to manage PMDT cases during the continuing phase. These volunteer shall do house-to-house visit with the purpose of ensuring that patients have taken their daily medicines (DOTS).**

The abovementioned mechanisms (1-6) have been provided continuously in 2013. Assessment of its contribution to treatment adherence will be evaluated by the end of the year.

The 7th mechanism has recently been introduced as recommended by the GLC Mission 2012, when it was noted that there is an increasing default rate based on the 2009 cohort. As recommended by the GLC, the country developed an enhanced enabler package intensifying mechanisms 1-6 and introducing mechanism 7, which was initiated only in June 2013. Qualitative assessment on the efficiency of the enhanced enabler package can be evaluated by the end of 2013. However, analysis of the monthly default trend of 2012 and 2013 showed that patient default is lower after the initiation of the package which indicates positive effects of the said mechanism to mitigate/reduce default.

The PMDT enabler package is fully funded by the Global Fund. The PR has commissioned a perception survey and is current being conducted among patients and providers on the value of the enablers to patient treatment adherence. The results will be ready by end of September 2013. Notably, significant efforts being led by the NTP and with technical support from USAID (IMPACT and Health Policy Projects) are currently being done for the development and implementation of an MDR-TB Package under the Philippine National Health Insurance (PhilHealth), which takes into consideration the sustainability of providing enablers to patients to support treatment adherence and aid in mitigating default. Another joint initiative being pursued is the lobbying among LGUs to appropriate funds to provide enabler support to their local constituents affected by the disease. Local Models on the latter are existent and will serve as reference in replicating such models to other LGUs.

Status of the NTP Drugs and Commodities Supply Management

(1) Drugs used in NTP

NTP started using the fixed dose combination TB patient kits since 2003. Starting 2009, medicines for TB in children have been available in single drug suspensions from the program. Second-line drugs (SLD) regimens have been standardized to 2 regimens, which later in the treatment is individualized based on patient's DST results.

Table 1: List of medicines for NTP treatment regimens in the Philippines

Treatment Regimen	Medicines
Category 1	4 HRZE, 2HR
Category 2	2S, 3HRZE, 5HR+E
TB in Children	7 bottles 120ml H, 7 bottles 120ml R and 4 bottled 120ml Z
MDR-TB	Z-Km-Lfx-Pto-Cs
Other Drugs	H,R, E, Cm, Mfx, Cfz, Amx-Clv, Clr

(2) First Line Drugs

Selection, quantification and procurement of first line drugs are done once a year, following annual budget release from the government. NTP does the selection and quantification of medicines and other commodities based on utilization rate from the previous year. A purchase request is submitted to the DOH Procurement Department (PD) or the Central Office Bids and Awards Committee (COBAC). COBAC conducts the procurement following the national regulation Republic Act 9184, which guides the procurement process of all government agencies. Being a decentralized health care system, local government units (LGUs) also have a line budget for medicines. Although bulk procurement of TB commodities is done at the central office, LGUs also set funds for emergency procurement in times of impending shortage. LGUs also buy TB medicines in single dose formulation (SDF) for use among patients experiencing adverse reactions to FDC.

From the awarded supplier, medicines and commodities are delivered to the central warehouses (Quirino and Tayuman warehouses). Quirino warehouse stores all DOH medicines while the Tayuman warehouse stores DOH commodities other than medicines such as medical supplies and forms. Both warehouses are managed by the DOH Materials Management Division (MMD). Upon delivery of medicines, FDA representatives pull samples of medicines for quality testing in the FDA laboratory. NTP prepares an allocation list for distribution of medicines and commodities by MMD to the peripheral levels, pending quality assurance result from FDA.

Distribution of medicines starts from the central warehouse to the DOH regional offices (Center for Health Development or CHDs), then to provincial governments, chartered cities, and selected hospitals. The CHDs distribute medicines and commodities to the provincial and city health offices (PHO/CHO), and to PPM DOTS facilities. The provincial/city health offices (PHO/CHO) distribute to the rural health units, health centers, and other DOTS facilities (private, NGOs, hospitals, jails/prisons, etc.). Sometimes, MMD employs cross-docking strategy wherein medicines and commodities are distributed from the central directly to the PHO/CHO or to rural health units (RHU). This is done mainly in agreement and coordination with all relevant institutions. For instance, a cross docking from central warehouse to PHO warehouse includes close coordination and agreement with the regional office. The main reason for cross-docking is the lack in storage space at the intermediate levels and/or urgency of need of the medicine.

Drug distribution of first-line TB medicines is a "push system." An allocation list is prepared based on received reports of case accomplishment. The NTP central office prepares an allocation list of medicines for distribution to the CHDs. The CHDs prepare the allocation list for distribution to the PHO/CHOs in their respective regions, while the PHO/CHO prepares the allocation list for distribution to the DOTS facilities.

MMD contracts out the transport to an external private courier. At the regional, provincial and city level, transport is agreed upon whether for delivery by CHD/DOH vehicle, or for pick up by the PHO / chartered CHO.

(3) ***Second Line Drugs***

Forecasting and quantification of SLD are performed by PMDT/LCP. Monthly, SLD supply status is reviewed based on stock on hand, pending orders, on-going consumption, and number of patients that will be treated. LCP prepares a procurement form annually and submits this to PBSP. PBSP directly coordinates with GDF for the procurement and delivery of medicines to MMD central warehouse.

Only NCR and Region 1 CHD warehouses are currently storing SLDs. The usual practice is to send SLDs directly from the central warehouse to the treatment centers. PHO and CHOs coordinate requisitions and distribution from treatment centers (TC) to the treatment sites (TS).

PMDT drug distribution is a pull system where treatment centers submit drug requisition to PMDT every quarter. PMDT prepares allocation based on requisitions received from all TC and STC. On the other hand, treatment sites prepare drug requisition and submit to the PHO/CHO. PHO/CHOs consolidate the TS requests and forward this to the TC. PHO/CHOs pick up the drugs from the TC and deliver to TS.

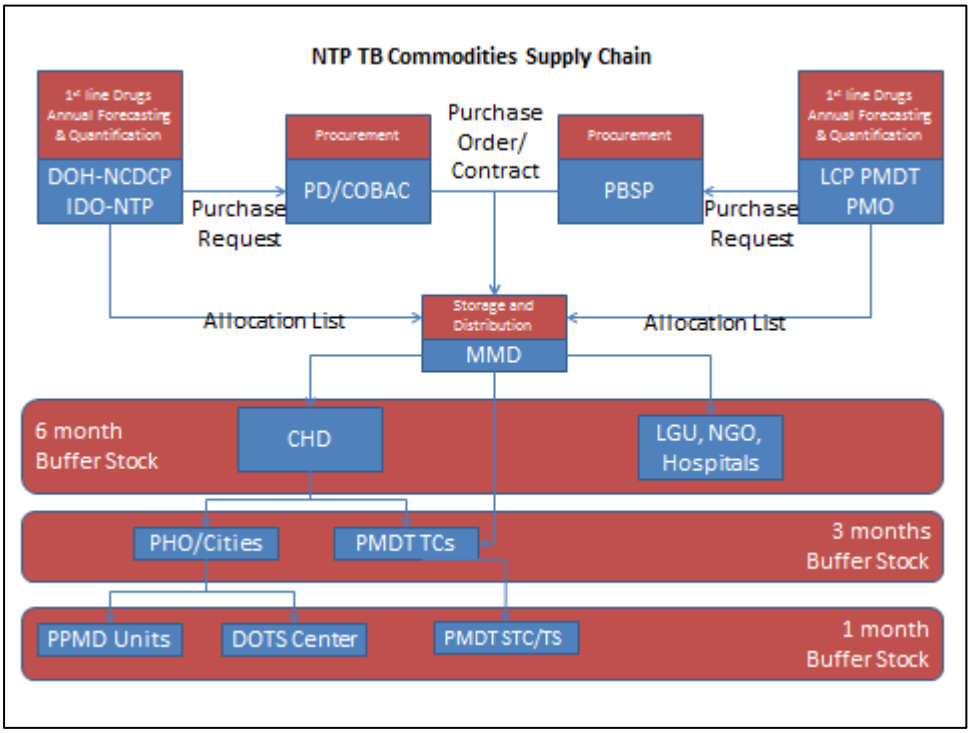


Figure 7. NTP Commodities Supply Chain

(4) Supply Management Process

From 2003 to 2008, DOH procured TB patient kits directly from the Global Drug Facility (GDF). In 2009, the DOH stopped procurement from GDF and shifted to local suppliers due to national regulations regarding use of foreign currency. The Anti-money Laundering Council (AMLC) regulation restricts the use of foreign currency for procurement of commodities, and the Philippine Flag Law or RA8491 urges government entities to procure from local suppliers as much as possible. Second-line anti-TB drugs, on the other hand were not affected and are still directly procured from GDF with Global Fund support.

All first line drugs (FLD) are available in private pharmacies. The private sector is also allowed to carry SLD, except for the following: prothionamide, cycloserine, para-aminosalicylic acid and clofazimine. Capreomycin is also not available although registered locally with FDA Philippines.

Table V. Supply Chain Functions and Responsible Agencies

	FLD	SLD
Selection	**NTP**	**NTP**
Quantification	**NTP**	**NTP-LCP**
Procurement	**DOH COBAC (local procurement)**	**PBSP (through GDF)**
Distribution	**Allocation:** **NTP, CHD, PHO and CHO** **Distribution and storage:** **MMD, CHD warehouse, PHO/CHO**	**Allocation:** **LCP and MMD** **Distribution and storage:** **MMD, CHD, treatment centers (TC),**

	warehouse, DOTS facilities	treatment sites (TS)
Use	DOTS facilities	PMDT treatment facilities (TC, TS)
Funding	Government of the Philippines (GOP)	GFATM

The ongoing USAID/SIAPS project is helping DOH to improve the pharmaceutical and laboratory management system for the PMDT, in support of the NTP. SIAPS works with NTP and partners to ensure an effective drug management system for second-line anti-TB drugs. The technical assistance provided by SIAPS includes forecasting, inventory and lead time procurement, with no danger of stock outs on SLD.

While there is a DOH manual of procedure for warehousing available, the provisions are difficult to implement because there is not enough storage space at the central and peripheral warehouses. The USAID/SIAPS is currently developing the practical guides for (1) pharmaceutical management (for support to warehouse management) and for (2) management of TB pharmaceuticals (for management of all TB commodities including FLD, SLD, and laboratory commodities). To complement the following guides, SIAPS is developing job aids for quick references to the staff. These are all expected to be finalized by September 2013. Upon finalization of the guide, SIAPS, together with NTP, MMD, IMPACT and PQM, will develop a rollout plan, which will then include conduct training of trainers and training of warehouses and treatment facility staff.

USAID/ IMPACT will support training in US Government (USG) assisted sites, while PQM will support training for those in selected non-IMPACT sites, as per NTP's request. SIAPS currently conducts monitoring visits, together with PMDT Program Management Office (PMO) staff to warehouses and treatment facilities. During these visits, they provide supportive feedback and coaching to improve practices, as well as improving capacity of the PMDT PMO in monitoring and supervising the warehouses and treatment facilities.

As verified by the JPR 2013, there has been incident of stock-out of FLD at facility level, while stocks are available at the central level. This is mainly due to the long waiting time for the release of quality test results from FDA. As a matter of procedure, the central stocks cannot be released until there is FDA certification of quality. Central warehouse sometimes employs cross docking as per request, wherein instead of sending the stocks from central warehouses to regional warehouse so that the region will distribute to their respective provincial or city warehouses, the central warehouse sends the stocks directly to the peripheral levels, (i.e., provincial or city warehouses) circumventing the regional warehouses with the condition that documents and information of said transfer are shared with the region.

For SLDs, SIAPS is enhancing the monitoring tool for PMDT drugs that the PMDT PMO is utilizing for supervising treatment facilities and warehouses and working on tracking the availability of TB medicines and other commodities from the central down to the peripheral level. This is to support zero stock- outs and build capacity at all levels to analyze stock levels and develop early warning stock out system. SIAPS is also involved in the monitoring of consumption, movement and availability of TB commodities and provide critical information and feedback to NTP. SIAPS is coordinating with MMD and the IMS for this activity and the implementation of National Online Stock Inventory Record (NOSIRS). PQM ensures that there are no stock outs for reagents used by the FDA.

NTP and MMD have limited capacity to monitor the stocks and warehouses at the regional levels. Correspondingly, the regional levels have limited capacity to monitor stocks and warehouses at the PHO/CHOs. Majority of the treatment facilities do not maintain stock cards or alternative records. The Department of Health is currently rolling out the implementation of a national online stock inventory system (NOSIRS).

(5) Quality Assurance

Quality assurance and quality control systems (including standard operating procedures) for medicines are in place. This is within the mandate of the Philippine FDA. FDA, as an ISO certified agency, currently has a QA plan, written SOPs and work instructions in every section for testing of food, cosmetics and drugs, including NTP drugs, which are submitted to FDA either for registration or monitoring quality. USP PQM supported the ISO certification. The FDA, together with PQM conduct post- marketing surveillance, by collecting samples from procured drugs, warehouses, and local pharmacies. The results are usually released between 15-30 days for products that passed the standards. For those that did not pass, confirmatory testing is done at FDA's central laboratory and referred to the legal department, when necessary. This might take about four months before the results are released and the decisions are made to recall the batch of failed drugs. PQM supported the establishment of eight sentinel sites in the country and provided Minilab kits.

(6) Pharmaco-vigilance

USAID is providing TA to NTP through the United States Pharmacopeia (USP) - Promoting the Quality of Medicines Program (USP/PQM). PQM has been actively providing the technical and professional assistance to the FDA, the DOH and the NTP to strengthen Quality Assurance and Quality Control (QA/QC) system. Since 2008, PQM has provided technical assistance for the establishment of the Post Marketing Surveillance (PMS) through the Medicines Quality Monitoring (MQM) program (1) to detect the quality of anti-TB drugs; (2) to enhance the FDA regulatory capacity in evaluation & registration of pharmaceutical products through the internationally accepted quality standards, guidance, processes and protocols; and (3) to raise awareness among the general public about medicine quality issues to mobilize policy makers, regulators and health professionals. PQM also supports the establishment of the Philippines Bioavailability and Bioequivalence Testing center. In addition, USAID/SIAPS has started collaborating with the FDA on pharmoco-vigilance (SIAPS has received FDA's comments and is currently finalizing the PV report together with MSH HQ) and GF on adverse drug reaction.

3.3 Enhancing TB/HIV Collaborative Activities

All **TB and HIV funding request(s)**, must describe the scope and status of ongoing TB/HIV collaborative activities.

Describe:

a. How the funding request will strengthen TB/HIV collaborative activities.
b. The linkages between the respective national TB and HIV programs in the country, including service delivery, reporting systems, and policy development and coordination processes.

Tuberculosis and HIV co-infection is a serious problem to every TB and HIV control program. Since HIV weakens the immune system, people with TB infection have a very high risk of developing TB as a disease. It is estimated that HIV-infected persons have 5 to 10% annual risk and 30% lifetime risk of developing TB disease. While the HIV epidemic potentially fuels and further magnifies TB epidemic, TB significantly impacts the quality of life of People Living with HIV (PLHIV) being the most common co-infection and one of the main causes of AIDS-related deaths.

The Philippines is one of the countries with high burden of TB, but with increasing albeit still low prevalence of HIV. Based on the 2007 Department of Health (DOH) estimate, there are 7,490 Filipinos living with HIV, for a national HIV prevalence of 0.168%. Furthermore, a study on TB patients in San Lazaro Hospital revealed that out of 160 patients, 10 or 6.25% tested positive for HIV. Cognizant of these facts and the issue of underreported cases, the DOH saw the need to heighten efforts to address the joint burden of both diseases and avert future scenario of an epidemic.

The TB-HIV Collaborating Committee was created in 2006 through the DOH Department Personnel Order 2006-1869 (Annex 3.3A) to ensure proper collaboration between the National TB Control Program (NTP) and the National AIDS/STIs Prevention and Control Program (NASPCP). The main function of the committee was to formulate policies and guidelines on the establishment of cross-referral mechanisms between NTP and NASPCP to provide access for TB- HIV services and to standardize management of TB HIV co-infection. These TB- HIV collaboration policies and guidelines are embodied in the Department Administrative Order No. 2008-0022 (Annex 3.3B)

Under this policy, Provider Initiated HIV Counseling and Testing (PICT) was offered to all registered TB cases initially in six selected DOTS facilities in Metro Manila and was expanded to all DOTS facilities in Metro Manila, Davao City, Angeles City and Cebu City by 2012. From 2007 to 2012, a total of 13,390 TB cases were counseled and tested and 21(0.15%) were confirmed to have HIV.

