The Global Fund

FUNDING REQUEST APPLICATION FORM
Full Review

SUMMARY INFORMATION			
Applicant	PHILIPPINES CCM		
Component(s)	TUBERCULOSIS		
Principal Recipient(s)	PHILIPPINE BUSINESS FOR SOCIAL PROGRESS		
Envisioned grant(s) start date	01 JANUARY 2018	**Envisioned grant(s) end date**	31 DECEMBER 2020
Allocation funding request	***USD 78,543,887***	**Prioritized above allocation request**	USD 34,872,481.32

IMPORTANT:

To complete this funding request, please:

- Refer to the accompanying ***Funding Request Instructions: Full Review;***
- Refer to the Information Note for each component as relevant to the funding request, and other guidance available, found on the Global Fund website.
- Ensure that all mandatory attachments have been completed and attached. To assist with this, an application checklist is provided in the Annex of the *Instructions*;
- Ensure consistency across documentation.

Applicants are encouraged to submit a joint funding request for eligible disease components and resilient and sustainable systems for health (RSSH).

Joint TB/HIV submissions are compulsory for a selected number of countries with highest rates of co-infection. See the related guidance for more information.

This funding request includes the following sections:

Section 1: Context related to the funding request
Section 2: Program elements proposed for Global Fund support, including rationale
Section 3: Planned implementation arrangements and risk mitigation measures
Section 4: Funding landscape, co-financing and sustainability
Section 5: Prioritized above allocation request

SECTION 1: CONTEXT

This section should capture in a concise way relevant information on the country context. Attach and refer to key contextual documentation justifying the choice of interventions proposed. To respond, refer to additional guidance provided in the *Instructions*.

1.1 Key reference documents on country context

List contextual documentation for key areas in the table provided below. If key information for effective programming is not available, specify this in the table ("N/A") and explain in Section 1.2 how this was dealt with within the context of the request, including plans, if any, to address such gaps.

Applicant response in table below.

Key area	Applicable reference document(s)	Relevant section(s) & pages nb.	N/A
Resilient and Sustainable Systems for Health (RSSH)			
Health system overview	1) Philippine Development Plan	Page 10.1-10.4	☐
	2) Philippine Health Agenda	1	☐
	3) National Objectives for Health	1	☐
Health system strategy	4) Health Sector Assessment 2016	xxii	☐
	5) Other DOH NSPs	Reference Folder	☐
	6) EU PSM Evaluation Report	1,31,41,43	☐
	7) OPTIONS Analysis	vii-xii	☐
Human rights and gender considerations (cross-cutting)	8) National Demographic Health Survey 2013	169	☐
Disease-specific			
Epidemiological profile (including interventions for key and vulnerable populations, as relevant)	9) WHO Country Profile 2016	1	☐
	10) Draft NTP Annual TB Report 2016	1	☐
	11) TB EPI Review 2016 (Dr. Yamada)	1-4	☐
	12) Mapping of Vulnerable Groups	Chapter V	☐
Disease strategy (including interventions for key and vulnerable	13) **NSP for TB:** Philippine Strategic TB Elimination Plan Phase 1 (PhilSTEP1)	Full	☐

populations, as relevant)	14) NTP Protocols List	Reference Folder	☐
Operational plan, including budgetary framework	15) NTP Work and Financial Plan 2017	Reference Folder	☐
	16) NTP Regional Plans	Reference Folder	☐
Program reviews and/or evaluations	17) Joint Program Review 2016	10-19	☐
	18) Autumn Modelling Final Report	1-4	☐
	19) Laboratory Network Strategic Plan Assessment 2015	27-28	☐
	20) Rapid Assessment of GX Scale up in the Philippines 2015	11-20	☐
Human rights and gender considerations (disease-specific)	21) Stigma in the Philippines Philippine Gender & TB Notes	294-304	☐
Other Relevant Documents	22) Republic Act 10767, or the Comprehensive TB Elimination Plan Act	Full	☐
	23) PhilSTEP Estimates 2017-2022	1	☐
	24) Notes on TB Care and Prevention	1-4	☐
	25) Notes on MDR-TB	1-4	
	26) Notes on GX Utilization/Expansion	1-4	☐
	27) Phil Patient Pathway Analysis 2017	5	☐
	28) Market Size Pattern Study	1	☐
	29) Philippine Quick Statistics	1	☐
	30) GX TB Detection Trend	1	☐
Add rows as relevant, for any additional key area as relevant to the funding request			

1.2 Summary of country context
To complement the reference documents listed in Section 1.1 above, provide a summary of the critical elements within the context that informed the development of the funding request. The brief description of the context should cover disease-specific and RSSH components, as appropriate, as well as human rights and gender-related considerations. **(maximum 2 pages per component)**

The Philippines is an archipelago of 7,100 islands with around 102 million people (NSO, 2015). It is a low-middle income country with a GNI per capita of USD 3,550 and 21.5% are poor. Around 45% of the poor population are in highly urbanized cities and provinces. Public

health care is devolved up to the city/municipality level. Health care is dominated by the private sector contributing to high out-of-pocket (OOP) expenses (68% of the 2013 health expenditure report). The Philippine Health Insurance Corporation (PHIC) covers 80% of the population in 2015[1]. The high OOP and coverage of PHIC can be rationalized by: (1) PHIC support value is low at 40% of total health cost, (2) OOP is incurred before insurance can be used, (3) lack of general knowledge on PHIC benefits among the general population, and (4) Low insurance utilization. Furthermore, there is also a need to look into other social protection programs on how they can be used to support patient diagnosis and treatment.

The specific goals and strategies for health systems strengthening is embodied in the 6-year Philippine Health Agenda (PHA) of the Duterte administration. With the vision for Universal Health Care, PHA will work towards (1) ensuring best health outcomes for all, without socio-economic, gender, and geographic disparities; (2) promote health and deliver healthcare through means of respect, value, and empower clients and patients as they interact with the health system; and (3) protect all families especially the poor, marginalized, and vulnerable against the high cost of healthcare. These will be achieved by (a) advancing health promotion and primary care delivery, (b) ensuring high coverage against health-financial risks, (c) strengthening health human resource systems, (d) investing on e-health, (e) enforcing standards, (f) patient empowerment, and (g) multi-stakeholder engagement for health **(Annex 02)**.

