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

PROPOSAL FORM
ROLLING CONTINUATION CHANNEL

The Applicant named below is invited to apply to the Global Fund to Fight AIDS, Tuberculosis and Malaria for additional financing for up to six years in regard to the interventions targeted in the expiring grant indicated below. This avenue to receive funding is called the Rolling Continuation Channel and the accompanying '**Guidelines for Proposals**' further explain the application content and process.

Different to the 'Rounds' channel of funding, open to all Applicants, this Proposal Form may only be completed by Applicants who qualify to receive an invitation to apply for this additional financing.

Importantly, the Rolling Continuation Channel is specifically offered to Applicants with strong performing grants. Within their proposal, the Applicant is required to demonstrate that the proposal's goals and objectives will contribute to demonstrate the potential for impact on the relevant epidemic and show sustainability. This should be an important focus of your planning and proposal development.

The rationale for the Rolling Continuation Channel and its purpose is fully explained in the Guidelines for Proposals. Please read these carefully, as they provide all the information required to complete this application.

Applicant Name	**The Country Coordinating Mechanism of the Philippines**
Country/countries	**Philippines**
Component	**Tuberculosis**
Expiring Grant Number	**PHL-202-G02-T-00**
Applicant Type	**CCM**

The deadline for submission of proposals is: 11:59 pm, local Geneva time on 3rd January 2008.

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1 Proposal Overview

1.1 General information on proposal

Proposal title
Sustaining TB control and ensuring universal access to comprehensive quality TB care

Currency in which the proposal is submitted

*Please check only **one** box below. **Please note that you must use this same currency throughout the whole Proposal Form**.*

☐ US$ **OR** ☒ Euro

1.2 Summary of funding request

Please fill in the amount requested for each year of the proposal term below. This amount must be the same as the totals of the corresponding budget summary by cost category in table 5.3.

Table 1.2 – Total funding summary

Total funds requested over proposal term						
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
11'471'583	17'555'598	22'555'931	22'537'774	22'342'058	18'428'148	114'891'092

1

1.3 Contact details for enquiries by the Global Fund

*Please provide full contact details for two authorized persons **who will be** readily accessible to the Global Fund for technical or administrative clarification purposes for approximately **two months** following the deadline for submission of proposals, as set out on the cover page of this Proposal Form.*

Table 1.3 – Contact details for enquiries by the Global Fund

Contact Details for Enquiries on the Applicant's Proposal after Submission		
	Primary contact	**Secondary contact**
Name	Thelma E. Tupasi, MD	Jaime Y. Lagahid, MD
Title	Executive Director	Director III
Organization	Tropical Disease Foundation	National Center for Disease Prevention and Control - Infectious Disease Office, Department of Health
Mailing address	GF Montepino Building, Gamboa cor. Amorsolo St., Makati City 1229, Philippines	San Lazaro Compound, Manila, Philippines
Telephone	(632) 888-9044 and 817-0489	(632) 743-8301 local 2350 to 2352
Fax	(632) 840-0714	(632) 711-6808
E-mail address	tetupasi@tdf.org.ph	drlagahid@yahoo.com
Alternate e-mail address	jmerilles@tdf.org.ph	ccmsecretariatphil@yahoo.com or loybons@yahoo.com

1 Proposal Overview

1.4 Overview of Applicant's proposal

Provide a brief summary *(maximum two pages)*:

The **goal** is to reduce the prevalence, incidence and mortality of TB by 50% in 2010 and beyond 50% thereafter from a baseline established in 2000 in support of the Millennium Development Goals for poverty alleviation.

RCC has **two objectives.**

Objective 1: To achieve universal access to high quality TB care through:

1a) sustaining and expanding the provision of quality DOTS in the public sector, including the strengthening of TB laboratory network;

1b) engaging all care providers in areas not covered by Rounds 2 and 5 to ensure access by all TB patients including marginalized and special population groups;

1c) empowerment of patients and communities through advocacy, communication, social and resource mobilization, and community TB care at the local level.

Objective 2: To scale-up the Programmatic Management of DR-TB (PMDT) beyond Metro Manila and provide nationwide coverage and improved access.

The overall strategy in this proposal is broadening of the TB Round 2 Objectives, guided by the National Strategic Plan to Stop TB in the Philippines 2006-2010, in accordance with the WHO Stop TB Strategy the Stop TB Partnership Global Plan 2 (2006-2015) and the new challenges as outlined in the Global MDR-TB and XDR-TB Response Plan 2007-2008. The implementation of the RCC will entail health systems strengthening in accordance with the national strategy of Fourmula One for Health launched in 2005. FOURmula for Health (also known as F1) includes governance, regulation, health financing and quality service delivery.

Four approaches will cut across the two objectives. The first approach is the engagement of all non-NTP public and private health care providers using the PPM approach and the promotion of the International Standards for Tuberculosis Care (ISTC) aimed at expanding access to diagnosis and treatment by all TB patients including the vulnerable groups such as children, and those in the hard to reach areas, the urban and rural poor including indigenous people, and prison inmates. The second approach is health systems strengthening specifically strengthening the TB laboratory network of the country beyond sputum microscopy to include TB cultures and Drug Susceptibility Testing (DST), human resource development, procurement and supply management and monitoring and evaluation by harnessing it into the current efforts of the national Fourmula One for Health strategy. The third approach is the implementation of a national advocacy, communication, and social mobilization (ACSM) strategy. Advocacy strategy will target national and local leaders for an enabling policy environment and resource generation and marginalized populations for a comprehensive TB care. Behavior change communications will target the affected populations to enhance health seeking behavior. Social mobilization activities will target the community aiming for social awareness and ownership of the program thus attaining universal access to comprehensive TB care and for community systems strengthening. The fourth approach that will cut across the two objectives includes the conduct of operational and evaluation studies that would measure program efficiency, effectiveness, and impact.

Planned Outputs:

- **Service points supported:** For the 6 years duration of the proposal 2,600 DOTS facilities (public and private)

will be strengthened to provide services for children, prison inmates, urban and rural poor populations. Forty-four Provincial Coordinating Committees (PCC) for PPM, tasked to initiate engagement of non-NTP health care providers in the areas, conduct advocacy activities and monitor the participation of these health care providers in the delivery of TB services to all TB patients will be established in areas not covered by PPM in Rounds 2 and Rounds 5. Seven national jails and 182 provincial/city jails will be provided with access to DOTS services in a phased manner, at most 10 work force organizations/institutions will be engaged in TB care, and at least 270 task forces established nationwide under Round 2 TB project will be supported with funds for income generating projects through the Area Development Programs (ADPs) and other mechanisms. Five new DST centers will be established on top of the 3 other facilities under Round 5 to support the overall TB control program including Programmatic Management of DR-TB (PMDT), TB in Children and TB/HIV, and 35 new treatment centers (on top of the existing 7 in Round 5) capable of managing MDR-TB cases established in the first 3 years of the proposal. 39 culture centers (including 22 from the private sector) on top of the existing 5 facilities will be either established or strengthened during the project life. 14 urban/rural poor community sites empowered for PMDT integrated services.

- **People Reached :** Of the total population of the Philippines by 2014, an estimated 101 million

people will be covered by the quality DOTS services. A cumulative total of 464,015 of new smear positive adult TB cases will need the TB services in the six year period. During the six year period, with 85% detection rate, a cumulative total of 387,806 new smear positive TB cases will be provided free treatment. In addition, a similar number of all TB cases will be covered in the project life. Under the NTP approximately 107,416 children will receive treatment to include those covered by this RCC proposal and 85% of this will be successfully treated. In addition, 219,732 children will be covered for chemoprohylaxis during the same period. Two thousand six hundred twenty children with TB will be covered by the RCC and the remainder through the GOP TB budget. Of this figure, the PPM initiative will contribute 21,235 from the 44 provinces, representing

approximately 6% of the total cases nationwide. About the same number of smear negative TB cases will also be reached through PPM and receive treatment. Altogether the PPM initiative under Rounds 2, 5 and the RCC will contribute to about 12% increase in case detection rate nationwide; 11,991 new smear positive cases will be detected and treated from the urban and rural poor, 3,710 new smear positive cases among prison inmates will have access to TB care.
A cumulative total of 10,625 (9,485 with RCC support and 1,140 with government support) DR-TB cases in the RCC will be treated on top of the 3,000 cases covered by Rounds 2 and 5. At least eighty percent of urban, rural poor, indigenous peoples, children and correctional facility inmates with TB, MDR-TB cases will have access to TB care by 2014.

- **Service deliverers trained:** All the existing DOTS facilities will be supported through training on DOTS**.** At least 4,240 service deliverers will be trained on DOTS to provide quality services and 4,707 for PMDT. For PPM, 4,400 newly engaged service providers will be trained in DOTS, PMDT and TB in children. In addition, 2,000 previously trained private referring physicians from Rounds 2 and 5 will also be trained on PMDT and TB in children. Two hundred members of the provincial coordinating committees will be trained on the conduct of situational analysis and planning for the engagement of all health care providers and on advocacy. Two hundred eighty partners will be trained on ACSM and 458 Health Education and Promotion Officers and TB coordinators will be trained on community TB care for all TB patients. In addition, 2,190 community volunteers will be trained as treatment partners in children and 100 TB patients will be empowered to participate in DOTS and PMDT.
- **Commodities distributed:** RCC will provide first line anti-TB drugs for 20,000 TB cases detected by all initiatives in addition to those supported by the GOP. First and second line anti-TB drugs will also be distributed to the implementing service points to treat 9,485 drug resistant TB cases from RCC and 1,140 from the GOP. For PPM, 2,200 advocacy packages for engagement of health care providers and 660,000 promotional materials on TB will be distributed for the duration of the project. Laboratory supplies, microscopes, BSL equipment and engineering control measures for infection control will be provided to 42 treatment centers, 44 culture, and 6 DST centers in addition to 250 microscopes for selected microscopy and QA centers.
- **Beneficiaries:** The main beneficiaries will be TB patients particularly those who have limited access to TB services. This will include cases from the urban, rural poor and/or indigenous peoples, vulnerable groups, such as children (less than 15 years of age, from urban poor and working children),TB patients from prisons and DR-TB patients not covered under Rounds 2 and 5 projects. In the area of health systems strengthening all health care providers involved in treatment and diagnosis will be benefited, the expected results will be in line with the sector wide development approach for health (SDAH) reform and the DOH FOURmula One (F1) for health strategy. Training received by health care workers on the management of all types of TB patients will provide them with treatment options for DOTS failures, which has not been available earlier without PMDT. In community system strengthening, the beneficiaries are the empowered TB patients who will undergo training on the strategies under DOTS and thereafter participate in the implementation of the DOTS strategy. Behaviour change communications to destigmatize TB and strategies for income generation for affected individuals and families will likewise benefit TB patients. In addition, the communities and households where the TB patients reside will benefit from halting TB transmission through the treatment of infectious TB cases
- **Broadened scope:** The PPM approach will engage health care workers other than the private practicing physicians. Accordingly, the health units providing medical services within the Bureau of Corrections through Public-public Mix will be engaged to improve the TB services for prisoners. Other caregivers such as Faith-based organizations (FBOs), Community-based organizations (CBOs), and Peoples' organizations (POs) shall likewise be engaged to cover the vulnerable populations in the urban and rural poor and indigenous populations, PPMD units with good DOTs performance will have an increase in the scope of the services provided including PMDT, TB in children, and TB/HIV co-infection. The scope of the laboratory services to support the NTP will go beyond DSSM to culture, DST, and QA of laboratory services.
- **Scale-up:** A scaling-up in the geographic coverage of the strategies is also proposed. PPM will be implemented in 44 provinces with an estimated population of 42,746,343. ACSM will now be nationwide going beyond the 2.8 million population covered by the Rounds 2 and 5 projects. PMDT will be available in 14 regions with the development of 35 new treatment centers, and will decentralize in approximately 2,600 DOTS centers providing DOT in the continuation phase and default tracing. Scaled up laboratory services including cultures and DST will be available nationwide with the establishment of 39 new culture centers and 5 new DST centers.
- **Outcome and Impact on national disease control:** The universal access to TB care will break TB transmission, prevent more generation of MDR-TB and Extensively Drug Resistant TB (XDR-TB). The table below compares the intended impact/outcome of the RCC with the on-going Global Fund TB projects:

Outcome and Impact Indicators	Round 2 Project (2003-2008)	Round 5 Project (2006-2011)	RCC Proposal (2009-2014)
Prevalence (smear positives)	1.9 per 100,000	1.9 per 100,000	1.6 per 100,000
Incidence (smear positives)	84 per 100,000	72 per 100,000	65 per 100,000
Mortality	34 per 100,000	26 per 100,000	24 per 100,000

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Case detection rate (all smear positives)	85%	85%	>85%
Treatment success rate (new smear positives)	88%	>88%	90%
DRTB cases put on treatment	500	2,500	9,485
Treatment success rate (DR-TB)	---	72%	78%

1.5 Technical Assistance provided during proposal preparation

*Please check the applicable box(es) if you received any technical assistance during preparation **of this proposal** for the sections set out below. Indicate which organization(s) or individuals (if any) provided assistance, and over what duration this was provided.*

Table 1.5 – Technical assistance for proposal preparation

Section	Name of organization(s) or individuals providing assistance and type of assistance provided	Duration of technical assistance
☒ Sections 1 to 3B	Dr Michael N. Voniatis, World Health Organization Editing of the proposal	November-December 2007
☒ Proposal Strategy Section 4	Dr. Michael N. Voniatis, World Health Organization: Technical inputs Dr. Milton Amayun, International Aid Technical Inputs	September – December 2007 November 2007
☒ Proposal Budget Section 5	Dr. Michael Voniatis, World Health Organization: use of WHO planning and budgeting tool	October –December 2007

*The section describing **(i) the amounts disbursed by the Global Fund** has been pre-filled.*

*Please provide **specific details of (ii) amounts expended under existing Global Fund grants for the same disease as targeted in this proposal** (by Round) as **at 31 March 2007**. For more detailed information, see the Guidelines for Proposals, section 1.6.*

Table 1.6.1 – Previous Global Fund same disease financial support

1.6 Previous Global Fund grants/proposals recommended for funding

Table 1.6.1 – Previous Global Fund same disease financial support

Same Disease Component as targeted in this Proposal Form	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 December 2007	Total cumulative amount already expended (by the PR and SRs) under prior Global Fund grants as at 31 December 2007
Round 1		
Round 2	11'141'102	9'968'767
Round 3		
Round 4		
Round 5	11'355'888	8'109'631
Round 6		
Total	22'496'990	18'078'398

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*Where relevant to the goals and objectives of this proposal, also identify any **existing HSS or Integrated** components (e.g. HIV/TB) in the table below.*

Table 1.6.2 – Previous Global Fund HSS and other financial support

HSS or Integrated	Total cumulative amount disbursed by Global Fund under grants to Principal Recipient(s) as at 31 December 2007	Total cumulative amount already expended under prior Global Fund grants as at 31 December 2007
Round 1		
Main disease targeted		
Round 2	8'912'882	8'075'445
Main disease targeted	TB	
Round 5	9'084'710	4'684'573
Main disease targeted	TB	
Total	17'997'592	13'931'162

2 Income Level Eligibility Questions

2.1 Eligibility Requirements linked to World Bank Income Level Classification

In the table below, the Global Fund has pre-identified the World Bank income level classification for your country, and provided information on the latest available date of that information. You may cross-check that information at the following link: Weblink to World Bank Income Level Data

***Applicants should complete only** those questions in this section 2 that are identified in the "Next Steps" column below as relevant to their income level classification.*

Country Name	World Bank income level classification	Date of latest World Bank information	**Next Steps**
	Low-income	1 July 2007	➔ *Go straight to **section 3A**, Applicant Type*
Philippines	Lower-middle income	1 July 2007	➔ *Complete **both** sections 2.2 and 2.3, and **then go to section 3A***
	Upper-middle income	1 July 2007	➔ *Complete sections 2.2 and 2.3 **and** 2.4, and then go to section 3A*

2.2 Counterpart financing and greater reliance on domestic resources

Indicate in the table below the extent of domestic 'counterpart financing' being contributed to support the national response for the disease targeted in this proposal. Indicate, first, the resources requested in this proposal (Line A), and then domestic resources other than those requested in this proposal (Line B).

➔ *For definitions and details of **counterpart financing** requirements, see the Guidelines for Proposals, section 2.2.*

***Important notes**:*

1. *The field "Total requested from the Global Fund" in table 2.2.1 below must equal the budget request in section 1.2, section 5 and the budget breakdown by cost category in table 5.3.*

2. ***Amounts included in line A and line B in the tables below should be in figures not percentages.***

Table 2.2.1 – Counterpart financing

Financing sources ⬇	**Counterpart Financing calculation over proposal term** *(same currency as in section 1.1)*					
	Year 1	**Year 2**	**Year 3 estimate**	**Year 4 estimate**	**Year 5 estimate**	**Year 6 estimate**
Line A ➔ Total requested in this proposal **[from table 5.3]**	11,471,583	17555598	22,555,931	22,537,774	22,342,058	18,428,148
Line B ➔ Amount of country counterpart financing	1,564,323	2,470,227	3,461,538	4,692,307	11,422,059	11,972,010
Counterpart financing as a percentage of total financing: [B/(A+B)] x 100 = %	12.00%	12.34%	13.30%	17.23%	33.83%	39.38%

2 Income Level Eligibility Questions

2.3 Focus on poor or vulnerable populations

Lower-middle income and Upper-middle income countries must demonstrate a focus on poor or **vulnerable population groups**. Proposals may focus on both population groups but **must** focus on at least one of the two population groups.

Describe which poor and/or vulnerable population groups your proposal is targeting; why and how these population groups have been identified; how they were involved in proposal development and planning; and how they will be involved in implementing the proposal. *(Maximum half a page.)*
The urban and rural poor including indigenous populations will be the focus of this proposal as lack of knowledge about TB symptoms and socio-economic barriers impede their access to available TB services in the community. Existing non-government organizations including faith-based organizations providing services to poor people have been consulted and will be engaged through Public-Private Mix initiatives or through community-based TB care for these poor population **.** In addition, health system barriers to access of TB care for the **labor force** will be addressed by pursuing TB services at the workplace, including those for the informal labor force. This group was identified through networking with other public non-health partners under the Comprehensive and Unified Policy (CUP) for TB control. **Prison inmates** are selected as a target group because of the high risk of TB transmission. Doctors providing medical services to prison inmates were consulted and have specified the need for enhanced TB services in prison. **Vulnerable populations that have geographic barriers to access:** These include **indigenous peoples** who live in hard to reach areas. FBOs currently providing medical services to them were consulted during the preparation of the proposal. In addition, TB patients who have barriers to access to TB services include chronic TB patients such as **MDRTB patients** who live away from the catchment area of the existing MDR-TB Treatment Centers in Metro Manila. These patients have recommended the scale up of PMDT services to be more accessible to other MDR-TB patients living outside Metro Manila. **Vulnerable populations with biological barriers** such as children with TB have been the subject of the proposal submitted by the Christian Action for Relief and Empowerment (CARE) , the FBO that has been providing nutritional and other aid for urban poor and working children as they have identified this to be a major problem in the communities where they work. The services will focus on children in three urban poor areas in Metro Manila. A copy of the TB Technical Working Group minutes of meeting done on September 20, 2007 discussing the findings and recommendations on the submitted concept proposals is in Appendix 1.

2.4 Upper-middle income high disease burden minimum thresholds

Upper-middle income countries must also demonstrate that they **currently face** a high national disease burden.
➔ *Countries falling under the 'small island economy' lending eligibility exception as classified by the World Bank/ International/Development Association are exempt from meeting this requirement*.

Confirm that the Upper-middle income country targeted in this proposal is **currently** facing a high **national disease burden**, as defined by data from WHO.

3A Eligibility of Country Coordinating Mechanism

From July 2005, the Board of the Global Fund has mandated that CCM, Sub-CCM and RCM Applicants must continue to comply with six minimum eligibility requirements to remain eligible to submit proposals. Annex 1 to this Proposal Form lists all of these requirements and some Applicants will need to complete Annex 1. Please read on to see if this is relevant to your application.

This section requests information as to how, as a Coordinating Mechanism Applicant, your proposal has been prepared in a manner which is compliant with these important minimum eligibility requirements.

3A.1 Coordinating Mechanism compliance history

As a preliminary step, the Global Fund has identified below your Coordinating Mechanism eligibility status as determined at the end of Round 6 (September 2006).

Table 3A.1 – Applicant's history of Coordinating Mechanism compliance

Global Fund record of application history		Your Next Steps
☒	Applied in Round 6 **and** determined as being compliant with the minimum eligibility requirements.	***Complete section 3A.2 and sections 3A.3 and 3A.4 below.***
☐	Did not apply in Round 6 **or** determined non-compliant with the minimum eligibility requirements.	***Instead of completing this section 3A, complete all of Annex 1 to this Proposal Form*** *(refer to page 40).*

3A.2 Changes in Coordinating Mechanism's operations compared to last application

Describe any changes in the Coordinating Mechanism's rules of procedure; or the sectors represented on the Coordinating Mechanism; or the representative selected by a sector; or the main operations of the Coordinating Mechanism since submission of your Round 6 application to the Global Fund. In particular, describe if new processes have been adopted to manage conflicts of interest; or oversee the work of implementation partners. If there are changes in sectors represented on the Coordinating Mechanism, or in the representative for a particular sector, the Coordinating Mechanism must show how the sector itself made a transparent selection of their representative.

If there are any changes, these must be described in detail below and you must attach documented evidence of how the Coordinating Mechanism continues to meet requirements numbered 1 to 6 in Annex 1 to this Proposal Form.

Expanded CCM Membership: The 2nd Forum of the Philippine Partnership to Fight Tuberculosis, Malaria and AIDS held on March 23, 2007 was attended by various organizations representing all sectors including: Governmental public health agencies, non-health governmental agencies/corporations, Academia, NGOs/community-based organizations, community representatives of people living with HIV/AIDS, TB and/or malaria , private sector and professional organizations, faith-based organizations, public-private coalitions, and multilateral and bilateral development partners. Break out sessions of the various sectors selected the nominees to run for election to represent their constituency in the CCM. An election from among the nomined organizations was held last August 16, 2007 coinciding with the annual PhilCAT Convention. Six new representatives were elected as CCM members:

Academia:UP-NIH and Social Dev't. Research Center-De La Salle University

Private/corporate sector organizations: Phil. Business for Social Progress Inc.(PBSP)

Professional organizations: Philippine College of Occupational Medicine (PCOM)

NGOs: Institute for Social Studies and Action (ISSA), Phil. Legislators Committee on Population and Development Foundation

These newly elected organizations will be inducted as new members in the CCM in January 2008 (Appendix 2).

New CCM Chair: In September 2007, Undersecretary Ethelyn Nieto, CCM chair retired. She has been replaced by the Officer in Charge of the Health and Policy Standards Development Cluster **Undersecretary Mario C. Villaverde.**

3A Eligibility of Country Coordinating Mechanism

3A.3 Summary of PR(s) identified in this proposal

Topic Area	Yes or No	If no, explain why not
Are the Principal Recipient(s) identified in section 4.8.1 of this proposal from a different entity than the Chair and Vice Chair of the Coordinating Mechanism.	Yes	If no, **you must attach as an annex to your proposal,** the Coordinating Mechanism's current policy to mitigate potential and actual conflicts of interest.