During the last quarter of 2012, a series of consultative workshops with stakeholders were conducted to assess TB- HIV collaboration implementation and plan for more improved strategies. Annex 2.1D includes the TB- HIV Sub-Plan which is essentially the joint plan for TB-HIV Collaboration in the country covering interventions from 2014 to 2016.

The main challenge for TB-HIV Collaboration is the non-compliance to NTP policies and guidelines in the provision of TB services for PLHIV and IPT. Referral mechanism for TB and HIV services is not yet established and access to HIV services is limited and focused to urban areas. There is inadequate logistics coupled by the fast turnover of staff especially medical technologist providing HIV testing. The recording and reporting system for TB- HIV are not yet institutionalized.

Put briefly, the following mechanism for collaboration were agreed upon:

1. ***Strengthen coordination between NTP and NASPCP through harmonized planning, information sharing, joint monitoring and evaluation of the collaboration;***
2. ***Proper case holding and management of patients with TB- HIV co-infection;***
3. ***Engagement of CHDs, LGUs, private sector, and affected communities for TB/HIV collaborative activities;***
4. ***Conduct of annual joint planning among all stakeholders;***
5. ***Capacity building for public and private DOTS facilities, PMDT Treatment facilities, HIV Treatment Hubs, Social Hygiene Clinics and laboratory facilities; including CHDs and LGUs;***
6. ***Focused monitoring and evaluation of collaborative activities; and***
7. ***Build up surveillance of TB among PLHIV and of HIV among TB patients.***

The JPR 2013 emphasized on the increasing HIV incidence and the fact that 55-70% of PLWHA have TB infection. The JPR recommended for the implementation of the TB-HIV sub-plan to ensure co-morbidity is efficiently addressed.

Under the NFM, the collaboration between the two programs will be institutionalized and at the same time the services will be expanded improving access for HIV testing for TB patients and TB services for PLHIV.

Patients with confirmed positive result will be referred to HIV Treatment hub and will undergo baseline laboratory tests (CBC, urinalysis, liver function test and CD4 count) as facilitated by the DOTS facility and PMDT Treatment facility. Treatment Hubs will administer CPT and ARV for patients with TB/HIV con-infection. CPT regimen will be given to all TB patients that are HIV+ and taking ARV. Availability of CPT and ARV is through the DOH- NASPCP.

On the other hand, DOTS and PMDT Treatment Facilities will refer the TB patient with confirmed HIV to a Treatment Hub. The DOTS/PMDT Treatment Facilities will send the accomplished TB-HIV Collaboration Referral Form, SACCL Confirmatory Test Result, copy of the consent (HIV Rapid Testing), DOH-NEC Form A: Personal Information Sheet and DOH-NEC Form B: Physician's HIV/AIDS Case Reporting. All PLHIV at the SHC or Treatment hub shall undergo TB screening: symptomatic screening (cough of any duration, fever, night sweats, and loss of weight) and Chest x-ray. If with any one of the four symptoms/signs, sputum shall be collected for Xpert MTB/Rif MTB/RIF. If with no symptoms but positive findings on Chest Xray, patient will be tested for Xpert MTB/Rif MTB/RIF. (Annex 3.3C TB-HIV Algorithm).

TB screening for PLHIV shall be done upon HIV diagnosis and every follow-up visit. TB treatment shall start once the patient is found to have active TB based on the GeneXpert MTB/Rif test (TB Rif susceptible, TB Rif Resistant) or with radiographic findings consistent of TB or with extra-pulmonary TB based on

clinical and laboratory diagnosis TB treatment shall be based on the NTP policies and guidelines. PLHIV with MTB Rif Resistant shall be referred to the PMDT treatment facilities.

PLHIV with no active TB (no symptoms, negative for TB in Xpert MTB/Rif MTB/RIF and CXR), including latent TB, shall be given Isoniazid Preventive Treatment (IPT) for 6 months by the HIV Treatment hubs. IPT is made available through the DOH-NASPCP.

The PhilPACT sub-plan for TB-HIV collaboration, as discussed above prioritizes its implementation among HIV Category A and B sites (those cities/municipalities with high HIV prevalence).

For Non- HIV Category A and B sites, the following will be done:

1. **All PMDT providers will be trained on HIV VCT/PICT and all PMDT treatment facilities will provide PICT to all enrolled DR-TB patients;**
2. **ALL DR-TB cases with confirmed HIV will be treated for both infections following established protocols;**
3. **All PLHIV with confirmed TB will be treated for TB following established protocols;**
4. **All cases on co-infection will be recorded and data will be shared between both programs at all levels; and**
5. **The expansion of the TB-HIV collaboration service delivery coverage will be aligned with the expansion timeline of the NASPCP for its Treatment Hubs and Social Hygiene Clinics.**

SECTION 4: FUNDING REQUEST TO THE GLOBAL FUND

4.1 Programmatic Gap Analysis

The programmatic gap tables submitted in this section provide the analysis to explain the underlying rationale for the funding request.

a. For the **3-6 priority interventions for which funding is** requested, complete the relevant number of Programmatic Gap Tables (below). The tables describe the extent to which key interventions are supported, and where key gaps remain.
b. If some of these priority interventions are **difficult to quantify** (i.e. not service delivery interventions), explain this in narrative form below, including the types of programs in place, the populations or groups involved, and the current funding sources and gaps.
c. In order to understand the **overall funding landscape** of the national program, briefly describe the program areas currently receiving financial support and the source of such funding (domestic and/or donor). Highlight in particular the areas that are adequately resourced by this funding and are therefore not included in the request to the Global Fund.

Anchored on the up-to-date findings from the Joint Program Review of the Philippine National TB Program (JPR 2013), the Philippine CCM in consultation with key stakeholders (experts, patients, providers, policy makers, donors, interest groups, etc) have prioritized the following interventions to be requested for funding support under this GF NFM early application for TB:

1. **INTENSIFYING AND ACCELERATING DOTS DELIVERY** ***that will improve access to quality DOTS services and improve case finding especially among vulnerable groups to address inequity and regional performance variation*****;**
2. **MAINSTREAMING PMDT SERVICE DELIVERY** ***to increase program coverage, while reducing default and improving quality service delivery for better treatment outcome*****; and**
3. **STRENGTHENING TB-HIV COLLABORATION** ***to establish much-needed systems and protocols to efficiently manage TB-HIV co-infection and reduce morbidity.***

These three priority interventions were shortlisted from a long list of recommended interventions after very thorough review of the TB disease burden and trend in the country; and analysis of the NTP performance (its strengths, weaknesses, challenges and opportunities) as evidenced by the JPR 2013 findings (accomplishments and challenges).

These key interventions are consistent with the major challenges being faced by the NTP and are directly aligned to the priorities of the NTP as outlined in the enhanced PhilPACT. These prioritized interventions are able to consolidate approaches and focus on key strategies that can address majority of the challenges currently faced by the NTP.

The GF NFM investment on these priority interventions is critical as these clearly supplement the resource limitations of both the Government of the Philippines and the Donor Community in support of attaining the goals and objectives of the Philippine NTP. GF support/investment on these priority interventions is also most strategic and cost efficient as successful execution of these key interventions would be able to greatly contribute to achieving attributable and measurable results (output, outcome, impact) in the fight against TB in the country.

The following matrix and discussion details the JPR 2013 major recommendations to address the challenges detailed in Section 3.1 and 3.2. It also outlines the NTP action agenda on the various recommendations. Most importantly, the matrix outlines the committed support from the government and donor partners and identifies the key interventions where the GF NFM grant would be maximized.

To guide the discussion below, the matrix presents the major recommendations from the JPR 2013 categorized by recommended action agenda supporting three NTP program components--A) finding all TB patients; B) ensuring that all TB patients are cured; and C) securing an enabling environment for quality TB control.

A. Finding all TB patients (5)

JPR 2013 Main Recommendations	NTP Action Agenda and Committed Support
A1. Re-include TB as a notifiable disease. In 2008, TB was removed from the list of notifiable diseases. This limits the ability of the NTP to ensure notifications from the private sector and to effectively monitor the disease incidence in the country. TB has important epidemic potential, with high transmission in some foci and the potential for rapid emergence of MDR-TB hot spots.	**As part of the enhanced PhilPACT strategy 2 (Monitor health system performance) and strategy 7 (Certify and accredit TB care providers and facilities), the DOH-NTP with technical assistance form USAID/HPDP and USAID/IMPACT Projects will pursue lobbying for the re- inclusion of TB as a notifiable disease.** **Furthermore, under the USAID/IMPACT Project, the Philippine Tuberculosis Society Inc. (PTSI) will be subcontracted beginning 2013 up to 2017 and part of their deliverable is to incorporate DOTS as part of private hospital/clinic licensing that will support adoption and reporting of cases to the NTP. PTSI will work with the DOH- Health Facilities Development Bureau (HFDB)**
A2. Rapidly accelerate the engagement of all care providers (DOH and stakeholders). The JPR concluded that while the Philippines has been a model internationally for its early engagement of the private sector, the contribution from the private sector and public hospitals to case finding should be twice the current levels. To reach this target, the JPR recommends (A2.1 to A2.5):	
(A2.1) PhilHealth refine its accreditation and reimbursement process for DOTS facilities to support quality assurance within private sector and public hospitals; e.g. no reporting to the NTP, no reimbursement	**Under the Enhanced PhilPACT Strategy 7, the DOH through its CHDs commits to fully cover the cost requirements to certify all DOTS providers leading to Phil Health accreditation and ensure infection control measures are put in place in all DOTS facilities nationwide.** **USAID/IMPACT Project also commits to provide technical assistance for the DOTS certification,**

	PhilHealth accreditation and Infection Control for their 43 priority provinces/cities. **The NTP will also pursue maximizing PhilHealth to support this recommendation, and this is discusses in C3.**
(A2.2) The NTP engages the medical directors successfully implementing hospital-based DOTS to advocate to and mentor additional hospitals. The NTP ensure regular and sustained supervision and monitoring to hospitals.	**Under the enhanced PhilPACT Strategy 3, DOH r its NTP sub-allotment to NTRL and CHDs will support basic DOTS training requirement of all public health facilities & laboratories while USAID/IMPACT project will cover for the same trainings for private providers.** **A harmonized protocol on integrating DOTS in public and private hospitals (Hospital-Based DOTS) has been developed from pilot efforts among the DOH- NTP (TGF/PBSP/PhilCAT), WHO Philippines (CACTH-TB), and USAID/TB LINC (SECURE TB). Critical in the protocol is a standardized training for private providers on DOTS and promoting private-public referral mechanisms to increase access to the free quality anti-TB medicines subsidized by the government, which essentially reduces out-of-pocket expenditures of patients, particularly the poor.** **Using the harmonized protocol, the NTP will expand hospital-based DOTS implementation to cover at least 90% of public hospitals and 65% of private hospitals by 2016. *NTP will do this with the support of USAID/ IMPACT Project to cover private hospitals within its project sites (43 cities/provinces), while the non-USAID sites will be supported under the GF NFM Grant for TB for both public and private health facilities. Details in Section 4.2*****
(A2.3) The NTP, in collaboration with FDA, defines a pharmacy engagement strategy that considers the lessons learned from piloted pharmacy engagement projects. All options should be considered, including restricting the availability of TB drugs in the private sector	**Under the previous USAID TB projects (PhilTIPS and TB LINC), several DOTS program models engaging pharmacies (pharmacy owners and pharmacists and point-of-sale personnel) were developed and piloted. The pilots have demonstrated successful implementation of local initiatives (with LGUs) on restricting commercial anti-TB drug dispensing across the country.** **Banking on these models, the NTP will pursue policy advocacy at the national level to limit/eliminate anti-TB drugs commercial marketing. Both the USAID/IMPACT project and the USAID/HPDP project committed to provide TA to DOH in this regard.**

	Under the GF NFM Grant for TB application, the NTP will also engage international consultants to aid in this policy advocacy.
(A2.4) The NTP support inter-local health zones to expand DOTS to neighbouring hospitals and associated physicians	**Consistent with the enhanced PhilPACT strategy 1 on localizing DOTS implementation, the NTP will strengthen the regional and provincial TB coordinating councils to plan and monitor implementation of DOTS through establishment/ strengthening of local TB service delivery networks which essentially links all care providers within a geographic catchment area.** **Furthermore, these local coordinating bodies will be capacitated to ensure integration of TB control initiatives in the local investment plans for health.** **On top of LGU funds, the NTP through sub-allotment to the CHDs will support costs related to maximizing these councils nationwide covering non-USAID sites, as USAID/IMPACT has committed to strengthen/establish regional coordinating bodies for TB control and ensuring DOTS compliance among all their project sites up to 2017.**
(A2.5) The NTP collaborates with BJMP/BUCOR and ICRC to ensure scale-up of TB control in jails and prisons. The NTP shall evaluate the quality of implementation of existing TB screening and treatment protocol(s) for prison entrance, ensure access to DOH drugs, and support monitoring of patients.	**Under the enhanced PhilPACT strategy 5 on addressing MDR-TB, TB-HIV and the needs of vulnerable populations, inmates have been identified as among the vulnerable populations prioritized by the NTP.** **DOTS implementation in all prisons and jails nationwide will continuously be supported by the NTP, CHDs and LGUs (funded by NTP sub allotment, ICRC, KOFIH, and USAID/IMPACT). For 2014, the NTP, with technical assistance from USAID/IMPACT, will evaluate the quality of the implementation of existing TB screening and treatment protocol(s) for DOTS for inmates (prisons/jails).** **NTP will also look into program implementation gaps and action agenda to ensure that all inmates have access to DOH drugs and that systems are in place to support monitoring of patients. The NTP commits to support DOTS for inmates and cover 100% of prisons and jails by 2016.** ***GF NFM will focus its support to DOTS delivery for inmates by establishing mechanisms to provide quality PMDT services in jails and prisons nationwide.***

A3. Strengthen case detection in DOTS facilities (NTP). To ensure that TB patients are not missed by health facilities, the JPR recommends (A3.1 to A3.2):	
(A3.1) Dissemination of information and provision of technical assistance to out-patient departments and general and specialty clinics to increase the number of TB suspects referred for diagnosis. Priority can be given to RHUs that refer to laboratories with smear positivity rates above 10%.	**Anchored on the NTP communications framework and strategy, part of the intervention is a communications plan to support marketing and promotions of the (a) quality services provided in all DOTS facilities (including PMDT facilities) and (b) PhilHealth TB Packages among the general population and sub-populations (vulnerable groups) that will be done through various multi-media formats. The USAID/CHANGE project has committed to provide technical and financial assistance to the DOH (NTP, NCHP and PhilHealth).** ***Both the USAID/IMPACT Project (among their project sites) and the GF NFM (non-USAID sites) will support the localization/customization and dissemination/utilization of communication materials and tools developed at the national level by the NTP with USAID/CHANGE, PhilHealth, and NCHP. Details in Section 4.2***
(A3.2) The NTRL is encouraged to urgently implement the laboratory sub-plan under the PhilPACT. The JPR emphasizes the need to strengthen the capacity and ensure the quality and accreditation of culture and drug sensitivity testing (DST) facilities.	**Under the Laboratory Strengthening Sub Plan of the enhanced PhilPACT, the NTP will respond to the recommendation to bring quality diagnostics nearer to clients by establishing microscopy centers alongside hospital-DOTS services and, for communities, Remote Smearing Station (RSS) — both of which have been pre-tested and found to be effective. NTP also plans to establish more microscopy centers in cooperation with LGUs and introduce better diagnostic tools for TB detection.** **The implementation of the laboratory sub plan will be overseen by the DOH-NTP through the NTRL. Technical assistance for NTRL/Laboratory network capacity building (technical, leadership and management) will generally be supported by NTP-sub-allotment and USAID/IMPACT project TA plan. In addition, RIT/JATA and USAID/SIAPS will support the technical capacity strengthening of NTRL/laboratory network.** ***Under the GF NFM, the infrastructure development of the NTRL and the laboratory network is proposed, specifically with reference to procurement and efficient utilization of new diagnostic tools including Led FM and Xpert MTB/Rif, as well as related support for supplies***