Although the country achieved its 2015 MDG target for TB, it remains to be on the WHO list of top 30 TB-burdened countries (TB mortality rate of 13/100,000) and TB incidence rate of 322 /100,000 (CI 277-370/100,000). Based on the DOH HIV Registry, HIV Infection in the general population was less than 1% and HIV among tested TB cases was 0.89% in 2016. The WHO estimated that the prevalence rate of MDR/RR-TB among the notified TB cases was 2.6% among new cases and 29% among the retreatment cases. In 2015, the country had an estimated 17,000 MDR/RR-TB cases among the incident TB cases and 15,000 among notified PTB cases. Latent TB Infection (LTBI) treatment coverage among children was 14% in 2015. Based on 2010 statistics, children aged 0-14 years comprised 33% of the population. The male to female ratio among the notified TB cases is 1.8, which is consistent with the 2007 NTPS (National TB Prevalence Survey). In 2013, prevalence rate of smear positive among inmates was 1250/100,000. With the ongoing war on drugs, it is expected that jails will become more congested[2], making TB transmission more rampant. The 4th NTPS is ongoing and final results will be released by Q3 of 2017.

The TB treatment coverage was 85% of all forms (276,672) in 2015. The three most populous regions (NCR, IV-A and III) contributed to almost 40% of all notified TB cases. Only 36% were bacteriologically confirmed and 12% were children. Low coverage in children is primarily due to limited access to PPD, X-ray and drug shortages. Of the total notified cases, about 65% were from the RHU/Health Centers, 14% from the private health care providers, 14% from other public health facilities like hospitals and jails. And 7% were referred by the communities.

Treatment Success Rate (TSR) among new smear positive cases was 85% in 2015 and 49% for MDRTB cases (2013 cohort). The key variable contributing to this performance is access, whereby DSTB services are available in all of the 2,600 RHUs while DRTB is being

[1] The National Demographic Health Survey (NDHS) 2013 **(Annex 08)** reports that 3 out of 5 women aged 15-49 are covered by PHIC and about 2% are covered by private insurance.
[2] The Bureau of Jail Management Penology reports an average congestion rate of 544% across all regions.

provided in only 155 facilities as of December 2016. In 2016, enrolment rate of notified MDR/RR-TB was 93% 12% drug sensitivity testing (DST) coverage.

To date, the key challenge is finding the missing TB cases for both drug sensitive TB (DSTB) and MDR/RR TB. In year 2015, the total missing cases was 15% of estimated incident cases based on the incidence rate of 322/100,000. For DRTB, only 32% of estimated DRTB cases were detected in 2015. Also critical in managing DRTB cases is to reduce the high loss to follow up among those enrolled. Furthermore, all these estimates are likely understated. The study conducted in 2013 entitled *"Market size and sales pattern of TB drugs in the Philippines"* concluded that "An enormous quantity of anti-TB drugs was channelled through the private market outside the purview of the Philippine NTP, suggesting significant out-of-pocket expenditure, severe underreporting of TB cases and /or misuse of drugs due to over-diagnosis and over treatment." **(Annex 28)**. The results of the ongoing national TB prevalence survey will aid the NTP and its partners in customizing interventions in finding missing TB cases and progress towards TB elimination.

Stigma persists alongside cases of discrimination in the Philippine setting despite investment made, including support for multi-media campaigns. What is critical to address however, is the stigma and discrimination reported by patients from care providers, particularly among DR-TB cases. NTP with its various partners has initiated efforts to analyse this and come up with concrete action plans to make TB care delivery more gender-responsive and patient-centered in 2017 and onwards.These initiatives will be supported by the Government of the Philippines and other donors.

The Philippine NTP is shifting its gears from control to elimination. Anchored on (1) Republic Act 10767, otherwise known as the "Comprehensive TB Elimination Plan Act of 2016 **(Annex 22)**; (2) Philippine Health Agenda; (3) WHO End TB Strategy/ UN SDGs; (4) 2016 Joint Program Review; and (5) various stakeholder consultation session conducted; the 2017-2022 Philippine Strategic TB Elimination Plan Phase 1 (PhilSTEP 1) was crafted. This NSP is an interim plan, as estimates and targets may be adjusted after the release of the results of the NTPS and catastrophic cost study in the latter part of 2017.

PhilSTEP1 envisions a TB-free Philippines, adopting the target of the WHO End TB Strategy. In a nutshell, it aims to address the programmatic gaps of the program to find and treat all TB cases and prevent progression of infection to disease. It endeavours to: (1) Activate communities and patient groups to promptly access quality TB services, (2) Collaborate with other government agencies to reduce out-of- pocket expenses and expand social protection programs, (3) Harmonize local and national efforts to mobilize adequate and competent human resources, (4) Innovate TB information generation and utilization for effective TB elimination, (5) Enforce standards on TB care and prevention and use of quality products, (6) Value clients and patients through integrated patient-centered TB services, and (7) Engage local government units on multi-sectoral implementation of TB elimination plan.

Specific for years 2018 to 2020, the PhilSTEP 1 has an estimated funding requirement of USD 393 million and the estimated funding gap is about USD 247 Million. Under this funding request to the Global Fund, the major activities listed in PhilSTEP 1 is focused on finding the missing TB cases for both DS and DR TB cases and successful treatments. For the rest of the gap, domestic and other external financing mechanisms need to be mobilized.

1.3 Past implementation and lessons-learned from Global Fund and other donor investments

a) List recent disease-specific Global Fund grants from the 2014-16 allocation periods and summarize key lessons learned from their implementation.

b) Include lessons-learned from specific HSS grants or any HSS investments embedded in the disease-specific grant(s) from the 2014-16 allocation period as applicable.

c) Outline lessons learned from investments by other donors as applicable.

For each of the above, explain how these lessons learned are taken into account in this funding request.