3A.4 Country-driven, coordinated and multi-sector approach to proposal development

To be eligible to submit a proposal under the Rolling Continuation Channel, Coordinating Mechanism Applicants (CCM, Sub-CCM and RCM) must also provide evidence that they have complied with the proposal specific minimum eligibility requirements (which comprise a sub-set of the six minimum eligibility requirements). These minimum requirements are those listed as Requirements 3(a), 3(b), 4(a) and 5(a) in Annex 1 to this Proposal Form, at page 40.

Applicants are requested to review these minimum requirements carefully, and then provide detailed answers to the questions set out in the text box below.

3A.4.1 If you are proposing to continue/scale up some or all of the interventions from the expiring grant, describe in detail the transparent process that the Coordinating Mechanism followed in order to ensure that:

(a) a broad group of stakeholders (including Coordinating Mechanism and non-CCM stakeholders) have been involved in evaluating the appropriateness of the interventions; and

(b) the decision to continue these interventions was made after discussion among the broad group of stakeholders consulted.

Applicants are reminded that they must also attach documentation (as numbered annexes to their proposal) to provide evidence of the transparent, broadly inclusive processes they adopted and describe below to develop this proposal. ➔ *Refer to the Guidelines for Proposals for a list of minimum documents, section 3A.4.1.*

In May 27, 2007 , the CCM placed a paid advertisement in *Philippine Star*, a daily nationwide circulation newspaper to announce that the Country Coordinating Mechanism is proposing to submit a country proposal for Round 7 and the Rolling Continuation Channel (Appendix 3). The Catholic Relief Services submitted a concept proposal for general TB care in Maguindanao where they are currently funded by USAID. In addition to this, an email was circulated to member organizations of the Philippine Coalition against Tuberculosis (PhilCAT), inviting all members to submit a proposal for the TB control project for possible support from the RCC. Concept proposals from three member groups (Appendix 4), Christian Action for Relief and Empowerment (CARE), Cordillera Coalition against Tuberculosis (CorCAT) and the University of the Philippines NIH, National Telehealth Center were evaluated by the Technical Working Group and deliberated on for possible integration into the country proposal.

A consultative meeting was held September 20, 2007 with stakeholders (Appendix 1), including care givers in the national prisons (National Bilibid) and local jails (Quezon City and Marikina), the Christian Action Relief and Empowerment (CARE), public sector agencies dealing with urban poor, non-government organizations and faith-based organizations such as the Rotary Club, and Gawad Kalinga, the officers and members of the TB and MDRTB patient associations (Samahang Ligtas Baga and Samahang Lusog Baga). In addition, NGOs and FBOs providing services in the rural poor areas were met, and patients expressed their suggestions on the scale up of TB services to have it near their homes.

Several meetings of the Technical Working Group (TWG) with technical advisers from WHO and International Aid have also been held to deliberate on proposal development. The draft proposal was circulated by email to all the CCM members in September 25 and concept proposal was presented to a CCM meeting on September 11 (Appendix 2) and discussed again in November 21 (Appendix 5). Final deliberation and endorsement by the CCM was reached during the CCM meeting in December 19, 2007 (Appendix 6).

3A Eligibility of Country Coordinating Mechanism

3A.4.2 **If you are also proposing <u>new interventions</u> or <u>where a new/additional PR is proposed</u>**, describe in detail the transparent process that the Coordinating Mechanism followed to ensure that:

(a) a broad group of stakeholders (including Coordinating Mechanism and non-CCM stakeholders) were involved in the documented and broadly inclusive process to solicit submissions (for new interventions or a new PR) and review these for possible integration into this Rolling Continuation Channel proposal; and

(b) the decision of whether to include new interventions, or select a new or additional PR, was made after these submissions were received, transparently evaluated and discussed by the Coordinating Mechanism. **Applicants are reminded that they must also attach documentation (as numbered annexes to their proposal) to provide evidence of the transparent, broadly inclusive processes they adopted and describe below to develop this proposal**. ➔ *Refer to the Guidelines for Proposals for a list of minimum documents, section 3A.4.2.*

New interventions to broaden the objectives of GF Round 2 TB in accordance with the current WHO Strategy to Stop TB was discussed in TWG meetings with the technical advisers from WHO (Appendix 7). Prior consultants from the KNCV and IUATLD (The Union) engaged by WHO as well as a CDC consultant engaged by the USAID, had advocated for laboratory strengthening to support the strategic interventions to address challenges of TB/HIV, drug-resistant TB, including M(X)DR-TB (Appendix 8). Addressing TB vulnerable populations in prison, children, urban and rural poor was discussed in a consultative meeting held September 20, 2007 (Appendix 1 & 7) with stakeholders, including care givers in the national prisons (National Bilibid) and local jails (Quezon City and Marikina), the Christian Action Relief and Empowerment (CARE), public sector agencies dealing with urban poor, non-government organizations and faith-based and civic organizations such as the Rotary International Club, and Gawad Kalinga, that are providing medical services to the Philippines' rural poor. This was held to inform them of the country proposal strategies, introduce the officers and members of the TB and MDRTB patient associations, and to invite inputs on how to broaden the implementation of these interventions. The record of discussions of this consultative meeting is submitted as part of Appendix 1. This consultative meeting also included FBOs and NGOs engaged in malaria services covered by GF Round 6 malaria project, in an attempt to reach the rural poor and tribal populations who live in hard to reach areas. All these organizations are being considered to serve as sub-sub recipients, under the IDO, PhilCAT and WVDFI.
It was proposed by the TWG that the same Principal Recipient will continue to administer and coordinate the implementation of the RCC. This was approved by the CCM during the November 21, 2007 meeting (Appendix 5).

➔ *After completing this section,* ***go to section 3B.***

3B Proposal Endorsement

3B.1.1 Leadership of the Coordinating Mechanism

Identify below the requested information regarding the Chair and Vice Chair of the Coordinating Mechanism.

Table 3B.1.1 – Coordinating Mechanism leadership information

	Chair	Vice Chair
Name	Undersecretary Mario C. Villaverde	Dr. Aye Aye Thwin
Title	Undersecretary of Health	Chief, Office of Health
Organization	Department of Health	USAID
Sector represented	Government	Bilateral/Multilateral
Mailing address	San Lazaro cpd, Sta Cruz, Manila	8th Floor PNB Financial Center Roxas Pasay City
Telephone	63(2)7116077	63(2)5529869
Fax	63(2)7125866	63(2)5529800
Main e-mail address	mcvillaverde@doh.gov.ph	aathwin@usaid.org

3B.1.2 Summary of sector representation on the Coordinating Mechanism

Please note ➔ to be eligible for funding, Coordinating Mechanism Applicants must demonstrate evidence of membership of people living with and/or affected by the disease(s). Where stigma is an issue, the level of information required is explained in the Guidelines for Proposals. Also, it is recommended that the membership of the Coordinating Mechanism comprise a minimum of 40% representation from non-governmental sectors. ➔ *Refer to the Guidelines for Proposals section 3B.1 and the Coordinating Mechanism Guidelines.*

Revised Table:

Table 3B.1.2 – Summary of Coordinating Mechanism members

Summary of Membership of Coordinating Mechanism	
Please make sure that the total number of members in the table below equals the total number of members in 'Attachment C' to your proposal.	
Sector Representation	**Number of members representing the sector**
☒ Academic/educational sector	1
☒ Government	10
☒ NGOs/community-based organizations	4
☒ People living with and/or affected by HIV/AIDS, tuberculosis or malaria	2
☒ Private sector	2
☒ Religious/faith-based organizations	1
☒ Multilateral and bilateral development partners in country	7
☒ Other *(please specify):*Public-private collaboration	3
Total Number of Members	30*

**Six new member organizations elected during the August 16, 2007 CCM election will be joining by January 2008.*

3B Proposal Endorsement

3B.1.3 Coordinating Mechanism proposal endorsement

Coordinating Mechanism members must endorse this proposal to confirm their support, as representatives of the sector they represent. **Coordinating Mechanism endorsement is demonstrated by each member signing Attachment C in the final column once all membership information has been completed in that attachment**.

Please note ➔ The **original** (not photocopied, scanned or faxed) **signatures of the Coordinating Mechanism members** must be provided in **Attachment C**. The minutes of the Coordinating Mechanism meeting at which the proposal was considered and endorsed must be **also be attached** as an annex to this proposal. The entire proposal, including Attachment C and the minutes, must be received by the Global Fund Secretariat by 03 January 2008.

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4.1 Requested proposal term

Please fill in the proposal term start date (based on the former grant's expiration date) and the end date (up to a maximum of six years).

Table 4.1 – Proposal term

	From	To
Month and year:	October 2008	September 2014

4.2 Key changes in the stage, type or dynamics of the disease

Comparing the strategy and interventions of this proposal to those in the Coordinating Mechanism's earlier proposal for the expiring grant, describe **the main** changes in the **stage**, **type or dynamics** of the disease, including any changes in the **most affected population group(s)**. For key changes identified indicate whether this change has led to changes in the approach taken in this proposal.

Applicants are requested to specifically comment on current trends in mortality and morbidity impact indicators within the populations targeted in this proposal, and the assessed contribution of the expiring grant towards more favorable trends in those indicators. *(Maximum of one page.)*

The NTP has attained and exceeded the global targets of 70% case detection (CDR) and 85% treatment success rate in 2004 and has sustained and increased their rates since, including the unpublished data for 2006. This success has been attributed to the implementation of quality DOTS including EQA for sputum smear microscopy and improved quality of DOTS services attained through policy development such as on Fixed Dose Combination (FDC) drugs, through refresher training for all types of care providers. In addition, there was increased demand through social mobilization and community organization. Implementation of the quality Public-Private Mix DOTS (PPMD) resulted in an increase in case detection of new smear-positives of 4% nationwide in 2006 and 17% at the local level under the GF TB Round 2 by 2007. The Philippine success of PPMD strategy was recently documented in a case study that was presented at a WHO High Level Meeting on Health Equity in Phnom Penh, Cambodia (Appendix 9). In addition, the Green Light Committee (GLC) approved (PMDT) project undertaken by a PPMD unit established in 1999, has expanded into the public sector, and has shown a sustained improved cure rate of 73%. The overall impact of the Global Fund grants thus far has shown a consistent downward trend in the incidence of new smear positive TB over the last three years, with TB mortality rate following a similar pattern, while the case notification rate showed an upward trend due to improved Quality DOTS implementation. As a result of the interventions in GF Round 2 implementation, the incidence in new sputum smear positive cases has begun to decline and if the gains are sustained, the projected decline as shown in the years leading up to 2015 will substantially prevent the generation of MDR-TB. In 2004, the Drug Resistance Survey done by the National TB Reference Laboratory (NTRL) showed a prevalence of 4.0% MDR-TB among new cases (compared to global figures of 1.7%) and 21% in previously treated patients (compared to global average of 7.7%) which is higher than the prevalence of 1.5% and 14.5%, respectively, reported in 1997. The PMDT has indicated a progressive improvement in the cure rate of MDR-TB The recent WHO document on the Global MDR-TB and XDR-TB Response Plan 2007-2008 cited the Philippines as the 16th of 25 high MDR-TB priority countries which together are responsible for 85% of the global MDR-TB burden. With the emergence of XDR-TB and the epidemic outbreak of XDR-TB in coinfected HIV patients in Tugela Ferry, KwaZuluNatal, South Africa, the early and high mortality rate in this population showed that MDR-TB will be a threat not only to TB control but to HIV/AIDS control as well. Accordingly the Global Plan to STOP TB 2 has been revised to treat 1.8 million MDR-TB cases from 2006 – 2015. To attain this, 60% of all MDR-TB patients in the 25 priority countries for MDR-TB should be treated in the ten years and on 2015, universal access for MDR-TB management should be available to approximately 80% of MDR-TB incident cases for that year. In the Global Response Plan to MDR-TB, 2007-2008 and 15% and 28% of MDR-TB patients should be treated in the Philippines in those years, equating to 1473 and 2610, patients, respectively. Currently we are planning only on treating 396 and 640 in these years with Global Fund Round 5 proposal. Obviously, there is a need for a rapid scale up with the accelerated human resource development required to undertake this. These needs cannot be possibly met even by the significantly increasing national resources for TB control even with the current support for Global Fund TB projects Round 2 and Round 5, and other donor agencies' contributions. These goals entail the expansion and implementation of quality DOTS for marginalized populations, the engagement of care givers to NTP DOTS through increased PPM coverage from 66% to 100% nationwide to prevent the emergence of drug resistant TB, and the scaling up of the PMDT to provide access to MDR-TB services in all regions and provinces in the Philippines to break transmission and prevent the emergence of XDR-TB. In addition, gaps in addressing TB in children, in prisons, and in the urban and rural poor will be part of the strategy in the RCC proposal consistent with the Strategic Plan to Stop TB in the Philippines 2006-2010. Children less than 15 years of age will be a beneficiary of this proposal since childhood TB is a leading cause in mortality with the highest rates among the 5-9 and 13-14 year age groups. This population group contributes 25% of cases detected in pilot areas where TB treatment in children is currently piloted.

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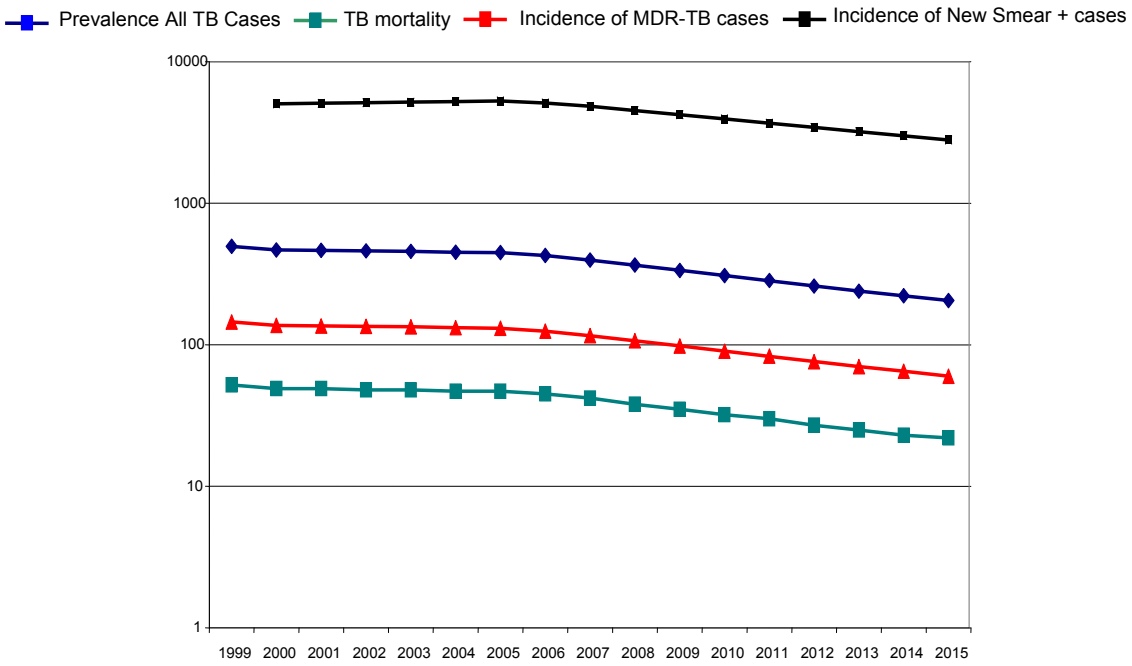
Prevalence of all TB cases, TB mortality, Incidence of New Smear Positive Cases and MDR-TB



4.3 Current national program context

4.3.1 Epidemiological and disease-specific background relevant to your country

In the table below: **(i)** identify the total population of the country **and (ii)** provide current estimates of the stage of the disease (prevalence rates) in the listed population groups where the groups are applicable to your national epidemiological framework, and where there is existing available data.*The 'source of estimate' (final column in the table below) may be from recent published estimates of WHO (as relevant to the disease component of this proposal), but may also be published national estimates or statistics.*

Table 4.3.1. – Estimated disease prevalence within key population groups

Population	Estimated number	Year of estimate	Source of estimate
(i) **Total Population** (all ages)	83,054,000	2004	World Population Prospects, the 2004 revision, UN Population Division, NY, USA
(ii) **Current estimates on the stage of the disease in the following population groups**:			
People living with all forms of tuberculosis	373,743	2005	WHO Global Tuberculosis Control, WHO Report 2007
People with new smear-positive tuberculosis	108,800	2005	WHO Global Tuberculosis Control, WHO Report 2007
People treated for new smear-positive tuberculosis	70,437	2004	WHO Global Tuberculosis Control, WHO Report 2007
Tuberculosis related	39,036	2005	WHO Global Tuberculosis Control,

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Population	Estimated number	Year of estimate	Source of estimate
deaths per year			WHO Report 2007
Number of cases of multi-drug resistance per year	5,405	2004	Drug Resistant Survey, DOH//WHO/JICA, 2004
Case detection rate of new smear-positive cases	75%	2005	WHO Global Tuberculosis Control, WHO Report 2007
DOTS treatment success rate	87%	2004	WHO Global Tuberculosis Control, WHO Report 2007
DOTS treatment success rate (relapse)	76%	2004	Global Tuberculosis Control WHO Report 2007
PPMD Contribution to Case Detetcion in NSP	4% of NSP cases 8% all cases of TB	2006	Department of Health, TB Annual Reported Data, 2006
MDR-TB in new sputum smear Positive tuberculosis	4%	2004	Drug Resistance Survey 2004
MDR-TB in previously treated PTB	21%	2004	Drug Resistance Survey 2004

4.3.2 National disease specific planning framework

Describe how the country's disease specific planning frameworks** have evolved since submission of the proposal relevant to the expiring grant, to support national efforts to prevent and control the disease.

Comment on factors including (but not limited to):

(a) how the national plans have been amended to take into account changes in the disease profile and the current epidemiological status *(from sections 4.2 and 4.3.1 above)*;

(b) whether, and in what ways, a broad range of national, regional and local health sector stakeholders (including the public, private, and NGO sectors and communities affected by the disease) have been included in the evolution of the national/country disease prevention and control plan(s); and

(c) how national planned outcomes *(e.g., the number of people identified as needing treatment by 2015)* have been determined, having regard to strengthened experience in key service provision, and the increasing availability and predictability of national, bilateral and multilateral financing.

** Plans which may be described, depending on in-country circumstances include: the disease prevention and control initiatives set out in the National Health Sector Development Plan; a National Disease Control Strategy or Plan; a poverty reduction strategy paper; sub-sector policies relevant to the proposal *(e.g. national or sub-national human resources policies, or norms and standards)*; and the National Monitoring and Evaluation Plan *(health sector, disease specific, or other)*.

Where such plans exist, they should be attached to the proposal to assist proposal review

The **National Strategic Plan to Stop TB in the Philippines 2006-2010** (Appendix 10) was developed in response to the current scenario of the country, in order to sustain the gains of ongoing interventions. Quality DOTS implementation is still the overarching framework of this plan and public-private partnerships are exemplified as crucial strategies in the attainment of the NTP targets. Creation of social demand through social mobilization and community participation are described as supporting activities to improve case detection, particularly of the public sector. Aside from regular DOTS implementation, the plan also dwells on addressing special challenges, mainly the MDRTB. Learning from the experience of the GLC-approved Project, the Philippines has included in this plan the programmatic approach of managing this public health problem. Initiated by a private organization, the current direction is to mainstream MDRTB management into the public sector and eventually, becoming fully integrated in the entire Program.

In a WHO Regional TB Technical Advisory Group meeting conducted in Busan, South Korea last March 2006, in

developing the National Strategic Plan to Stop TB in the Philippines 2006-2010 the "**Global Plan to Stop TB**", the "WHO **Stop TB Strategy**" and the "**Strategic Plan to Stop TB in the Western Pacific 2006-2010**" and the "**Intenational Standard of TB Care**" were taken into consideration. This plan was endorsed by the Western Pacific Regional Office after the launching of the Strategic Plan to Stop TB in the Western Pacific 2006-2010. At present, this document serves as the country's key reference in the development of the NTP's Annual Work and Financial Plan/Operational Plan and for other Project assistance such as the TB LINC. In general, the six-point agenda of the Global Plan Strategy to Stop TB and the core objectives of the Strategic Plan to Stop TB in the Western Pacific 2006-2010 were adopted as the major highlights in this proposal. However, being one of the 25 priority countries for MDR-TB, we had to revise dramatically upward the number of MDR-TB patients treated under the plan consistent with the revised Global Plan to Stop TB (2006-2015) and the Global MDR-TB and XDR-TB Response Plan 2007-2008 launched June 2007. This obviously had significant repercussions on the financial gap that expanded accordingly.

The **National Objectives for Health (NOH), Philippines 2005-2010** (latest published date, October 2005 available at: http://www2.doh.gov.ph/noh2007/NohMain.htm) provides the "road map" for the period 2005 to 2010 **in accordance with the *FOURmula One (F1) for Health*, has four major thrusts: *health care financing, health regulation, health service delivery and good governance.*** This aims to unify the entire Philippine health sector towards improving the health of all Filipinos by spelling out a common direction and setting achievable medium-term goals for all its citizens. Built from the framework of health sector reforms, its guiding philosophy and strategic approaches are designed to implement health interventions and strategies with speed, precision and effective coordination. The National TB Program is one of the more mature public health Programs where the four pillars of *F1* are applicable and it is upon this framework that the activities proposed in this RCC will be undertaken to ensure sustainability. The Strategic Plan of the National TB Control Program 2006-2010 is adapted to the *F1* model of the NOH, as an example for the other public health programs.

The activities of this proposal are also consistent with both the WHO Stop TB Strategy and the Regional Strategic Stop TB Plan of the Western Pacific Region. The **Medium Term Philippine Development Plan (MTPDP) 2004-2010** encompasses the attainment of the Millennium Development Goals (MDGs), that the country has adopted in its commitment to end poverty, to improve access to health, education and other basic social services and to attain greater national development. Chapter 12 entitled *"Responding to Basic Needs of the Poor"* supports the activities for the pursuit of public health program reforms, including health financing reforms and addresses the protection of vulnerable groups, such as children.

4.3.3 Common funding mechanism arrangements (only where relevant)

*This section only requests information from Applicants if funding requested in this proposal is **intended to be contributed through a common funding mechanism,** such as a Sector-Wide Approach (SWAp), basket or pooled funding arrangement (whether at a national, regional or the health sector level).*

(a)	Is part or all of the additional funding requested in this proposal intended to be contributed through a common funding mechanism? *(Note ➔ streamlined administrative arrangements such as procuring medicines through pooled procurement arrangements are not considered a 'common funding mechanism' for the purposes of this question).*	☐ Yes ➔ *complete this section* ☒ No ➔ *go to section 4.4*
(b)	If only part of the funding requested in this proposal will be contributed into the common funding mechanism, please explain the rationale for such an approach?	