	and commodities for the use of LPA, MGIT, and the Xpert MTB/Rif (cartridges). Details in Section 4.2
A4.1 Strengthen active/intensified case finding measures, particularly to reach vulnerable populations. **The NTP and its partners are encouraged to urgently implement the national communications strategy, with enhanced focus on the provision of written materials for patients and their families/communities in local languages. The use of all available human resources and networks, such as the barangay (village) health workers, community health teams, community-based organizations and non-governmental organizations should be engaged at sub-national level in the rollout of the communications strategy.**	**Under the Enhanced PhilPACT Strategy 4 on promoting and strengthening positive behavior of communities on TB, the DOH through the NTP and DOH-NCHP, with technical support from the USAID/CHANGE project, and in consultation with multi-stakeholders, has developed the NTP communications framework, strategy and plan detailing interventions at both the national and local levels that will improve health-seeking behavior, reduce self-medication practices, and minimize treatment default. This also includes development and implementation of behavior change communication packages (customized and localized to key sub-population segments or target audiences: suspects, patients, health providers, general public) to promote and strengthen positive behavior toward TB control.** **NTP will pursue provision of performance-based grants for local TB implementation in the LGUs, whereas USAID/IMPACT will release grants to NGOs, CSOs and POs on local TB implementation, especially reaching the urban poor population.** **In the next three years, NTP and its implementing partners will take on more active/intensified case finding activities to identify the "missing cases". The program aims to scale up successful models and expanded DOTS service delivery to reach bigger coverage, in order to include the elderly, indigenous peoples, and people with disabilities. *Intervention for both urban and rural poor will be further scaled up by supplementation of frontline health workers in the 300 poorest municipalities in the country, through the GF NFM application. (Details in Section 4.2)*** **DOH, through NTP and the CHDs, in cooperation with all LGUS, will support nationwide (100% coverage) implementation of TB control among inmates, children, and the elderly.** **For DOTS among inmates, the NTP action agenda is discussed under A2.5 above.** **For TB in children, the NTP through the CHDs will ensure that 100% of DOTS facilities will be capacitated further to provide quality pediatric DOTS services. This includes improving diagnostic**

	equipment (phased application of Xpert MTB/Rif for diagnosis), provision of free anti-TB drugs including those drugs for preventive therapy, and even exploring improving drug packaging and formulation). NTP, with USAID/IMPACT assistance, will also work with the Philippine Pediatric Society and the Philippine Medical Association to build their capacities on managing TB among children. **For DOTS among the elderly, NTP with the TA of USIAD/IMPACT will work on developing service delivery models for DOTS delivery among the elderly in confined/institutionalized settings (such as Home for the Aged).** ***GF support is requested for technical assistance in protocol development and adoption of TB control interventions among diabetics, including development and mainstreaming of PMDT service delivery systems and processes to cover these vulnerable population segments (particularly PMDT for children, inmates and TB-HIV cases). This is further discussed on Section 4.2*** **USAID/IMPACT will support in selected pilot sites the development of protocols and relevant interventions for TB control among persons with disabilities and miners, and in emergencies (disaster), while GF support will be on the provision of access to PMDT services among these special population groups.** **Section 4.7 provides discussion on the vulnerable population groups identified and prioritized by the Philippine NTP.**
A4.2 NTP must proceed with the implementation of the TB-HIV sub plan under the updated PhilPACT.	**The DOH-NCDCP, which houses both the NTP and the NASPCP, is committed to pursue the TB-HIV sub plan covering 2014-2016.** ***Majority of the interventions is part of the GF NFM application, previously discussed under Section 3 and detailed in Section 4.2***
A4.3 In addition, resources should be mobilized to reinforce the success of contact tracing. The JPR recommends the following policy changes: **(A4.2.1) At LGU level, promote the inclusion of TB screening and treatment compliance as a condition for the issuance of business permits;**	**The NTP will look into the operationalization of recommendation A4.2.1 with the technical assistance of USAID/HPDP whose task will be to support the localization of NTP. As discussed above in A1, a similar intervention will be employed for renewal of permits to operate among private clinics and hospitals.**

(A4.2.2) To reach poor families via the existing condition cash transfer program, include TB screening and treatment compliance as conditions for allocation of the monthly funds.	Currently, the NTP with TA from USAID/IMPACT and PBSP, is cooperating with the Department of Social Welfare and Development (DSWD), the agency which anchored the CCT program. Dialogue has already been staged integrating TB education, testing and completion of treatment as conditions for CCT.
A5. TB diagnosis using Xpert MTB/Rif must be used in 100% of the high-risk groups of DR-TB, including TB-HIV patients and inmates. In a phased-in manner, Xpert MTB/Rif will be introduced especially in smear-negative and pediatric cases (NTP and NTRL).	The NTP aims to address this by establishing a stronger committee to oversee the implementation of the TB-HIV sub plan covering 2014-2016. Essentially, this covers development of systems and protocols for quality service delivery, expanding coverage and building capacities of both NTP and NASPCP for TB-HIV co-management.

B. Ensuring that all TB patients are cured (3)

JPR 2013 Main Recommendations	*NTP Action Agenda and Committed Support*
B1. Address the high default rate among patients treated for MDR-TB (NTP and partners). Operational research is recommended to fully understand the financial, logistical, medical, social and other barriers to treatment compliance. A revision of the PMDT strategy to address these barriers is a priority. The JPR recommends that all modalities to address patient barriers be considered, including the evidence-based use of incentives. The JPR endorses the proposed scale up of treatment sites, despite the high default rates, as the centralized nature of treatment has been contributing to default. The JPR recommends a concurrent decentralization of the treatment of drug-resistant cases to trained RHUs and BHWs.	The NTP shall pursue the implementation of the PMDT sub plan under the enhanced PhilPACT. This includes a more in-depth analysis of factors increasing DR-TB default and developing action responses (strategies) to avert/mitigate the high default rate. The plan also looks into developing and piloting more customized enabler packages to address specific treatment adherence barriers from both the patient and provider side; and maximize early decentralization and community/home-based care for DR-TB patients. Despite the increasing DOH budget for TB control, the high burden exhausts the GOP funds to support all TB forms, except for DR-TB. ***As such, 70% of the GF NFM application request is directed to augment DOH funds to provide quality PMDT care. Full discussion on this component is detailed in Section 4.2***
B2. Test the applicability of a shorter (nine months) MDR-TB regimen (NTP and NCPR/LCP). Given the high default rate, consideration of the nine-month regimen being successfully implemented in other countries is recommended. Effectiveness and patient safety in the Philippine context must be evaluated.	The DOH-NTP is open to testing the applicability of a shorter treatment regimen to address increasing default and improving treatment outcomes. The DOH-NTP, with LCP and NTRL, is in current cooperation with the STREAM project to look into the Philippines' potential participation in the operations research.
B3. Develop improvements in the drug supply management system. Develop a sub-plan for strengthening the drug supply management	The NTP recognizes the immense challenge on DSM, not only for the program, but more so for the entire DOH DSM system, which is currently

system, including all steps in the process from forecasting and procurement to stock reporting and distribution. The JPR recommends increasing the buffer stock of first-line TB medicines to 75% at national level. To maintain this, the DOH is encouraged to make use of all available procurement modalities, such as emergency procurement processes and international process (WHO/GDF) when domestic procurement has failed bidding, quality problems are detected, or a stock-out is imminent.	**being addressed by the DOH MMD and COBAC.** **At the level of the program, the NTP articulates its planned action provided under the enhanced PhilPACT strategy 6, i.e. regulating and making available quality diagnostic tests and drugs (including commodities), which is aimed at strengthening its drug and commodity supply management capacity (systems and processes) aligned with the overall and on-going reform being done in the DOH procurement system.** **Based on the recommendation of JPR, NTP plans to (a) request partners for support in the training of logistics team at the national level and development of forecasting tool and system; (b) advocate to DOH management the purchase of at least 75% of the annual buffer stock and getting additional warehouse; (c) strengthen monitoring and supervision to include logistics; and (d) install an early warning system by coordinating with the DOH managing NOSIRS.** **In addition, the DOH will also look into considering international procurement to prevent stock-outs and work with providers on more flexible procurement/delivery schedules to compensate DOH's limited warehousing capacity. This is in addition to exploring outsourcing options through PPP.** **As discussed in later portions of Section 3.2 on the current NTP DSM system, the USAID through its various projects (SIAPS, PQM, IMPACT) will provide TA to DOH (MMD, COBAC, BFAD, FDA) to improve the entire DSM system, and build its unit capacity to oversee NTP DSM processes.** **The DOH will take on the cost and responsibility in rolling out the NOSIRS.** ***Under the GF NFM application, proposed support will cover (1) technical personnel augmentation at the IDO-NTP to beef up and improve NTP DSM systems and processes; (2) development/finalization of the Laboratory Management Information System (LMIS) of the IT IS and ensuring its link to the NOSIRS, (3) and (4) procurement of consulting services to provide technical assistant to the DOH on international procurement and outsourcing.***

C. Securing an enabling environment (9)

JPR 2013 Main Recommendations	*NTP Action Agenda and Committed Support*
C1. Address the human resource shortages. The JPR acknowledges the ongoing rationalization of staff which will further reduce the number of DOH employees. Given this reality, the JPR encourages DOH to monitor and ensure the assignment of core TB functions to remaining staff at all levels of the health system. The JPR further recommends that, given the magnitude of the managerial and technical leadership responsibilities of this program and the need to ensure the containment of MDR-TB, the staffing of the central unit must be given priority within the rationalization. The JPR suggests that partners carefully monitor and respond to the human resource gaps after the rationalization process concludes. Other modalities recommended by the JPR include C1.1 to C1.3	**NTP, guided by the updated sub-plan for HSS under the enhanced PhilPACT, will establish within the next three years a program management office for itself within the DOH-IDO and capacitate its personnel at all levels in order to improve staff competencies and establish systems for more efficient management of the program.** **However, the approval of the DOH rationalization plan very recently (announced early September 2013), which includes reduction of DOH personnel by 50% at the regional level, places the NTP in limbo, as the details and implications of this major change is yet to be defined in the coming months.** **While the NTP recognizes the need for the DOH to engage core personnel to perform its mandate and not to depend on project-supported staff, it is necessary, at this point, to mitigate the potential effects of the DOH rationalization plan in the current NTP performance, especially that the country is moving toward scale up of PMDT services nationwide in the next three years.** ***As such, part of the GF NFM application is to seek GF support for temporary manpower augmentation in the various NTP facilities at all levels to beef up its operations while the DOH manpower transition under the rationalization plan is not yet finalized. The project will work toward advocating for sustainability by encouraging local chief executives to increase local investments for health, particularly on increasing manpower complements in their local health facilities. Furthermore, the grant will also support the capacity building of the NTP to be able to help them outsource services using NTP budget and at the same time capacitate CHDs and LGUs to use their NTP sub-allotments to augment manpower requirement for the NTP at the regional and peripheral levels.***
(C1.1) Outsourcing: Some of the administrative and non-specialist tasks can efficiently be outsourced to private and NGO sectors. The JPR recommends that the DOH and its partners build capacity to outsource tasks such as the	**PBSP, with funding support from USAID/IMPACT and the GF NFM, is currently building the capacity of the DOH-NTP national and regional levels on developing the essential skills and learning the processes in outsourcing services. This is part of**

administration for meetings, logistics for training, IT support, and drug distribution.	**the OD support plan for the NTP to be able to devolve routine functions and focus on program management.**
(C1.2) Creation of on-the-job tools: The JPR noted a lack of on-the-job guides or tools to serve as reminders to key policy and implementation principles. As the infrastructure to support electronic data management rolls out, potential for web-based refresher training may be optimized to address the ongoing training needs that result from high staff turnover.	**The NTP communication framework, strategy and plan includes development of materials and tools for health providers, which includes development of the JPR-recommended on-the-job tools.** ***DOH (NTP, LCP, and NTRL) with TA from USAID/CHANGE will support the development and local production of such tools; dissemination will be through the GF NFM (for non-USG sites) and USAID/IMPACT (for USAG sites).***
(C1.3) Enact policy change to enable DOH funds to be used to train contractual workers, i.e. non-DOH salaried staff; and to enable contractual workers to conduct supervision with DOH funds.	**The current policy allows the use of the NTP sub-allotment for engagement of contractual personnel at the regional and peripheral levels. However, the threshold is low, which is something that the NTP will look into and lobby for increase of threshold. USAID/IMPACT will provide TA to the NTP in this regard.**
C2. **Ensure regular supervision and quality assurance (NTP and NTRL). Intensify supportive supervision of RHUs, laboratories and treatment partners to ensure implementation of technical standards, including the DOT policy and PMDT (NTP). Review and revise the tools available that guide staff in their supervision of more decentralized levels.**	***Under the GF NFM application, the NTP will look into the current MSE tools and processes for all forms of DOTS, including PMDT and laboratories (on DSSM, culture, DST and related EQA). This also includes conduct of trainings among CHD personnel and production of tools and related materials under the grant.*** **USAID through IMPACT and SIAPS projects will help improve systems related to PMDT and NTRL/laboratory network strengthening.**
C3. **Increase and ensure rational distribution of the reimbursements for TB under PhilHealth. The JPR acknowledged the centrality of PhilHealth's success to the sustainability of an expanding TB control program. The JPR recommends that the NTP collaborate closely with PhilHealth at central and regional levels to ensure (C3.1–C3.6)**	
(C3.1): Assistance to PhilHealth for the finalization of the revision to the current package to include category 2 drugs. PhilHealth NTP coordinators will collaborate with PhilHealth at regional levels to ensure the availability of information regarding changes to the benefits package.	**Part of the enhanced PhilPACT under strategy 8, i.e. securing adequate funding and improving allocation and efficiency of fund utilization focuses on maximizing cooperation with PhilHealth to maximize its utilization.** **The GOP takes the lead role for this strategy. Technical assistance has been committed by USAID Projects (HPDP and IMPACT), particularly in working with the National Health Insurance Program (NHIP) to enhance the PhilHealth DOTS package, develop the MDR-TB package, and promote LGU investment on health by 100%**

	enrolment of their constituents, particularly their indigenous peoples and vulnerable population (poor communities).
(C3.2) Finalization and dissemination of information regarding the revised TB packages: NTP and partners to provide technical assistance	***Part of the NTP communication plan aims to (1) promote Philhealth enrolment, and (2) market the products of PhilHealth, including those for TB. The USAID/CHANGE project will provide TA support in the development of communication materials whereas localization will be under the USAID/IMPACT and the GF NFM Grant.***
(C3.3) NTP and partners will solicit multi-sectoral buy-in and support PhilHealth's efforts to issue stronger guidance regarding the sharing of reimbursements to include health workers and treatment partners, and requiring the creation of TB trust funds to enabling monitoring of the use of TB reimbursements for TB activities;	**NTP will closely work with PhilHealth as the latter designs and implements new financing mechanisms (e.g. Local TB trust funds) to ensure that reimbursement reaches DOTS facilities, and to explore the possibility of PhilHealth reimbursements to support DOTS reporting and recording.**
(C3.4) NTP and partners to provide technical assistance to PhilHealth to develop and implement a reimbursement package for the management of MDR-TB;	**Covered in C3.1**
(C3.5) PhilHealth to fast track the rollout of electronic eligibility portals to DOTS facilities. NTP coordinators at regional level will collaborate with PhilHealth regional offices to ensure 1) immediate availability of NHTS lists to all facilities, and 2) installation and use of the electronic portals when available; and	**NTP will support and facilitate CHD participation in the data needs of PhilHealth to operationalize the planned local eligibility portals.**
(C3.6) PhilHealth to consider reviewing the current TB reimbursement package in 2014 to ensure consistent methodology for costing the package compared with other, newer packages.	***Covered in C3.1***
***C4.* Accelerate disbursement of funding to LGUs. The JPR recommends that BLHD prioritize activities to build the planning and financial management capacity at central, regional, and LGU levels. This may include the development of templates and the provision of technical assistance, potentially from central to zonal levels, to promote the timely and accurate planning for TB within Provincial Investment Plans for Health, and the establishment of SLAs. The JPR acknowledges the benefit of moving away from proposal-based financing of LGUs.**	**NTP, in coordination with BLHD, with TA from HPDP and IMPACT is currently revising the mechanics of its performance-based grants to better address the needs of the LGUs in implementing TB control, while improving systems for financial efficiency (access and utilization).**