(maximum 1 page per component)

The Philippines was an early applicant for The Global Fund NFM Grant for TB in 2014 and was also awarded an extension year for 2017. Key insights and learning from the grant implementation that serves as anchor for this funding request include the following:

1. **On implementing MDR-TB.** The most significant challenge was addressing the high number of missing cases and loss to follow up among DR-TB cases due to lack of access. By end of December 2016, there were 199 operational GX sites and 155 MDR-TB treatment facilities[3]. Critical to this end is improving access to diagnosis and treatment (under this funding request) by: (a) ensuring GX (as primary diagnostic tool) and (b) ensuring DR-TB treatment is available at point of care and linked to DS-TB service delivery. It is also necessary that (c) the health care workers are equipped technically and emotionally to provide decentralized patient-centered care, (d) customized patient enablers are provided to support treatment adherence and manage ADRs- one of the primary reasons for patient default, and (e) engagement of communities and patient groups in case finding and case holding interventions, including immediate actions to prevent treatment interruptions and LTFU.

2. **On finding missing cases from Geographically Isolated and Depressed Areas.** Under the grant, around 300 nurses (called AIDERS) were deployed to GIDA areas to find the missing TB cases. It was able to contribute 10-15% increase only in total cases detection in the 300 GIDA areas covered, making us realize that there are more missing cases are actually in the urban areas, where the funding request will focus.

3. **On finding missing cases from public and private hospitals.** The GF grant supported finding missing TB cases from non-NTP providers, particularly from public and private hospitals[4]. Collectively, the hospital engagement under the GF NFM grant contributed to 4.9% of notified TB cases in 2015. However, intra-hospital coordination and referral still leave much to be desired in relation to patients who are

[3] The Patient Pathway Analysis **(Annex 27)** reports that access to TB diagnosis at 1st case seeking is 19% and availability of treatment for TB at 1st care seeking is 25%. In addition, access to GX sites is currently at 14%.
[4] Since 2014, the grant was able to reach 326 public and 352 private hospitals, of which 89% decided to become DOTS referring facilities and only 11% became DOTS providing facilities. As of December 2016, 92% of total public hospitals and 77% of total private hospitals have been engaged to be part of the NTP.

missed between referral and actually enrolment. There is much contribution to expect from hospital engagement since case notification of extra pulmonary cases is low at 2% in 2015, compared to more than 10% in other countries. With the advent of the TB Law, there is also an urgent need to create a platform for TB case notification from all hospitals and stand-alone practicing physicians treating TB cases which is part of this funding request.

4. **On strengthening TB-HIV Collaboration.** Under the GF NFM grant for TB, the project endeavoured to establish TB-HIV services in all Category A & B[5] sites of the HIV program and 100% of all MDR-TB facilities nationwide. Successfully, all related systems and protocols for TB-HIV collaboration have been put in place. Key action moving forward is to ensure that TB-HIV policies and protocols are discussed together by the TB and HIV program implementers and locally adopted and customized, anchored on the unique dynamics of the key population groups and the local health service delivery networks.

5. **On establishing and utilizing the ITIS.** Prior to ITIS, the NTP report were delayed up to 12 months. The establishment of ITIS (real-time and web-based information system) therefore, is one of the most significant investments of the GFTB grant for the Philippines. Key action moving forward is building the capacity of local TB program managers to analyse and use available data in managing their local TB prevention and control/elimination plans.

Simultaneous with the GF NFM grant for TB in the Philippines is the USAID/IMPACT project (2014-2017) that shared key learning and insights that is relevant to this funding request:

- Engaging Community Based Organizations (CBOs) and patient groups for TB control resulted in higher contribution to local case detection **(Annex 24)**;
- Private hospitals yielded significant contribution but a substantial proportion (31%) of patients preferred to be treated privately instead of referred to a DOTS facility; These hospitals will be engaged as providers or will be linked in the DOTS network.
- The model of Stand-Alone Practicing physician (SAP) shows good potential to be mainstreamed as a system of mandatory TB notification under the TB Law;
- Under the Pharmacy DOTS Initiative, Pharmacies identified a large number of presumptive TB clients but further support is needed to ensure full compliance to the recently approved pharmacy law which requires recording of patients referred and dispensed TB drugs; and
- Systematic screening of different risk groups showed high yield among household contacts, inmates and the urban poor. As such systematic screening among high risk groups and vulnerable populations will be done.

[5] The HIV Program categorizes cities and municipalities based on HIV burden. Category A sites are those cities and municipalities with 50% of its high risk population positive of HIV and for Category B sites are those with 30 to less than 50% high risk population positive for HIV.

SECTION 2: FUNDING REQUEST (Within Allocation)

This section should describe and provide a rationale for the program elements proposed for this funding request. Attach and refer to completed **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework and Budget**, and refer to national strategy documents as applicable.

To respond, refer to additional guidance provided in the *Instructions.*

Ensure that the funding request as described in questions 2.1 and/or 2.2 meets the focus of application requirement as outlined in section 2.3.

2.1 Disease-specific funding request

Not applicable if the application is a standalone RSSH request.

Given the context and lessons learned outlined in Section 1,

a) Describe the disease-specific funding request(s), the rationale for prioritizing modules and interventions, and how these choices ensure the highest possible impact with a view to ending the three diseases and removing human rights and gender-related barriers to accessing services.

   For any priority modules for which gaps are difficult to quantify in the programmatic gap tables, explain here the barriers being addressed, the proposed interventions and the population or groups involved.