(c)	**Provide an overview of the common funding mechanism and the way it functions**. In your response, identify development partners who are part of the common funding mechanism and their respective level of financial contribution (in percentage terms) to the common funding mechanism. *(Note ➔ Documents describing the functioning of the common funding mechanism should be provided as an annex to your proposal to enable a review of the governance and operational arrangements. These documents may include: the agreement between contributing parties; joint Monitoring and Evaluation procedures, management details, joint review and accountability procedures, etc.)*

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(d)	Have funds from the expiring grant been managed through a common funding mechanism to date? If yes, explain the outcome of the latest evaluation of the common funding mechanism's processes. **In particular, Applicants should fully explain any adverse outcomes and/or lessons learned, and what actions were taken to respond to these findings**. *Note ➔ Attach, as an annex to your proposal, the most recent audit or other external assessment of the programmatic and financial operations of the common funding mechanism.*
No	

(e)	Describe the Applicant's assessment (**including by reference to any criteria used during the assessment process**) of the capacity of the common funding mechanism to absorb the additional funds generated by this proposal **and** ensure effective supervision of the work that is proposed. *Note ➔ Where relevant, provide details of any changes in financial controls or management arrangements that have been agreed with the common funding mechanism to ensure that the funding (if approved) will be used in a **transparent, efficient and timely manner**.*
N/A	

(f)	Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by (or will serve as additionality to) resources currently or planned to be available to the common funding mechanism. *Note ➔ If the common funding mechanism is broader than this disease component, Applicants must explain the process by which they will ensure that funds requested will be used for interventions specific to achieving impact in respect of disease targeted in this proposal during the proposal term*.
N/A	

4.4 Overall Country Disease Prevention and Control Needs Assessment

The outputs and outcomes planned to be achieved under this proposal (as a scale-up of the interventions under the expiring grant, or, as relevant, the introduction of a broader package of interventions) **should be based on an analysis of program and financial gaps in national plans/programs/strategies to prevent and control the disease**.

Applicants should follow these steps to complete section 4.4 and 4.5:

Step 1 **Section 4.4.1** requests Applicants to identify gaps in the main "key service" (program) areas targeted by this proposal, and the **level of additional coverage that is requested through this proposal**. *This is a summary of the main needs only. Applicants must still describe the specific interventions/activities planned under this proposal (in section 4.6) and the targets and indicators that are proposed to evaluate performance during the proposal term (in the 'Targets and Indicators Table', Attachment A)*.

Step 2 **Section 4.4.2** requests Applicants to describe any health systems strengthening strategic actions ('**HSS Strategic Actions**') that are essential to ensure that the planned outputs and outcomes of this proposal will be achieved, **and to identify how much support for these actions is requested in this proposal**. HSS Strategic Actions are more fully discussed in the Guidelines for Proposal (section 4.4.2). *This section also requests information on other current and planned levels of support for the same HSS Strategic Actions.*

Step 3 **Section 4.5** requests Applicants to identify the country's **overall disease specific financial needs** to prevent and control the disease. **Thus 'Line A' in table 4.5 should include both program and essential disease specific health systems needs. All other lines in the table should also include both program and health systems needs if these are essential to the national disease prevention and control plan.** *This is a summary of the financial needs only. Applicants must provide a detailed budget request by disease component (within section 5) and summarize this request in table 1.2.*

Note ➔ *Depending on absorptive capacity (whether actual or increased capacity to be developed through this proposal or other support), an Applicant's proposal may plan to respond to the whole of the needs identified in the "key services", or only part of the needs/gaps identified.*

Step 4 In section 4.6, Applicants should fully describe the specific interventions/activities which are included in this proposal to ensure that the programmatic needs targeted by this proposal are fully met.

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See the Guidelines for Proposals, sections 4.4 and 4.5, for further explanation.

4.4.1 Key Service Needs Assessment

4.4.1 Overall Key Service national program needs assessment

(a) Based upon an existing Health Sector Strategic Plan**, describe below the country's overall disease specific prevention and control needs in terms of '*people in need of key services*', commenting on at least five of the major 'people in need of key services' areas

*** If there is no existing Health Sector Strategic Plan (or equivalent), Applicants are requested to respond to this question by reference to an analysis of national/regional goals, together with analysis of disease surveillance data and target group population estimates for relevant prevention and control strategies as described in section 4.3.1.*

National Strategic Plan to Stop TB in the Philippines 2006-2010: Needs Assessment

An analysis of the program needs through program implementation reviews, assessments, and consultative meetings led to identifying gaps that should be addressed . The needs analysis considered the strategies undertaken by the NTP and partners and the financial support provided by the Philippine Government, ongoing Global Fund grants, and other donor support. A recent consultation initiated by the WHO (Appendix 8) and another by the USAID local mission reviewed the basic needs for scale up of PMDT (Appendix 11) which included the enhancement of an enabling policy environment, the human resource development for program implementation, establishment and capacity building and strengthening of the required TB laboratory network to support the comprehensive TB control and the PMDT scale up, and to benefit from the expertise developed in the current PMDT project undertaken by the Tropical Disease Foundation jointly with the DOH to serve the training needs of the country for the scale up. This scale up is in line with the revised Global Plan to Stop TB (2006-20015) and more recently launched Global Response Plan 2007-2008 to the MDR/XDR-TB Crisis.

The following are the National Key Services for TB Control:
Quality DOTS: Timely detection and quality treatment of cases through DOTS (scale and scope change)
The National TB Control Program (NTP) adopted the DOTS strategy as its overarching framework in its delivery of basic TB services. The strategy introduced in 1996 and reached 100% coverage of the public sector in 2002, attained the global targets of >70% CDR and 88% treatment success among the New Sputum smear positive cases in 2004. For this specific intervention, gaps in coverage include 1) people receiving health services from non-health public sectors, such as the teachers working under the Department of Education,2) the labor force in the work/employment sectors, 3) the urban poor and rural poor and indigenous populations, other, 4) vulnerable populations like prisons/inmates and 5) children . These are also addressed in this proposal. Health care financing through DOTS certification and accreditation to sustain quality DOTS implementation, improving the technology for TB diagnosis and service delivery through health systems strengthening, and impact measurement through monitoring and evaluation are significant program activities that the NTP need to expand.

Public-Private Mix DOTS (PPMD):(scope and scale change)
With the adoption of the PPMD strategy in 2003, 116 PPMD Units have been established under the GF Rds 2 and 5 projects as of September 2007; another 54 is expected to be operational in 2008. Altogether, there will be 221 units including 51 established from other initiatives. PPM covers 41.5% of the national population and has engaged about 3,000 Private Physicians in DOTS. In 2006, PPM strategy contributed to a 4% increase in CDR nationwide with good treatment outcomes, of which 2% was contributed by the 70 Round 2 PPMD units. There is a need to scale up this strategy to cover the remaining 48.2% of the population not covered by Rounds 2 and 5. This scale up is expected to increase CDR by another 6%. The "Operational Guidelines for PPMD in the Philippines" has provided the guidelines for a strong infrastructure for monitoring, supervision, and technical assistance with the establishment of a National Coordinating Committee and 16 Regional Coordinating Committees (Appendix 12). This scale up will need the establishment of 44 Provincial Coordinating Committees to support PPM implementation in these areas. For sustainability, the introduction of the TB DOTS Out-patient Benefit Package by the Philippine Health Insurance Corporation (PhilHealth) in May 2003 provides subsidy to the PPMD units. Additional 4,400 private physicians and 176 NGOs and FBOs providing health services to people living in hard to reach areas such as the indigenous populations, urban poor dwellers. public health care providers outside the NTP will be engaged in the RCC . These providers will not only provide services to adult TB cases but will also address the needs of vulnerable groups and those in hard to reach areas.

The mature PPMDs from Round 2 and 5, particularly those that are privately initiated and providing only TB services are considered for possible expanding the scope of the services they provide by undergoing more capacity building to be engaged as treatment centers for the Programmatic Management of DR-TB as a convergence of Objective 1b and Objective 2 of GF TB Round 2.

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People needing this service will include 1) people living in small cities and municipalities, 2) rural poor and indigenous peoples living in hard to reach areas, 3) MDR-TB patients from other regions and provinces outside of those reached by the existing Treatment Centers .

Advocacy, Social Mobilization for TB (ASMT) (Scope and Scale Change)
This proposal will include a broadened ACSM through a national plan. This national plan addresses 1) the policy makers to ensure an enhanced policy environment to provide resource for TB control and local ownership of the TB control activities, 2) the general public to increase awareness and improve health seeking behaviour of the general population 3) community and patient empowerment for community-based TB care through ACSM in convergence with PMDT to improve treatment adherence as the services will be provided in the community where the patients reside. In the RCC, this strategy will have an increased scope as it will reach various levels in the population, including the 1) political leaders and policy makers for advocacy and resource generation, 2) general public to increase awareness, 3) the affected peoples and their families for patient empowerment to engage in community-based TB care in the 14 regions where PMDT will be implemented.

MDR TB (scale change)
GF TB Round 2 project covered only the pilot project area at Makati Medical Center with the objective of treating only 500 patients; in Round 5, it was extended to other cities/municipalities of Metro Manila and another urban area in Region VII. In response to the revised Global Plan to STOP TB (2006-2015) and the Global MDR/XDR-TB Response Plan 2007-2008, a rapid escalation of the implementation of PMDT is required to attain the MDG goal No. 6 by 2015. Considering that the Philippines ranks 9th of the 22 high burden countries, and 16th of 25 priority countries for MDR-TB, this proposal addresses MDR-TB patients nationwide. A significant human resource for health development for the implementing treatment centers and treatment sites and laboratory strengthening for culture centers and DST centers will be required by this scale up. The main people in need of these services will be 1) MDR-TB suspects/patients living in other urban and rural communities that are out of the coverage of the Round 2 and 5 TB projects, 2) MDR-TB patients in prisons, 3) MDR-TB patients in HIV co-infected individuals and household contacts of infectious MDR-TB patients.

TB Laboratory Strengthening (Increased Scope and Scale-up)
Laboratory strengthening to provide support for TB services should improve their External Quality Assessment (EQA) of sputum smear microscopy to all microscopy centers including PPMD units (as provided by GF Round 2 and 5), and also to develop capabilities for culture and drug susceptibility testing (DST) A three tiered laboratory network should be established and sustained to support the new interventions on children and for TB and HIV co-infection as well as the scale up of the PMDT. Accordingly, laboratories should be upgraded to provide *M. tuberculosis* cultures and drug susceptibility tests (DST). The NTRL should take the lead in developing this laboratory network, with technical assistance from the Research Institute of Tuberculosis (RIT), Japan and the Mycobacteriology Research Laboratory of the Tropical Disease Foundation which at this time has acquired proficiency through participation in 4 rounds of Proficiency Testing under the Korea Institute of Tuberculosis (KIT). The NTRL is responsible and should ensure Quality Assurance (QA) not only of direct sputum smear microscopy but also of *M. tuberculosis* culture and DST. The people in need of these services are 1) TB symptomatics and patients, 2) MDR-TB suspects and patients, 3) close household contacts of MDR-TB patients, and 4) TB symptomatic HIV patients.

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(b) **People in Need of Key Services targeted by this proposal**

Complete table 4.4.1 to illustrate the main (but not only) 'people in need of key services' **that will be targeted by this proposal**.

Please note:

(i) **complete Part A** of table 4.4.1 for up to three of the **main** (not only) 'people in need' key services that are continuing from the expiring grant;

(ii) **where relevant, complete Part B** of table 4.4.1 for up to three of the main 'people in need' key services that are new (representing a scope change) compared to the expiring grant;

(iii) each of lines A, B, C and D for each 'key service' in table 4.4.1 should contain quantitative information in regard to 'needs' and 'people' to be reached; and

(iv) this gap analysis should guide the completion of the 'Targets and Indicators Table' (the framework by which performance will be evaluated according to the Global Fund's performance based funding criteria) required under section 4.6. *Please note ➔ the Targets and Indicators Table should have a greater number of performance and impact measurement indicators than simply the key services covered in table 4.4.1, as these.are only the 'main' key service areas.*

Specify below additional information (if any) you believe relevant concerning the groups and/or areas or regions targeted and any assumptions including target size of the population groups.

1. Previously treated patients with chronic TB symptoms and MDR-TB, those who fail in Category I and II DOTS regimen as well as MDR-TB patients among household contacts (Scale change):
Based on the recently-developed PMDT policies, the patients in need to Programmatic Management of Drug-resistant Tuberculosis (PMDT) are previously treated TB cases such as Relapse, Treatment Failure, Return After Default and others who were previously treated outside of the DOTS program, non-converters from Category 2, confirmed HIV (+) cases with symptoms of pulmonary TB and contacts of confirmed MDRTB cases. The incidence of new MDR-TB cases as of 2007 is estimated at 4,840 and cumulatively will total to 30,841 in the following years up to 2015. These patients come from various regions and provinces in the Philippines including those out of the catchment areas of the existing PMDT treatment centers. A decentralized system for the implementation of PMDT should become an integral component of the NTP. The increase in scale will entail the involvement of PPMD units and the engagement of private physicians who are engaged through the PPM strategy. Their engagement can be optimized through proper referrals to the respective PPMD units that will be trained to identify MDRTB symptomatics and provide programmatic management for detected MDR-TB patients.
Based on the burden of MDR-TB in the country, and in response to the call for a rapid scale-up to reach the MDG goal of 2015, a total of 35 new MDR-TB treatment centers will be established by the RCC with a cumulative total of 10,625 (9,485 with RCC support, 1140 with government support) patients put on treatment in the six years leading up to 2015, with an expected goal of universal access by 2015 being attained with 80% of incident cases put on treatment.

2. Prison inmates
This group is a fertile ground for TB transmission if DOTS services are non-existent in their environment. Treatment adherence is operationally feasible in this setting due to their nature of environmental captivity. A survey in a local jail in Quezon City showed that case notification is nearly doubled than the rate amongst the general population. If this is unattended, there is transmission occurring during incarceration of infectious TB cases in congregate settings. Thus, transmission and generation of more active cases that will eventually spill out into the population will occur. This poses a great risk, especially, if they acquire the more serious form of the disease that is, MDRTB.

Prisons in the country are managed by two different government agencies depending on their level. There is one national penitentiary, one correctional institution for women and five penal farms at various regions, all governed by the Department of Justice. The more peripheral ones (provincial, city, and municipal jails) are under the Department of Interior and Local Government (DILG)-Bureau of Jail Management and Penology (BJMP). There is an estimated 90,000 people serving sentences in these jails. Implementation of TB-DOTS services by these two other government organizations, are in-partnership with the health agency, both at the national and peripheral levels. Quality DOTS will be implemented in national penitentiaries, provincial and local jails and to include infection control measures to prevent transmission in congregate settings.

3. Urban and rural poor populations
Patients who have barriers to access TB services, either due to poverty or due to living in areas that are hard to reach areas, will be the main focus of partnerships with local government units and with existing NGOs and FBOs providing medical services in these areas through a private public mix intervention.In the 2nd 1997 National TB Prevalence Survey (NTPS), an extended study showed that *M. tuberculosis* infection was 4 times higher among the urban poor than the non-poor and the prevalence of TB disease was 1.5 times higher than in the non-poor urban dwellers. The vulnerability to TB emerges in this group because of overcrowded and substandard living or working conditions, poor

nutrition, interaction with other diseases and migration, and also due to lack of access to TB services. Addressing poverty is a primary concern of the MDGs and the NTP can be an opportunity to promote the links between TB and poverty. Identification of the barriers to accessing TB services faced by this group shall be assessed. Reaching-out to the providers and communities, to expand the primary health care and access to DOTS services are to be undertaken in this proposal to overcome the barriers.

The informal sector of the labor or work force becomes a vulnerable group for TB disease due to barriers present within their working conditions. The lack of access to health services is a common limitation why laborers are predisposed to TB. It is therefore important that the NTP looks into avenues or mechanisms on how to reach-out to these groups. Providing health services, including that of TB-DOTS services, can improve access to these groups and eventually, render them the appropriate TB care and management. Office staff of non-health public sector agencies will also benefit from the RCC as expansion of the DOTS services will likewise be done through public-public mix. This will include school teachers and other staff in the bureaucracy.

4. Children with TB infection and TB disease in the urban poor including working children:
Aside from the adult TB cases, ***children*** afflicted with TB are also identified as people in need of key services. TB is still a top leading cause of mortality among aged 1-14 and is highest at age groups 10-14 and 5-9, being the 6th and 9th leading cause of mortality respectively *(FHSIS Report, 2000).* Due to their physiologic immaturity, this group usually contracts the more serious and debilitating forms of TB. Because they comprise the future generation of the country's economic workforce, there is social responsibility to protect them from health risks and render them cured from health vulnerabilities such as TB disease, during their childhood state. There have been previous Childhood TB Projects utilizing the DOTS strategy, undertaken by the NTP in partnership with key private groups and the Pediatric societies. Although an advanced implementation has already been initiated in 16 cities (1 city per region), there is a need to expand the services for a wider capture. Childhood TB guidelines are already present under the NTP and these shall be revised accordingly to attune to the current developments in childhood TB management. Internationally-recommended and locally-accepted standards shall be adopted for a broader coverage of these target beneficiaries.

Household contacts of infectious TB cases traced are at average of 4.4 per infectious index TB case. As of 2007, it is estimated that there are 103,999 infectious TB cases with a total of 457,596 household contacts. Of these contacts, 48,408 (10.4%) are children less than 5 years of age with a cumulative total of 306,175 for the years leading up to 2015. The risk of rapid progression from TB infection to disease within 2 years is greatest in this population. These children are target group for treatment for Latent TB Infection (LTBI).

IMPORTANT INSTRUCTIONS FOR THE COMPLETION OF TABLE 4.4.1 ON THE FOLLOWING PAGE

Refer to the M&E Toolkit when completing this table for information on "key services" (termed "service delivery areas" in the M&E Toolkit).

Importantly – table 4.4.1 (Part A and Part B) is only for the main 'key people in need' services (e.g. provision of medicines delivered to people) and not a table for Applicants to also identify human resource and other HSS needs. These needs should be included in Table 4.4.2.

Only complete table 4.4.1 after reviewing the Guidelines for Proposals.

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IMPORTANT INSTRUCTIONS FOR THE COMPLETION OF TABLE 4.4.1 ON THE FOLLOWING PAGE

Refer to the M&E Toolkit when completing this table for information on "key services" (termed "service delivery areas" in the M&E Toolkit).
Importantly – table 4.4.1 (Part A and Part B) is only for the main 'key people in need' services (e.g. provision of medicines delivered to people) and not a table for Applicants to also identify human resource and other HSS needs. These needs should be included in Table 4.4.2.
Only complete table 4.4.1 after reviewing the Guidelines for Proposals.

PART A: Interventions continuing and scaling-up from the expiring grant

Continuing Key Service 1 – continuing	**Actual**			**Targeted**						
Timely detection and quality treatment of cases through DOTS to include PPMD and urban and rural poor (scale and scope change)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: People in need of key services: *TB cases identified among TB symptomatics from urban and rural poor, PPMD initiatives and community TB care*	112,071	113,934	103,285	96,786	90,757	85,062	79,682	74,609	69,838	65,464
B: Extent of need already planned to be met under existing/future funding (including R2 and R5 accomplishments) *(This figure **must take into account** all planned resources, domestic and external, including Global Fund grants for the same disease, and all as yet undisbursed Phase 2 potential amounts)*	80,639	86,308	80,356	77,625	74,113	68,536	62,818	58,595	54,960	51,953
C: Expected annual deficit in 'key service' needs	31,432	27,626	22,929	19,161	16,644	16,526	16,864	16,014	14,878	9,865
D: Extent of total need covered by this proposal under the PPMD initiative					678	3,216	4,771	4,450	4,174	3,946
E: Extent of total need covered by this proposal thru Urban and rural poor engagement					0	636	1942	2637	3357	3419
F: Extent of total need covered by this proposal thru TB in prisons					254	431	527	537	638	649

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Continuing Key Service 2 – continuing	Actual			Targeted						
Community TB Care - Advocacy, Communication and Social Mobilization	**2005**	**2006**	**2007**	**2008**	2009	**2010**	**2011**	**2012**	**2013**	**2014**
A: People in need of key services: *(from national or, where relevant, regional annual, plans)*	1,114	1,500	1,508	1,419	1,325	6,005	6,472	6,045	5,679	5,379
B: Extent of need already planned to be met under existing/future funding *(This figure **must take into account** all planned resources, domestic and external, including Global Fund grants for the same disease, and all as yet undisbursed Phase 2 potential amounts)* *TB symptomatics in rural and urban areas*	48	553	911	878	795	745	701	654	615	582
C: Expected annual deficit in "key service" provision *TB symptomatics in rural and urban areas*					530	5,260	5,772	5,391	5,064	4,797
D: Extent of need covered by this proposal					0	3,603	3,883	3,627	3,408	3,227

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Continuing Key Service 3 – continuing	Actual			Targeted						
MDR-TB (scale change)	**2005**	**2006**	**2007**	**2008**	2009	**2010**	**2011**	**2012**	**2013**	**2014**
A: People in need of key services *(from national or, where relevant, regional annual, plans)*	5267	5098	4840	4519	4223	3943	3681	3434	3203	2998
B: Extent of need already planned to be met under existing/future funding *(This figure **must take into account** all planned resources, domestic and external, including Global Fund grants for the same disease, and all as yet undisbursed Phase 2 potential amounts)*	191	254	488	524	854	1525	2240	2450	2625	2800
C: Expected annual deficit in "key service" provision	5076	4844	4352	3995	3369	2418	1441	984	578	198
D: Extent of need covered by this proposal					230	900	1425	2200	2365	2365

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PART B: **New interventions that alter the scope of the expiring grant - but which are still in line with the broader package of interventions to which the expiring grant was contributing.** ➔ ***Applicants are strongly encouraged to refer to section 4.4.1 of the Guidelines for Proposals*** *(at page 14)* ***before completing this table.***

Key Service 1 – new	**Actual**			**Targeted**						
Laboratory	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
A: People in need of key services *(Previously treated TB patients including MDR-TB suspects; children with symptoms of TB disease, Extrapulmonary TB, and TB symptomatics in HIV patients)*	21068	20392	19360	18076	16892	15772	14724	13736	12812	11992
B: Extent of need already planned to be met *under existing/future funding	764	1016	1952	2096	3416	6100	8960	9800	10500	11200
C: Expected annual deficit in 'key service' needs	20304	19376	17408	15980	13476	9672	5764	3936	2312	792
D: Extent of total need covered by this proposal					920	3600	5700	8800	9460	9460

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4.4.2 Strategic actions to strengthen health systems

As explained at the start of section 4.4, certain '**HSS Strategic Actions**' may be essential (dependent on country specific contexts) to ensure achievement of the outputs and outcomes targeted by this proposal, including where there is a planned scale up or scope change compared to the expiring grant. These HSS Strategic Actions may include actions to improve grant performance, address current or anticipated barriers, and/or support and sustain expansion/scale-up of interventions to prevent and control the disease.

The Global Fund therefore strongly encourages Applicants to include in their proposal a request for support of relevant HSS Strategic Actions which are coordinated with the national disease control strategy.

Before completing this section, Applicants should refer to the Guidelines for Proposals, section 4.4.2, where significantly greater detail is provided on HSS Strategic Actions supported.

4.4.2 Complete table 4.4.2 below to describe, for up to five main actions:

(a) the **HSS Strategic Actions** that are **essential to achieve the planned outputs and outcomes of this proposal** and therefore the broader disease prevention and control plans at the national level;

(b) **how the actions link to the planned program work during the proposal term** and **address** key points in regard to current or expected challenges *(including those arising due to the injection of the additional funding requested in this proposal)* arising in the health system; and

(c) **other support currently available or planned/anticipated for the same actions**.