C5. **Sustain central funding and procurement of first-line drugs for smear-positive TB and increase DOH funding to cover the costs of managing all forms of TB (DOH), including DOH financing and procurement of category 2 and second-line drugs, and Xpert MTB/Rif cartridges. To align funding with PhilPACT strategy, give equal priority to all cases, and avoid disruption if external sources of funding stop, the JPR recommends that the DOH gradually increase its funding to cover costs of managing all forms of TB.**	**The DOH is committed to maintaining provision of free anti-TB drugs for categories 1 and 2 TB and TB in children. In the next three years, NTP gradually take on the cost of managing a limited number of DR-TB cases, (SLD and ancillary medicines) including cost of Xpert MTB/Rif cartridges and commodities to maintain the molecular diagnostic tools.**
C6. **Establish adequate storage facilities for anti-TB medicines. Central and regional warehouses with adequate capacity must be built or rented. Consideration of quarterly receipt of orders should be considered to better manage stocks in the constrained space.**	**The DOH has expressed current limitation to build additional warehouses and willingness to outsource the service, as well as to improve stock management and distribution arrangements with private providers.** **The NTP sub-allotment is also open to support infra renovations, including warehouses.**
C7. **Systematically operationalize electronic data management systems (IMS). To optimize the rapid introduction and uptake of the electronic data management system for TB IT IS, the JPR emphasizes the need for urgent infrastructure investments to secure computers, internet connections and phone lines. The JPR recommends that the development of a reporting module be accelerated to enable extraction of the data once the system is operational at facility level. Harmonization of the IT IS and ClincSys must be completed. IMS is urged to test the IT IS in three pilot regions and to address any implementation constraints prior to rolling it out nationwide, including for the management of MDR-TB.**	**As part of the Enhanced PhilPACT Strategy 2, GOP commits to support all routine monitoring and evaluation requirement for the NTP and aligning it with national reporting systems and standards within DOH.** **USAID/IMPACT commits to provide technical assistance in ensuring data quality and analysis among local DOTS facilities and USAID/SIAPS on data quality on PMDT clinical and laboratory information. The critical intervention without committed funds under this strategy is the utilization of the Integrated TB Information System (IT IS) by all NTP service delivery units and its linkage with other DOH information systems such as Clinic system, HOMIS and NOSIRS.** ***The NTP plans to roll out the IT IS beginning 2014 and this is part of the GF NFM application. This is detailed further in Section 4.2.***
C8. PMDT scale up must be planned and executed through the NTP structure (NTP, NTRL, LCP). With further scale up of diagnosis anticipated and decentralization of treatment being recommended, the solid foundation of the existing DOTS network that can support patients all the way to their communities must similarly be the foundation for the management of drug-resistant cases. The JPR recommends that the NTP and NTRL be primarily responsible for ensuring	**By design, the GOP will support DOTS implementation as its key strategy to prevent the increase of MDR-TB. This is consistent with the biggest funding allocation of NTP for first line anti-TB drug procurement. The high cost for managing patients with MDR-TB limits the scale up of PMDT with the GOP funds and even with the help of donor-funded projects. The USAID/IMPACT project currently limits its commitment to providing technical assistance**

that PMDT activities are incorporated into routine DOTS planning, implementation, supervision and monitoring activities.	**services to improve operating systems surrounding the delivery of PMDT. KOFIH will particularly support case finding using a mobile laboratory with GeneXpert MTB/Rif machine only in the province of Palawan. USAID/SIAPS and USAID/PQM Projects will only support PMDT in pharmaco-vigilance and improving logistics systems for LCP and NTRL and the determination of quality medicine for the FDA. Procurement of SLDs and ancillary drugs, including enabler support for patients remains unfunded.** **The NTP aims to address this by mainstreaming PMDT into DOTS by decentralizing the delivery of DR-TB service to peripheral DOTS facilities—bringing the service closer to the clients. Initial assessment of PMDT decentralization performed by the NTP and the GLC is favorable.** ***In this proposal, the GF NFM grant is requested to help mainstream PMDT services into DOTS facilities to improve access, mitigate default, and improve treatment outcome. This includes increased access to Xpert MTB/Rif, procurement of SLDs and provision of enabler support. In addition, empowerment of MDR-TB patients and their support groups and involvement of local community-based organizations will also be done to provide quality continuum of care. Details on this are in Section 4.2.***
C9. Allocate at least 5% of the DOH budget for TB to operational research (NTP) to support evidence-based innovations and monitoring of approaches.	**The NTP recognizes the need for ORs to improve program performance and will include provisions for this purpose on its annual budget.** **Note that annually, the NTP convenes a TA planning session with its key stakeholders to determine its TA needs, which also includes discussion and agreement of key OR agenda for the country.** ***Under the GF NFM application, several ORs have been included in the areas of TB-HIV and PMDT. Cost for preparatory activities of the planned NTPS 2017 is also included. More details in Section 4.2.***

A resource mapping exercise was done followed by a series of consultations with donors to determine their level of commitment and the priority intervention areas under the NTP that they would support (Annex 4.1A). This document provides the funding landscape showing the contribution/areas of support of the various donors to prevent duplication of effort and to define limitations of support. In a nutshell, the donor-committed investments are focused on the following:

- **USAID funding for TB focuses on providing technical assistance services to NTP. USAID/PBSP-IMPACT TA is focused on improving demand generation and service delivery systems and reducing policy barriers; USAID/CHANGE focuses on TA on the development and implementation of the NTP communications plan; USAID/HPDP focuses on providing TA to localizing NTP, policy development and financing; USAID/MSH-SIAPS focuses on TA on drug and laboratory logistics management and USAID/USP-PQM focuses on pharmaco-vigilance.**

- **RIT/JATA focuses its support on community-based care for selected urban poor sites in Metro Manila**

- **KOHFI focuses on piloting the use of mobile laboratory in delivering TB services in Palawan**

- **ICRC focuses on TB in prisons**

PROGRAMMATIC GAP TABLE (Per Priority Intervention) *(create 3-6 programmatic gap tables as needed)*					
Priority Intervention		**Enhancing Basic DOTS**			
Selected coverage indicator		**Number of notified cases of all forms of TB (bacteriologically confirmed plus clinically confirmed)**			
Rationale for chosen indicator		**This is the indicator that will directly contribute to the impact targets**			
		National targets over next implementation period			
Current National Coverage (2012)	**217,354** **82%**	**Year 1** **2014**	**Year 2** **2015**	**Year 3** **2016**	**Comments/ Assumptions**
Current Estimated Country Need					
A. Total estimated population in need		**257,972**	**258,443**	**261,145**	Based on the computed estimated incidence of all forms (2012 WHO Report)
B. Country targets (from National Strategic Plan)		**219,276**	**224,845**	**235,031**	2012 baseline is already 82%
		85%	**87%**	**90%**	
Needs already covered					
C. Country needs planned to be covered by domestic and other sources		**213,021**	**210,451**	**207,131**	Based on 2012 accomplishment
		83%	**81%**	**79%**	
D. Country needs already covered by other existing Global Fund grants		**0**	**0**	**0**	
		%	**%**	**%**	
Programmatic Gap					
E. Expected annual gap in achieving need		**44,951**	**47,992**	**54,014**	
A-(C+D)		**17%**	**19%**	**21%**	
F. Additional targets requested with indicative funding		**4,560.00**	**11,880.00**	**18,400.00**	Expected contribution from hospitals and poor communities
(can be equal to, or less than annual gap)		**2%**	**5%**	**7%**	
G. Coverage with indicative funding		**217,581**	**222,331**	**225,531**	
C+D+F		**84%**	**86%**	**86%**	
H. Additional targets requested with above indicative funding		**1695**	**2514**	**9500**	
(can be equal to, or less than annual gap)		**1%**	**1%**	**4%**	
I. Total coverage with above indicative funding		**219,276**	**224,845**	**235,031**	
(G+H)		**85%**	**87%**	**90%**	

PROGRAMMATIC GAP TABLE (Per Priority Intervention) *(create 3-6 programmatic gap tables as needed)*					
Priority Intervention		**Mainstreaming PMDT**			
Selected coverage indicator		**Number of cases with bacteriologically confirmed drug-resistant TB cases (DRTB and/or MDRTB) who began second-line treatment**			
Rationale for chosen indicator		**This will measure the number of MDR-TB cases detected and provided treatment which will directly address the problem of MDR-TB.**			
		National targets over next implementation period			
Current National Coverage (2012)	**1,807** **16%**	**Year 1** **2014**	**Year 2** **2015**	**Year 3** **2016**	**Comments/ Assumptions**
Current Estimated Country Need					
A. Total estimated population in need		**12,225**	**12,472**	**12,942**	**This is based on first DRS (i.e. 21% of retreatment and relapse cases plus 4% of new cases will turn out as MDR-TB). Please see attached table on Philippines estimated TB cases.**
B. Country targets (from National Strategic Plan)		**3,668**	**4,365**	**5,177**	**This is based on the current capacity of the country considering the number of treatment facilities and laboratories.**
		30%	**35%**	**40%**	
Needs already covered					
C. Country needs planned to be covered by domestic and other sources		**0**	**0**	**0**	USAID/IMPACT will provide TA for HSS
		0.00%	**0.00%**	**0.00%**	
D. Country needs already covered by other existing Global Fund grants		**2684**	**0**	**0**	
		21.96%	**0.00%**	**0.00%**	
Programmatic Gap					
E. Expected annual gap in achieving need		**9,541**	**12,472**	**12,942**	**For MDR-TB, there are no other fund for SLD procurement (aside from GF) existing at the moment.**
A-(C+D)		**78.04%**	**100.00%**	**100.00%**	
F. Additional targets requested with indicative funding		**16**	**3,097**	**3,609**	**The increase in the number of patients targeted for enrolment annually is low because of budget considerations and limited absorptive capacity among**

				providers. The program also prioritizes other components like the Basic DOTS package, TB-HIV, and HSS.
(can be equal to, or less than annual gap)	**0.13%**	**24.83%**	**27.89%**	
G. Coverage with indicative funding	**2,700**	**3,097**	**3,609**	
(C+D+F)	**22.09%**	**24.83%**	**27.89%**	
H. Contribution of 'above indicative' funding to total need	**968**	**1268**	**1566**	**This reflects the number of patients necessary to cover 100% of the PhilPACT target (National Strategic Plan)**
(can be equal to, or less than annual gap)	**7.92%**	**10.17%**	**12.12%**	
I. Total coverage with above indicative funding	**3,668**	**4,365**	**5,177**	**PhilPACT Target**
(G+H)	**30%**	**35%**	**40%**	

PROGRAMMATIC GAP TABLE (Per Priority Intervention) *(create 3-6 programmatic gap tables as needed)*					
Priority Intervention		**TB-HIV package for high-risk groups in selected sites**			
Selected coverage indicator		**Number and percent of TB patients with known HIV status: TB patients registered during the reporting period who had an HIV test result recorded in the TB register among the total number of TB patients registered during the same reporting period**			
Rationale for chosen indicator		**As of 2012, WHO reports that the current HIV prevalence in the Philippines remains less than 1% of the total population .Considering this and as provided by the enhanced PhilPACT (for 2014-2016), TB-HIV collaboration initiatives under the NTP will focus on TB patients in pre-determined areas with high HIV incidence (Category Sites A and B), including all sites nationwide with PMDT treatment facilities. The targeted population represents the estimated TB cases qualified for PICT based on the parameters mentioned previously. All health facilities other than Category A and B sites provide information on the benefits of HIV testing and prevention.**			
		National targets over next implementation period			
Current National Coverage (2012)	**3,917/10,618** **37%**	**Year 1** **2014**	**Year 2** **2015**	**Year 3** **2016**	**Comments/ Assumptions**
Current Estimated Country Need					
A. Total estimated population in need		**58,325**	**61,148**	**64,109**	**This includes the number of drug-susceptible TB cases in Category A and B areas and all drug-resistant TB cases nationwide. Yearly targets are based on 5% increment for drug susceptible and annual MDR-TB targets.**
B. Country targets (from National Strategic Plan)		**46,660**	**48,918**	**51,287**	**Note that the program will provide HIV counseling to 100% of the total estimated population in need. Recognizing that not all will be willing to proceed for HIV testing (since the Philippine AIDS law supports voluntary testing only), the program estimates only 60% (for Yr1), 70% (for Yr2) and 80% (for Yr3) will likely proceed for HIV testing.**
		80%	**80%**	**80%**	
Needs already covered					

C. Country needs planned to be covered by domestic and other sources	**13,998**	**14,676**	**15,386**	**This pertains to 30% of the Country Needs**
	24%	**24%**	**24%**	
D. Country needs already covered by other existing Global Fund grants	**0**	**0**	**0**	
	%	**%**	**%**	
Programmatic Gap				
E. Expected annual gap in achieving need	**44,327**	**46,472**	**48,723**	
A-(C+D)	**76%**	**76%**	**76%**	
F. Additional targets requested with indicative funding	**32,662**	**34,243**	**35,901**	**This pertains to 70% of the Country Target**
(can be equal to, or less than annual gap)	**56%**	**56%**	**56%**	
G. Coverage with indicative funding	**46,660**	**48,918**	**51,287**	**This pertains to the Country Target**
(C+D+F)	**80%**	**80%**	**80%**	
H. Contribution of 'above indicative' funding to total need				
(can be equal to, or less than annual gap)	**0%**	**0%**	**0%**	
I. Total coverage with above indicative funding	**46,660**	**48,918**	**51,287**	
(G+H)	**80%**	**80%**	**80%**	

NOTE: The current national coverage for 2012 only reflects those in the National Capital Region (NCR), as this is the only available data. It is the total number of TB cases provided with PICT over the total number of registered TB cases for the NCR. TB-HIV collaboration is fully implemented in NCR.

4.2 Summary of the Funding Request

In order to provide an overview of the entire funding request:

a. Summarize the **programmatic focus and rationale for the request**, including how it contributes to the full expression of demand, and highlight the gains expected from this investment.
b. Explain how the 'above indicative' request builds on the indicative request, and describe the **additional gains** to be expected from further investment.
c. Summarize the community systems strengthening, human rights and/or cross-cutting HSS modules and/or interventions in the request, including **how these specifically address the barriers** identified in the country context, and contribute to the objectives of this funding request.

The GF NFM application for TB aims to actively respond to the recommendations of the JPR 2013 and contribute to the achievement of country targets as provided in the enhanced PhilPACT, consequently, supporting attainment of the set commitments aligned with the MDGs and the AHA. Specifically, this request shall directly contribute to:

- ***Increase case detection rate for all forms of TB from 82% in 2012 to 90% in 2016;***
- ***Increase MDR-TB case detection rate from 22% in 2012 to 40% in 2016;***
- ***Sustain treatment success rate for all forms of TB at 90%; and***
- ***Increase treatment success rate for MDR-TB from 56% in 2012 to 75% in 2016.***

Aligned with these targets, the programmatic focus for the GF-NFM request for funding will be on the following:

1. **Accelerating and Intensifying DOTS.**

Majority of the GOP funds for TB control in the country support nationwide basic DOTS service delivery. While the GOP budget allocation is increasing, the high TB incidence and prevalence exhausts these funds to cover 100% of all anti-TB medicines for pan-susceptible TB in both adults and children and support for operating expenses of 2,314 DOTS Centers, 2,561 microscopy centers, and 16 public and private regional laboratories. This financial challenge shackles the program from reaching more patients. The GF investment requested under the NFM shall complement GOP funds by:

(1a) Addressing the lack of quality TB diagnostic services by supporting the expansion of TB diagnostic facilities providing LED-FM services nationwide. The investment will help the NTP to establish remote smearing stations in geographically isolated and depressed areas (GIDA), including both the rural and urban poor settlements. Consistent with JPR 2013 recommendations, the Xpert MTB/Rif will be primarily used for PMDT. It will also be introduced in a phased manner for TB diagnosis among vulnerable population, such as children and people in prisons/jails, as well as for TB-HIV collaboration. It is hoped that the use of the Xpert MTB/Rif for TB in children will address over/under diagnosis of TB in this particular vulnerable population segment.

(1b.) Reducing wide NTP performance variation, addressing inequitable service provision, and providing manpower augmentation for NTP program implementation in the 300 poorest municipalities in the country with high TB burden by engaging Health AIDERS that will support implementation of local DOTS and PMDT and sustained health promotion initiatives to increase treatment adherence, reduce default and improve health-seeking behavior among pan-susceptible and drug-resistant TB cases.

> ***TB services are not adequately available in the poor areas (urban and rural poor) such as the 600 poor municipalities, the GIDA (e.g., villages located in the mountains, islands where transportation is difficult), and conflict areas such as ARMM where sporadic fighting between the military and rebel groups occur leading to community displacement.***

As shown in the attached document, there is regional variation in accessing TB services which most likely led to low performance and high TB burden as measured by the mortality rate. These factors are essentially (a) high population per health worker or facility ratio; (2) poverty incidence; (3) geographical characteristics and (4) managerial capacity, among others. The document showed that regions with these problems such as CALABARZON and ARMM have low program performance.

The AIDERS is being included in this CN to address the JPR finding about the lack of manpower to support local DOTS implementation, especially among populations that lack access to DOTS services, particularly the rural and urban poor populations. It is also being introduced to mitigate the effects of the impending approval of the DOH rationalization plan which will reduce DOH manpower at the local levels by 50%.

Under the proposed GF support, Health AIDERS (Accelerating Implementation of DOTS Enhancements to Reach Special populations) will be deployed to 300 poor municipalities and cities (50% of the total poor municipalities/cities nationwide) with GIDA areas, from 32 provinces with around 10 million population (approximately 10% of the country's total population).