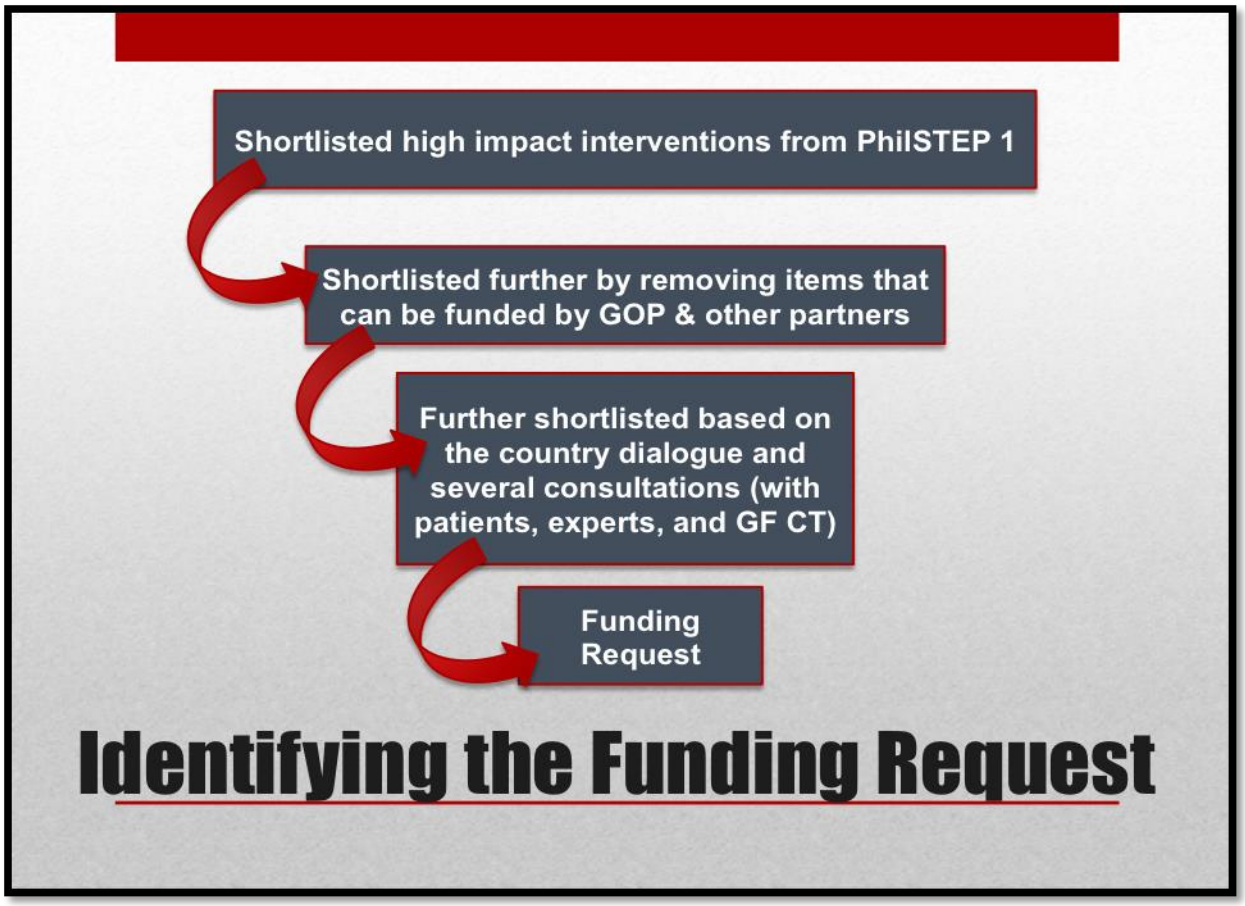
b) Explain how the funding request addresses the key funding gaps reflected in the Funding Landscape Table(s) for the disease program(s) in the current allocation cycle, and specify other actions planned to cover remaining gaps.

For funding requests including both HIV and TB components:

c) Describe the coordination of joint TB and HIV strategies, policies and interventions at different levels of the health system, including community systems, and expected impact and efficiencies from the joint programming.

Ensure the answer appropriately reflects the separate disease programs in addition to cross cutting modules where appropriate.

(maximum 4 pages per component)



The identification of the investment areas for this funding request underwent a comprehensive process presented in the diagram above.

The resulting investment areas include actions on three modules, namely: (1) mainstreaming service delivery systems for DRTB cases, (2) finding missing cases through strategic engagement of non-RHU TB care providers, and (3) expansion in TB-HIV Collaboration.

1. Mainstreaming service delivery systems for DR-TB cases. [MDR-TB Module]

The over-all approach is transitioning the delivery of MDR/RR-TB diagnosis and treatment services as a regular service offering of the RHUs, for both DSTB and DRTB.

About 73% of the total funding request will directly support detection and enrolment of 42%, 46%, and 51% of estimated MDR/RR-TB cases in the Philippines for 2018, 2019, and 2020 respectively. This coverage reflects about 73% of the annual targets for MDR-TB outlined in PhilSTEP 1 **(Annex 23)**. Other sources of funds (Government of the Philippines and other partners) will cover the rest of the targets for treatment coverage.

Within this module, key investment of the grant is directed into procurement of various health products, particularly SLDs (35%), non-pharma products (19%), and health equipment (12%).

The grant will significantly contribute to mainstreaming of the Shorter Standard Treatment Regimen (SSTR) for MDR/RR-TB and improving access to MDR-TB services through expansion of iDOTS[6] with community-based care (CompCare). With GF support, about 30% of the 2,600 RHUs will be upgraded as iDOTS and GX Centers by 2019. The rest of the RHUs will provide community-based care for directly observed treatment for the MDR/RR TB patients in their areas. However, for higher level services like Adverse Drug Resistance management and periodic monitoring, they will link with the nearest iDOTS and MDR/RR TB treatment centres. For MDR-TB patients who fail in the SSTR, the WHO standardized regimen will be used.

Consistent with the PhilSTEP 1 strategy to improve case detection and mitigate clinical diagnosis, the grant will support introduction of GX (OMNI/Single-module) as primary TB diagnostic tool available at the point of care. The grant will also support establishment of 2 additional LPA centers needed for the SSTR, improve systems for specimen collection/ transport, and improve QA for laboratory services.

To achieve at least 85% TSR for DRTB in 2020, the grant will work towards making the service delivery pathway across the TB care continuum more patient-centered. It will include improving infrastructure, systems, and protocols, and more importantly building the technical and emotional capacity of health care providers in effectively managing their patients and their needs. These interventions, coupled with active case finding, contact tracing, and more robust interrupter tracing (to closely follow up interrupters and bring them back to treatment before they are lost-to-follow-up) will reduce lost-to-follow-up and improve treatment outcomes. Focus will be particularly on the key regions like NCR, North Luzon and South Luzon, which contribute to 18%, 15%, and 15% of the notified MDR/RR TB cases, respectively. With assistance from USAID/TREAT-TB project, mechanisms for zero interruption will be put in place beginning April 2017.

Within the grant period, the grant will facilitate discussions and provide technical assistance support that may be needed by the NTP to ensure inclusion of all SLDs into the National Drug Formulary and work on DOH policies and processes to effectively and efficiently procure SLDs using government funding. The Government of the Philippines has the resources to increase investment for DR-TB treatment, but is currently challenged by its weak procurement and supply chain management system.

NOTE: A portion of this module will be funded though the catalytic funding request, particularly the procurement of GX machines for use as an initial diagnostic test at the point of care.