Ensure that the HSS Strategic Action(s) is/are consistent with (where one exists) the national Health Sector Development Plan/Strategic Plan and its time frame. *(Ensure you provide this Plan as an annex to the proposal as requested in section 4.3.2).*

To clearly demonstrate the link requested in (b) above, Applicants should relate proposed HSS Strategic Actions to disease specific goals and their impact indicators. ***Refer to information on possible indicators for HSS actions in the Guidelines for Proposal at section 4.4.2.*** *(Where only one strategic action is proposed, Applicants must explain the rationale behind this decision with reference to the guidance provided in the Guidelines for Proposals.)*

Copy and repeat the table for up to five HSS Strategic Actions.

Table 4.4.2A – Summary of essential HSS Strategic Actions requested in this proposal

4.4.2A Summary of funding requested for HSS Strategic Actions in this proposal

In the table below summarize, by year, the total funding requested for HSS Strategic Actions in this proposal for this disease component. *This will be the sum of the 'Funding Request' for each year for each HSS Strategic Action included in this disease component, as detailed in part B of table 4.4.2 (**on the following page, copied for up five HSS Strategic Actions**).* *Applicants are reminded that they must ensure that the overall funding needs (table 4.5) include both program and essential disease specific health systems needs to ensure that the financial gap analysis reflects all available, planned and required resources.*

Total funds for essential HSS Strategic Actions requested over proposal term						
Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
10'718'732	16'297'177	21'009'131	20'989'830	20'814'330	17'457'941	107'287'141

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Table 4.4.2 – Summary of Strategic Actions essential to this proposal

Action 1	**Service Delivery and Infrastructure**: TB in prisons and TB in children are new strategies requiring support for service points. In addition, Private Public Mix DOTS providing quality service as treatment center for Programmatic Management of DR-TB and PPMD and DOTS centers providing quality service as treatment sites for Programmatic Management of DR-TB

A: Describe below, through 'key words' *(refer to the Guidelines for Proposals at page 16)*, the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term.

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
22 Provincial Coordinatiing Committees covering small provinces and cities Scale up in the MDR-TB treatment through the establishment of PMDT training Center, 7 culture centers and 1 new DST center and 10 new treatment centers for the PMDT.	Provincial coordinating committees nationwide (22) to expand PPM coverage to 100% Quality DOTS to improve TB care in Children in 15 sites, in 2 prisons, urban and rural poor communities and expansion to 15 PMDT treatment centers, 11 culture centers for PMDT and 4 DST centers	10 new treatment centers and 11 culture centers for PMDT. Scale up from 2 to 7 national and regional penal farms for quality DOTS in prison.	Nationwide PMDT to be served by 42 treatment centers, 8 DST centers and engagement of private laboratories in diagnosis of MDR-TB to make up 44 culture centers .	Increase in the service delivery areas to 60 sites from the original of 30 sites to improve TB care in children, universal access to PMDT in 80% of incident MDR-TB cases	Additional 15 service delivery points for childhood TB to improve TB care in children

B: Identify below (in summary only) the amount requested in this proposal for HSS Strategic Actions. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget.)*

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
4,034,909	5,101,388	6,180,402	6,312,959	7,002,691	7,812,809

C: Describe below other current and planned/anticipated support for this action over the proposal term.

*In the left hand column below, please identify the name of **other sources** of HSS strategic action support (including from existing Global Fund and other donor grants/loans etc). In the other columns, please provide information on the type of outputs/outcomes.*

Name of supporting stakeholder ⬇	**Timeframe of support for HSS action**	**Level of financial support provided over proposal term** *(same currency as section 1.1)*	**Expected outputs/outcomes from existing and planned support**
Government	2009 to 2014	60,226,195	2,600 health facilities supported
Other Global Fund Grants with HSS elements	2006-2011	15,798,338	2600 DOTS facilities (100 PPMD units included); 120 task force groups; 6 treatment centers; 3 culture centers; 1 DST
Other: *(identify)* Private sector	2009-2014	48,645,714	72 private institutions participating in TB control

			through PPM activities,

Action 2	**Human Resource Development**: Training of implementers of the new strategies such as TB in children and TB in prisons and in the rural poor will have to be done to develop capacity. In addition, to enhance the absorptive capacity for the scale up of PMDT, training of laboratory staff and clinical staff is required in diagnosis and treatment of MDR-TB in all regions of the country to provide universal access

A: Describe below, through 'key words' *(refer to the Guidelines for Proposals at page 16)*, the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term.

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
1,190 health workers at all levels trained on DOTS and other initiatives 458 trained on community TB care 2,800 private sector personnel trained 510 service deliverers trained on PMDT	1,676 health workers at all levels trained on DOTS and other initiatives 1,550 trained on community TB care 2,800 private sector personnel trained 596 service deliverers trained on PMDT	1,740 health workers at all levels trained on DOTS and other initiatives 2,663 trained on community TB care 2,600 private sector personnel trained 820 service deliverers trained on PMDT	1,312 health workers at all levels trained on DOTS and other initiatives 458 trained on community TB care 2,600 private sector personnel trained 392 service deliverers trained on PMDT	1,864 health workers at all levels trained on DOTS and other initiatives 458 trained on community TB care 400 private sector personnel trained 1,144 service deliverers trained on PMDT	1,950 health workers at all levels trained on DOTS and other initiatives 458 trained on community TB care 1,230 service deliverers trained on PMDT

B: Identify below (in summary only) the amount requested in this proposal for HSS Strategic Actions. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget.)*

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
2,576,006	3,662,737	3,219,722	2,868,346	2,597,043	2,711,058

C: Describe below other current and planned/anticipated support for this action over the proposal term.

*In the left hand column below, please identify the name of **other sources** of HSS strategic action support (including from existing Global Fund and other donor grants/loans etc). In the other columns, please provide information on the type of outputs/outcomes.*

Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term *(same currency as section 1.1)*	Expected outputs/outcomes from existing and planned support
Government	2009-2014	9,768,717	10,600 health workers
Other Global Fund Grants with HSS elements	2006-2011	6,702,707	4140 service deliverers
Other: *(identify)*			

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Action 3	**Community and Patient empowerment**: Strengthening of partnership with existing non-health public sector agencies providing TB services, NGOs, FBOs, TB patients who can provide services in the implementation of DOTS and PMDT.

A: Describe below, through 'key words' *(refer to the Guidelines for Proposals at page 16)*, the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term.

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
70 Task Forces provided with income generating projects 270 community-based organizations with plans and regular monitoring systems	4 NGOs, FBOs including TB patients engaged 81 Task Forces provided with income generating projects 4 community-based organizations with plans and regular monitoring systems	10 NGOs, FBOs including TB patients engaged 95 Task Forces provided with income generating projects 10 community-based organizations with plans and regular monitoring systems	108 Task Forces provided with income generating projects	122 Task Forces provided with income generating projects	135 Task Forces provided with income generating projects

B: Identify below (in summary only) the amount requested in this proposal for HSS Strategic Actions. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget.)*

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
163,731	679,741	1,099,109	1,511,105	1,537,839	1,541,163

C: Describe below other current and planned/anticipated support for this action over the proposal term.

*In the left hand column below, please identify the name of **other sources** of HSS strategic action support (including from existing Global Fund and other donor grants/loans etc). In the other columns, please provide information on the type of outputs/outcomes.*

Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term *(same currency as section 1.1)*	Expected outputs/outcomes from existing and planned support
Government	2009-2014	414,125	12 infomercials, commemoration of World TB Day and National TB Day per year

Other Global Fund Grants with HSS elements	2008-2011	4,573,667	90,766 symptomatics referred; 9,076 NSP cases referred
Other: *(identify)*			

Action 4	**Procurement and Supply Management**: The procurement process shall be the undertaking of the PR with assistance from the Department of Health and/or the World Health Organization or UNICEF as the case maybe. The Department of Health as the primary implementing sub-recipient will develop the system for storage, distribution and inventory using the pull and push combined approach to prevent any stock outs in the areas of distribution. Drugs supply management will be monitored in addition to the usual monitoring of the TB service implementation

A: Describe below, through 'key words' *(refer to the Guidelines for Proposals at page 16)*, the planned outputs/outcomes that will be achieved in regard to these HSS Strategic Actions during the proposal term.

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
2,600 health facilities reporting no stock outs of first line anti TB drugs and laboratory supplies for DSSM 10 health facilities reporting no stock outs of second line anti TB drugs. Laboratory	15 health facilities reporting no stock outs of second line anti TB drug and laboratory supplies for TB cultures and DST	10 health facilities reporting no stock outs of second line anti TB drugs and laboratory supplies for TB cultures and DST	7 health facilities reporting no stock outs of second line anti TB drugs and laboratory supplies for TB cultures and DST	Prompt diagnosis of all TB patients and Uninterrupted supply of quality assured drugs for all TB patients	Prompt diagnosis of all TB patients and Uninterrupted supply of quality assured drugs for all TB patients

B: Identify below (in summary only) the amount requested in this proposal for HSS Strategic Actions. *(Specific financial information on the funds requested must be included in section 5 in the detailed budget.)*

Year 1	Year 2	Year 3	Year 4	Year 5	Year 6
3,944,086	6,853,312	10,509,899	10,297,419	9,676,757	5,392,911

C: Describe below other current and planned/anticipated support for this action over the proposal term.

*In the left hand column below, please identify the name of **other sources** of HSS strategic action support (including from existing Global Fund and other donor grants/loans etc). In the other columns, please provide information on the type of outputs/outcomes.*

Name of supporting stakeholder ↓	Timeframe of support for HSS action	Level of financial support provided over proposal term *(same currency as section 1.1)*	Expected outputs/outcomes from existing and planned support
Government	2009-2014	481,540	19 distribution points and warehouses supported
Other Global Fund Grants with HSS elements	2006-2011	659,938	support for distribution and warehousing
Other: *(identify)* World Lung	2007-2009	28,890	Operations research on Logistics inventory of TB Drugs through Radio Frequency

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Foundation			Identification (RFID)
Other: (identify) German Technical Cooperation Agency (GTZ)	2007-2009	20,800	Development of inventory module within a financial system (ACCPAC)

4.4.3 Risks and capacity issues arising from HSS Strategic Action support

➔ Applicants are strongly encouraged to refer to the Guidelines for Proposals at section 4.4.3 for further information before completing this section. Specifically, Applicants should refer to the explanation of 'risks or implications' for sub-question (a) below at page 17 of the Guidelines for Proposals.

(a) Describe your consideration of any risks or implications arising from the provision of the requested additional support for the HSS Strategic Actions included in this proposal.

The recruitment of additional staff to undertake the scale up and new interventions proposed faces the challenge of the health care attrition in the country due to the diaspora of health professionals including physicians who train and study to become nurses to be able to migrate to the US to gain employment and earn more than in the Philippines. To mitigate against this, the engagement of non-professionals to participate in the implementation of the strategies should be allowed through policy changes within the public health sector that will waive the application of the medical act, the medical technology act, and similar laws that restrict the case management of diseases to duly licensed physicians, the administration of medications only to nurses, and the performance of diagnostic tests only to registered medical technologists. The public good should prevail over the legal restrictions, especially if there are no physicians, nurses, or medical technologists willing to serve in remote and poor communities.

The retention of the staff trained and engaged is another risk and may be mitigated by community-strengthening interventions where the community that is benefited by their interventions may eventually be able to provide some form of user fee either through health financing through the Philippine Health Insurance Company (PhilHealth) outpatient packages.

The establishment of a laboratory network to provide comprehensive diagnostic services for TB including Culture and Drug Susceptibility Testing confined only within the public sector may limit access. To mitigate this potential risk, an assessment of existing laboratories with culture and DST capabilities within the private sector will be initially made and considerations of engaging these laboratories through a public private laboratory partnership arrangement similar to the PPMD concept of the engagement of private practicing physicians could be negotiated. Another risk is the for profit principle upon which these private laboratories are being managed. To mitigate against this potential risk, a PhilHealth package for diagnostic services provided by these laboratories could be arranged. The current set-up of the National TB Reference Laboratory is under the administrative control of a DOH research institution and not directly under the NTP.

Limited global supply of anti-TB second line drugs and other health commodities essential for TB control. This is a constraint for scale up of PMDT. A global initiative to be lead by the UN agencies like the WHO and the relevant divisions within it specially also the STOP TB Partnership and the Global Drug Facility should be proactive in advocating for expedited prequalification of drug manufacturers and for quality assurance. A pooled procurement system that could be initiated by the GF could leverage the price of these essential drugs and health commodities.

Currency exchange fluctuation will throw off procurement forecasting and the cost calculation of all the thirteen budget categories required by GF. A procedure and policy statement from on mitigation of this risk from the GF secretariat or Board should be developed as guideline for implementers.

(b) **Applicant Capacity for Health Systems Strengthening Issue identification**

Describe below how the Applicant is ensuring that they have, or are developing and/or strengthening, their capacity in regard to their level of understanding of health systems needs and linkages (including identification of strengths, weaknesses, treats and opportunities) to disease specific prevention and control plans and interventions. Applicants should describe if there have been any changes in their relative capacity over the term of the expiring grant.

Strengths:

- Enhanced policy environment spearheaded by the Executive Branch with the passage of the Comprehensive Unified Policy (CUP) making DOTS the framework for TB control for public and private sector partners has enhanced the introduction and implementation of DOTS strategy. The strategic plan to STOP TB in the Philppines 1 and 2 have provided the blueprint for the National TB program. Policies in the implementation of this blueprint have been duly developed.
- Governance: Although the health program is devolved, there is still efficient implementation by the local government units owing to the strong leadership of the NTP in being able to organize a central level of technical assistance, supervision and monitoring the local government health agencies, thus enhancing the performance of the LGU health facilities. In addition, with technical assistance from WHO and the collaboration with other partners, both public and private, organic structures such as the National Coordinating Committee, the Regional Coordinating Committees have been established, supervising the implementing PPMD units within. In addition, the development of policies and implementing guidelines on Private Public Mix DOTS, TB in children, and the

Programmatic Management of DR-TB provide standards for implementing units in the public and private sector.

- The current significant increase in financing by the government of the TB control programme provides new opportunity for scaling up the overall financing and meeting the increasing gap, whereas health financing through the PhilHealth outpatient package has provided a means of sustainability of the PPMD within both the private and public sector.
- Human resource for health development: The innovative strategies of the NTP primarily the vibrant partnership between the NTP and private partners in the implementation of various strategies including public private mix DOTS, TB advocacy and social mobilization with community-based TB care, and the implementation of the Programmatic Management of DR-TB has helped the country to attain the global targets and the resulting decline in the incidence of TB in the country. These strategies have actually increased the human resource for health from the private sector in implementing the DOTS strategy.
- Successful track record in the implementation of DOTS nationwide with the attainment of the global targets of case detection rate and treatment success rates in 2004, the second of four high burden countries to attain those global targets.

Weaknesses:

- The required laboratory network to support new strategies such as the Programmatic Management of DR-TB requires a lot of capacity building to attain the standards required for the implementation of these new strategies. New laboratory technology for rapid culture and DST is not in place.
- Procurement of drugs from the Global Drug Facility (GDF) both for the first line drugs and second line drugs (SLDs) is attended by a lot of delays due to inadequate global supply particularly of the SLDs. Distribution to the peripheral implementing units need to be enhanced to prevent stockouts.
- Monitoring and evaluation: a national Monitoring and Evaluation plan is still to be rolled out utilizing the electronic TB registry which has been developed locally. Integrating this to the Field Health Information Surveillance System (FHSIS) and to ME3 national M+E plan to avoid duplication needs to be pursued with requisite mandate clearly delineating the section/unit responsible for this.

Threats:

- The accelerated scale up of new interventions to attain the Millennium Development Goals require close monitoring to prevent further worsening of the problems of drug resistant tuberculosis which may threaten the gains of the NTP.
- Lack of resource allocation by the respective government agencies to enforce infection control measures in congregate settings such as the prison system will enhance TB transmission including MDR-TB.
- Barriers to access such as poverty, stigma, and geographical issues may leave pockets of high TB transmission within the country.

Opportunities:

- The increase in budgetary allocation for TB control within the Department of Health will provide sustainability of resources to support NTP.
- Continuing investments made by other donors such as the USAID in complimentary areas of Policy Development, and technical assistance in health systems strengthening through human resource for health development, Behaviour change communications that are currently being undertaken by the TB Linc initiative will complement the activities of the GF projects and the NTP.
- Demonstration project of the Foundation for Innovative and New Diagnostics (FIND) at the TDF TB laboratory, introducing rapid methods of culture, identification of isolate through Capillia, and the future planned HAIN test for MDR-TB detection can facilitate the introduction of new diagnostics.
- The recommendation for the TDF to be developed as a center of excellence for MDR-TB with the support of the WPRO and the USAID as well as the development of training modules on MDR-TB management supported by WHO HQ and Lilly Foundation will facilitate human resource for health development for MDR-TB in the country.
- PhilHealth outpatient TB package planned expansion to include MDR-TB or previously treated TB patients will provide health financing to provide more sustainability to the NTP
- Policy and guidelines on MDR-TB, TB in children, TB and HIV developed by the NTP with technical assistance of the WHO, IUATLD and in collaboration with partners will provide the basis for the implementation of these programs within the NTP
- The continued collaboration with the PhilCAT and related local coalitions in provinces and regions to engage more constituents to TB control consistent with the new STOP TB Strategy of engagement of all care givers
- The continued collaboration with the WVDF and other NGOs and FBOs in advocacy, communication, social

mobilization consistent with the New STOP TB Strategy of community-based TB care will enhance the NTP

- The empowerment of TB patients through patient organization for advocacy and participation in DOTS as treatment partners, peer educators, and default tracers are consistent with the Patient Empowerment in the New STOP TB Strategy.

4.4.4	Health Systems Strengthening cross-cutting issues	
(a)	Did you also submit a proposal in response to the Round 7 call for proposals?	☐ Yes ➔ *complete this section* ☒ No ➔ *go to section 4.5*
(b)	**If yes to (a)**, are there any cross-cutting HSS Strategic Actions integrated in this proposal that will benefit any component included in the Round 7 proposal?	
(c)	**If yes to (b)**, provide below a short description of the relevant component(s) in the Round 7 proposal and how the HSS Strategic Actions in this proposal will benefit achievement of the outputs and outcomes targeted in the Round 7 proposal.	
(d)	If relevant, provide a detailed justification (*with clear information on direct linkages to this proposal)* for those cross-cutting HSS Strategic Actions in this proposal which you believe should still be funded even if some or all of the Round 7 proposal is not recommended for funding. *(**Two page maximum**, including summary details of relevant actions and budget amounts. Also ensure that the budget amounts for HSS Strategic Actions are clearly indicated in the detailed budget required in section 5 for this component.) Refer to the Guidelines for Proposals, section 4.4.4 for additional guidance.*	

4.5 Overall Country Financial Needs Summary

4.5.1 Overall Disease Specific Financial Needs Assessment

Based on an analysis of the national goals and objectives for preventing and controlling the disease, **describe below** the overall disease specific financial needs. Include information about how this costing has been developed (e.g., through costed national strategies, Medium Term Expenditure Framework [MTEF] or other basis).

As described in step 3 under section 4.4, such analysis should recognize any required investment in essential disease specific HSS Strategic Actions.

The National Strategic Plan to Stop TB in the Philippines 2006-2010 enumerates the goals and objectives of the NTP as follows:

GOAL: To reduce the prevalence and mortality by half by 2010 contributing to the achievement of the overall MDG*

OBJECTIVES:

1) To optimize and sustain the quality of DOTS implementation
2) To improve the detection of TB cases
3) To adapt DOTS to respond to high-risks populations including MDR-TB and TB-HIV

TARGETS:

1) Success Rate of 85% or more
2) Case Detection Rate of 70% or more
3) DOTS-Plus support to at least 10% Failure Cases

The NTP case detection rate and treatment success serve as the bases for estimating the financial needs of the NTP. Although the TB program is devolved, the national government of the Philippines (GOP) has been the main source of domestic funds to support the program in terms of drugs and laboratory supplies, in addition to the human resources in the Central and Regional levels of the DOH as well as provincial DOH representatives involved as NTP.coordinators. Government support provides for more than half of the financial requirements that showed an increase in 2008 to almost seven times the previous budgetary allocation.

Under the health sector expenditure framework of the DOH, the NTP shows the current funding sources supporting the Program with the Global Fund accounting for the majority of the external supports. Other sources (USAID, WHO, EC, JICA) contribute about 3-4% of the health expenditure for NTP. Global Fund support from Round 2 and Round 5 projects account for nearly 38% (mainly from Round 5) and a gap of 16% in 2006 which has been increasing due to the revised Global Plan 2 to meet the millennium development goals by 2015 and the Global Response Plan 2007-2008 to the MDR-TB crisis that was ignited by the XDR-TB epidemic outbreak in South Africa..

The Philippines is the 9th of the 22 high burden countries for TB and although global targets have been met in 2004 and a decline in incidence has been demonstrated, the burden remains substantial with pockets of hot spots with vulnerable populations with barriers to access due to socio-economic, geographical, and biological factors. Hence, these vulnerable populations will be the focus for DOTS expansion in children with TB, TB in prisons, and TB in urban and rural poor.

In addition, the recent DRS done 2004, also indicate a substantial burden of MDR-TB with 4.0% MDR in new cases and 21% MDR-TB in previously treated cases. These equates to an estimated incidence of 5036 in 2006, making the Philippines No. 13 of 25 priority countries responsible for 85% of MDR-TB burden globally. Accordingly, to meet the global response plan and the revised GP2, 16% and 28% of MDR-TB in 2007 and 2008, respectively, should be treated. In absolute numbers, these represent 1473 and 2640, respectively. Our plan previously was to treat only 396 and 640 MDR-TB cases in these respective years. Therefore, to break transmission of MDR-TB, an accelerated scale up is urgently required. This will include a systematic health systems strengthening including human resource for health development and laboratory strengthening to support the TB services to include culture and drugs sensitivity tests (DST), procurement and supply management, strengthening of monitoring, supervision, evaluation, information systems and operational research, and a strengthening of community systems to support a community-based TB care which will enhance DOTS implementation to cover vulnerable populations and the scale up the programmatic MDR-TB management. While this accelerated scale up for PMDT is being undertaken, quality DOTS needs to be sustained and enhanced to prevent the emergence of MDR-TB. To meet these demands for a significant health systems strengthening, the budget to support the scale up is shown in the figure on 4.5.2.b

Even with the increased budgetary allocation from the GOP in 2008, the resources required for the scale up with the end of Round 5 TB project there still exists a significant financial gap even as the GOP assumes the previously covered support from other previous donors as well as part of the expanded budget (as shown in the dark blue bars above) . The estimated budget for the scale up is 150,473,559 Euro, of which 35,582,467 Euro (24%) will be assumed by the GOP. This will leave a significant financial gap of 114, 891,092 Euros, which we are applying for in the Rolling Continuation Channel. The financial requirement will increase with time as the health systems strengthening has to be built initially in the first phase of RCC to enhance the absorptive capacity to provide the required services to attain Universal access to TB care for all patients with TB.

4.5.2 Current and planned sources of funding

(a) Domestic Sources

Describe current and planned financial contributions, from all relevant domestic sources (including loans and debt relief) relating to the disease targeted in this proposal. Please also explain the process of prioritization of such funding to ensure that resources are utilized efficiently and on a timely basis (e.g., explain if there are significant available in-country resources, such as HIPC [Heavily Indebted Poor Country] debt relief or other such resources which are available to support disease prevention and control strategies, and how these resources are being efficiently used).