The roles and functions of the health AIDERS are specific for TB, and will complement those of the RN HEALS and CHTs. The activities of the health AIDERS will focus on improving access to TB care for the urban/rural poor and GIDA areas by strengthening the capability of CHTs to identify and refer TB suspects to health centers, working with existing community organizations or NGOs in the area, assisting NTP in establishing remote smearing station (RSS), conducting community health education on TB, and supervising volunteers doing DOTS. These activities will not only increase case detection in the area, but will address the equity and human rights issues as well. Health AIDERS will also assist in identifying MDR suspects and ensuring that they will be screened using the rapid diagnostic tools available at the treatment/satellite treatment centers. AIDERS will also oversee the implementation of the home/community-based care for PMDT.

To ensure that the interventions and services established by AIDERS are sustained and mainstreamed after three years, the following sustainability measures will be implemented: advocacy to local officials to absorb the health AIDERS later or to share staff cost between municipalities under the inter-local convergence zone initiative; and tapping existing community groups or NGOs working in the area at the onset, where TB information, early identification of TB suspects, and referral process will be introduced in their activities. The PR in collaboration with the NTP and the Health Human Resource Development Bureau of DOH, will be in charge of the hiring and deployment of the health AIDERS. It will also work closely with the municipal/city health office and the local social welfare and development office of the LGUs.

1c. Standardize TB treatment while finding the missing/missed cases from among public and private hospitals, including private physicians through expansion of hospital-based DOTS. This is based on the 2007 NTPS which showed that 50% of TB patients access the private sector for TB diagnosis and treatment but private physicians do not follow the international standards of TB care (ISTC).

(1d.) The request will also support improving the logistics management system for anti-TB drugs and TB-related supplies and commodities at the national, regional and local levels to ensure better forecasting, procurement, inventory, distribution and quality assurance procedures and prevent episodes of stock-out by ensuring availability of quality goods. Through the project, the following will be done to prevent stock-out of FLDs and other commodities:

- ***Build the capability of the program managers at all levels (national, regional and provincial/city) and their partner supply officers. This includes (1d1) appointing a logistics team (composed of logistics Xpert MTB/Rif and two assistants) to NTP to help in the forecasting of logistics to be purchased, following-up of decisions/issues raised by the Central Office Bid and Award Committee, and immediately responding to them (logistics allocation shall be based on the***

status of supply at all levels), monitoring and overseeing the DSM for both the FLD and SLD (the logistics team will capacitate the NTP staff and LCP staff in managing the FLD and SLD to ensure sustainability); and (1d2) conducting capability-building of the regional and provincial/city TB coordinators and the supply officers based on the handbook on logistics management. SIAPS will help in the conduct of the training of trainers. The government will fund the nationwide scale up that will be done by the regional TB team and supply officers.

- *Establish early warning system using information from the national online stock inventory reporting system (NOSIRS) which tracks all logistics bought and distributed by the DOH. This has just been implemented by DOH. The logistics team at IDO and the regional TB teams will coordinate with the supply officer in reviewing the information from NOSIRS to know the monthly status of anti-TB drugs and laboratory supplies. Based on this information on supply status, appropriate decision and action will be made. Vehicles will be provided to all the 17 regions to ensure that drugs and other logistics are regularly distributed by the region to the provinces and cities. This will also be used for monitoring of logistics and re-distribution of supplies, if needed.*

- *Monitoring and supervision of PSM. Conduct regular monitoring visit and use this for mentoring on logistics management as supplement to the training.*

- *Advocacy to LGUs to procure if there is impending drug/laboratory supply shortage*

- *Shifting from SDF to FDC for pediatric drugs ensure simultaneous availability of all pediatric drugs*

(1e.) The fund will also be tapped to continue its support to the nationwide rollout of the ITIS to support real-time data gathering for sound decision making for NTP planning, development and implementation.

The NFM grant will support the development of the Laboratory Management Information System as part of the ITIS. The ITIS will be further enhanced with the development of a reporting module for automatic data processing and analysis to aid NTP decision making. Infrastructure (hardware and internet connectivity) will be covered by the DOH-IMS and the NFM grant will support the training and nationwide rollout of the ITIS. The NFM grant will also support the bridging of the ITIS with the DOH e-FHSIS and NOSIRS.

2. Mainstreaming of PMDT.

Anchored on the recommendations of the JPR 2013, the enhanced PhilPACT covering 2014-2016 aims to mainstream PMDT into the local DOTS Service Delivery Network and increase treatment coverage up to 40% of the estimated annual MDR cases by 2016. In order to achieve this, financial support through the GF-NFM will allow the country to:

(2a) broaden PMDT service points via integration of PMDT services into strategically selected DOTS centers at the peripheral levels;

The current approach in PMDT is discussed in Section 3.2, from page 26 to 31. The proposed changes in the approach is presented in the figure below:

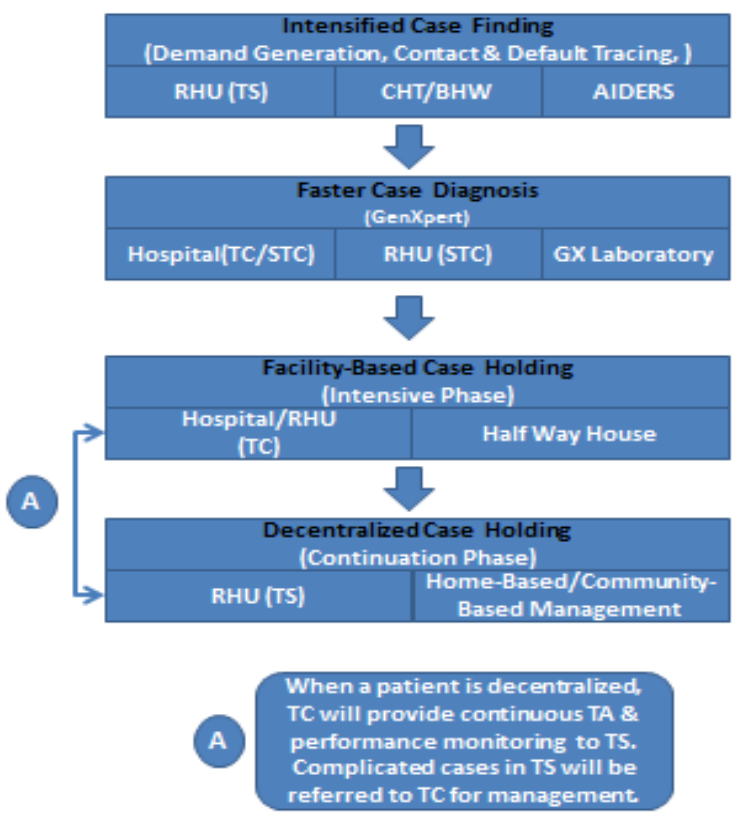


Figure 9. Continuum of Care for PMDT under the NFM TB Grant

In the enhanced approach for PMDT under the GF NFM Grant for TB, the following process is proposed: (a) Intensified case finding among the DR-TB suspects will be taken on by the RHUs with the support of the Community Health Teams, Barangay Health Workers and AIDERS. Intensified case finding includes conduct of demand generation activities in communities, default tracing, contact tracing and active case finding. (b) Suspected DR-TB cases are then referred to TC/STC for assessment and specimen collection. Diagnosis using Xpert is done at the point of care, which may be within the TC/STC or an adjacent Xpert-enabled laboratory; (c) Xpert-confirmed cases will then undergo pre-enrollment procedures similar to the current protocols. Upon completion of the procedure, confirmed cases will be enrolled into treatment. Patients will be managed by the TC/STC until culture conversion is confirmed and halfway house provision will be maintained, including customized enabler packages specific to the patient needs; (d) Patient decentralization to TCs will be done immediately after culture conversion, as early as three months after treatment initiation, provided the patient is able and willing. Home-based and community-based management of cases will be part and parcel of the decentralization. The TS will be responsible in preparing the family member or the identified community representative (CHT/BHW/Volunteer HW) in ensuring DOTS. Customized patient enabler packages will still be provided to the decentralized patient, when deemed critical. (e) The TC/STC will maintain coordination with TS to provide technical assistance services and program performance monitoring. TS shall refer severe ADRs and complications to their TC/STC for case management and/or referral to special health service facilities, as may be necessary.

Compared to the current approach in PMDT, the new approach introduces <u>active</u> case finding and establishing/improving the capacity of existing DOTS Centers to provide PMDT services.

Decentralization will be also be initiated earlier (from current practice of decentralization being initiated on the sixth month to the third month in the new approach – provided culture conversion is already achieved). Critical in the new approach is investing in capacitating families/support group and community health workers to support PMDT patients in their treatment and eventual recovery and re-integration as productive members of their communities.

Operating within the concept of mainstreaming and sustainability, the upgraded DOTS facilities (technically upgraded to include PMDT services as part of their regular services as PMDT STC/TS), are under the LGUs, thus will continue to be directly managed by the city/municipal health officers. As such, the LGUs will become more accountable to the program and will then actively support demand generation and case holding for DR-TB cases—as a result of eliminating the parallel service delivery system between regular DOTS and PMDT. Eventually, converting all RHUs under the LGU to become STC/TS will be taken on by the LGU (i.e. outside of GF support and using their own NTP sub-allotments or Internal Revenue Allotments). Simultaneously, the grant will pursue building the capacity of local hospitals (city/municipal/provincial) to become providers of comprehensive PMDT services (similar to the current TC) and thus will eventually be the reference hospital for complicated DR-TB cases. The CHDs will remain the arm of the NTP to monitor local PMDT performance and provide technical assistance. The Lung Center of the Philippines will be the national reference of clinical DR-TB management and the training arm for PMDT. The NTRL will manage the laboratory component of PMDT as mandated, and the NTP will take on the overall management of PMDT, as an integrated component of the NTP DOT strategy.

By the end of 2013, the Philippines would have a total of 52 operational PMDT treatment facilities (20TCs and 32STCs). Under this proposal, the target is to establish an additional 82 TS between 2014 up to 2016. The 123 PMDT treatment facilities (TC/STC/TS) correspond to at least 1 PMDT facility for every key city and province in the country. It must be clarified that the scale-up does not mean establishment of new infrastructure, but rather tapping on existing private and public DOTS facilities that can mainstream PMDT services into their existing health services package. Selection criteria on the DOTS facilities that will upgraded to become TS is discussed below:

1. ***The existing DOTS facility must have an MD and an RN trained on the management of pan-susceptible TB Cases;***
2. ***The facility must have DOTS performance of at least 85% cure rate for new smear positive cases; treatment success rate of 90%; and defaulter rate of less than 10% and has an existing clinic space for DOT and triaging patients for screening purposes;***
3. ***The facility must be strategically located in the city or province, where more patients will have easy access for diagnosis and treatment;***
4. ***The DOTS clinic management (hospital chief, LGU, others) must have political commitment of to provide MDRTB services; and***
5. ***There must be post-project sustainability, with plans and capacity to absorb the additional staff to augment the existing staff, and sustain PMDT services beyond project life.***

The plan of mainstreaming PMDT is directly tied with addressing high default among DR-TB patients through earlier onset of patient decentralization. This is one recommendation form the JPR 2013, where one key barrier identified in treatment adherence is the proximity of the treatment facility to the patient's place of residence/work. By improving access, patients are also brought closer to their support group (families and significant others) essential to motivate treatment compliance/adherence.

Under the NFM grant, the program will further improve quality of PMDT service delivery by following the JPR 2013 recommendations to (1) strengthen health workers' ability in addressing adverse drug reactions among DR-TB patients; (2) build the capacity of the local DOTS units at the periphery for effective and efficient decentralization by addressing HR issues, provision of trainings, supervision and necessary commodities; (3) explore new approaches to hasten specimen transport for Xpert MTB/Rif test ; (4) conduct research to investigate on the reasons why high proportions of Xpert MTB/Rif tests among presumptive DR-TB cases are turning out negative; (5) strengthen PMDT supervision at all levels by engaging regional and provincial health units to monitor RHU performance, particularly in routine monitoring of presumptive DR-TB cases progression from diagnosis to treatment initiation; and (6) ensure that national consilium provide regular supervision, coaching and mentoring among regional consilia to ensure quality diagnosis and patient management.

The program, through the assistance from the Global Fund Project, will also augment manpower requirements at the initial phase of operations of the newly established treatment facility. The satellite treatment center will be provided with one (1) clinic nurse to assist the existing physician and nurses of the facility in the implementation of PMDT. The augmentation will be provided in the first year of implementation with an agreement that the facility, through its LGU, would eventually absorb or take over the manpower expenses of the program.

(2b) Improve access to faster diagnosis of DR-TB by establishing GeneXpert MTB/Rif sites in every province/city including coverage of vulnerable population (specially inmates, children).

As part of this request, additional 140 GX machines will be procured to bring DR-TB diagnosis at the point of care, i.e at the level of the STC/TC. Essentially, the 140 units will be strategically placed to cover all provinces and key cities nationwide. The inclusion criteria for the site selection and distribution are seen below.

***Considerations for Xpert MTB/Rif Allocation** (See Annex 4.2A for details)*

- *Use for detection of MDR-TB, drug-susceptible smear negative TB, and EPTB to complement existing diagnostic tools (e.g., sputum microscopy, culture/DST)*
- *Making Xpert MTB/Rif available through countrywide network of laboratories*
- *Data analysis of local NTP performance & TB Burden*
- *Geographic setting, infrastructure (power supply, roads, transport system)*
- *Other aspects of TB program implementation (availability/accessibility and performance of diagnostic services)*

PMDT Service among Vulnerable Population:

- **Health personnel in all PMDT centers are trained to provide PICT to all MDR-TB patients. It is protocol for these patients to be provided with PICT as part of the treatment package. Those tested positive are provided treatment once qualified for ARV (CDR count less than 200; as determined by the HIV treatment hub physician). Patient co-management is done by the DOTS center physician and the HIV treatment hub physician. HIV testing kits are provided by the TB program, but ARVs are provided by the HIV Program.**

- **PMDT services are provided to inmates through a referral network whereby the clinics in jails and prisons are capacitated to be DOTS providers. DR-TB suspects among inmates are identified and sputum samples are collected and sent for testing by the nearest PMDT diagnostic/treatment facility. Treatment of confirmed cases is managed by the PMDT-trained clinic MD and RN. For those without in-house health care providers, a PMDT treatment center staff takes on the task for daily administration of treatment until the**

nearest DOTS center is capacitated to take on the task.

- **The mechanism for providing PMDT services among people with disabilities depends on the situation of the patient, but will not veer away from the usual service delivery mechanism. For people with disabilities located in aggregate settings, the mechanism is similar to PMDT service delivery mechanism for inmates.**

(2c) Procure SLD and ancillary medicines for 13,210 MDR cases for three years;

(2d) Reduce MDR default rate by providing enabler support and increasing community-based/home-based care and support for DR-TB patients. Note that the mainstreaming of PMDT also covers all vulnerable population, including PLHIV, PWD, children and inmates.

The current enabler package, also discussed in Section 3.2 on the Briefer on the status of PMDT in the Philippines, details the various forms/mechanisms of patient enablers provided to the patients. Enablers are provided only to patients categorized as "Class C" based on the socio-economic classification of the Philippine Department of Social Welfare and Development (DSWD). Class C segment of the population are those who are poor, defined by combined family annual income and assets lower than PhP7,500/month or USD170/month. Of the 1,908 DR-TB patients enrolled under PMDT 92% are class C patients.

The JPR 2013 recommends that provision of patient enablers to address financial barriers in adherence to treatment is critical in the goal of reducing high default rate. It also recommends piloting and testing of innovative and sustainable/country-specific enabler packages according to the patients' needs.

In 2012, the country and the GLC noted the increasing default rate based on the 2009 cohort. As recommended by the GLC, the country developed an enhanced enabler package that was initiated in June 2013. Qualitative assessment on the efficiency of the enhanced enabler package can be evaluated by the end of 2013. However, analysis of the monthly default trend of 2012 and 2013 shows that patient default is lower after the initiation of the package which indicates positive effects of the said mechanism to mitigate/reduce default. An externally commissioned perception survey is current being conducted among patients and providers on the value of the enablers to patient treatment adherence. Preliminary results show that the default rate among those with enablers is lower than those without. Earlier drop-out is also seen among those patients without enablers. Initial analysis also shows that the enablers, in general, are important, but not critical to treatment completion as the over-arching reasons for default remains to be (1) proximity of patient to the facilities, (2) socio-economic status of patients were priority is addressing basic survival of family rather than health and (3) event of adverse drug reactions. Akin to the JPR 2013 recommendation, the current enabler package should be reconstructed to be more customized based on patient needs and be more holistic. Realizing these recommendations through testing of other forms/modalities of enabler delivery is part of this GF NFM application.