2. Finding missing cases though strategic engagement of non-RHU health care facilities, including private facilities. [TB Care and Prevention Module]

Roughly 10% of the funding request will be invested on finding the missing cases particularly from high-risk groups (inmates, close contacts and urban poor) and those captured by the private health care sector, which remains un/under-reported in the NTP registry. The funding request will support TB case notification of bacteriologically confirmed cases to about 10% of the total notified TB cases annually from 2018-2020. This is additional to those cases notified from non-NTP providers already as part of the DOTS network (resulting from joint

[6] iDOTS or Integrated Delivery of TB Services refers to RHUs certified by the DOH to provide services for all forms of TB from diagnosis to treatment.

efforts in the previous years from the GF-NFM TB Grant, USAID/IMPACT Project and the DOH-Regional Offices). Under this module, the grant will support systematic screening among high-risk groups mentioned above, engagement of community based organizations, patients and patient organizations in case finding and case holding, and expanding private sector engagement in the NTP.

Continuing the success of the TB Caravan in the current GF NFM grant for TB, systematic screening aided by mobile clinics will be pursued in 18 jails/prisons to yield up to 5400 TB cases for 3 years. With the active stance of the government against drug dealers and drug users, increase in the populations of jails and drug rehabilitation centers is expected . Such active case findings will also be conducted among the urban poor in five regions with the highest urban poor population (Regions 3, 4A, NCR, 6 and 11) to yield an estimated 11,430 TB cases for 3 years. In addition, the grant will support patient contact tracing to find 3,100 cases and community referral for additional 15,000 cases. The grant will therefore support systematic screening covering these population groups.

The engagement of community-based organizations, patients and patient groups in case finding and case holding will be supported under this grant. This is linked to making TB service delivery more patient-centered by addressing barriers such as stigma and discrimination and improving access through community participation and patient-to-patient interaction for improved treatment adherence and outcomes.

Expanding private sector engagement is the key strategy in finding missing cases. This is anchored on the fact that 25% of the population, who seek medical attention, seek it from the private sector **(Annex 27)**. Data on commercial sale of anti TB medicines from 2007 up to 2011 also confirm that the TB cases being catered by the private sector was 2.4 times higher than those enrolled under the NTP. Critically, these cases remain uncaptured by the NTP registry. The private sector engagement strategy under this funding request will be anchored on the engagement of 150 field workers in 34 highly urbanized cities (as a jumpstart). These workers will promote and provide phased assistance to stand-alone physicians and those hospital-affiliated medical practitioners who are providing TB services. This activity will help them to comply with the TB law, particularly on TB case notification, and to adopt the Clinical Practice Guidelines (CPG) for TB detection and treatment and the NTP Manual of Procedures. Since these fieldworkers are meant to jumpstart the engagement of the private sector, they will only be engaged for the duration of the grant up to Dec 2020 when the private sector has been mainstreamed into the NTP DOTS Network. The grant will also support design and implementation of a mobile-based TB Case Notification platform acceptable to the private health care sector. This platform will also build the capacity of the provincial and city health offices on compliance monitoring of the mandatory case notification policy and ensure that all notified case are actually enrolled for treatment. Furthermore, investment will also support integration of the SAP into the TB local service delivery network for strengthened patient care continuum.

NOTE: The cost of this entire module is part of the catalytic funding request.

3. Expanding TB-HIV Collaboration (TB-HIV Module)

In the current NFM Grant, TB-HIV collaboration was implemented in Category A and B[7] sites of the HIV Program and 100% of all MDR-TB treatment centers. For this funding request, investments for improving TB-HIV collaboration will be concentrated in the National Capital Region, Region 3 and Region 4A but sustaining what has been started in the other parts of the country. These are the highly populated regions contributing 40% of the country TB cases. These regions also are category A and B sites of the HIV program. The government budget for the HIV program has increased tremendously for 2018 and as such, this funding request, with focus of TB-HIV collaboration, will ensure its full implementation in the National Capital Region, Region 3 and Region 4A. About 3% of the funding request will be utilized to reach 100% programmatic coverage for TB-HIV collaboration in the three target regions for (1) HIV testing among notified TB cases, (2) TB screening for all PLHIV, and (3) provision of ART and TB treatment to all TB patients diagnosed with HIV Infection.

Specifically, the funding request will support (1) building capacity for both TB and HIV facilities and private providers in Provider-Initiated Counselling and Testing, (2) strengthening TB-HIV support groups to improve treatment initiation and adherence. The grant will also provide temporary HR support for roving medical technologists and nurses to support TB-HIV service delivery in the full coverage of the Big three regions.

2.2 RSSH funding request	
The Global Fund strongly encourages funding requests for RSSH investments to be submitted within a ***single*** application, and preferably to be requested in the first submission.	
Does this funding request include an RSSH component?	☒ Yes ☐ No
If yes, describe the request below and how it is strategically targeted. Referring to the national health strategy, gaps and lessons learned outlined in the previous section, describe the funding request for RSSH and how the investment is strategically targeted to strengthen systems for health and achieve greater impact on the diseases. In your explanation, refer to the Funding Landscape Table on 'government health spending', Performance Framework and Budget as appropriate. Note that it is optional to complete a Programmatic Gap Table for RSSH. **(maximum 3 pages)**	

The FR investment for RSSH will focus on providing assistance to the DOH in crafting a strategic plan to improve its entire procurement and supply chain management system that will benefit all its programs.

Investment will also focus on operation and maintenance of the ITIS, including the development and operationalization of the IOS and Android versions of the information system. In support of the TB Law, particularly on the mandatory TB case notification, the grant will support the development and rollout of a web and mobile-based TB case

[7] The HIV program categorizes cities and municipalities based on HIV burden. Category A sites are those cities/municipalities with more than 50% of its key population are positive for HIV. Category B sites are those with 30-50%.

notification platform that will be acceptable to all health care providers and facilities, especially the vast private health sector.

Several researches are also going to be supported by the grant to include the following:

- 2018: Inventory Study about under-reporting & 3rd Drug Resistance Survey
- 2019: 2nd Catastrophic Cost Study[8] and Joint Program Review
- 2018-2020: Modelling for TB-free areas

The Pharmaceutical Management is composed of the interconnected elements of selection, procurement, distribution, stock monitoring and rational use that needs management support and rests in the foundation of policy, law and regulation. To ensure the availability, accessibility and affordability of health products there is a need to implement activities to strengthen resilient and sustainable systems for health (RSSH) across all health programs.