The main domestic source of the country's NTP is from the Government. As mentioned, all the drug and laboratory requirements of the NTP since the start of DOTS implementation in 1996, has been sourced-out from Government funds. Majority of these are specifically from the national Government, DOH, and local government units provide augmentation through additional drugs, primarily, single dose formulations. The funds for NTP from the DOH has been stable for a long time (139 Million pesos) while those from the local units vary accordingly.

1) Government Investments

With the creation of then TB Control Service of the Department of Health (E.O.# 102), the Government has translated its political commitment on TB control into provision of human resources working for TB and logistical support (drugs and laboratory supplies for adult cases). Though the country's health system went into a major reform under the devolution in 1993, the DOH, has maintained the drug and laboratory supports of the NTP. Presently, under the devolved set-up, the primary source of these items is still the national government with augmentation from the various local government units. Also, key human resources, (NTP Coordinators) are present at all levels of health care delivery. The NTP laboratory facilities are also equipped with laboratory experts/Staff but to a minimal number.
With the initiation of the PPMD strategy, the NTP also provides the drug needs of all these installed PPMD units. Much of the NTP's budget goes into drugs to support all these DOTS facilities, including the PPMD units.

The Government has also started investing on the problem of MDR-TB. In the country, MDR-TB was firstly addressed by a private organization (a privately-initiated PPM DOTS unit) and gradually mainstreamed into the public's NTP through the Lung Center of the Philippines (LCP), a government-owned, hospital-based DOTS facility. Though second-line drugs and other logistics come from external resources (GFATM), the DOTS services such as first line drugs, basic microscopy needs and management operations of the LCP are government supported. At present, there is gradual scale-up of MDR-TB management in strategic areas or regions, through a Programmatic approach. Thus, what started out as the DOTS Plus Project is now termed as Programmatic Management of DR-TB (PMDT) of the NTP and policies have been developed in the context of a program implementation.

All of these investments are in support of sustaining quality DOTS implementation for both the public and the private sectors. PPMD units are assured of first-line drugs to enable them to continue with their operations and deliver better services. Drugs play a vital component on the DOTS strategy and the NTP ensures that provision of these goods from the Government is sustained.

2) Private sector investments

Through the strategy of private public mix DOTS, 41 private institutions including hospitals and clinics will invest a

total of € 8,107,619 will be invested yearly for a total of € 48,645,714 will be invested in the total of 6 years of the RCC. This investment will include facilities, staff, laboratory equipment that are required to support the activities of the PPMD including case detectiion, case management, case holding, etc required for DOTS and PMDT.

Also summarize such financial amounts for past and future years in table 4.5 and provide an overall total in Line B.

(b) **External Sources**

Describe current and planned financial contributions anticipated from all relevant external sources relating to the disease targeted in this proposal (including, based on section 1.6, existing grants from the Global Fund and any other external donor funding).

Global Fund Round 2 (Expiring Grant) and Round 5.

The greatest bulk of foreign funded support to the NTP is through the Global Fund, comprising two projects. The country's Global Fund Round 2 (2003-2008) covers the improvement of quality DOTS implementation in the public sector through improvement of service provision and creation of public demand. This grant also supports the PPMD strategy where private sector engagement resulted in the installation of 70 PPMD units. This grant also provides support for the conduct of the 2007 3rd National Prevalence Survey which is ongoing . Part of the grant supported the GLC-approved DOTS Plus Project in the management of only 500 MDR-TB patients cumulatively until the end of Project in 2008. In 2006, the GF Round 5 project supported the scaling-up of NTP's interventions in Round 2 plus a component on TB HIV based on the collaborative strategy proposed for the region. The grant supports the enhancement of quality DOTS implementation through capacity building and technical assistance utilizing the revised Manual of Procedures 4th Edition, expansion of the External Quality Assurance (EQA) on microscopy, laboratory management and DOTS certification and accreditation. An expansion of the area of implementation of the advocacy, communication, social mobilization and community organization to further Increase the demand for DOTS services complements these interventions. DOTS Task Forces, who serve as treatment partners in the community. Private practicing physician engagement through PPMD strategy will further be scaled-up with the installation of an additional 100 PPMD units. The grant also supports the strengthening of PPMD units installed from previous/other initiatives, through technical assistance. The DOTS-Plus Project is scaled-up under this round to become the Programmatic Management of MDRTB (PMDT) and will contribute to the treatment of additional 2,500 MDRTB cases by end of Project in 2011. Additional interventions covered by Round 5 include TB-HIV collaboration and the development of the Electronic TB Registry (ETR) for data management as the format for the national M and E system.

Other Donor Support:

- A USAID-assisted Project for TB control, Linking Initiatives and Networking to Control TB (TB LINC), includes: a) improvements in policy, financing and regulatory environment 2) enhancement of human capacities and systems for quality DOTS implementation and 3) influencing behavior/attitudes to improve utilization of DOTS facilities and services. The Project operates in 21 sites across the country, with majority at Mindanao areas, including ARMM.
- The European Commission (EC) is also providing assistance to Local Government Units to improve their implementation of public health programs and this includes the NTP. EC grants have provision for equipment/capital outlay, such as microscope, which is integrated in their respective Provincial Investment Plan for Health (PIPH). The Project covers the 16 F1 sites identified by the DOH.
- Until August 2007, the Government of Japan has provided technical support and grants in aid for TB control. Foremost of this is the construction and establishment of the National TB Reference Laboratory and the technical assistance provided for the establishment of the External Quality Assurance nationwide, the conduct of Drug Resistance Survey (DRS) and for quality DOTS implementation in Manila city and Quezon City. In addition, they also provided vehicles and microscope to support the NTP.
- WHO provides technical assistance through a full-time TB Medical Officer in the Philippines for improvement of Quality DOTS implementation, Public-Private Mix approaches, MDR-TB Management, TB/HIV collaboration, guidance in policy development, monitoring and evaluation, and in the conduct of the Drug Resistance Survey, the Nationwide TB Prevalence Survey and other operational research, and for equipment support through the provision of microscopes.

To meet the demands for a significant HSS the budget to support the scale is shown in the figure below:

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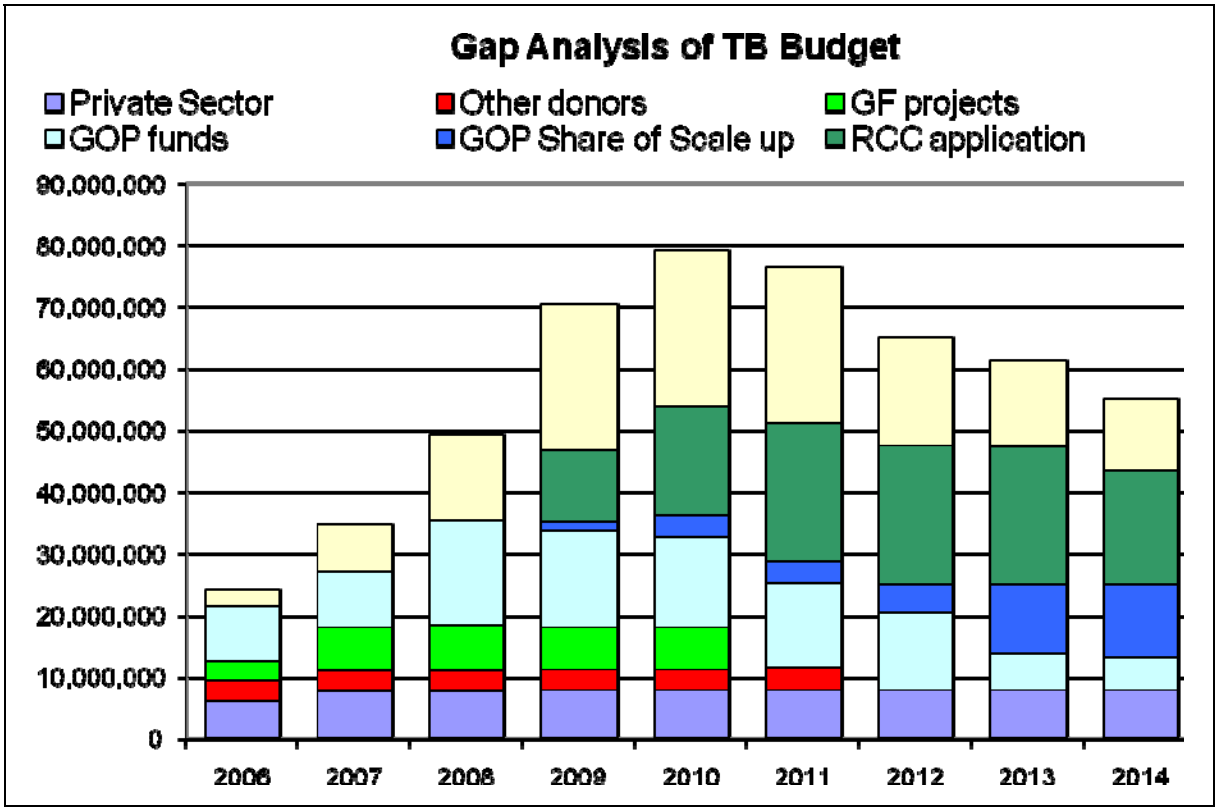

4.5.3 Overview of Financial Gap

In table 4.5, Line E, provide a calculation of the gap between the estimated overall need (Line A, table 4.5) and **current and planned available resources for this component** (Line D, table 4.5).

*This table is a summary **only** of overall funding gap. Applicants must provide a detailed budget (see section 5) to identify the amount requested in this proposal.* ***Note*** ➔ Depending on absorptive capacity (whether actual or increased capacity to be developed through this proposal or other support), an Applicant's proposal may plan to respond to the whole of the needs identified in the "key services", or only part of the needs/gaps identified. Questions in section 4.8 focus more fully on absorptive capacity.

4.5.4 Additionality

Describe how Global Fund resources received will be additional to existing and planned/anticipated resources, and will not substitute for such sources. Explain plans to ensure that this additionality will continue for the proposal term.

The current financial resources of the NTP are mainly from Government support through the DOH and with augmentation from the various local government units. In addition, the private sector has also invested an average of € 8,107,619 annually. For 2008, there is a Philippine Congressional approval of an increase in the TB control budget of the Department of Health from € 4,517,514 to € 16,121,231 (still under consideration by the bicameral committee). This increase will cover most of the first-line anti-TB drugs (adult and children), microscopy supplies, culture services and provision of PPD solution for diagnosing children. With the scale-up of the NTP's coverage that will now include other high-risks populations such as urban/rural poor communities, prisons and children and the scale-up of PMDT nationwide, this Government budget shall include provision of additional first-line drugs (complete set) and diagnostics for these additional cases including MDR-TB patients, to be detected and treated starting 2008.

As demonstrated by the increasing financial gap and despite the increasing government contribution to the TB control financing there is still a large need for additional external financing that even the other external donors cannot meet. This financial gap can be only be met by large investment through GF matching the major contribution of the Government of the Philippines and to lesser extent of the other donors.

The commitment of other major donors is up to 2011. The commitment of the Government of the Philippines can be further enhanced through the approval of this RCC proposal which can be used as an advocacy tool and leverage towards sustainable government funding. It is evident that financing of TB control by the Government of the Philippines has been steadily and significantly increasing since the initial approval of GF funding in 2003 and 2006.

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Table 4.5 - Financial contributions to national response

Financial gap analysis *(same currency as selected in section 1.1)*									
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned/**		**Estimated/Forecast**				
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Line A ➔ Overall disease specific needs costing including essential disease specific health systems needs	23,907,523	34,800,884	49,122,747	70,220,579	79,008,594	76,326,596	64,909,989	61,312,273	55,136,358
Domestic source **B1**: Loans and debt relief (*provide donor name*)									
Domestic source **B2**: National funding resources (GOP)	8,953,846	8,953,846	17,094,017	17,094,017	18,094,016	17,094,017	17,094,017	17,094,017	17,094,012
Domestic source **B3:** Private Sector contributions (national)				7,745,748	7,745,748	7,745,748	7,890,198	7,890,198	7,890,198
Total of Line B entries ➔ Total current & planned domestic resources	8,953,846	8,953,846	17,094,017	24,839,765	25,839,764	24,839,765	24,984,215	24,984,215	24,984,210
External source **C 1**: All current & planned Global Fund	3,115,385	7,000,000	7,307,692	6,923,077	6,923,077	-	-	-	-
External source **C 2** (*provide donor name*) WHO, EC and USAID	3,346,154	3,346,154	3,346,154	3,346,154	3,346,154	3,760,923	-	-	-
External source **C3** (*provide donor name*)									
External source **C4**: Private Sector grants/ contributions (International)				7,745,748	7,745,748	7,745,748	7,890,198	7,890,198	7,890,198
Total of Line entries C ➔ Total current & planned external resources	6,461,539	10,346,154	10,653,846	18,014,979	18,014,979	11,506,671	7,890,198	7,890,198	7,890,198
Line D ➔ Total current and planned resources ➔ (i.e. Line D = Line B Total +Line C Total)	15,415,385	19,300,000	27,747,863	42,854,744	43,854,743	36,346,436	32,874,413	32,874,413	32,874,408

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Financial gap analysis *(same currency as selected in section 1.1)*									
Refer back to instructions under section 4.4, step 3	**Actual**		**Planned/**		**Estimated/Forecast**				
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Line E ➔ Total Unmet need (Line A – Line D) -	8,492,138	15,500,884	21,374,884	27,365,835	35,153,851	39,980,160	32,035,576	28,437,860	22,261,950
The table above is provided for planning purposes to identify the ceiling of funding needs. The Global Fund recognizes that the proposal term (if approved) may straddle calendar years depending on the start date of the grant agreement that may be signed. The Global Fund also recognizes that in meeting figures in forward years may be indicative and not confirmed but must still be included on the basis of reasonable projections in reliance on existing and past practices. Please mark the indicative amounts with an asterisk (*) in the table above where this applies.									

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4.6 Detailed Proposal Strategy

Work on Attachment A prior to filling out this. This section describes the strategy of the Rolling Continuation Channel proposal based on its continuation of strengths from the expiring grant's goals and objectives and changes (including a possible scale-up and/or change of scope) arising from identified implementation gaps, weaknesses and/or changing contextual factors from the original proposal. The concepts of scale-up and scope change in a Rolling Continuation Channel proposal are further defined at both Part A.2 (pages vi and vii) and sections 4.6.3 to 4.6.5 (pages 22 to 24) of the Guidelines for Proposals. **Applicants are strongly recommended to only proceed to complete section 4.6 below after a full review of this information**.

➔ *Applicants are reminded that Rolling Continuation Channel is specifically offered for strong performing grants, where the Applicant can demonstrate that the proposal has, or has the potential to have, impact in regard to the national disease prevention and control program, and for sustainability. This should be an important focus of your planning and proposal development.*

In support of this section, all Applicants must submit :

1. A **Targets and Indicators Table** ➔ This is included as **Attachment A** to the Proposal Form and comprises the framework upon which **program performance and impact** will be evaluated during the program term according to the Global Fund's performance based funding criteria.

   *When preparing this table, **please ensure that the proposed outcomes are consistent with the key service program needs analysis** in section 4.4 **and consistent with** measurement of impact related to the overall proposal goals, although it is recognized that Attachment A may have more service delivery areas than the number of 'people in need of key services' identified in section 4.4*. All targets should be measurable and identify the current baseline. For definitions of the terms used in this table, see the 'Explanatory Note' provided on the first sheet in 'Attachment A' (Targets and Indicators Table) to the Proposal Form. For further guidance, Applicants should also refer to the latest 'Attachment' to the PR's grant agreement with the Global Fund for the expiring grant.

2. A detailed **Work Plan** ➔ which must meet the following criteria:

   (a) *Structured along the same lines as the proposal strategy - i.e. reflect the same goals, objectives, service delivery areas and activities.*

   (b) *Covers the first three years only of the proposal term and is:*
   - ***i. detailed for year 1, with information broken down by quarters; and***
   - ***ii. indicative for years 2 and 3,** with information at least half yearly.*

   (c) ***Consistent with the Targets and Indicators Table** (Attachment A to the Proposal Form) mentioned above and the planned outputs/outcomes set out in section 4.4.2 (HSS Strategic Actions).*

4.6.1 Planned Service Delivery Areas and Specific Interventions

Referring to your overall needs assessment in section 4.4 above, provide a brief description of the proposal's objectives, service delivery areas and planned interventions/activities you have identified in the 'Targets and Indicators Table' (Attachment A to your proposal), and how these will contribute to overall impact in regard to the disease. Also include areas of synergy between the three diseases if any are included in this proposal's strategy.

*The information below should be **no longer than two pages**, and Applicants should provide **detailed quantitative information in Attachment A** ('Targets and Indicators Table') **to this Proposal Form**. Where actions to strengthen health systems are planned, Applicants are required to provide descriptive information at section 4.4.2.*

Objective 1: To achieve universal access to high quality care of people with TB through: 1) sustaining and expanding the provision of quality DOTS in the public sector, including the strengthening of TB laboratory network; 1b) engaging all care providers to provide access to marginalized and special population groups; 1c) empowerment of patients and communities through, advocacy, communication, social and resource mobilization, and community TB care at the local level.
This RCC proposal addresses the issue of limited engagement of all health care providers by using an approach where all these care providers, institutions and individual providers, both public and private will be engaged, their role in TB control identified and their potential contribution optimized. To provide technical support, oversee engagement of all care providers and ensure sustainability of the partnership, a coordinating structure will also be created at the level of the province. The existing capacity of these care providers to

participate in DOTS and address needs of the vulnerable and high-risk groups will be harnessed and optimized. Likewise engagement will be sustained through continuous advocacy and provision of IEC materials in support of health provider engagement.The RCC will include support for the scaling up of the PMDT into other regions of the Philippines through an integration into the NTP of an initiative from the private sector.

Service Delivery Area: Timely detection and quality treatment of cases through quality DOTS
The provision of quality DOTS for all sputum smear positive cases will be expanded and enhanced.

- The Identification of infectious cases among the general population, vulnerable groups including prison inmates, urban and rural poor and children
- Laboratory strengthening starting with the National TB Reference Laboratory as the apex of the laboratory network that will develop the capacity for culture and DST to support comprehensive TB Care and specifically the programmatic management of MDR-TB.
- Training and retraining, and retention of staff of the DOTS centers will be essential for sustaining the gains on DOTS attained
- Monitoring and evaluation will be augmented with operations research to determine the efficacy and efficiency of program implementation.

Service Delivery Area: Laboratory:
The EQA provided nationwide for sputum smear microscopy will be sustained. However, to support comprehensive TB care and the scale up of PMDT, laboratory strengthening should be pursued with the development of a laboratory network to provide on top of microscopy, quality assured TB culture and Drugs Susceptibility Testing to be lead by the National TB Reference Laboratory (NTRL). The following activities will be carried out to enhance laboratory capacity:

- Capacity building of the NTRL in EQA of cultures and DST to provide technical assistance to all 17 regional laboratories to develop the laboratory network to support comprehensive TB care and PMDT scale up
- Training of laboratory personnel of regional culture laboratories on culture and the 3-4 DST centers to be provided by the NTRL with the attainment of a quality assured culture service and with proficiency test for DST in the respective DST centers and sustaining EQA for sputum smear microscopy..
- Assessment of existing laboratory facilities in the private sector to determine feasibility of engagement of these private laboratories in a manner akin to Private Public Mix strategy for DOTS implementation after appropriate quality assurance by the national TB Laboratory network.

Service Delivery Area: PPM (Public Private Mix)
The activities under this SDA will focus on the engagement of non-NTP public and private health care providers who can potentially contribute to TB control by undertaking one or more of the several essential tasks of referring, diagnosing, managing and notifying TB cases. Engagement will be at the level of the province, involving care providers in all municipalities with less than a 100,000 including small cities, which were not covered by Round 2 or Round 5. The following activities will be carried out to ensure all TB patients have access to high quality diagnosis and treatment and to ensure sustainability of the private- public partnership:

- Planning workshop for the Provincial Coordinating Committee (PCC) on Public-Private Mix (PPM) to build their capacity to initiate engagement of non-NTP health care providers (institution and individual providers) , from both the public and the private sector;
- Mapping of all public and private health care providers at the level of the province to a) determine whether they are presently linked with the NTP and their present role; b) assess what potential contribution the providers can make and c) to identify input required to optimize their contribution;
- Development of operational guidelines and advocacy packages for the engagement of all health care providers at the level of the province;
- Creation of the PCC tasked to plan, implement, and monitor PPM activities at the province;
- Conduct of a workshop to build capacity of the PCC to effectively take on the task of advocating for the engagement of all health care providers in TB control and to participate in the training of these providers on DOTS;
- Advocacy to all care providers and other stakeholders about TB, DOTS and PPM to generate commitment to TB control in the 44 provinces;
- Training of 2,200 private physicians in Year 1 and another 2,200 in Year 2 in the 44 provinces on DOTS;
- Development of IEC materials to promote DOTS as an acceptable strategy among non-NTP health care providers;
- Conduct of advocacy activities such as World TB Day Commemoration to create awareness and sustain the partnership in the 44 provinces
- Conduct operations research to enhanced PPM strategies and optimize its contribution in sustaining increase case detection and high success rates;
- Training FBOs and NGOs providing health services for indigenous peoples in hard to reach areas and those providing health services for the urban poor communities

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Service Delivery Area: Community TB care:
Community TB care is a strategy towards sustainable, equitable and accessible TB services. This requires that all communities at all levels are empowered to remove the threat of TB to human health by applying Advocacy, Communications and Social Mobilization (ACSM) strategies .
A country-level strategic plan of engagement with decision-makers, care providers and those most affected by TB should foster optimal participation in the development a policy enabling environment and implementation of key behavioral and social strategies that will contribute to sustainable increases in TB case detection and cure rates. The lack of attention of the social and economic benefits of a healthy citizenry towards economic productivity by governing units at various levels hinders the provision of affordable, acceptable, quality and accessible TB services to the citizenry. In addition, the lack of accurate and appropriate information about the disease that would encourage TB symptomatics to take appropriate action on their health condition could be addressed through a broadened behavioral change communications strategy.
The RCC will support:

- A national Advocacy, Communication, and Social Mobilization (ACSM) plan and strategy to mobilize political support at the national, local, and community levels to increase resources ensuring quality TB diagnosis and management through
    - mass media and development of various Information, Education, Communication (IEC) materials
    - Behavioral Change Communication (BCC) materials to increase awareness on TB and MDR-TB prompting them to take appropriate actions.
- Social Mobilization strategies engaging inter-sectoral organizations to participate in TB prevention and control by assisting in raising awareness, delivery of DOTS services, MDR-TB management, and strengthening community participation in TB prevention and control.
- Advocacy Activities through
    - A National ACSM strategic planning workshop and regional ACSM Consultation, orientation, and planning Workshops,
    - Launching of the National ACSM Strategic Plan and role out to provinces and cities
    - Orientation of governors, city and municipal mayors on TB policies and issues and their relationship to socioeconomic development in their areas of responsibilities
    - Orientation of journalists on TB related policies and issues.
    - Monitoring of ACSM funding support from the Local Government Executives
- Community-TB Care (CTBC) through
    - Referral of TB symptomatics by communiy-based workers including empowered TB patients
    - Detection of TB patients
    - DOTS implementation for TB patients as treatment partners and default tracers
    - Support group to TB patients to minimize default

Objective 2: To scale-up the Programmatic Management of DR-TB beyond Metro Manila and provide nationwide coverage and universal access.