Significant efforts led by the NTP and with technical support from USAID (IMPACT and Health Policy Projects) are currently being done for the development and implementation of an MDR-TB Package under the Philippine National Health Insurance (PhilHealth), which takes into consideration the sustainability of providing enablers to patients to support treatment adherence and mitigate default. Another joint initiative being pursued is the lobbying among LGUs to appropriate funds to provide enabler support to their local constituents affected by the disease. Local models on the latter are existent and it is hoped for to serve as reference in replicating such models in other LGUs in the future

Under this application, the enabler packages being provided to patients will be revisited and customized to be more specific to the barriers surrounding non-treatment adherence and default. Operations research will also be pursued, as recommended by the JPR 2013 to be able to identify the factors affecting default for proper identification of sustainable and efficient action agenda.

Under the grant, the PR will also work closely with NTP and support the NTP Program Management Office

to advocate for/lobby support from both national and local governments, particularly PhilHEalth to increase support and ensure sustainability of PMDT beyond project support.

The indicative funding will support the program to reach 30% of the estimated MDR cases in the country by 2016. The above indicative funding will help the country increase coverage to 40%, which is the country target for PMDT.

1. Enhancing TB-HIV Collaboration.

To realize the goals of the TB-HIV collaboration plan (Annex 2.1D), it is prioritized in the GF-NFM application considering the very limited internal and external resources for HIV (due to the country's' low HIV prevalence which is less than 1%) and recognizing its co-morbidity with TB.

GF investment via the NFM will cover:

(3a) Capacity building for TB-HIV and HIV-TB case management;

(3b) Enhancement of the TB-HIV referral network nationwide;

(3c) Procurement of HIV testing kits;

(3d) Increasing access of PLWHA to Xpert MTB/Rif services; and

(3e) Conduct of operations research on using non-medical technologists providing HIV Rapid Tests.

4.3 Modular Template and Summary Budget by Module (Indicative and Above Indicative)

The **Modular Template (Attachment 2)** is to be completed as the core document for this funding request.

a. For the indicative request, list **modules and interventions in order of priority**, associated indicators and targets, plus costs and budget assumptions for each intervention.
b. For requesting funds **above the indicative amount**, add any additional modules and/or interventions (listed in order of priority) and include the associated indicators and targets, as well as costs and budget assumptions for each intervention.

In the summary table below,

c. Provide an **overview of the total funding request** budget by module, as detailed in the Modular Template, for both the indicative and the 'above indicative' request. Present the modules in decreasing order, by funding amount.

Modules	Sum of indicative budget for three years	Sum of 'above indicative' budget for three years	Total of full request budget for three years	Percentage of indicative request	Percentage of full request
DOTS	5,946,700	1,053,571	7,000,271	8%	7%
MDR-TB	52,404,111	20,309,222	72,713,334	73%	78%
TB-HIV	798,281	-	798,281	1%	1%
M&E	4,212,615	118,429	4,331,043	6%	5%
PM	8,818,293	-	8,818,293	12%	9%
Total	72,180,000	21,481,222	93,661,222	100%	100%

**Annex 4.3A – 4.3E provides the details of the cost assumptions for the modules

4.4 Indicative Funding Request

Referring to the modular template:

a. Provide an overview for the indicative request, and how the proposed investment maximizes impact. Explain of the **rationale for the selection and prioritization** of these modules and interventions.

b. Describe expected **impact and outcomes** of the request (with reference to modular template and the programmatic gap tables). Please refer to any available evidence of effectiveness of the interventions being proposed.

The indicative request includes the indicative amount, plus any existing Global Fund financing that will be invested (or reprogrammed) during the funding request period.

c. For these **consolidated funding requests** (i.e. where there is existing Global Fund support for the component requested) explain how current grants will be adapted, discontinued or extended to maximize impact.

(1) Accelerating and Intensifying DOTS

The indicative funding request on accelerating and intensifying DOTS attributes to 8% of the total

indicative funding request. This GF investment translates to at least 2%, 5% and 7% additionality *(attributable to the expanded Hospital-Based DOTS and Health AIDERS initiative)* to the case detection rate for 2014, 2015 and 2016, respectively. This contribution will support achievement of 90% CDR, 90% TSR by 2016.

Forty-nine percent of the indicative funding request will support improvement in the diagnostics, while 8% will be for hospital-based DOTS and 49% for the Health AIDERS (Accelerating Implementation of DOTS Enhancements to Reach Special Sub-Populations).

The indicative funding request will support case detection and diagnosis by supporting the procurement of 113 LED-FM to increase service delivery points and, at the same time, improve access to quality TB diagnostic facilities nationwide. The Xpert MTB/Rif machines will primarily be used for PMDT and will be phased in for use in case detection among TB in children, inmates and TB-HIV patients.

With the goal of engaging all health care providers, the GF-RCC Phase 2 would have contributed to 39% and 24% achievement of country targets for hospital-based DOTS among public and private hospitals, respectively. Under the NFM request, GF investment will support country target achievement at 69% and 80% by 2016. The remaining gap will be supported by both GOP (for public hospitals) and USAID/IMPACT Project (for private hospitals).

Concomitantly, the engagement of health AIDERS would increase community participation in case finding and case holding and increase LGU investment in managing local implementation of TB control program implementation in 300 poor cities and municipalities. The AIDERS will support case finding and case holding for all forms of TB, including DR-TB cases. This initiative will also reduce inequitable service provision and increase TB screening among high risk/vulnerable populations, particularly those from urban poor communities and GIDA.

(2) Mainstreaming PMDT

The indicative funding request for mainstreaming PMDT, on the other hand, takes up 73% of the total indicative funding request, primarily due to the high cost for managing DR-TB patients and the minimal internal resources available for direct service delivery of PMDT services in the country. GF investment for the PMDT component through the indicative funding will fully support enrollment of 9,406 MDR-TB cases that will be diagnosed from 2014 up to 2016, which represents 22%, 25% and 28% coverage of estimated MDR cases, respectively.

GF Investment will cover for case finding, case detection (laboratory-related diagnostics services including procurement of 123 MTB/RIF Machines) and treatment for all MDR/XDR-TB cases detected from 2014 to 2016. It will also support the engagement and training of health care providers from both public and private health facilities on PMDT and engagement of local communities in case finding and case holding through the AIDERS, CHTS and BHWs. The number of the MTB/RIF machines correlate to one machine for every province/key city in the country. The selection criteria are anchored on case incidence, geographical setting and availability of infrastructure.

Approximately 48% of the requested funds for PMDT will support procurement of SLD, ancillary and procurement related costs. Cost for health products and health equipment attributes to 20% of PMDT budget with majority supporting patient laboratory requirements. Thirteen percent of PMDT budget will be used for enablers to ensure treatment compliance/adherence. HR augmentation support for the PMDT treatment facilities accounts for 11% of the requested fund. It must be highlighted that GF support for all items will gradually reduce from 2014 to 2016, as GOP and LGU investment is forecasted to increase and the PhilHealth Package for MDR-TB has been approved and will be made available for utilization by 2015.

(3) Enhancing TB-HIV collaboration.

The indicative funding request for TB-HIV collaboration equals to about 1% of the total indicative funding request. GF investment will account for 70% of the funding requirement and will complement the 30% counterpart funding from the GOP to support the full implementation of the TB-HIV Collaboration Joint Plan for 2014-2016.

The 82% of the total requested indicative amount will support HIV testing among TB patients and 18%

will be for capacity-building related interventions.

Specifically, GF investment will support screening for TB among HIV patients and vice versa. Focus of the investment is capacity building for TB and HIV health providers on TB-HIV case referral and management. The funding request will also support procurement of HIV test kits, including systems enhancement for improved case finding, detection, TB-HIV co-management, cross referral networks, recording and reporting.

The indicative funding request will support provision of quality PICT for HIV among all the registered TB cases in HIV Category A and B sites and all MDR-TB enrolled cases nationwide (Annex 4.4A).

Note: The NASPCP and the Philippine National AIDS Council (PNAC) will ensure that STI/HIV-AIDS education-prevention program will cover nationwide. USAID/CHANGE and ROMP projects will also work to support health promotion on the same.

(4) Monitoring and Evaluation

Six percent (6%) of the total indicative funding request will be used to support M&E-related interventions under the grant.

Sixty-five percent (65%) of the M&E grant allocation will be used for routine M&E, while 33% will be on activities related to analysis/review/transparency and 2% for special studies, including surveys.

Routine M&E-related costs are for logistics support in the conduct of related activities for ITIS rollout, hospital-based DOTS, TB-HIV collaboration, health AIDERS and PMDT.

The M&E-related cost for analysis, review and transparency for both PR and SR include regular assessment and performance monitoring (programmatic and financial) related costs in their conduct of their roles as grant administrator and implementers, respectively. Also included here is the annual GLC payment for WHO.

PMDT-related studies that are part of this request include: (1) Study on PMDT community/home-based care models, (2) Enabler Functionality Assessment (3) Drug Interactions and (4) Identifying innovative interventions to address default.

Other key studies for DOTS and program sustainability were also included in this request, such as: (1) study on TB burden among women and children, (2) study on sustainability for hospital-based DOTS among public and private facilities, (3) improving laboratory QA certification, (4) functionality assessment on ITIS, (5) assessment on sustainability of PMDT laboratories, (6) validation of tools for rapid detection for drug resistance, (7) strategic screening for TB-HIV; (9) evaluation of various models for TB-HIV service delivery, and (9) health economics research on HSS.

Cost for the preliminary activities that will be done in 2016 in preparation for the 2017 NTPS is also included in this request.

(5) Program Management

The requested amount for PM is 12% of the total indicative funding request that will support related cost of the PR and its four SRs in the management and implementation of the NFM Grant for TB, including HR augmentation requirements of the NTP (IDO, NTRL, IMS, LCP) at the national and regional levels to implement the commitments under this proposal and mitigate effects of manpower reduction brought about by the DOH rationalization plan.

79% of the budget is for grant management while planning and coordination takes on 17 % of the budget and the remaining cost is for PSMC (4%).

4.5 'Above Indicative' Funding Request

Further to the indicative funding request in Section 4.4, describe and rank in order of priority the 'above indicative' funding request. In the response:

a. Provide an **overview for the 'above indicative' request**, including the additional modules and/or interventions requested. Clearly describe the **rationale for their selection and rank them in order of prioritization**.\

b. Describe expected **impact and outcomes** and any **additional gains** from this request, including how these have been estimated (with reference to the modular template). Please refer to any available evidence of effectiveness of the interventions being proposed.

The total above indicative funding request amounts to USD 21,481,222--which is 23% of the full request. Ninety-five percent (95%) is being requested for PMDT to increase coverage by 12% which is 3,802 additional MDR-TB cases enrolled for treatment. The remainder (5%) is for procurement of additional LED FM units for High Quality DOTS.

The above indicative request under this concept note covers for 3 of the 5 modules:

(1) For the DOTS Module, the above indicative request will be used to procure additional 287 LED-FM units to complete the 400 LED-FM units. Adequate supply of LED FM units will add to the strengthening and improvement of the DOTS laboratory component. Related training for use of these technologies will be through GOP funds and by other FAPS. Approval of the above-indicative funding request will contribute to an additional CDR of 1%, 2% and 2% for 2014, 2015 and 2016 respectively and supporting achievement of 90% CDR by 2016. It must also be noted that despite the increasing DOH budget for TB control, government policy on use of budget does not allow procurement of laboratory equipment and related commodities.

(2) For the MDR-TB Module, the requested above indicative amount will essentially support the same cost items covered in the indicative request and provide increase program coverage by 8% (2014), 10% (2015) and 12% (2016) to be able to achieve PhilPACT target for PMDT by 40% in 2016. The scaled up PMDT operations for the country have established systems and mechanism for accommodating increased number of patients but the insufficiency in funds, particularly funds to cover for medicine and management cost of additional patients, limit the PMDT operations' capacity to render service to its fullest.

(3) For the M&E Module, the above indicative request is intended for covering all routine M&E requirements for the additional patients to be enrolled on MDR-TB treatment described above.

4.6 Commitment to Financial Sustainability and Additionality

Financial sustainability is important to ensure continuity of impact. In particular, implementing country governments must fulfill their obligations to sustain and increase contributions to the national response. The counterpart financing requirements of the Global Fund are set forth in the Policy on Eligibility Criteria, Counterpart Financing Requirements, and Prioritization (ECFP).

Please complete the Financial Gap Analysis and Counterpart Financing Table in Attachment 3.

a. Indicate whether the counterpart financing requirement has been met. If not, provide a justification that includes actions planned during implementation to reach compliance

b. Describe whether and how this funding request to the Global Fund will be complemented by additional funding commitments from the Government.

c. Describe how this funding request to the Global Fund can leverage other donor resources.

The counterpart financing requirement for this application has been met with 51% counterpart versus the indicative funding request and 44% for the full request.

The GOP budget for health, particularly for TB control has been in an increasing trend for the past 5 years. This is forecasted to be higher in the coming years due to the approval of the "sin tax" (higher taxes for alcohol and cigarettes). However, the current policy on the use of GOP funds limits the necessary health investment for sustaining TB control measures such as infrastructure, health products and health equipment.

(1) Supporting improvements on the expansion and enhancement of TB diagnostics for both pan-susceptible and drug-resistant forms of TB;

(2) Providing full support to PMDT, considering that the GOP fund is focused on covering for Basic DOTS Services and health commodities although the NTP forecasts increasing budget to support DR-TB Related medicines (SLD and ancillary Drugs) in the coming years;

(3) Providing HR augmentation support for the program at all levels, while efforts are being done by the NTP and partner groups to advocate to local chief executives the creation of plantilla health positions to support and sustain their local health systems. This is related to the current devolved system for health in the country. In addition, HR Augmentation is provided under the GF funding request which is only particular for the identified poorest municipalities in the country with high TB burden.

(4) Performing special studies to enhance NTP implementation and;

(5) Financing related interventions that will support health systems improvement of the NTP, particularly on logistics and data quality; and ensure sustainability of investments made in the country.

Annex 4.1A provides an overview on the complementation of the GOP funds with all existing foreign assisted projects (FAPs), including TGF. Also, this demonstrates the program's plan to ensure that attribution and non-duplication of interventions as well as double-funding is monitored and prevented. The areas of operations for all FAPs are also well defined to ensure better program coverage and equity in support to high burden areas and vulnerable populations.

In summary, the existing co-operation in the implementation of the NTP delineates the roles of the key players whereby the DOH-IDO is the over-all program owner and CHDs as lead regional technical supervisors; LGUs as local NTP implementers in coordination with other TB care providers; with NTRL as its laboratory manager and LCP as policy, research & training center (for DR-TB).

WHO and USAID Health Project Portfolio will be the lead providers for delivering Technical Assistance (policy, standards, governance, regulation, logistics, data management) and GF NFM will support pre-determined program interventions/operations prioritized by the NTP.

Several CSOs and AID projects are also supporting the NTP to address various program interventions targeting special population groups at pre-determined sites.

4.7 Focus on Key Populations and/or Highest Impact Interventions

This question is <u>not</u> applicable for Low Income Countries.

Describe whether the Global Fund focus of proposal requirement has been met as listed below:

a. If the applicant is a **Lower-Middle Income Country,** describe how the Funding request focuses at least 50% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

b. If the applicant is an **Upper-Middle Income Country,** describe how the Funding request focuses 100% of the budget on underserved and most-at-risk populations and/or highest-impact interventions.

<u>Approaching Vulnerable Groups</u>

In the Philippines, identified TB vulnerable groups include the elderly, children, persons with disabilities, inmates, people residing in Geographically Isolated and Displaced Areas (GIDA), indigenous peoples, urban

poor and TB-HIV co-infected patients. The table below shows the estimate population per vulnerable group and respective data sources.

Table VI. Population of Vulnerable Groups in the Philippines and Data Sources

Group	Definition	Estimated Population (nationwide)	Data Source/Year
Children	Less than 15 years old	31,389,020	Census/2007
Indigenous peoples	A group of people or homogenous societies identified by self-ascription and ascription by others, who have continuously lived as organized community or communal bounded and defined territory, and who have, under claims of ownership since time immemorial, occupied, possessed and utilized such territories, sharing common bonds of language, customs, traditions and other distinctive cultural traits, or who have, through resistance to political, social and cultural inroads of colonization, nonindigenous religions and cultures, became historically differentiated from the majority of Filipinos. (RA 8371. The Indigenous Peoples Rights Act of 1997)	11,320,476	NCIP/2011 (National Commission for Indigenous People)
Geographically Isolated and Disadvantaged Areas/ Rural Poor	Refer to communities with marginalized population, physically and socio-economically separated from the mainstream society. (DOH AO 185, s. 2004)	9,105,842	BLHD,DOH/2010 (Bureau of Local Health Development)
Urban Poor	People residing in an urban area whose income falls below the official poverty threshold (NSCB, 2006).	6,900,000	NSCB/2006 (National Statistics Coordinating Board)
Elderly	More than 59 years old	5,498,848	Census/2007
Persons with disabilities	A person suffering from restriction or different abilities, as a result of mental, physical or sensory impairment, to perform an activity in a manner or within the range considered normal for human beings. (RA 9442. Magna Carta for Persons	942,048	NCDA Census/2000 (National Council for Disability Affairs)

	with Disability as Amended)		
Inmates		126,000	BJMP, BuCor reports/ 2010
TB-HIV	A person diagnosed with both HIV infection and TB	1,100	WHO TB report/ 2012

Generally, vulnerable groups have increased risk to acquire tuberculosis due to their living conditions. Most of the groups live in conditions of poverty that are characterized by overcrowding, lack of ventilation and with underlying malnutrition. In addition, there are limitations in access to health services resulting to marginalization of the groups. Stigma may add to this marginalization (eg, for TB-HIV). Inherent susceptibility due to decreased immunity are considered aggravating factors (eg, in elderly, children and TB-HIV).