The Department of Health, through the various health programs, is continuously enhancing its pharmaceutical management system in order to build a resilient and sustainable health system, which is cross cutting for all programs. Specifically in the experience for TB, the National Tuberculosis Program has implemented most recommendations of the 2011 Joint Program Review specific to drug management. However, there are still important challenges to improve the TB Drug Supply Management, including critical need to explore options for improving the procurement and supply chain management of pharmaceutical and laboratory commodities.

The current DOH pharmaceutical management system is challenged in all its phases. Quantification and forecasting is based on procurements in the previous years without taking into account the new needs and current stock levels. DOH has a fragmented national and sub-national procurement system with inadequate delivery and tracking system. Warehousing is poor and recording/reporting of stock levels are incomplete, delayed and unreliable. Quality assurance is much to be desired.

In consultation with the DOH, agreement has been reached to include in this funding request solicitation of investment to support strengthening of the DOH procurement and supply chain management system through the following strategies:

1. **Development of a national strategic plan to strengthen the current pharmaceutical management system of the DOH.** Currently, various units under the Department of Health are managing multiple parallel supply chain systems (i.e., *Logistics Management Division, Pharmaceutical Division, Central, and Procurement Service*). This makes it difficult to establish strong leadership and governance on pharmaceutical management. This funding request will facilitate the formulation of a national strategic plan on pharmaceutical management for the DOH that will serve as the basis for improving the system and define action points in the short, medium and long terms.

[8] The 1st catastrophic cost study is ongoing and the results will be ready in Q3 of 2017.

2. **Enhancement of data management at all levels.** The DOH is currently updating and enhancing its data management systems and the funding request will support engagement of technical assistance providers to assist in the development of a functional data management system for PSCM.

3. **Strengthening supply planning and distribution at facility, provincial/regional and central levels.** Occurrence of stock-outs and supply expiry is recurrent across all DOH programs. For the National TB Program in 2015, 27.1% of RHUs reported to have experienced stock outs of anti TB medicines. Three major reasons cited were (1) no regular delivery schedule due to transport problems (41.7%), (2) quantity delivered was less than what was ordered (37.5%), and (3) errors in forecasting and quantification (29.2%). Defining processes, institutionalizing tools and technologies and building capacity to perform activities, such as quantification and forecasting, is critical to strengthen supply chain planning. These capacity building interventions are being requested under this funding request.

4. **Integrating procurement mechanisms at the regional and central levels of the Department of Health through procurement framework contracts.** There is a need to review and enhance the procurement system of the DOH to mitigate failed bids, ensure product quality and improved turnaround time. Part of the funding request is to look into systems improvement and exploring opportunities for integrated procurement mechanisms that will help achieve drug availability, ensure drug quality and promote reasonable drug pricing. In the long term, this strategy is critical in order for the country to be able to sustain and make essential medicines available and maximize existing resources.

The DOH efforts will be supported by EU, USAID, and GF through a coordinated provision of technical assistance support and provision of other needed resources.

If no:

a) Indicate when the RSSH funding request was/will be submitted; and,

b) **If the RSSH funding request has not yet been submitted**, highlight below the elements of the planned RSSH investment that will directly support the disease program in this funding request.

(maximum ½ page)

[*Applicant response*]: N/A.

2.3 Focus of application requirement [9] This question is required for Lower-Middle Income (LMI) and Upper-Middle Income (UMI) countries. It is not applicable for Low-Income (LI) countries. To respond, refer to guidance provided in the *Instructions.*	
For LMI countries: - Does the funding request focus at least 50% of the budget on: disease-specific interventions for key and vulnerable populations; programs that address human rights and gender-related barriers and vulnerabilities; and/or highest impact interventions?	☒ Yes ☐ No
- For RSSH, does the funding request primarily focus on improving overall program outcomes for key and vulnerable populations in two or more of the diseases, and is it targeted to support scale-up, efficiency and alignment of interventions?	☒ Yes ☐ No
For UMI countries: - Does the funding request focus 100% of the budget on interventions that maintain or scale-up evidence-based approaches for key and vulnerable populations, including programs that address human rights and gender-related barriers and vulnerabilities?	☐ Yes ☐ No
Ensure that the funding request as described in questions 2.1 and/or 2.2 meets this focus of application requirement.	

At least 73% of the funding request from the allocation grant is targeting the detection and treatment of drug-resistant cases, which complements the government funding which fully supports drug-sensitive cases. Intervention includes enhancement of case finding and case holding protocols, including facility improvement and health care worker soft skills development to be more patient-centered—to ensure human rights and gender-related concerns are addressed.

The RSSH request is towards improving the procurement and supply chain management system of the Department of Health which will benefit all programs of the department, across all levels of health care service delivery. A more effective and efficient logistics management system will ensure uninterrupted delivery of quality pharmaceutical and non-pharmaceutical products to ensure health for all.

[9] Refer to the Global Fund 2017 Eligibility List for income level. LMI and UMI countries have specific requirements in terms of the focus of applications as set forth in the Global Fund Sustainability, Transition and Co-Financing Policy.

SECTION 3: OPERATIONALIZATION AND RISK MITIGATION

This section describes the planned implementation arrangements and foreseen risks for the proposed program(s). Applicants are encouraged to **attach an updated Implementation Arrangements Map.** To respond, refer to additional guidance provided in the *Instructions.*

3.1 Implementation arrangements summary

Do you propose major changes from past implementation arrangements, e.g. in key implementers, flow of funds or commodities?	☐ Yes ☒ No

If **yes**, provide an overview of the new implementation arrangements and elaborate how these changes affect the operationalization of the grant.

If **no**, provide a summary of high-level implementation arrangements focusing only on lessons learned for the next period.

In **both cases**, detail how representatives of women's organizations, key populations and people living with the disease(s), as applicable, will actively participate in the implementation.

Include a description of procurement mechanisms.

(maximum 1 page)

The implementation arrangement for this funding request will be similar with the current implementation arrangement under the NFM Grant, considering that the modules are the same and major investment focus remains to be for MDR-TB.