Service Delivery Area: MDR-TB
The scale up in the cases will be in accordance with the Global Response plan and Global Plan 2 to Stop TB, to attain by all MDR-TB of universal access to quality PMDT by on or about 2015 With quality DOTS implementation and the Programmatic Management of DR-TB (PMDT), the generation of new MDR-TB cases and the transmission will both be diminished.
The RCC will support.

- delivery points:
    - Establishment of 35 MDR-TB Treatment Centers in a phased scale up of PMDT (10 centers in year 1, 15 centers in year 2, and 10 centers in year 3) which will eventually cover 14 regions of the Philippines
    - Treatment Sites and communities for the decentralization of patients
- People reached
    - A phased-increase in the number of MDR-TB suspects screened and diagnosed as MDR-TB.
    - A phased increase up to >9,000 MDR-TB patients treated according to international standards to attain universal access for Programmatic Management of DR-TB around 2015
    - A total of 4,602 health care providers trained in PMDT

Service Delivery Area: Human Resources
The human resource for development required for the scale up is essential in the 22 high burden countries and 25 priority countries for MDR-TB, of which the Philippines is one, to reach the MDG goals by 2015, specifically in response to the Global Plan to Stop TB 2 and the global response plan 2007-2008 in view of the MDR-TB crisis ignited by the XDR-TB emergence and epidemic outbreak among co-infected HIV patients in KwaZuluNatal, South Africa.
The RCC will support:

- Hiring of additional personnel to support the initiatives under the RCC
- Capacity building within the NTP to provide Technical assistance, training and retooling to retain health

personnel, monitoring, supervision and evaluation of the program
- Logistic support for the PMDT center of excellence to provide the appropriate training required for the scale up of PMDT within the country including human resource development
- Human resource development for providing DOTS services to Patients with TB in prison
- Convergence of strategies implemented in Round 2 including"
    - capacity building of PPMD units to provide TB services to patients with MDR-TB and children with TB
    - training of referring physicians and PPMD providers on the diagnosis and treatment of MDR-TB and TB in children to enable them to provide quality-assured TB services to these target groups
    - Training of community task force members, NGOs and FBOs to engage in PMDT services including referral, providing peer support system, patient treatment partner, and default tracing.
    - Patient empowerment to provide advocacy, DOTS services including for PMDT in their own communities.

Analysis of planned interventions – Scope and Scale Considerations

4.6.2 Incorporation of lessons learned into this proposal

Describe below:

(a) the **strengths** of the expiring grant that have facilitated successful implementation and strong grant performance to date (e.g. PR management, implementation capacities of partners, procurement and supply management strategies). Summarize how the strategy of this proposal continues and builds upon these key strengths;

(b) how this proposal **addresses and resolves weaknesses or bottlenecks** encountered during implementation of the expiring grant (e.g. in regard to PR management and Coordinating Mechanism oversight, implementation capabilities of partners, etc.**). **Where there have been issues in implementation capacity, ensure that in this section** (or in the response to section 4.8) **the Coordinating Mechanism describes how capacity issues have been addressed in this proposal to ensure strong performance** (including through, where relevant, the selection of new/additional PR(s) from appropriate sectors – whether public sector, civil society, for profit sector, or otherwise)**; and**

(c) if relevant, how other lessons learned (outside of the expiring grant) have been incorporated into this proposal.

*(**Applicants may find it useful to refer to, for example, feedback from the Global Fund at the time of receiving notice of their qualification for the Rolling Continuation Channel, the most recent 'Progress Updates and Disbursement Requests' from a Principal Recipient, or the 'Grant Scorecard' published by the Global Fund after a grant has completed Phase 1 when commenting on grant implementation issues).*

Facilitating factors and strengths

The implementation of the TB project was facilitated by the strong leadership in the NTP and the commitment and dedication of the implementing partners from the Philippine Coalition against TB, (PhilCAT), the World Vision Development Foundation (WVDF), the Tropical Disease Foundation (TDF) in effectively implementing their specific strategies. This was likewise supported by a strong Technical Working Group particularly from Technical Staff of the WHO and a supportive Country Coordinating Mechanism.

The Principal Recipient (PR) was facilitatory, ensuring that funds were disbursed to implementing sub-recipients in a timely fashion to avoid any disruption of program implementation. Monitoring and Evaluation by the PR PMU was well coordinated with the implementing sub-recipients and was program oriented while paying particular attention also to fund utilization. Operational guidelines for M&E and Financial Management as well as Procurement Supply Management have been produced and discussed with implementing SRs. In addition, the PR has organized the external evaluation of the PPMD, by technical experts from the WHO to assess impact and the needed capacity building required to improve implementation.

Public-Private Mix: Round 2 grant has made it possible for the Department of Health (DOH) and the Philippine Coalition Against Tuberculosis (PhilCAT) to finalize and publish the Operational Guide for Public-Private Mix DOTS (PPMD) in the Philippines which was utilized as the reference for the activities to be undertaken for both Rounds 2 and 5. This document details the general policies, implementing structure and mechanisms for PPMD. A National Coordinating Committee for PPMD (NCC-PPMD) and 16 Regional Coordinating Committee for PPMD (RCC-PPMD) had been created to provide technical assistance, oversee the implementation of PPMD, monitor and supervise the PPMD implementation across the country. These implementing structures ensured the rapid expansion of the PPMD strategy and the active participation of the private sector through the local coalition/private sector representative. Furthermore, a well organized and experienced Project Management Unit (PMU) managed by PhilCAT provided administrative, financial and technical support. Advocacy packages were developed by the unit and a monitoring system was set-up using

an electronic TB registry to ensure timely and accurate reporting. Sustainability beyond project life was also given particular attention. A five-year strategic plan toward technological, economic, political and socio-cultural viability was developed and progress was monitored through a set of indicators covering the four sustainability elements.
The overall success of the PPMD strategy in the Philippines has been recently well documented in a case study that was presented at a WHO Regional High Level Meeting on Health Equity in Phnom Penh, Cambodia in October 2007.
Advocacy, Social Mobilization for TB: One of the strengths of the expiring grant was its ability to engage communities in health development work, a strategy that was implemented by World Vision through its Social Mobilization on Tuberculosis Project. Further, as the social marketing arm of the Global Fund TB Project, World Vision was able to produce, distribute, and make available various Behavioral Change Communication (BCC) materials on TB to the communities. The communities have found the BCC materials useful in doing community TB education. The increase in the number of TB symptomatics seen at DOTS centers through the task force activities, and the resulting increase in case detection of new sputum smear positive cases demonstrated the additionality of community TB task force activities. An external evaluation of a team of experts including the SMT evaluation team lead by Johns Hopkins showed potential for impact and evident (Appendix 13).
MDR-TB. From the economic analysis of the Programmatic Implementation of Drug Resistant TB (PMDT) on an outpatient setting, it was found to be feasible, effective and cost-effective in a resource poor setting like the Philippines. (Appendix 14) The project, based on a PPMD unit is supported by a Quality assured Mycobacteriology Research Laboratory of the Tropical Disease Foundation, which has gained a proficiency that equals or even exceeds SRLs. It has expanded into the public sector through referrals with the DOTS centers in the public sector as well as with PPMDs to provide DOT and default tracing for patients who have graduated into the continuing phase of treatment. It has likewise partnered with the Lung Center of the Philippines to set up a satellite MDR-TB Treatment Center. Through the supervision and monitoring provided by the Green Light Committee, success rate has improved progressively from 50% during the first year of operating the project in 1999 to 74% in 2004-2005 cohorts.

Limitations of the approach and prospects for achieving universal access to TB care and addressing new challenges (TB in children, TB in prisons, in the workforce, in urban and rural poor populations including indigenous peoples)

In Round 2 and Round 5, the engagement of the care providers in TB control was limited to private physicians. This was based on surveys showing that about a third of patients with symptoms of TB preferred the services of private physicians who are presently non-NTP providers. . In this approach, the opportunity to ensure universal access was missed as there are still other public and private health care providers outside the network of the NTP who have not been engaged. Pockets of high TB transmission and prevalence have not been provided access to Quality DOTS services. Engagement of care providers who are currently providing medical services to these populations and enhancing their skills with technical assistance to address these vulnerable groups will be undertaken in the RCC. Likewise engagement will be sustained through continuous advocacy and provision of IEC materials in support of health provider engagement.

The diagnosis of TB provided by the supporting laboratory services has been limited to direct sputum smear microscopy (DSSM). This now has to be expanded to *M. tuberculosis* culture and DST to provide diagnostic services to detect MDR-TB. In addition, procurement and supply management to ensure uninterrupted supply of first and second line anti-TB drugs has to be improved, and the monitoring and evaluation system should become integrated into the National M and E system that is being developed.

Public-Private Mix
In Round 2 as well as Round 5, a criterion was set to identify areas where PPM as a strategy will be adopted. This included municipalities/cities with a population catchment of 100,000 of the selected public or private and where there are at least 15 private physicians. At the same time, private physicians were the main target for engagement based on the 1997 National Tuberculosis Survey findings which showed that about one third of patients with symptoms of TB consulted a private physician. This approach however, despite the fact that it has improved access, has not ensured universal access to quality-assured TB care by all TB patients. Engagement of other public and private care providers who are presently non-NTP providers in municipalities/cities with small population and with few private physicians needs to be covered by the RCC. The scope of TB care in the PPMDs established was also limited to adult TB patients. Those with MDR-TB and children with tuberculosis did not have access to quality-assured TB care.

The strong points as well as the limitations of Round 2 were all incorporated in the RCC. Municipalities and cities that were not included because of the selection criteria set, will be targeted in the scale-up and scope change of TB care under the PPM strategy, which will now include, in addition to DOTS, PMDT and TB in children. A PPM structure at the level of the province to oversee the PPM implementation in the 44 targeted provinces will be created and a strong PMU will also be established.

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Advocacy, Communications and Social Mobilization for TB: Based on the Phase 1 Evaluation Report on the project, strategy of engaging communities, particularly in organizing Task Forces, has a potential for expansion. However, there is a need to look at the cost of organizing new groups in the communities for the purpose of case detection, treatment supervision, and conducting TB education vis-a-vis the communities' population size and TB epidemiology. Further, these isolated TB groups, particularly in large rural provinces, may not be that effective in influencing the policy environment thus, there is a need to unify them into a larger group to be able to do better advocacy. With these findings, this proposal aims at slightly modifying the project implementation still using its key strengths. World Vision will still engage communities by engaging existing community-based organizations this time with significant population coverage in doing advocacy, communication, and social mobilization (ACSM). This strategy is being envisioned to become another social mobilization model. Further, in close collaboration with PMDT, these organizations will include empowered TB patients that will bring community TB care (CTBC) closer to MDR-TB patients. In this proposal, mass media will also be maximized to widen the reach in increasing awareness on correct information on TB, DOTS and now MDR-TB, and advocacy to policy makers and political leaders will be included.

MDR-TB : Absorptive capacity to handle the rapid scale up is a limiting factor which should be addressed through a rapid human resource development in both the public and private sectors. Expertise gained by the TDF as the first GLC approved DOTS-Plus pilot project is a factor that the GF RCC proposal should capitalize on. With the recommendation of the WHO WPRO, USAID may support the development of the existing project in TDF as a center of excellence in MDR-TB training. Recruiting of the trainees may prove to be a challenge but the existing staff in the PPMDs that will be developed into treatment centers would be among the best candidates for this training.

The diagnostic studies to confirm MDR-TB are too slow with a turn around time from submission of the first sputum specimen from 5-7 months, delaying start of treatment further by one to two more months. This delay in diagnosis has lead to early default of patients and to deaths among patients while waiting for treatment to be started. These findings indicate the need for rapid tests to facilitate timely diagnosis and early treatment of MDR-TB patients. The implementing SR for this strategy is currently part of the Foundation for Innovative New Diagnostics (FIND) demonstration project on MGIT liquid culture for TB and the capillia species identification, which both cut down on the turn around time for the isolation and diagnosis for MDR-TB. Retooling with these new diagnostic technologies will be approached in the latter half of the RCC after proficiency with solid culture media will have first been established in the TB laboratory network in the first three years.

The procurement of second line drugs has been hampered by lack of global supply underscoring the need for a global solution including prequaification of drug manufacturers to increase the global supply of second line drugs (SLDs).In addition, second line drug management is complicated because of the long lead time, short shelf life and difficult forecasting.

Furthermore, PMDT is a complex intervention that requires expertise, compassion, and attention to other patient issues such as the psychosocial issues confronting MDR-TB patients. A wholistic approach, preferrably through CTBC would be most ideal. This approach is now being considered for the RCC application through the convergence of PMDT in areas where PPMDs and where CTBC are already established. All these aspects will be considered in the human resource for health development at the PMDT center of excellence to be undertaken by the TDF in collaboration with DOH and with the technical assistance of the WHO and partners.

4.6.3	**Continuation of Expiring Grant's strategy**	
(a)	Does this proposal <u>continue</u> the same objectives, same service delivery areas, and same focus and range of interventions as the expiring grant (without any changes to program scope or scale)?	☐ Yes ➔ *answer (b) below and go to section 4.6.6* ☒ No ➔ *go to section 4.6.4*
(b)	If yes, describe how the continuation of the original proposal's implementation strategy is the most effective approach to achieve sustained disease specific health outcomes and impact consistent with the national plan. *Applicants should support this explanation by referring to technical, disease trend and managerial factors.*	

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4.6.4 Program scale adjustments in this proposal

This section requests a description of any planned change in the scale of interventions within this proposal as compared to the expiring grant's strategy. *(In this context, a 'scale-up' of interventions should be used by Applicants to categorize a significant increase in the outcomes of planned interventions. Examples of programmatic 'scale up' include: a significant increase in: the number of people with advanced HIV infection receiving ARV treatment, or number of ITNs distributed to people at risk, or the number of facilities with adequate staffing per level to enable an efficient and effective implementation of DOTS.)* ➔ ***Refer to the Guidelines for Proposals for further information.***

Applicants are advised that any proposed reduction in the scale of interventions/services in this proposal compared to the expiring grant would need to be supported by clear and objective information on the reasons for this change. *(Examples may include the availability of resources from an alternative source to replace some portion of the interventions from the expiring grant).*

(a)	Does this proposal include a significant planned scale adjustment (whether a scale up or a reduction in interventions) compared to the expiring grant's planned focus and outcomes?	☒ Yes ➔ *answer question (b) below* ☐ No ➔ *go to section 4.6.5*

(b) **If yes to (a) above**, describe the planned scale adjustments. Provide logical and technical justification as to why this change will create more effective and sustained strategies for greater health outcomes and impact. All

Examples of reasons for a change in the scale of interventions include: a changed country context, changing disease patterns, synergies between the diseases, changes in evidenced-based interventions and knowledge and increased coverage.) Applicants are strongly encouraged to include a diagram or map to explain expansion-focused interventions where relevant. ➔ ***Refer to the Guidelines for Proposals*** *(page 22)* ***for further information.***

The quality DOTS implementation in this proposal will cover children, prisoners, and rural poor populations including indigenous peoples living in hard to reach areas through strengthened partnership with non-health government sector and civil society including faith-based organizations and community-based and peoples' organizations.

The services will integrate the Programmatic Management of DR-TB and management of TB in children with DOTS through partnership with all care givers including Public-Private Mix DOTS units privately initiated as well as public sector initiated units.

Partnership between the public health sector with the private sector will be strengthened including new partners with the people affected including those TB patient organizations that have been mobilized through patient empowerment methods; partnership with the academe to engage them to adopt the NTP as part of the curriculum for the teaching of medical students and students of paramedical profession as preservice education to inculcate the public health aspect of TB management rather than the current emphasis on clinical management alone. For the undergraduate trainees, this could be through curricular change which was initiated by the PhilTIPS project and for post graduate training, this could be through the use of the International Standard of TB Care (ISTC)

Capacity building for human resources, procurement supply management, and monitoring and evaluations to support the interventions that are being scaled up in bigger geographic areas, like from Metro Manila to all regions of the country for PMDT will be supported by the RCC. The table below shows the scope and scale change in RCC of interventions in the expiring grant.

Round 2	Round 5	Scale change RCC
Quality DOTS		

Diagnosis through direct sputum smear microscopy	Diagnosis through direct sputum smear microscopy	DSSM will be complemented by *M tuberculosis* culture and DST
Human Resource Component through capacity building of existing workforce	Human Resource Component through capacity building of existing workforce Hiring of additional staff for NTP and for ETR implementation	Human Resource Component through capacity building of existing workforce on PMDT in addition to TB/HIV and TB in children. Hiring of additional staff for NTP, NTRL and for zonal monitoring
PPMD		
Engagement through the installation of 70 PPMD units was limited to individual private physicians (1,305) whose participation in TB control was limited to the management of adult TB cases. Geographic coverage was 13.5% of the total population	Engagement as in Round 2 was through the installation of additional 100 PPMD units. This was also limited to individual private physicians (1,500) whose participation in TB control was only to refer and manage adult TB cases. Geographic coverage was 28.0 % of the total population	Engagement will be through the establishment of 44 Provincial Coordinating Committees (PCC) and will not be limited to private physicians alone but will include other partners from both the public and private sector. Scope of involvement in TB will now include MDR-TB, TB in children and other vulnerable groups. The scale-up will result to engagement of 4,400 private physicians, 176 public health care agencies/organizations and 88 private health care providers which shall include FBO's and NGO's present in the 44 provinces. Geographic coverage further increased by 48.2%.
Capacity building for PPMD units installed Staff and private physicians engaged Covered only the provision of quality-assured TB services for adult TB patients.	As in Round 2, capacity building for PPMD units installed Staff and private physicians engaged Covered only the provision of quality-assured TB services for adult TB patients.	Broaden service scope of selected Rounds 2 & 5 PPMD units strategically located to include MDR-TB management Training of referring private physicians on Programmatic Management of DR-TB and TB in children.

Both Rounds 2 and 5 engaged individual private physicians solely for the provision of DOTS services to adult TB patients. In this RCC, capacity of these physicians to provide quality-assured TB services to MDR-TB cases and children with TB will be developed since there is now an increasing demand to address this issue.

Advocacy, Communication, Social Mobilization.		
Round 2	**Round 5**	**Scale change in RCC**
Advocacy to general population and to TB symptomatic patients through task force organization	Advocacy to general population and to TB symptomatic patients through task force organization members and community health workers	Advocacy to policy makers, political leaders for commitment and for resource mobilization. Advocacy for general population on improved awareness of TB Advocacy for the symptomatic patients to improve health seeking behaviour
Community based TB care confined to task force members	Community based TB care confined to task force members and health care workers	Engagement of existing NGOs, FBOs, COs and POs in areas with urban and rural poor. Engagement of empowered patients to provide TB care
Training of task force members on DOTS	Training of task force members on DOTS and of health workers on community mobilization	Training of task force members on DOTS. PMDT, TB in children

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MDR-TB: Round 2 supported the treatment of 500 patients in the DOTS-Plus pilot project at the TDF DOTS center in Makati Medical Center. Round 5 supported the establishment of a total of 6 treatment centers in Metro Manila and one Treatment center in Cebu to treat 2,500 cumulatively for five years. RCC will scale up programmatic MDR-TB treatment in 35 new treatment centers in 14 regions to treat 10,852 patients in leading up to attain the MDG by 2015.

MDR-TB Round 2	Round 5	Scale change in RCC
Support for the GLC approved DOTS plus pilot project to treat 500 patients	Development of additional (6)Treatment Centers in Metro Manila and one Treatment Center to treat 2,500 patients in five years.	Development of Treatment Centers in 35 new sites in 14 regions resulting on an aggregate total of: 42 Treatment centers 45 Culture Centers 6 DST centers

4.6.5 Program scope change planned in this proposal

As set out in the Guidelines for Proposals, program scope change is possible for Rolling Continuation Channel proposals where the planned scope change facilitates the introduction of a broader package of interventions to which the expiring grant is contributing. (Examples of reasons for a change in scope may include: a changed country context, changing disease patterns, synergies between the diseases, changes in evidenced-based interventions and knowledge and increased coverage.) *However, proposals which are determined by the Global Fund to be materially different from the expiring grant (e.g. propose different overall goals, different overall objectives, etc.) are not supported under the Rolling Continuation Channel. Such proposals should be submitted under the Rounds based channel.*

For increased information on scope change, Applicants are strongly encouraged to refer to section 4.6.5 of the Guidelines for Proposals.

(a)	Does this proposal include a proposed change in scope as compared to the expiring grant's scope?	☒ Yes ➔ *answer question (b) below* ☐ No ➔ *go to section 4.6.6*
(b)	**If yes to (a)**, describe below the planned scope change below as compared to the expiring grant's strategy *(e.g. describe the new 'key service' coverage areas and planned interventions/activities)*. Provide logical and technical justification as to why the planned scope change is a priority to ensure the creation of more effective and sustained strategies for greater health outcomes and impact.	

TB Laboratory Network Strengthening

In Round 2 and Round 5 of GF approved proposals very little support was given for the development of a TB Laboratory Network in the context of comprehensive TB care with reference to the WHO Global Stop TB Strategy (2006-2015) and the International Standards for TB Care (ISTC) and the rapidly increasing needs for effective PMDT. RCC will provide for the development of an effective TB Laboratory Network for Comprehensive TB care and PMDT beyond the existing EQA Sputum Smear Microscopy

Round 2	Round 5	Scope change in RCC
Direct Sputum Smear Microscopy Laboratory Management Workshop	Direct Sputum Smear Microscopy EQA implementation Laboratory monitoring	Direct Sputum Smear Microscopy EQA implementation Laboratory monitoring Access to Culture and Drug susceptibility testing of MDRTB suspect cases

DOTS services in DOTS centers through passive case finding	DOTS servcies in DOTS centers through passive case finding of patients consulting	PMDT services by DPMDs in response to the scale up of MDR-TB management required by the global response plan to the MDR-TB crisis and the revised GLoba Plan 2 and the convergence of strategies including CBTC for the implementation of PMDT instead of a facility-based strategy.	PMDT s

4.6.6 Interrelationships and dependencies on other support for the national program

➔ *Refer to the Guidelines for Proposals, section 4.6.6 (page 25) for further information before completing the following questions.*

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(a) **Other proposals which have impacted the scope and/or scale of the expiring grant**

Describe whether (and if so, to what extent) any other proposal(s) submitted to the Global Fund after the start date of this expiring grant already involves a scale-up of the interventions in the expiring grant, or a scope change to the expiring grant. **If there is any overlap between this proposal and earlier proposals to the Global Fund, Applicants should clearly explain why this proposal is asking for support for the same 'key services' or interventions, and why this is not a request for duplicative funding.**

The RCC proposal is not a request for duplicative funding because it requests funding for the continuation of interventions with broadened scope and scale-up of geographic coverage, with adequate government co-funding.