As a result, there is evidence that prevalence of tuberculosis is higher among some of the vulnerable groups identified compared to the general population. The prevalence of TB is:

- 4-5x higher among inmates (PTSI, 2011)
- appreciably worse among urban poor at 66 active TB case per 1,000 population (Tupasi, 2000)
- with higher risk of severe disease and death among those below 5 years old (WHO, 2007; International Lung Disease 9:1299-1304, 2005)

Although there are no local data on TB prevalence in the other groups, there are various international documents that cite similarly higher prevalence, such as among those with HIV patients and the elderly. Furthermore, assuring access to services for these groups raises human rights and equity issue that the program hopes to address.

One of the recommendations of the recently concluded joint program review (JPR) is the shift from a current passive case finding approach to a more active approach through intensified case-finding among vulnerable groups. This strategy will address the issue of access as well as increased case finding since a "higher yield" per number screened among this group is expected compared to the case finding among the general population.

Looking at the estimated nationwide population of the vulnerable groups (Table VI), it is evident that special strategies directed at children, indigenous peoples, GIDAs, urban poor and elderly would result to more cases by mere magnitude of the group's population. Currently, specific TB control strategies are being implemented as presented below:

Vulnerable Groups	Committed Investments
Children	DOH-NTP Sub allotments will cover 100% coverage of the needs to implement TB in Children, including free anti-TB drugs. Use of GX will also be introduced for diagnosing TB among children, proposed under this CN. USAID/IMPACT will provide TA to NTP for improved service delivery system for TB in Children, including exploring more acceptable formulations for this population.
Indigenous peoples (IP)	DOH-NTP Sub allotments will cover 100% coverage of the needs to ensure DOTS coverage for IPs. USAID/IMPACT will pursue development of appropriate BCC models to improve health seeking behavior among IPs for DOTS. Also, German Doctors will continue to provide DOTS for IPs specific to

	the provinces of Mindoro (Mangyan) and Bukidnon.
Geographically Isolated and Disadvantaged Areas/ Rural Poor (GIDA)	**To be covered under the NFM CN, discussed below.**
Urban Poor	**To be covered under the NFM CN, discussed below.**
Elderly, Persons with disabilities and Miners	**DOTS service delivery models for these vulnerable populations (in institutions/ congregate settings) will be covered under the USAID/IMPACT project.**
Inmates	**DOH-NTP Sub allotments will cover 100% coverage of program activities to ensure DOTS coverage for all prisons and Jails. PMDT Services will be provided to the same group under the NFM. USAID/IMPACT will provide TA for improving the DOTS delivery system in prisons and jails. ICRC will continue infrastructure development support to provide isolation rooms for TB patients, particularly for DR-TB cases.**
TB-HIV	**To be covered under the NFM CN, discussed below.**

In 2004, the DOH issued AO 185 which initiated the establishment and institutionalization of a system for managing local health development in GIDA communities and aims to ensure provision of quality health care services. But, although various strategies for improving access and provision of health services to these areas have been implemented, currently there are neither TB-specific interventions nor information on TB burden and TB services. It is, likewise, not specifically addressed by any particular development partner except for some GIDAs in USAID project sites.

Considering the resource mapping above, availability of GOP funds for TB Control in the country and current commitments from various FAPs, the GF funding request will be used to support specific needs of the following vulnerable / special population segments:

(a) Rural & Urban Poor TB patients and symptomatics from 300 poor municipalities that covers 32 provinces / cities with a population of 9 million. The prevalence of TB among the poor is relatively high, they have poor access to TB care leading to delayed diagnosis and treatment due to financial constraints, poor health-seeking behavior, geographical difficulties, and with unavailable or erratically provided quality health services. These 300 municipalities contain 273 villages that are categorized as part of the GIDA (geographical isolated, depressed areas). The financial support will be specific for the deployment of Health AIDERS (accelerating implementation of DOTS enhancements to reach special sub-groups) to assist the health center staff and guarantee the following:

- **Acceleration of capability-building of the community health teams**
- **Strengthened community health systems**
- **Provision of diagnostic and treatment services**
- **Supervision among treatment partners**

(b) MDR-TB patients who are economically challenged due to unemployment had incurred high health transaction costs and are generally stigmatized.

(c) TB HIV patients who are have difficulty in accessing TB care due to discrimination, lack of financial means, uncoordinated TB and HIV service care providers.

Note: Majority of these three groups of patients is in Income Level C or lower.

SECTION 5: IMPLEMENTATION ARRANGMENTS			
5.1 Principal Recipient (PR) Information			
Complete this section for each nominated PR. For more information on Minimum Standards refer to the Concept Note Instructions.			
PR 1 Name	**Philippine Business for Social Progress (PBSP)**	Sector	**NGO**
Does this PR currently manage a Global Fund grant(s) for this disease component or a stand-alone cross-cutting HSS grant(s)?		X Yes	☐No
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and planning		**PBSP performance as PR for GFTB Phase 1 and 2 (2010-present) has been assessed to be satisfactory, with grant performance consistently rated as B1.** **The grant will be directly managed by a project team and will be lodged under PBSP's Program Management Office for Health (HPMO). A project management committee comprised of PBSP directors (executive office, finance, operations, internal audit, health project managers) oversees the HPMO and reports directly to the PBSP Board.**	
2. The Principal Recipient has the capacity and systems for effective management and oversight of Sub-Recipients (and relevant Sub-Sub-Recipients)		**PBSP, has 45 years of experience in grant management and administration. Specific for the GF-supported projects, PBSP operates according to their manual (Annex 5.1A) that aids the project team in performing effective management and oversight of SRs/SSRs. PBSP employs an "account managers/account coordinators" to oversee grant management and administration of each SR/Project Component. The SR assessment and selection is done by the PR following GF requirements and that of the PRs. Gaps identified in the assessment are communicated to SRs through management letters, requiring time-bound action responses. The PR also provides technical assistance support (training, coaching/mentoring and even assigning consultants) to help SRs improve their systems and performance. The PR also conducts mid-year and annual SR performance assessment to improve program performance. Akin to the GF management of the PR, the PR adopts performance-based approach for the grant implementation.** **PBSP is a grant-making institution. As such, management of grantees, subcontractors and**	

	other grant-making arrangements with local implementers is innate for the organization. Under the ongoing USAID/IMPACT project, PBSP has 3 consortium partners, 4 ongoing subcontracts and will be engaging at least 6 NGOs for community-based TB service delivery engagements. All of which, are performance-based.
3. There is no conflict-of-interest for the selection of the Principal Recipient(s) and Sub-Recipients	**PR was selected by the CCM as discussed in Section 2 of this document. The process conforms to the PR selection guidelines of TGF.** **PBSP employs a rigid selection process that is competitive and transparent and aligned with the CCM COI policy and the TGF SR selection guidelines. The process is also detailed in the PBSP GFTB Project Operations Manual, developed for GFTB Phase 1 and 2 projects. The selection process is exhaustively discussed in Annex 5.1A.**
4. The program-implementation plan provided in the funding request is sound	**The program implementation plan submitted is aligned with the DOH Universal Health Care Program and the enhanced Philippine Plan of Action to Control TB (PhilPACT 2010-2016). It was developed based on the findings and recommendations from the recently conducted Joint Program Review 2013 on the NTP implementation and in consultation with various stakeholders: government, CSO/POs, health care providers, academe, medical eXpert MTB/Rifs, community groups, local government units and patient groups.**
5. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	**PBSP has a fully functional internal audit unit which reports directly to the PBSP board. It operates following an approved audit plan, which covers all PBSP projects. The Director of the Internal Audit Unit also leads the Foundation's Enterprise Risk Management System and ensures compliance among all PBSP units.** **In the performance of the GF grant, PBSP was able to demonstrate well-established internal control systems that were able to detect early signs of misuse and/or fraud within the institution and among all its SRs/SSRs. Financial monitoring for all SRs/SSRs is done on a monthly basis and PBSP's internal audit unit conducts random checks for the PBSP project and its SRs. The funding mechanism employed by the PR is Cash Advance and/or Revolving Fund which is released monthly.**
6. The financial management system of the Principal Recipient is effective and accurate	**PBSP's financial management has been rated "generally adequate" by the GF in the performance of the current grant. Furthermore, the same system has been assessed and approved by various donors, including USAID,**

	ADB, World Bank, AusAID, AECID, among others.
7. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	**Warehousing for the grant is provided through the DOH warehouses up to the regional level, including that of the NTRL. Under the previous grant, renovations were done at the level of treatment facilities to have adequate drug storage facilities. PBSP also employs service providers for health products requiring special storage. All of these observe good storage practices. Monthly monitoring is being done for all warehouses containing GF-procured goods and products.**
8. The distribution systems and transportation arrangements are efficient to ensure continued and secured supply of health products to end users to avoid treatment / program disruptions	**In the performance of phase 1 and 2, PBSP in cooperation with DOH and its service centers, has been able to develop clear logistics system to ensure timely delivery of quality goods. No stock-outs have been reported under the project, but with noted overstock (of PASER & Cs) PBSP shall improve its PSM system further in the new grant to ensure uninterrupted supply of quality drugs and avoid over/under stock and wastage.**
9. Data-collection capacity and tools are in place to monitor program performance	**The PR cooperated with the DOH in developing the M&E plan for the NTP. PR likewise has detailed M&E plans (Annex 5.1B) which it also requires from all its SRs. The plans detail the data and tools to be collected, including verification procedures. PBSP has also developed a system to assess SR performance, as detailed in its operations manual.**
10. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	**At the level of the NTP, PBSP facilitated the development of the Integrated TB Information System (IT IS), which is a web-based platform developed through the GF grants by the DOH-IMS. The IT IS will be the MIS of the NTP. The IT IS will be linked with the other IS of the DOH such as e-FHSIS and the NOSIRS. ITIS is currently being rolled out nationwide; complete coverage and full utilization of the system will be in 2015.**
11. The CCM actively oversees the implementation of the grant, and intervenes where appropriate	**PR reports regularly as required by the CCM through the quarterly dashboard and the semi-annual PUDR. The CCM Dashboard is a tool to routinely assess grant implementation. CCM procedures on the same and other related oversight and management functions are detailed in the CCM Operations Manual. On a quarterly basis, the PR presents to the CCM oversight committee the GF Dashboard. Sample minutes of meetings attached as Annex 5.1C.**
12. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-	**The project is supported by a PSM plan, which details procedures to ensure that quality requirement of WHO and the country are met.**

country supply chain	

5.2 Overview of Implementation Arrangements

Please provide an overview of the proposed implementation arrangements for the funding request. In the response, please describe as appropriate:

a. If more than one PR is nominated, how co-ordination will occur between PR(s).
b. Whether Sub-Recipients (SRs) have been identified and the type of management arrangements likely to be put into place.
c. How coordination will occur between each nominated PR and its respective SR(s).

The Philippine CCM will be the key oversight body for the GF Grant. The CCM will be chaired by the DOH and supported by a co-chair. Decisions of the CCM which are technical in nature will be based on the recommendations of the National TB TWG.

The GF NFM Grant for TB will be implemented by PBSP, the current PR for GFTB Phase 2, as recommended by the CCM. The PR will manage the grant and perform as fiduciary for IDO, LCP and IMS. The PR will engage 4 SRs, selected competitively, to support the grant implementation.

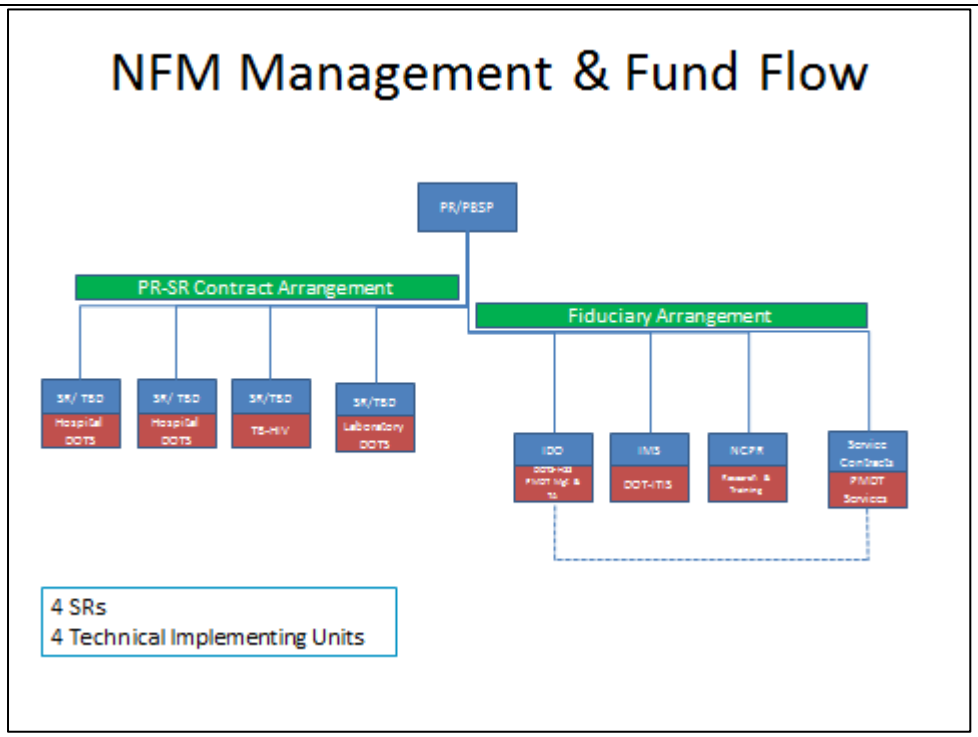
1. **For the Laboratory component of the DOTS module, an SR will be engaged to provide fiduciary management over the grant supporting component related interventions under the GF NFM for TB. Over-all technical management will be through the DOH-IDO-NTP with NTRL as the lead for laboratory network management; LCP as lead for PMDT Research and Training, IMS for TB data management and MMD for logistics management.**

2. **Considering the nature and function of the AIDERS, PBSP will take care of their recruitment and management. This is to ensure standardization of salaries and benefits, including staff development and performance management.**

3. **For the hospital-based component of the DOTS module, it will be awarded to 2 SRs that will be covering Luzon and Visayas/Mindanao. The SRs will be selected following GF-recommended and PBSP-approved selection processes.**

4. **For TB-HIV Collaboration, an SR will be engaged to implement the activities under the grant.**

The figure below provides a flow chart on the GF NFM CN for TB management and fund flow:



PBSP has an operations manual for the current grant that provides guidelines on the PR-SR coordination to ensure achievement of committed targets, including mechanisms for administration, management and performance assessment. This will be enhanced and will be employed under the new grant.

5.3 Current or Anticipated Risks to Program and PR(s) Performance

In reference to the Minimum Standards above and risk assessments conducted (if applicable), describe current or anticipated risks to the program and nominated PR(s) performance, as well as the proposed mitigation measures (including technical assistance) included in the funding request.

The GF risk assessment of the current GF TB grant showed "medium" grant risk for PBSP in 2012. The risk assessment also identified four (4) key risk areas as follows:

(1) Poor quality of health services (contributed by a high MDR-TB treatment defaulting rate)

(2) Non- achievement of grant targets

(3) Macroeconomic losses

(4) Poor access and promotion of equity and human rights

Various approaches to address (1) (such as addressing default through enabler mechanisms, strengthening lab support, and increasing community participation) have already been put in place to address. For (2), the 7th Progress Update report on the current grant reflects achievement of majority of the grant targets and the CCM/PR anticipates "A" rating. Risk (3) will no longer be relevant as the grant currency will be shifted to USD in the new grant. Addressing Risk (4) is covered in the discussion on the DOTS module in *Sections 4.2 and 4.4*

Anticipating the same risk under the NFM, *Section 4.2 & 4.4 GF NFM CN application* details the actions to be undertaken to mitigate the same.