PBSP will operate as the Principal Recipient and will directly administer the grant. Implementation of key interventions listed in the MDR-TB, TB-HIV, and RSSH modules will be through the DOH national and regional centers, in coordination with the health facilities at the various LGUs. For the TBCP module, three sub-recipients will be competitively selected assigned to cover pre-determined geographical coverage. All technical decisions will be made with DOH-NTP, TB-TWG, WHO, CCM and the GFCT. Grant financial approvals will be in compliance with the GF-PBSP grant agreement and PBSP's financial policies and procedures.

Patient participation is integral in the implementation of this funding request. Primarily, a patient's group called "Samahan ng Lusog Baga" sits as an active member of the TB TWG and CCM. This group will also help in the advocacy of support for TB patients. MDR-Community-based care is being expanded maximizing patient groups in case finding and case holding. For TB-HIV, patient support groups will be formed and strengthened. To find missing cases, community-based organizations and patient groups will be engaged in systematic screening among patients' close contacts, inmates (including jails and drug rehabilitation centers) and the urban poor. Their engagement will also extend in the conduct of behavior change communications campaigns in communities.

Provisions within the grant agreement and the PBSP procurement policy will guide all procurement related activities of this funding request. The PBSP procurement manual details all policies and procedures related to procurement and supply chain management of PBSP, which is applied to all its programs and projects. Noteworthy is the presence of Bids and

Awards Committee, PBSP Levels of Authority Manual, and a Fixed Assets Registry. Procurement of SLDs will remain to be via the GDF.

3.2 Key implementation risks

Using the table below, outline key risks foreseen, including those that were provided in the *Key Program Risks* table shared by the Global Fund during the Country Dialogue process. You can also add key operational and implementation risks, which you identified as outstanding over the previous implementation period, and the specific mitigation measures planned to address each of these challenges/risks to ensure effective program performance in the given context. Applicant response in table below.

Risk Category (Functional area)	Key Risk	Mitigating actions	Timeline
Programmatic	Low Data Quality	The ITIS will be used as the official source of data. DQA will be done routinely at the regional level.	From Dec 2016 and onwards
Programmatic	Poor Quality of Health Services	All TB service delivery mechanisms will be reviewed to adopt more patient-centered approaches. This will be detailed in the revised NTP Manual of Procedures	June 2018
Programmatic	High LTFU in MDR-TB	Ensure all planned interventions to reduce LTFU are in place, including the policy and guidelines for "Zero Interruption". Full details of the planned action are detailed in Annex 32.	Home visits for patients to ensure zero interruption begins April 2017
Procurement & Supply Management	Stock-Outs & Drug Expiry	Quantification and forecasting is being done based on actual utilization trends and procurement is being done at least 6 months in advance with deferred delivery options. In Q1 of 2018, assessment of the DOH PSCM system will be done and in Q2, strategic planning session for the same will be conducted. Depending on the capacity building needs, technical assistance will be provided in Q3-Q4.	Ongoing
Fixed Asset Management	Loss, Theft of non-financial assets	Ensure fixed assets registry are up to date and are covered by insurance. Ensure FAR is reconciled with expenditure reports. Ensure safety and security checks are made in all facilities with GF properties.	FAR is updated and insured as of March 2017. FAR-Financial Expenditure Reconciliation due end of June 2017
Financial	Poor Financial Efficiency, Fraud/Corruption or Theft of funds	Conduct of routine and special financial monitoring activities to all PR personnel, SRs and implementing partners involved in financial and procurement transactions. Ensure that the Enterprise risks Management System is in place and	Routine financial monitoring is done monthly

		operational	
External	Natural Disaster & Insurgencies	Insurance for fixed assets put in place and coverage of medical/accident and life insurance of personnel supporting the grant	Continuous
External	Macroeconomic losses	Use of USD as grant currency and conduct of close monitoring of forex movement and maximizing strength of peso by timely conversion to mitigate forex loss.	Continuous
Add rows for additional key risks as necessary			

SECTION 4: FUNDING LANDSCAPE, CO-FINANCING AND SUSTAINABILITY

This section details trends in overall health financing, government commitments to co-financing, and key plans for sustainability. Refer to the **Funding Landscape Table(s)** and supporting documents as applicable. To respond, refer to additional guidance provided in the *Instructions.*

4.1 Funding Landscape and Co-financing	
a) Are there any current and/or planned actions or reforms to increase domestic resources for health as well as to enable greater efficiency and effectiveness of health spending? **If yes,** provide details below.	☒ Yes ☐ No
b) Is this current application requesting Global Fund support for developing a health financing strategy and/or implementing health-financing reforms? **If yes,** provide a brief description below.	☐ Yes ☒ No
c) Have previous government commitments for the 2014-16 allocation been realized? **If not**, provide reasons below.	☒ Yes ☐ No
d) Do current co-financing commitments for the 2017-19 allocation meet minimum requirements to fully access the co-financing incentive, as set forth in the Sustainability, Transition and Co-financing Policy?[10] **If not**, provide reasons below.	☒ Yes ☐ No
e) Does this application request Global Fund support for the institutionalization of expenditure tracking mechanisms such as National Health Accounts? If yes or no, **specify** below how realization of co-financing commitments will be tracked and reported.	☐ Yes ☒ No
(maximum 2 pages)	

[10] Refer to the Sustainability, Transition and Co-Financing Policy.

Item A: Key actions to increase domestic funding includes:

1. DOH funding will increase aligned with increase in Sin Tax and PAGCOR allocation. Action is being undertaken by DOH with the Department of Budget Management and Bureau of Internal Revenue on the increasing tax imposed for tobacco and alcohol to be directed to support the GOP's health program, including the NTP. This will also hold true for the allocation for health from the Philippine Amusement and Gaming Corporation (PAGCOR).
2. PHIC TB packages for DSTB is being reviewed for revision and DRTB package is being studied for development. The DOH and PHIC have ongoing discussions to revise the PhilHealth outpatient package for DS TB to support treatment adherence and compliance of health care workers and facilities to NTP protocols in case detection and treatment. Both units are also in ongoing discussions to determine the cost of managing DR-TB patients to be able to come up with reasonable PhilHealth package for the same.
3. Through various technical assistance services from USAID, the leadership and management capacity of local chief executives are being enhanced to develop and implement investment plans for health, including TB. This includes ensuring Phil Health accreditation of its health facilities and workers, increase budget allocation from their Internal Revenue Allotment for health promotion and service delivery, including provision of patient and health care worker enablers.