Round 5 Global Fund TB project has broadened the scope of interventions in Round 2 by incorporating a component on HIV/TB collaboration as the 4th objective of the project. The scope of services to be implemented by the public sector will likewise broaden to include PMDT services as either a treatment center or a treatment site responsible for the intensive and the continuation phases of PMDT, respectively, but also as Culture Centers (through the development of TB Laboratory Network). In addition, another initiatve which is targeting the other vulnerable populations such as prisoners living in congregate settings and mountain tribes and indigenous peoples living in hard to reach areas will be taken up in this proposal in partnership with other public non-health sectors and non-government organizations and faith based organizations.

In addition, there was a scaling up of the Programmatic Management of DR-TB (PMDT) in the national capital region within Metro Manila with one treatment center planned for Cebu. This proposal will build the capacity in both diagnosis and treatment in various regions of the country so that PMDT services can be scaled up on a national level, within the regions, as a first step, and decentralizing them to the provincial level ultimately, so that universal access to PMDT services will be realized within the period building up to the due date of the MDGs.This accelerated scale up is in keeping with the revised Global Plan to Stop TB 2 and the Global response plan to the MDR/XDR-TB crises 2007 and 2008 in view of the emergence of XDR-TB with the epidemic outbreak in co-infected HIV patients in South Africa. To attain the MDG goal by 2015, a rapid scale up to treat 16% and 28% in years 2007 and 2008, respectively, and to provide universal access to international standard of Programmatic Management of DR-TB by 2015, these acceleration is required.

One hundred units of Private Public Mix DOTS (PPMD) will be installed in the Round 5. In addition, the supervising structures set up in Round 2 including the the National Coordinating Committee (NCC) on top, with decentralization of this function to Regional Coordinating Committees (RCC) with representatives form both public and private partners have taken under their supervision the monitoring and supervision of all previously installed PPMD within Round 2 and Round 5 and those self installed as well as those installed through other initiatives such as the CDC and the PhilTIPS project funded by the USAID. In this proposal, the scope of services to be provided by Stellar performing PPMDs will be broadened to include PMDT services as a treatment Center.

This proposal will broaden the scope and increase the coverage of the social mobilization for TB initiated in Round 2 and further expanded in Round 5. A national ACSM plan shall be implemented to attain a policy enhanced environment for TB control through advocacy activities targeting national policy makers and planners, improved health seeking behaviour of people with disease, and community ownership of the project for a sustained advocacy towards the fulfillment of the goals of the TB control strategy.

This proposal also builds up on the GF Round 2 and Round 6 approach of Malaria where people living in hard to reach areas are provided services by barangay malaria microscopists (BMM) and by rapid diagnostic tests (RDT) sites by trained community health workers living in their neighborhood. These BMMs and health workers in RDT sites will be engaged to integrate malaria services and TB services in their areas of responsiblity. This RCC proposal also builds on the partnership between the malaria service delivery system within the government sector with community based organizations including faith-based organizations and peoples organization that are now providing health services in the endemic areas for malaria.

(b) **Linkages to other Global Fund proposals** *(including a Round 7 proposal submitted but not yet reviewed)*

Describe any specific interrelationship or dependency between this proposal and the interventions targeted in: (i) any existing Global Fund grant; or (ii) a Round 6 or Round 7 proposal submitted to the Global Fund and not yet signed/approved (as relevant). *A dependency includes, for example, one proposal providing the framework for treatment interventions, and the 'interdependent' proposal containing, for example, a significant proportion of the medicines required to ensure that the treatment interventions can be achieved.*

Applicants are also strongly encouraged to comment on any significant levels of undisbursed funds under earlier Global Fund grants *(including 'Phase 2' amounts anticipated to become available).* ***The reason(s) why a Round 6 grant remains unsigned at the time of submission of this proposal should also be explained in detail****.*

The RCC proposal builds up on the interventions covered by expiring grant and scales up the on-going Round 5

TB grant . The expiring grant funded the initial pilot of the interventions, which were scaled up in Round 5 and are now further scaled up nationwide to ensure universal access to quality TB care. Examples here are the original PPMDs first set up in the expiring grants, then scaled up in Round 5, will now be modified in its implementation to be able to provice access to TB care in areas that would not necessarily qualify for the installation of a PPMD unit using the criteria earlier set up. In the case of objective No. 1 which is on basic DOTS, the RCC will support for the Implementation of DOTS in hard to reach areas, to the vulnerable populations not covered in the expiring grant and in Round 5. In the case of CTBC and advocacy and communications, these interventions will now be applied in urban Areas and included for ACSM would be nationwide coverage. In the case of PMDT, the expansion in Round 5 was to Cover Metro Manila and one site in Region VII, while in RCC, this intervention will become available beyond the coverages of the expiring grant and Round 5.

In addition, the engagement of all care providers to be purused in the RCC will include not only private practicing physicians but all other care givers in the publikc non-health agencies and in the private sector Including community-based organizations, FBOs, etc. Communications and social mobilization for TB care targeted initially the rural poor areas will now be targeting the urban poor areas. Convergence of all strategies will incorporate all interventions for TB control that have been included in the new strategies for TB control such as DOTS, focus on special challenges including MDR-TB, contribute to health system strengthening, engagement of all care providers, empower people with TB and communitities, and enable and promote research. Accordingly, in RCC, the PMDT will be included in the scope of services provided by both the PPMDs and the CBTCs, QA originally established only for DSSM will now be expanded to provide QA for TB cluture and DST, and these services will now be available for the

Vulnerabable populations including children, TB in prisons, and for the urban and rural poor populations.

(c)	Describe any major bottlenecks in current performance towards achievement of the disease specific national plan *(as supported by these other Global Fund grants and/or all other financial sources)*, and if so, what steps are being taken in-country to resolve these challenges?

Absorptive capacity of the existing health systems including human resource, procurement supply management system are the existing bottlenecks in the implementation of the TB control program. These bottlenecks are the areas that the RCC will cover through a health systems strengthening component to support the new interventions including targeting DOTS to vulnerable populations, scale-up of PMDT for nationwide coverage, through capacity building and strengthening of partnerships with the private sector, NGOs, FBOs, and patient organizations.

The procurement and supply management capacity will likewise be built up through technical assistance with appropriate agencies with this expertise, including but not exclusively with the Office of the Global AIDS Coordination (OGAC) which has provided technical support in these areas through a contract with a consortium of experts. This application for technical support has already been approved for implementation.
Human resource development particularly for PMDT is a major aspect of this proposal, both in the diagnostic and management areas of MDR-TB.

(d)	**Only if relevant**, indicate whether any part of the request for funding in this proposal arises from the discontinuation of support from another source? If so, explain the reason why that source of funding is no longer available.

Not relevant.

Private Sector Contributions

4.6.7	**Private Sector contributions**
(a)	If the Private Sector is intended to be a contributor/co-investor to the overall objectives of this proposal, describe below a summary of the main contributions *(whether financial or non-financial)* anticipated from the Private Sector during the proposal term, and how these contributions are important to the achievement of the outcomes and outputs.

➔ *Refer to the Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.*

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There are presently 72 private PPMD units operating nationwide providing quality-assured DOTS services to TB patients consulting private physicians. These PPMD units are situated in privately owned for profit hospitals or clinics and will be co-finance the delivery of TB services by providing the clinic space, paying for the utilities and the salaries of the nurse, the medical technologist and a part time physician as the PPMD head. In this RCC, these private PPMD units will continue to provide TB services not only to adult TB patients but also to children with TB and patients with MDR-TB. Strategically located PPMD units will be developed as Treatment Center and Treatment Sites for MDR-TB. The public-private Mix DOTS strategy in this RCC is expected to further case detection rate by 6% in addition to the 6% contribution of the Rounds 2 and 5 PPMD units.

(b) Referring to the population group(s) that will be the focus of the Private Sector co-investment partnership, identify in the table below the annual amount of the anticipated contribution. (For non-financial contributions, please attempt to provide a monetary value if at all possible, and at a minimum, a description of that contribution).

Size of population group that is the focus of the Private Sector contribution ➔	Through the PPMD approach, the catchment area to be covered will be expanded from that covered by Round 2 and 5 to a cumulative total of 18,812,035 population size equivalent to 21.2% of the national populations

Refer to the Guidelines for Proposals for examples on 'Contribution Description' *** Add extra rows below to identify each main Private Sector contributor*		**Contribution Value** *(same currency as selected in section 1.1)*						
**** Private Sector Contributor Name**	**Contribution Description** *(in words)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
11 private-initiated PPMD units installed in Round 2	Utilization of the clinic /hospital/ as facility for the provision of DOTS services for all TB patients and co-financing the cost of service delivery	€127,127	€127,127	€127,127	€127,127	€127,127	€127,127	€762,762
30 private-initiated PPMD units installed in Round 5	Utilization of the clinic /hospital/ as facility for the provision of DOTS services for all TB patients and co-financing the cost of service delivery	€202,260	€202,260	€202,260	€346,710	€346,710	€346,710	€1,646,910
31 private-initiated PPMD units installed through initiatives other than the Global Fund	Utilization of the clinic /hospital/ as facility for the provision of DOTS services for all TB patients and co-financing the cost of service delivery	€358,266	€358,266	€358,266	€358,266	€358,266	€358,266	€2,149,596
7411 private practicing physicians	Uncompensated time spent in TB control through referral of TB patients, TA in training, monitoring, accreditation of PPMDs.	€7,058,095	€7,058,095	€7,058,095	€7,058,095	€7,058,095	€7,058,095	€ 42,348,570.00

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Planning for Sustainability and Impact

For more detailed information on the requirements of this section, see the Guidelines for Proposals section 4.6.8.

4.6.8	Potential for sustainability
(a)	**Strengthening national capacity and processes** Describe how this proposal makes an important contribution to the strengthening and/or further development of national systems and institutional capacity (including the capacity of the public, private and NGO sectors, and communities affected by the disease(s). Refer to country evaluation reviews, if available.

This proposal offers an opportunity for the strengthening of NTP components, systems and its partners. The QTBCP final Project evaluation done in August 2006 concluded that DOTS implementation in the Philippine NTP has shown quality, impact and relevance. Since microscopy services are already in-place under the present NTP, there is a need to sustain the quality through the External Quality Assurance (EQA) system. Quality laboratory services, both for microscopy and culture, will be strengthened under the RCC where involvement of private laboratories will be engaged. This will also be an important standard for achieving DOTS certification and accreditation that will enable the DOTS facility to avail of the TB-DOTS OPD Benefit Package. Strengthening laboratory management will re-enforce the quality of NTP's microscopy services, necessary to sustain the attained NTP targets and outcomes. The introduction of an additional diagnostic tool, sputum culture, is a new process that can strengthen the detection of additional TB cases, not detected by simple microscopy. Strengthening this process will contribute to the improvement of TB diagnosis and management that is important in sustaining the NTP outcomes and in attaining the MDGs.

An external evaluation of the PPMD strategy was done in 2005 and results revealed that this intervention provided additionality to the NTP outcomes. At the national level, the contribution ranged from 3-4% while at the local level, the contribution ranged from 10-12%. Replication was recommended to gain more partners; and more involvement from the private sector (private physicians) would enhance the implementation of quality DOTS services. A similar study was undertaken through the TB LINC Project that looked into the financing sustainability schemes of PPMD units. The current health financing of PPMDs using the TB-DOTS OPD Benefit Package was noted to be useful as a basic scheme for financial sustainability. Now that PPMDs are already nationwide in distribution, approach for partnership development at the provincial level will offer a strengthened engagement of all the health and non-health care providers at the various sites identified under this proposal.

Task Forces were also externally evaluated under the GFSMT component of Global Fund Round 5 last 2005. The study showed that there was strong technical equipping provided to the Task Force community members thus, enhancing their knowledge on NTP and easily facilitating referrals from the community to the DOTS centers. Since these groups were largely community volunteers, their sustainability needs to be strengthened through income-generating strategies that are identified in this proposal.

(b)	**Alignment with Broader Developmental Frameworks** Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (HIPC) Initiative and the Millennium Development Goals. *Also include an overview of any links to international initiatives, e.g. as the WHO/UNAIDS 'Universal Access Initiative' or the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities, or the 'Roll Back Malaria Global Strategic Plan').*

The Global Fund projects in the Philippines are delivered within the framework for Health Reform in the Philippines. This reform framework, which is official policy of the Department of Health for all donor funded health initiatives, is called FOURmula One (F1). F1 is implemented at the provincial and municipal levels, with support from the national health and insurance agencies. The framework assures that necessary reforms in the Philippines health care system are implemented in a coordinated fashion at the sub-national level. The Global Fund projects form an important part of the F1 emphasis on improving primary health care services.

What is FOURmula ONE for Health?

Defining the Road Map for Reforms FOURmula ONE for Health is the implementation framework for health sector reforms in the Philippines for the medium term covering 2005-2010. It is designed to implement critical health interventions as a single package, backed by effective management infrastructure and financing arrangements.

This document provides the road map towards achieving the strategic health sector reform goals and objectives of FOURmula ONE for Health from the national down to the local levels.

FOURmula ONE for Health engages the entire health sector, including the public and private sectors, national agencies and local government units, external development agencies, and civil society to get involved in the

implementation of health reforms. It is an invitation to join the collective race against fragmentation of the health system of the country, against the inequity of healthcare and the impoverishing effects of ill-health. With a robust and united health sector, we can win the race towards better health and a brighter future for generations to come.

Starting the Race with the End in Mind:

Fourmula One for Health Goals and Objectives

Over-all Goals:
The implementation of FOURmula ONE for Health is directed towards achieving the following end goals, in consonance with the health system goals identified by the World Health Organization, the Millennium Development Goals, and the Medium Term Philippine Development Plan:

* Better health outcomes;
* More responsive health system; and
* More equitable healthcare financing.

General Objective:
FOURmula ONE for Health is aimed at achieving critical reforms with speed, precision and effective coordination directed at improving the quality, efficiency, effectiveness and equity of the Philippine health system in a manner that is felt and appreciated by Filipinos, especially the poor.

Specific Objectives:
Fourmula One for Health will strive, within the medium term, to:

* Secure more, better and sustained financing for health;
* Assure the quality and affordability of health goods and services;
* Ensure access to and availability of essential and basic health packages; and
* Improve performance of the health system

Within the F1 framework, the Philippines Global fund grants are implemented by a wide range of sub- and sub-sub-recipients. These implementing agencies include local government units (provincial and local governments), NGOs, for profit health providers, in local hospitals, clinics, and doctor's offices.

The strategies stipulated in the proposal are linked with the Global Plan to Stop TB. The country is part of the WHO DOTS Expansion Working Group, the PPMD Sub-Group and the DOTS-Plus Working Group. Philippine Coalition Against Tuberculosis is a member of the STOP TB Partnership.

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

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

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4.6.9 Evidence of impact/potential for impact

For the questions below, the concept of 'impact' refers to whether there is clear evidence of impact on the relevant disease epidemic or influence of planned interventions on disease prevalence, incidence, mortality and/or averted infections. In order to demonstrate impact on the relevant disease, the program may require increased coverage to reach a greater proportion of the population in need with care and support, treatment and prevention services. In addition, planning for impact will require an impact measurement system to capture monitoring and evaluation measures. Refer to the Guidelines for Proposals, section 4.6.9 for more information.

(a) **Potential for demonstrating impact**

How will the additional support provided by this proposal increase the capacity of the country to demonstrate that its national disease strategy will have, or has the potential to have, a measurable impact on the burden of the disease (whether expressed in terms of overall morbidity and/or mortality and/or averted infections).

The Philippines has made good progress with the burden of the disease since the Government adopted the DOTS strategy in 1996. The investment provided largely by the Government and those from partners, contributed to the progressive decline in incidence, prevalence and mortality that are impact indicators of the NTP per MDG targets. Using the WHO's planning and budgeting tool, the projected decline in these indicators coincide with the attainment of the MDGs by 2015. These targets can be achieved if access to quality DOTS will be sustained and there is a scaling-up in the number of MDRTB cases placed under programmatic management.

There is also the continuous increase in the CDR and Treatment Success rates at 75% and 90% in 2006 respectively. Improving the quality of DOTS implementation, with community-based participation and engaging the private sector, through the PPMD strategy, contributed to these achievements in CDR and Treatment Success rates.

The NTP is currently undertaking the **3rd National TB Prevalence Survey (NTPS)** to objectively determine the present magnitude of TB in the country. Through this study that will be completed by April 2008, more in-depth analysis and more substantial information on the current status of the disease burden will be presented.

(b) **Impact Measurement Systems (IMS)**

Describe the in-country systems and organization(s)/team(s) that evaluate potential for health impact, determine country impact measurement indicators, and track/monitor achievements towards national goals.

In your description, comment on the strengths and weakness(s) of the IMS (e.g., health information systems, surveys, mortality registration, and community registers), and solutions integrated into this proposal to overcome challenges and finance gaps to effectively report on performance and impact indicators over the proposal term.

Note ➔ **If there has been a recent national/external evaluation of the IMS, describe the main findings.**

There are several sources of health information in the country. These information are collected by various agencies both government and private through routine information systems, population surveys and special studies. There are, however, weaknesses in the management of such information. For instance, timeliness and completeness are two major limitations in generating health information. Most of the bigger surveys are published every 3 to 5 years. Official published reports are oftentimes delayed by more than two years as in the case of the Field Health Service Information System (FHSIS) and the Philippine Health Statistics (PHS). This is brought about by non-compliance and incomplete submissions of report by some local government units (LGU's) and private health facilities, and the delay in the submission of civil registry records to NSO or DOH by the LGUs. While several systems have been developed to generate vital information, these information systems have yet to be integrated (NOH 2005-2010, F1 ME3).

Given the gaps in the management of health information, there is a need to standardize health indicators and health information requirements in order to eliminate inefficiencies and reduce cost in data collection. A harmonization of health indicators were made in order to have a unified definition of health indicators and terminologies, and have standardized health information requirements to ensure the appropriate systems (whether automated or manual) are properly linked from the local to the national levels. Automation of systems translates into savings for the government if human resource handling the complex manual procedures is considered. These automated systems range from administrative systems (financial, procurement, document tracking) to public health (FHSIS, NESSS) and hospital systems (HOMIS) (Knowledge Management, DOH, F1 ME3, NEC 2007).

The main challenges are ensuring that data, information, researches, and best practices within the health sector are facilitated to reach provincial, regional and national policy makers, and how such information will be translated into use for policy making and program implementation. Other than enhancing information systems, inherent to addressing this challenge is the establishment of feedback mechanisms (monitoring and evaluation) to increase capacity in making evidenced-based decisions within the various levels of governance. Specifically, at the local level, increasing the knowledge among LGUs on how other local health systems are performing compared to theirs will create a competitive environment and benchmarking that may effect positive changes in health outcomes and over-all client satisfaction for their constituents.

The lack of information technologies is also a concern most especially at the local level. The high cost of computer hardware and internet connection facilities are preventing most LGUs to procure IT equipment. This is aside from the cost of building capacity to operate health information systems, which is a major sustainability issue.

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Little is invested in research, monitoring, evaluation and surveillance by the national and local governments. To address the gaps cited, the implementation of *Fourmula for Health (F1)* of the Department of Health which aims for better health outcomes, more responsive health system, and more equitable healthcare financing, had developed a ***Monitoring and Evaluation System*** that would ensure **E**quity in access and **E**ffectiveness in implementation ***(ME3***). *Performance Indicator Framework (PIF)* was developed to capture priority targets and indicators that will lead to the prioritization of activities that will impact the poor and activities at various levels that will contribute to the attainment of desired health outcomes. The PIF is composed of *Final Outcome (Impact) Indicators*, and includes Millennium Development Goals (MDG's), National Objectives for Health (NOH) and F1 outcomes for 1) health status; 2) financial risk protection; and 3) health system responsiveness and *intermediate outcome indicators*, for Access, Quality, Efficiency and Financial Burden. Pertinent to the identification of Final Health Outcomes (Impact) was the linkage of these causes with already set indicators found in the Millennium Development Goals (e.g. combating HIV/AIDS, Malaria and other diseases, TB), and National Objectives for Health, and from the Global Fund to Fight AIDS, TB and Malaria. Hence, the RCC is expected to support the implementation of the ME3, specifically measurement of the goals and objectives of this current TB component's RCC.

Therefore, TB prevalence, incidence, and mortality, etc. will be assessed by the ME3 as impact or final performance outcome indicators. Case detection, treatment success rate, and smear conversion rate are intermediate performance outcome indicators and so with Behavioral change assessments.

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(c) **Linking M&E activities under this proposal to the National IMS**

Describe how the data relating to measuring performance and impact in regard to this proposal will be accurately collected, collated and reported by implementing partners to the Applicant, the Global Fund and the body responsible for national monitoring and evaluation.

In your description also explain how this proposal seeks to: (1) use, to the extent that they exist, existing country systems for planning and budgeting, procurement and supply management, monitoring and evaluation and auditing; and (2) achieve greater harmonization and alignment of partners to country cycles in regard to procedures for reporting, budgeting, financial management and procurement.

In the Philippines, currently there are two major disease surveillance systems that provide information on notifiable diseases, including TB, malaria and HIV/AIDS. The Weekly Notifiable Disease Reporting System (WNDS) generates information on 17 diseases and 7 syndromes. The data in this system are used to estimate morbidity rates. The National Epidemic Sentinel Surveillance System (NESSS), a hospital-based surveillance system, yields information on admitted cases in sentinel hospitals. Vertical disease surveillance systems have also been established as a component of specific disease intervention programs. Project-based information systems like the Electronic Medical Record (EMR) which functions as the data base of multi-drug resistant TB cases in TDF MMC Clinic, the Electronic TB Register (ETR) which was strated with the Round 5 Gobal Fund TB project being implemented in selected service delivery points, and the Project Information Management System (PIMS), all being used in the GF TB projects, were created to respond to other information needs.

Previous reviews of local capacities to manage health information systems showed less desirable results. This occurs due to the lack of or inefficient information/surveillance systems, poor data utilization and/or lack of local capacities to carry out interventions. Other hindering factors include financial gaps, unfavorable administrative policies and lack of technical capacities. Existing resources at different levels of implementation (i.e., central, regional and local levels) are insufficient to carry out strengthening measures. Thus, strengthening institutional capacities, improving physical infrastructure and utilizing information, communications technology (ICT) support systems need to be undertaken. Notwithstanding the fact that problems on synchronization and integration of existing information system need to be addressed whenever and wherever appropriate.

The limitations of the existing systems and the need to respond to the WHO revised International Health Regulations (IHR) of 2005 which required all Member States to strengthen core capacities for surveillance and response calls for an urgent need to adopt an integrated approach for strengthening the existing systems. Administrative Order No. 0023 s2006 (Appendix 15), Implementing Guidelines for *Fourmula One* (F1) for Health as Framework for Health Reforms, will serve as the back bone for integration. The establishment of the ME3, the M&E system for F1, initiated this integration. And in order to meet the challenges in monitoring and evaluation, the Performance Indicator Framework was developed, of which, ETR and Philippine Integrated Disease Surveillance and Response (PIDSR) were among the data generation tools to be used. In this proposal, limitations in human resource, both in numbers and capacities will be addressed, including infrastructure needs through HSS. Data and information processing and harmonization of systems will be pursued at the level of provinces/cities and regions through integration of activities including training, supervision and mentoring without necessarily altering the way in which various sectors and levels operates.