In the Implementation of the GF NFM Gant, the following risks and actions will be considered:

For Programmatic & Performance Risks

On the current grant, risks are generally medium with reference to (1) limited program relevance, (2) Not achieving grant output targets, (3) not achieving program outcome and impact targets, and (4) poor aid effectiveness and sustainability. Low risk is seen on (5) inadequate M&E and poor data quality.

To ensure program relevance, and to aid effectiveness and achievement of targets, the CN for the new grant under the GF- NFM was developed which is anchored on an enhanced PhilPACT, aligned with the country's Universal Health Care (UHC) Program were prioritized in consultation with various stakeholders. Targets were set based on the current program performance (JPR Findings & related assessments) and the pertinent needs of the national health system.

To ensure sustainability, project guarantees development of PhilHealth packages for MDR- TB, continuous negotiation and advocacy with the LGUs and health care providers for PMDT Advocacy and absorption of project- supported personnel to be part of their respective human resource post- project implementation. In addition, with the full utilization of the ITIS, data quality will be improved and M&E systems will be better utilized.

For Financial and Fiduciary Risks:

(1) Macroeconomic losses were rated as a high risk due to the weakening Euro. In the new grant, USD will be used to balance the potential losses. The PR will closely monitor forex movements and maximize the strengthening peso by timely conversion to mitigate forex loss.

(2) Medium risks include low absorption capacity or over commitment and poor financial reporting. The utilization trend of PR is greatly influenced by ensuring value for money and on the approval screening of cost items based on its direct relation of activities to target. This practice has increased cost efficiency in the grant, rather than low absorptive capacity. This practice will be maintained by the PR. Poor financial reporting will be addressed by an increase in personnel to handle the sheer bulk of financial transactions under the grant. It must be highlighted that financial reporting challenges is inherent to the grant due to (a) misalignment of the GF calendar (Jan-Dec) and that of the PR (Oct-Sept), (b) Accrual basis of accounting in the Philippines versus Cash Basis accounting required by TGF, and (c) Weak financial systems of SRs. The PR will address the latter by providing TA to SRs at the onset of grant implementation.

(3) Low Risk includes Poor Financial Efficiency, Fraud/Corruption or Theft of Funds and Theft/Diversion of Non-Financial Assets. The PR has proven track record on financial efficiency, including ability for early detection of fraud/misuse. The PR will further strengthen its capacity by strengthening its Enterprise Risk Management (ERM) systems and influence its SRs to adopt the same. Furthermore, the PR has a fixed assets registry and management system that ensures all non-financial assets of the GF under the PR is safeguarded.

For Health Services & Product Risks

(1) Poor quality of health services are rated as "very high" risk and this is being addressed by GOP in its Universal Health Care program. At the project level, standard have been established to ensure quality health services is provided at all GF-supported facilities with close and regular monitoring procedures.

(2) Treatment Disruptions is rated as medium risk. As a matter of protocol, no treatment is initiated without confirmation on the availability of drugs for the full treatment regimen for patients taking 1st and 2nd line drugs. Particular for the PMDT, enablers are provided among poor patients to support treatment adherence. Some mechanisms employed include organizing patient support groups, contact tracing, patient incentive schemes, decentralization and adoption of community-based and home-based care services.

(3) A low risk rating was given on Substandard Quality Health Products. The PR procures SLD from IDA, which is accredited by WHO/TGF. Anchored on the PSM plan, quality of health products are maintained by the PR up to delivery and storage at the level of the health facility. Ancillary drugs are

also procured from verified sources, consistent with WHO/TGF requirements. From the perspective of the DOH, its related agencies and departments to ensure quality products (Philippine FDA, BFAD, COBAC and MMD) are undergoing systems improvements to ensure this in the long haul.

(4) The risk rating for "Poor Access and Promotion of Equity and Human Rights" was "unknown". For both the current and new grants, this is taken into much consideration as reflected by the selection criteria employed in the provision of patient enablers whereby patients are categorized based on socio-economic status and only those under Class C. This is also being addressed by the expansion of services to reach the vulnerable groups to include the urban poor, geographically isolated and depressed areas, inmates, indigenous populations, women and children, people with disabilities, among others. The use of the AIDERS as proposed under this concept note is aimed in providing manpower support to 300 of the 600 poorest municipalities in the country to access quality DOTS services.

PBSP is currently improving its current Enterprise Risk Management System (ERMS). Aligned with this is beefing-up its support units, particularly the Internal Audit and Financial departments as it prepares its system for the new grant. A management committee unit comprised of the executive office and the directors of the foundation, including program heads for the GFTB and USAID/IMPACT projects has been established and is currently operational to oversee both TB programs and ensure complementation to support the NTP for greater impact and cost efficiency.

5.4 Major External Risks

Describe any major external risks (beyond the control of those managing the implementation of the program) that might negatively affect the implementation and performance of the proposed interventions.

(1) Natural Disasters & Emergencies. The Philippines is affected by 20 typhoons in a year and is located in the ring of fire, making it prone to earthquakes. Natural disasters and emergencies are the major risk factors which may have negative impact on grant performance and management. However, the project, in cooperation with DOH and USAID/IMPACT project is developing protocols for managing TB in cases of disasters. The technology will be shared among all health care service delivery points, including those funded by the grant.

(2) Insurgencies. Grant operations in the Mindanao area, particularly in ARMM is also faced with possible risks from political/military-related insurgencies that might negatively affect service delivery in the region.

(3) Foreign Exchange. Due to the volatile status of currencies, the risk may be favorable or otherwise to the grant implementation. PBSP regularly monitors forex to better support its forecasting to minimize effects of this uncontrollable factor.

5.5 Addressing Implementation Efficiencies

Describe how the funding requested here links to any existing Global Fund grants or other funding requests being submitted by the CCM.

In particular, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.

The current GF-TB Grant in the Philippines covers 2012-2014. Considering the GF NFM early application, it was decided that the 2014 budget for the current grant be integrated in the NFM application since the interventions are based on more up-to-date data and enhanced strategies, interventions and targets.

One critical activity in the development of this concept note is the conduct of series of consultation sessions with various stakeholders, particularly with the donor groups, as part of the resource mapping. In this exercise, all donors from both private and public sectors were invited in a harmonization workshop to determine their funding plan for the NTP (enhanced PhilPACT). In the discussions on the funding plans of the donors, support for HR augmentation, conduct of trainings/seminars/workshops/similar activities, M&E-related costs (especially studies and researches to be undertaken) and planning and administration costs, including overheads were mapped out.

From the results of the consultations, the interventions with funding gap were prioritized and were then included in the concept note. Another layer of assessment was conducted to ensure that only those items not/cannot be covered by the DOH budget will be proposed for donor support and these are included in this concept note.

The CN also includes funding request for TB-HIV collaboration. While there is an existing GF grant for HIV in the country, there is no duplication since the current HIV grant generally covers for procurement of ARVs while the CN shall request for support to improve TB-HIV collaboration systems (diagnosis, case management, recording and reporting) anchored on the TB-HIV sub plan jointly developed by the NTP and the NASPCP in consultation with various stakeholders.

There is also an existing GF Grant for Malaria and the new grant will look into tapping the trained malaria microscopists and centers to double up as remote smearing stations and TB microscopists in convergence areas based on the 300 poor municipalities prioritized under the GF NFM Grant for TB.

Currently, PBSP is managing two (2) TB Projects, particularly the USAID/IMPACT project and the GFTB Phase 2 Project (that will eventually be replaced by the GF NFM Grant for TB). It must be noted that both projects are being implemented by independent project teams and difference financial management arrangements. Both projects are overseen by PBSP's Health PlaCEs Management Office (Health PMO). To strengthen oversight, a health management committee also oversees both projects; the committee is comprised of heads of various PBSP units (Executive Office, Corporate Planning, Internal Audit, Finance, Health PMO). At the board level, a board health committee oversees all PBSP health projects.

It must be noted that these various levels of oversight, and the regular coordination meetings between both projects ensures complementation and prevents duplication. The USAID/IMPACT project essentially provides technical assistance to the NTP, which complements the GF direct support to service delivery.

5.6 Women, Communities and Other Key Populations

Please describe how representatives of women's organizations, people living with the three diseases and other key affected populations will actively participate in the implementation of this funding request, including in interventions that will address legal or policy barriers to service access.

As evidenced by the concept note development process detailed in Section 2.1, key population groups (women, people living with the TB & HIV, patient support groups, NGOs, NGOs, private sector, local/ regional/national health care workers, community-based groups, local government units, etc.) were involved in the updating of the PhilPACT and preparation of the concept note. It must be noted that the CCM composition includes representations from all these groups and they have been primary in the development and finalization of the concept note. Their active involvement in the development process was most essential to ensure that their perspectives are seriously taken into consideration and that their expressed needs are addressed by the enhanced PhilPACT and concomitant interventions supported by all FAPs, including TGF.

In this GF Funding request for TB, the NGOs, CBOs, Patient Groups and Patient Support Groups will be engaged to support case finding and case holding, particularly ensuring treatment adherence and provide

psycho-social support. At the local level, they will be tapped to support local advocacy for local policy passage to increase budget allocation for local TB control and at the national level, to support the finalization and implementation of the enhanced PhilHealth DOTS Package for regular and drug-resistant TB.

Critical in the engagement of barangay health workers, community-based groups, patient groups and patient support groups is their role in health education to reduce misconception about TB to address stigma & discrimination; improve health seeking behaviour, and facilitate re-integration of the non-infectious and /or cured patients back into their communities and become productive members.

SECTION 6: LISTS OF ABBREVIATIONS AND ANNEXES

6.1 List of abbreviations and acronyms used by the applicant

Please list below all abbreviations and acronyms used in this funding request

AHA – Aquino Health Agenda

AIDERS – Accelerating the Implementation of DOTS Enhancements to Reach Special Sub-populations

ARMM – Autonomous Region for Muslim Mindanao

CATCH – Collaboration for Additional TB Cases through Contacts and Hospitals

CBO – Community-based Organizations

CCT – Conditional Cash Transfer

CDR – Case Detection Rate

CHD – Center for Health Development

CHO – City Health Office

CIDA – Canadian International Development Agency

CN – Concept Note

CNR – Case Notification Rate

COI – Conflict of Interest

COBAC – Central Office Bids and Award Committee

DOH – Department of Health

DOTS – Directly Observed Treatment Short Course Chemotherapy

DRS – Drug Resistance Survey

DSSM – Direct Sputum Smear Microscopy

DST – Drug Susceptibility Testing

EA – Early Applicant

EP – Extra-pulmonary

FAPs – Foreign Assisted Projects

GDP – Gross Domestic Product

GIDA – Geographically Isolated and Disadvantaged Area

GOP – Government of the Philippines

HC – Health Center

HCP – Health Care Providers

HOMIS – Hospital Management Information System

HR – Human Resource

IDO – Infectious Disease Office

IMS – Information Management Service

JPR – Joint Program review

IMPACT – Innovations and Multi-sectoral Partnerships to Achieve Control of Tuberculosis

IPT – Isoniazid Preventive Therapy

IT IS – Integrated TB Information System

KOFIH – Korea Foundation for International Healthcare

LCE – Local Chief Executive

LCP – Lung Center of the Philippines

LED-FM – Light Emitting Diode Fluorescence Microscopy

LGUs – Local Government Units

LPA – Line Probe Assay

MDGs – Millennium Development Goals

MDR TB – Multi drug resistant Tuberculosis

MGIT – Mycobacteria Growth Indicator Tube

MMD – Materials Management Division

NASPCP – National AIDS STI Prevention and Control Program

NCDPC – National Center for Disease Prevention and Control

NCR – National Capital Region

NEC – National Epidemiology Center

NFM – New Funding Model

NGO – Non Government Organization

NOH – National Objectives for Health

NOSIRS – National Online Stock Inventory Registration System

NPS – National TB Prevalence Survey

NSP – National Strategic Plan

NTRL – National TB Reference Laboratory

NTP – National TB Control Program

PAFP – Philippine Academy of Chest Physician

PBSP – Philippine Business for Social Progress

PCCM _ Philippine Country Coordinating Mechanism

PCCP – Philippine College of Chest Physician

PCR – Philippine College of Radiology

PhilPACT – Philippine Plan of Action to Control Tuberculosis

PICT – Provider Initiated HIV Counseling and Testing

PIPH/CIPH – Provincial Investment Plan for Health/City Investment Plan for Health

PHO – Provincial Health Office

PLHIV – People Living with Human Immune-deficiency Virus

PLWD – People Living With Disabilities

PMDT – Programmatic Management of Drug Resistant Tuberculosis

PPS – Philippine Pediatric Society

PR – Principal Recipient

PSMID – Philippine Society of Microbiology and Infectious Diseases

RITM – Research Institute for Tropical Medicine

RIT/JATA – Research Institute for Tuberculosis/Japan Anti-TB Association

RN HEALS – Registered Nurses for Health Enhancement and Local Service Project

RR TB – Rifampicin resistant tuberculosis

RSS – Remote Smearing Station

SECURE TB – System for Enhanced Comprehensive and Unified Referral, Recording and Reporting System

SHC – Social Hygiene Clinics

SLD – Second Line Drugs

SR – Sub-Recipient

TB – Tuberculosis

TDR – Total Drug Resistant

TGF – The Global Fund

TSR – Treatment Success Rate

TWG – Technical Working Group

WHO – World Health Organization

WPRO – Western Pacific Regional Office

XDR – Extremely Drug Resistant Tuberculosis

UHC or KP – Universal Health Care or Kalusugan Pangkalahatan

USAID – United States Agency for International Development

6.2 List of Annexes

List relevant supporting documentation attached to this funding request

Reference Number	*Name*	*Page Reference*
2.1A	**Sub- plan for NHSS**	
2.1B	**Sub- plan for PMDT**	

2.1C	Sub- plan for Laboratory Network (LNSP)	
2.1D	Sub- plan for TB-HIV	
2.1E	JPR Early Epidemiologic Findings (Yamada/Borja)	
2.1F	NTP OD Assessment Findings & Recommendations by Ricardo	
2.1G	PhilPACT Steering Committee and Task Force Meeting	
2.1H	PhilPACT Review and Enhancement Workshop	
2.1I	Documentation on the Concept Note Development Workshop	
2.1J	Development of CN Financial Section	
2.1K	Consultation with LGUs on Draft CN	
2.1L	CCM Special Meeting on 1st Draft CN for TB	
2.1M	Peer Review on Draft CN	
2.1N	CCM Regular Meeting presenting 2nd Draft CN	
2.1O	Summary of Responses to Early TRP Review Feedback	
2.1P	Summary of JPR 2013 Key Findings and Recommendations	
2.1Q	Minutes of CCM Meeting endorsing CN for TB submission	
2.2	CCM Minutes of Meeting (PR Selection)	
3.1A	WHO Global TB Report, 2012	
3.1B	Philippine Health Statistics 2010	
3.1C	National Prevalence Survey (1982, 1997, 2007)	
3.1D	NTP Performance Regional Characteristics	
3.1E	NTP Statistics by Region, 2011	
3.2A	Aquino Health Agenda on UHC	
3.2B	Original PhilPACT 2010-2016	
3.2C	Enhanced PhilPACT (2014-2016)	
3.2D	NTP Manual of Procedures, 2005	
3.2E	Matrix on Functional Areas for FAPS	
3.2F	Final Report on TB Mortality Survey by Anna Beirrenbach, May 2012	

3.2G	1st DRS Report	
3.2H	NTP DQA Report, July 2012	
3.2I	GLC Mission 2012 Report	
3.2J	GLC Mission 2012 Action Agenda Status of Implementation as of August 2013	
3.3A	DOH DO 2006-1869 on TB-HIV Committee	
3.3B	AO2008-0022 on TB-HIV Collaboration	
3.3C	TB-HIV Diagnostic Algorithm	
4.1	NTP Prioritization Matrix 2013	
4.2	GX Proposed Allocation in the Philippines	
4.3A	CN Costing Reference for DOTS	
4.3B	CN Costing Reference for PMDT Module	
4.3C	CN Costing Reference for TB-HIV Module	
4.3D	CN Costing for PM and M&E Modules	
4.4A	HIV Category A and B Sites	
5.1A	PBSP Project Operations Manual	
5.1B	PBSP Project M&E Plan	
5.1C	Sample of CCM Dashboard Presentation Sessions	
6	TB Estimates	

ATTACHMENT 1 - CCM Endorsement of Concept Note

Fill in the CCM endorsement form, signed by all CCM members, and list all relevant CCM related supporting documentation.

ATTACHMENT 2 – Modular Template

The ‘’modular template’ is a core document of the funding request. It can either be completed as an Excel template, or it can filled in using an online tool (Salesforce).

ATTACHMENT 3 - Financial Gap Analysis and Counterpart Financing Table

The Financial Gap Analysis and Counterpart Financing Table is a required attachment to be completed as an Excel template, or it can filled in using an online tool (Salesforce).