Item E: Tracking and reporting of co-financing commitments and its realization will be part of the Annual DOH-NTP expenditure report and will be part of the DOH NTP Annual Report. PRs are also now being requested to submit financing reports to the National Economic Development Authority (NEDA), who is the government agency responsible in tracking development investments.

4.2 Sustainability

Describe below how the government will increasingly take up health program costs, and actions to improve sustainability of Global Fund financed programs. Specifically,

a) Explain the costs, availability of funds and the funding gap for major program areas. Specify in particular how the government will increasingly take up key costs of national disease plans and/or support health systems; including scaling up investments in programs for key and vulnerable population, removal of human rights and gender-related barriers and enabling environment interventions.

b) Describe actions to improve sustainability of Global Fund financed programs. Specifically, highlight key sustainability challenges of the program(s) covered by the funding request, and any current and/or planned actions to address them.

(maximum 1 page)

The previous and current administration are supportive of the Philippine Health Agenda as reflected by the passage of policies that paved way to actual increase in investment to the Department of Health and its programs. Furthermore, the DOH's direction to maximize the Philippine Health Insurance Corporation also works towards universal health coverage and reduction of catastrophic costs.

Specific for TB, the NTP budget allocation is one of the programs with the highest budget allocation and has been increasing annually. However, a variable funding gap of about 40% is expected (PhilSTEP 2017-2022) as the NTP takes a bold step to shift from a control to an elimination mode. High level advocacy efforts during the grant period will be carried out to bridge this gap.

The detection and treatment of DSTB is almost completely funded domestically, particularly from the DOH, LGUs and PhilHealth. The challenge is extending this to cover DRTB cases, which is currently being supported by The Global Fund. While the government is keen to this end, critical steps will be undertaken during this grant period to strengthen the DOH procurement and logistics systems to ensure availability and access to quality and uninterrupted Second line and ancillary drugs for DRTB patients gradually. The funding request period (2018-2020) is being taken by the DOH-NTP as an opportunity to improve its ability to procure SLDs using GOP funds. Should this become successful, DOH-NTP will commit to a larger proportion of GOP-funded SLDs for MDR/RR-TB and other DRTB.

Due to limitation in the use of government program funds for capital expenditure, the NTP relies on the GF grant to procure GX machines. But all GX cartridges will continue to be funded by the DOH. The program will also continue to work with PhilHealth for the development of an MDR package and with other social security systems to take on the various patient enablers currently being covered by the GF grant.

The private sector engagement under the TBPC module of this funding request is an opportunity for the country to develop/test models that can promote/increase private sector participation in the NTP and comply with TB case notification. Resulting successful models will be replicated in the other areas using DOH sub-allotments to the DOH regional offices. Similarly, the systematic screening mechanism that will be employed under the funding request will serve as reference for the regional offices to implement.

The dependence for HR augmentation from the GF grant will be addressed through 1) policy revisions to permit increase HR for health, 2) coordination with DOH-Health Human Resource Development Bureau to maximize the DOH's Human Resource Deployment Program (that includes physicians, nurses, medical technologists, and midwives) to support the NTP, and 3) increasing participation of the private sector to complement the public health care system following the same protocols.

SECTION 5: PRIORITIZED ABOVE ALLOCATION REQUEST / UPDATE

Prioritized Above Allocation Request

Provide in the table below a prioritized above allocation request which, if deemed technically sound and strategically focused by the TRP, could be funded using savings or efficiencies identified during grant-making, or put on the Register of Unfunded Quality Demand to be financed should additional resources become available from the Global Fund or other actors (e.g. private donors and approved public mechanisms such as UNITAID and Debt2Health). This above allocation request should include clear rationale and should be aligned with the programming of the allocation for maximum impact. The request should reflect the order in which interventions will be funded if additional resources become available. In line with the Global Fund's Strategy to maximize impact and end the epidemics, the prioritized above allocation request should be ambitious (for example, representing at least 30-50 percent of the allocation amount).

Tuberculosis

Module	Interventions	Amount requested (USD)	Brief Rationale, including expected outcomes and impact (how the request builds on the allocation)
MDR-TB	Procurement of **1684** GX Machines (OMNI)	6,057,028	Critical to the success of the NTP in finding and treating missing cases is adopting GX as primary diagnostic tool and that making it available in all its 2600 primary health care units. To date, there are existing 336 GX machines and 580 are being request through this funding request (both from within allocation and matching fund). Through PAAR, an additional 1684 GX machines will help achieve 100% coverage.
MDR-TB	Detection and enrollment of additional **8,366** DRTB cases on top of allocation and catalytic funding request	17,104,095	Additional investment will ensure detection and enrollment of 100% attainment of the PhilSTEP1 target.
TBCP	Systematic Screening for detection and treatment of 66,609 missing cases	6,660,900	Target reflects the remaining programmatic gap to achieve 100% coverage of all estimated cases for the 3 years.
TBCP	Systematic Screening for TB-DM	2,500,000	This is an expansion of coverage of the systematic screening among vulnerable/ high risk population groups to find the missing cases.
TBCP	GX Alert Expansion in 580 sites (2018-2020)	836,915.32	This will ensure GX results are recorded and released real time to support immediate patient enrollment.

TBCP	TB-DM Collaboration	1,713,543	Establishment of TB-DM service delivery system at the RHU level for TB detection and case management among DM patients nationwide.
TOTAL AMOUNT		34,872,481.32	

Note: The PAAR request does not include matching fund of US$10 million. The request for matching fund is submitted separately.

Relevant Additional Information (optional)
Provide any additional contextual information relevant to the prioritized above allocation request (e.g. any explanations that further clarify linkages to the allocation funding; any considerations or data that informed the request or updates of the request; etc.)

The presence of GX at the point of care will address financial and geographical barriers to quality diagnosis of TB. This will directly increase case detection, increase treatment enrolment by decreasing delay to treatment and reduce the period of transmission. **Annex 26** presents the current status of the GX machines available and the projected requirement for the country towards TB elimination.