The PR is implementing PIMS, a management and monitoring system originally developed by the Principal Recipient of the Pacific Communities. The use of this system will help TDF as PR efficiently keep track of the different funding grant performance. The system is basically made up of two component parts; the first part records program and financial plans and disbursements. This is highly essential since program implementation is a dynamic thing and thus program plans should follow suit. Reflecting the plans in the electronic form which can be accessed by authorized individuals, plus the added feature of ensuring congruence with the approved maximum grant amount of funds, provide a certain level of security. The second part is the monitoring and evaluation component which archives and generates reports for implementing partners and donors on specified time periods. The full use of the system will ensure minimal or no errors especially on transcribing figures or encoding data since data reported by implementing partners/SRs can automatically populate corresponding sections of the report template upon verification and once clearance is issued by the PR. With the end view of having PIMS interfaced with the financial system and making it web-based will provide easy information access to the Coordinating Country Mechanism (CCM) and the TB Technical Working Group (TWG) members and other stakeholders.

The TWG is headed by the Director of the Infectious FDisease Office and includes the implementing sub-recipients: Infectious Disease Office-National TB Control Program (IDO-NTP), Philippine Coalition Against TB (PHILCAT), World Vision Development Foundation (WVDFI), Tropical Disease Foundation (TDF), the national TB Referecne laboratory (NTRL-RITM), Project Assistance to Control TB (PACT) represented by the WHO Adiviser on TB, and a representative of the PR. The functions of the TWG include development of implementation/operational guidelines and directions to field levels, provision of technical assistance for project implementeation and capacity building of implementing sub-recipients, evaluation and review of project outputs, and technical assistance in the development of annual program and financial plans.

With the use of other standard data collection instruments, including PIMS, ETR, a modified EMR, PIDSR among others, data for indicators depicting performance will be regularly collected and information reported. All the information generated can then be shared with the DOH, the aim being to provide specific information support for the

decision-making process in the health service system at large.

In terms of measuring impacts, external evaluations will be done by foreign and local counterparts, of which the NTP and NEC service people will be part. Whenever necessary, as in the case of the TB Prevalence Survey or the National Demographic Health Survey, impact measurement activities of the project will be linked up for maximum use of resources and information.

The Monitoring and Evaluation System for Equity in access and Effectiveness in implementation (ME3) framework of the *Fourmula One* (F1) for Health with NEC as the lead office will ensure that data, information and other common elements are generated and relayed so that information becomes a real resource for solving health problems at all levels of the health service system.

(d) **M&E Systems Strengthening plans**

By reference to the '*M&E Systems Strengthening Tool*' (describe, in a summary format only, how this proposal incorporates a plan to overcome any capacity gaps in the PR(s) and SR(s) M&E systems to ensure that M&E activities in this proposal will be effectively linked to the National IMS framework to finance relevant gaps *(as contemplated above).*

In particular, Applicants should comment on how gaps and potential/actual bottlenecks identified that are relevant to this proposal will be managed or mitigated during the proposal term. Budgetary implications arising from this assessment should be included in the budget information required in section 5. ***Note ➔ The Global Fund recommends that between 5 to 10% of this proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.***

To ensure that the M & E systems used in the monitoring of the GF projects are aligned with the National M & E system, the M & E strengthening tool was used. In line with this, the existing M & E plan and capabilities, and the data reporting systems of the PR, SR and national programs for TB, HIV/AIDS and Malaria were assessed. The activity was done to identify areas for improvement and to develop a costed action plan to integrate the GF M & E with the National M & E systems . The findings were:

The M & E plan

- Strengths:

System in place and M and E plan embedded in strategic plan. PR has complete data for verification and project-based E reporting (PhilCAT and CHD 3).

- Weaknesses:

No written plan on operationalization (processes for M and E), denominator data can't be disaggregated by socio economic status, data on client satisfaction not available, a written policy on retaining source documents is non existent, , covers a small pop coverage and cannot delineate clearly the contribution of TFs (WV), sustainability plan limited to WV, weak PR and SR link on data consolidation.

Data Management Capability

- Strengths:

PhilCAT, WV and PR- Partners and CHDs have adequate data mgt capacities (HR, logistical support), with strong central and regional data management system, with feedback mechanism from partners, NEC - RESUs and ESUs able to coordinate with programs at all levels (central to periphery with organized structures).

- Weaknesses:

Limited personnel for data management at the central and regional levels of DOH, limited LGU capacity on data management analysis, insufficient data, validation, collection, trainings conducted have limited topics on data management, skills on coaching /mentoring still limited (WV), no clear mechanisms to check on quality of data, no training needs assessment on program and on data management. Not all LGUs and CHDs with functional ESUs, no systematic process in place to check on data, among PR and all SRs resources for training are limited, with limited personnel, and fast turnover especially for public sector; for PR, there is no baselining of capacities on data management of SRs and implementors, the people designated to review data are not clear on their job description (position does not match with skill of hired staff) and with big workload at LGU level, limited funds for actual M and E, some heads of office do not prioritize M and E (lack of political commitment), QA at the local health level.

Data Reporting Systems

- Strengths:

Flow of information is standardized for all programs and LGUs manage to comply with the information system.

- Weaknesses:

National ID system not used, no mechanism in place to avoid double counting between partners / donors, commodity distribution system not in place, timeliness and accuracy at all levels, do not have single system for data flow from all partners (separate channels), there is no single unit responsible for giving information and data on all initiatives, no evaluation of post training performance of M and E staff , there is repository but there

is weakness in processing the data.

Planned strengthening measures

Planned activities	Focal Agency	Timeline	Funding Support
Review of existing indicators and work on integration	NEC/IDO - DOH	June 2007	Euro 1,600 (SEAMEO Trop Med)
Come up with a more relevant post training M&E mechanism	TDF, IDO-DOH	Dec. 2007 – March 2008	Euro 30,000 (GF TB project)
Finalization and production of the M&E guidelines	PR	January 2008	Euro 3,500 (SEAMEO Trop Med)
Workshop on data validation at the periphery level	PR, SRs	2007 – 2008 (on-going)	Euro 11,000 (GF TB R5)
Training on quality data reporting and data management workshop	TDF, NEC	2007 – 2008 (on-going)	Euro 39,000 (GF R5)
Development of training plan	DOH		
Make use of the National ID system in the development of the TB information system	NEC/IDO – DOH	2007 - 2008	Euro 8,500 (GF TB R5)
Development of an inventory/tracking system	TDF	August – December 2007	Euro 22,600 (GTZ)

On February 9, 2007, an update on the M and E workshop was reported to the CCM members. The National Epidemiology Center (NEC) of the Department of Health accepted the responsibility of harmonizing the M and E systems and to develop a single national M & E plan. In both February 7 and 9 activities, the LFA representatives were present. On June 18 to 20, 2007, NEC conducted a workshop for the Harmonization of M & E indicators as an initial step to developing a national M and E plan.

RCC proposal seeks to address other weaknesses and further the efforts started on harmonizing the existing systems. Administrative Order No. 0023 s2006 (Appendix 15), Implementing Guidelines for *Fourmula One* (F1) for Health as Framework for Health Reforms, will serve as the back bone for integration. The establishment of the ME3, the M&E system for F1, has initiated this integration. In this proposal, limitations in human resource, both in numbers and capacities will be addressed, including infrastructure needs through HSS. Data and information processing and harmonization of systems will be pursued at the level of provinces/cities and regions through integration of activities including training, supervision and mentoring without necessarily altering the way in which various sectors and levels operates.

4.7 Program and Financial Management

In this section, Applicants should describe their proposed implementation arrangements and if there are any changes from the expiring grant's management plan. See the Guidelines for Proposals, section 4.7, for more information.

Table 4.7: Nominated Principal Recipient(s)

(a)	Indicate if the existing Principal Recipient(s) (PR(s)) will change (e.g. adding an additional PR or replacing the current PR)?	☐ **Yes** *Answer (b) and (c) below before question 4.8*
		☒ **No** *Go to question 4.8*

If there is/are any new PR(s), Applicants are requested to complete the box below.

(b) **Responsibility for implementation**				
Name of new Principal Recipient(s)	**Sector**	**Name of Contact person**	**Address, telephone, fax numbers and e-mail address of contact person**	**Is the new PR replacing an existing PR ? Yes/No?**

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(c)	Describe the rationale for the proposed change(s) to PR arrangements. Also include a detailed description of the transparent, documented process utilized to select the PR(s) based on objective documented criteria, as this is required to ensure compliance with Coordinating Mechanism minimum requirement 4(a) in Annex 1 to this Proposal Form (and in Annex 1 to the Guidelines for Proposals).

4.8 Factors influencing implementation capacity

4.8.1 Principal Recipient capacities

Describe the respective technical, managerial and financial capacities of each PR in this proposal (continuing and new) to manage and oversee implementation of the proposal (or their proportion) having regard to the proposed changes in scale and/or scope identified in section 4.6.

What plan(s) exist to strengthen the PR(s)' capacity to absorb these changes into their implementation management framework, and ensure strong performance? Please also discuss any anticipated barriers to strong performance, and how they will be addressed, referring to any assessments of the PR(s) undertaken either for the Global Fund or other donors (e.g., capacity-building, staffing and training requirements, etc.).

The implementation of the first phases of the three grants approved in 2003 and 2004 have been successfully approved for Phase 2 implementation. This success can be attributed to the strong leadership of the PR and the very dynamic partnership between the PR and the implementing SRs in the three disease components. The approval of the application of the Philippines for eligibility to apply for the Rolling Continuation Channel based on impact realized from the project implementation indicates the impact that has already been attained in the two disease component projects: TB and Malaria, owing to the efficient implementation provided by the PR. It has efficiently implemented the core functions of the PR, including Monitoring and Evaluation, Finance Management, Procurement and Supply Management, Partnership Coordination, and Technical Coordination with the assistance of the Technical Working Groups in the two disease components. A realignment of responsibilities and functions and a creation of a Communication and Information Management Unit within the PMU is planned to enhance performance in partnership and technical coordination among all stakeholders.

To address capacity building needs, the PR has engaged third party evaluations. The Tropical Disease Foundation has been evaluated externally by the International Union Against Tuberculosis and Lung Diseases (IUATLD) in June 2006, continuing with two other consultations on M and E in January 2007 (Appendix 16), and in Human Resource Development in October of 2007 (Appendix 17). The reports of these evaluations indicate a high level of performance, and commitment of the PMU staff of the PR to the implementation of the Global Fund projects. During November 12-16, the Grants Management Solutions (GMS) evaluated the Procurement and Supply Management System Project funded by USAID conducted an initial assessment of the Procurement and Supply Management Systems and found the PR to have technically competent and highly motivated workforce who are keen to learn and advance. They found no current critical PSM problems, with some areas of weakness including constraints on the PSM systems, specifically on importation and patient rationing in view of the small number of patients to be treated in HIV, in particular. This Team will make two additional visits to complete their assignment.

Another set of experts from the GMS is evaluating the organizational structure and finance management systems of the TDF, and will undertake further visits with interventions to strengthen the performance of the TDF in these areas. The consultants found the TDF staff competent and highly motivated with productive working relationships. Further activities are planned to determine possible areas for improvement and assist TDF to prepare an institutional development plan for sustainability. TDF's current implementation of the Project Information Management Systems (PIMS) which is integrated with ACCPAC accounting system will substantially enhance the monitoring, evaluation and the FMS systems of the TDF.

Another team is expected to provide consultancy on Monitoring and Evaluation which will supplement the earlier Union consultation on Monitoring and Evaluation undertaken by the Union in January 2008.
All three assessments, including implementation steps agreed by TDF will be completed by the end of March 2008. TDF anticipates that PIMS and ACCPAC systems will also be fully functional by the same time.

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4.8.2 Sub-Recipient information		
(a)	Are the majority of sub-recipients (SR(s)) **from the expiring grant,** continuing their roles and responsibilities in this proposal?	☒ **Yes** ➔ *answer question 4.8.3* ☐ **No** ➔ *answer (b) before completing question 4.8.3*
(b)	**If no**, explain why, and for new SR(s) who will either receive a substantial proportion of the funding for this proposal or will be involved in funding to sub-sub-recipients: (i) describe the **transparent** process by which new SRs were identified **and the criteria** that were applied in the identification process. (ii) summarize the past implementation experience of these new SRs	

4.8.3 Sub-Recipient capacities

What plans exists to strengthen the capacity of the major SR(s) to absorb the continuing and/or expanded responsibilities under this proposal, and ensure strong performance? Please also discuss any anticipated barriers to strong performance, and how they will be addressed, referring to any evaluations by the existing PR(s) of SR capacities (e.g., capacity-building needs, staffing and training requirements, etc.).

The partnership among the PR and SR is vibrant and synergistic and has been a strong factor in the achievements attained thus far. The NTP staff at the central, regional levels, and at the National TB Reference Laboratory (NTRL) and the regional reference laboratories will be augmented through recruitment of seven new staff with specific responsibilities to help implement new strategies. The NTP staff have participated in various training courses organized by the WHO and will continue to do so in the future to be updated with new policies and practices in TB control. Logistic support through equipment outlay to be supported by RCC will supplement the increased investment of the GOP to support the maintenance operating expenses including improved physical outlay. With this investment, procurement of anti-TB drugs and laboratory supplies through the GDF will continue and increase with the augmentation of the drugs and reagents for the implementing LGUs. The other sub-recipients continue to perform beyond expectations because of commitment and their persistent aspiration for excellence through evaluation, technical assistance provided by the WHO, UNION and partners. This include quarterly program implementation reviews lead by the NTP. NTP external evaluation, the PhilCAT PPMD program review for sustainability through the Development Academy of the Philippines (DAP), GLC periodic reviews of the PMDT, and external evalution of the ACSM at midterm (through a team headed by Prof. Mosley) and interim evaluation by the University of the Philippines (Prof. Cabigon). In addition, KAP studies on baseline has been done, and a follow-up KAP survey will be funded by the RCC.

The same sub-recipients who are presently implementing Rounds 2 and 5 will be engaged in this RCC and with the addition of two other units: National Epidemiology Center (NEC) and the National TB Reference Laboratory (NTRL). The Project Management Unit (PMU) of these sub-recipients has the experience and know-how not only in the technical aspect of tuberculosis but also in managing the financial aspects of the Global Fund grant. For the last five-years these sub-recipients have continued to broaden their knowledge and skills in Global Fund project implementation through various trainings on tuberculosis disease and its preventions, monitoring, project management and sustainability and attendance to international workshops and conferences. To ensure absorptive capacity additional staff will be hired by each of the sub-recipients. These newly hired staff will undergo training on the various aspects of the project both technical and financial. For the hiring of staff, special attention will be given to the appropriateness of the educational preparation in relation to the task to be performed and past experience will also be considered. These staff will also be closely supervised by the Senior Staff who had been involved in the project for sometime and have already gained all the knowledge and skills needed to ensure a successful project implementation. All these sub-recipients have excelled in their past performance and had been able to absorb the responsibility. Technical trainings on tuberculosis will include the following: DOTS providers training, sputum microscopy, and NTP monitoring while for the administrative and financial aspects focus of training will be the guidelines that had been developed in the past including existing Global Fund Guidelines e.g. procurement.

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Applicants should carefully read the Guidelines for Proposals at section 4.9 and section 4.10 before completing the questions below.

4.9 Procurement and supply management (PSM) of health products

4.9.1	Overview of extent of change to PSM arrangements	
(a)	Does this proposal involve the procurement and supply management of a significant quantity of any medicines or other key health products? ➔ *Refer to the Guidelines for Proposals, section 5.3 (cost categories) for a definition of 'health products'.*	☐ **No** ➔ ***Go directly to the budget section*** *(section 5)* ☒ **Yes** ➔ *answer question (b)*
(b)	**If yes to (a)**, does this proposal give rise to **any change(s)** in the **roles and responsibilities** for the procurement and supply management of health products in comparison to the expiring grant?	☐ **No** ➔ ***Complete section 4.9.2*** *and then* ***go to section 5 and Attachment B*** *(detailing quantities and unit costs for health products)* ☒ **Yes** ➔ ***Go to section 4.10*** *before completing* ***section 5*** *and* ***Attachment B***

4.9.2 PSM of health products for continuing PR(s) involving a scale-up of ongoing activities

Describe:

(a) how implementation arrangements relevant to this proposal have been planned to ensure *(including, as relevant, plans to obtain necessary additional technical assistance, training or other capacity building assistance)* that continuing PR(s) have sufficient capacity to absorb the increased responsibilities in respect to the PSM of health products for the planned scale-up; and

(b) the extent to which the ongoing procurement and supply management of health products under this proposal will be coordinated with other procurement and supply management actions in support of the national disease prevention and control program to ensure greater impact on the disease.

The TDF has obtained Technical Assistance from the Grant Management Solutions (GMS) primarily for PSM to improve their capacity for PSM. This is ongoing at this time and will comprise of two more consultation visits with later follow-up of the implementation of their recommendations. In addition, there is an in-country PSM consultant, who is a member of the PSM team of the GMS who will continue to provide advice on capacity building for PSM.
All procurements to be done by the RCC will be discussed at the TWG meetings and schedules for procurement will be coordinated with the Materials Management Division of the DOH since the consignee of all procurements to be made will be the DOH.

➔ **For continuing PR(s) where there is no significant newly introduced responsibility for the PSM of health products, complete section 5 and Attachment B** *(see section 5.4.1).*

➔ **For new PRs and/or where a continuing PR's responsibilities are newly/significantly extending into the PSM of health products, complete section 4.10 to describe the revised PSM arrangements** before completing **section 5 and Attachment B.**

4.10 PSM of health products – New PR(s) and/or newly introduced PSM activities

This section should be completed where this proposal targets interventions which introduce significantly altered arrangements to those under the expiring grant, whether those changes arise from:

(a) **New PR or key sub-recipient** ➔ this proposal identifies an additional (or replacement) PR or sub-recipient whose responsibility it is to undertake a substantial proportion of the PSM of health products; or

(b) **Scope change** ➔ this proposal is targeting a broader package of interventions to which the expiring grant is contributing, in circumstances where these interventions include the PSM of health products as a new or significantly increased focus during implementation.

4 Proposal Strategy

4.10.1 Amended roles and responsibilities for PSM of health products

In the table below, describe the planned roles and responsibilities for procurement and supply management of health products under this proposal. *(For example, the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is PR for this grant application.) If a function is planned to be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health Department of Disease Control, or Ministry of Finance, non-governmental partner, technical partner).*	In this grant application what is the role of the organization responsible for this function? *(Identify if PR, SR, Procurement Agent, Storage Agent, Supply Management Agent, etc).*	Indicate if there is need for additional staff or technical assistance
Procurement policies & systems	Tropical Disease Foundation	PR	☐ Yes ☒ No
Quality assurance and quality control of pharmaceuticals	BFAD / WHO	Quality Assurance	☐ Yes ☒ No
International and national laws (patents)	Intellectual Property Office	Patent protection	☐ Yes ☒ No
Coordination	Tropical Disease Foundation	PR	☒ Yes ☐ No
Management Information Systems (MIS)	Tropical Disease Foundation	PR	☒ Yes ☐ No
Product selection	TDF PMDT Clinic / DOH NTP	SR	☐ Yes ☒ No
Forecasting	TDF PMDT Clinic / DOH NTP	SR	☒ Yes ☐ No
Procurement and planning	TDF / PMDT / DOH / WHO / IDA	PR / Procurement Agent	☐ Yes ☒ No
Storage and Inventory management	TDF PR / DOH (MMD & CHD Warehouses / Zuellig Warehouse	PR / Storage Agent	☒ Yes ☐ No
Distribution to other stores and end-users	TDF PR / DOH / Third-party logistics provider	PR / SR / Local distribution agent	☐ Yes ☒ No
Ensuring rational use	TDF PMDT Clinic / DOH	SR	☐ Yes ☒ No

4.10.2 Procurement capacity

(a)	Will procurement and supply management of medicines and other health products be carried out (or managed under a sub-contract) exclusively by the Principal Recipient(s) or will sub-recipients also conduct procurement and supply management of these products?	☒ PR(s) only ☐ SRs only ☐ Both

(b) For each new organization planned to be involved in the procurement of medicines and other health products, provide details of the current volume of medicines and other health products procured on an annual basis in the table below. *Use the "tab" button on your computer to add extra rows at the bottom of the table if more than four new organizations will be involved in **procurement**.*

Organization Name	Total value of medicines and other health products procured during last financial year *(In same currency as in section 1.2 of this proposal)*
WHO Western Pacific Regional Office, Manila	Euro 533,632.58
UNICEF	Euro 82,769.44
International Dispensary Association	Euro 133,207.76

4 Proposal Strategy

4.10.3 Coordination Capacity
Describe the extent to which ongoing procurement and supply management of health products under this proposal will be coordinated, to the extent possible and appropriate having regard to country contextual considerations, with other procurement and supply management actions undertaken in support of the national disease prevention and control program.
The PR Procurement and Supply Management Unit shall take charge of coordination. The current arrangement of the PR being in charge of the Procurement and the Sub-recipients in charge of distribution will now be integrated with the Materials Management Division of the Department of Health. Capacity building on procurement and management supply system in all levls of the national health delivery system will be a component covered under the Health Systems strengthening portion of the RCC. In regards to procurement of health products, to avail of concessional prices, 1st line anti-TB and 2nd line anti-TB drugs will be procured through the procurement agents of the Global Drug Facility including the GTZ for first line drugs and the International Dispensary Association (IDA) for 2nd line anti-TB Drugs. In the future, when either GDF or a similar body can also cover for the diagnostic kits for TB including MDR-TB, the procurement of these shall also be done through this agency to avail of concessional prices. The proposed voluntary pooled procurement that is currently being developed within the Global Fund will be explored in order to provide impetus to market dynamics in order to bring down the cost of health and non-health related products for TB control.

4.10.4 Supply management (storage and distribution)			
(a)	Will the same organization as in the expiring grant provide the supply management (storage and distribution) functions for medicines and other related health products during the proposal term?	☒ Yes ➔ *continue to question below*	
		☐ No ➔ *continue to question below*	
(b)	**Indicate** which types of organizations will be involved in the supply management of medicines and other related health products during the proposal term. If more than one of the adjacent boxes is checked, also briefly describe the inter-relationships between these entities when answering (c) and (d) below.	☒	National medical stores or equivalent Materials Management Division – DOH (MMD-DOH); Center for Health Development- DOH (CHD-DOH) Regional Warehouses - Nationwide
		☒	Sub-contracted national organization(s) *(specify which one(s) below)* Zuellig Warehouse
		☒	Sub-contracted international organization(s) *(specify which one(s) below)* GOETZ Brothers as forwarders
		☐	Other: *(specify below)*
(c)	Describe each organization's current **storage capacity** for medicines and other related health products, and indicate how a possible scaling up of interventions and increased requirements under this proposal will be transparently and effectively managed.		
For Sub-contracted National Organizations: 1. Zuellig (Regional facility in Asia) (will store PASER sachets particularly in the beginning of the project implementation as has been the case in the expiring grant and in Round 5). Zuellig has a total warehouse space of 180,000 sq ft (16,700 sq m); storage 14,000 pallets (air-conditioned); cold room storage with 3 individual cold rooms with total floor area of 5,000 sq ft. This is enough space for the temporary scaled up storage of PASER as eventually the national warehouse managed by the Materials Management Division of the DOH will be the responsible for central storage. Each of Zuellig's warehouses has sufficient cold chain capability to provide security and integrity of product quality throughout the distribution network. No other distributor in the country provides this level of integration in cold chain capability. Zuellig's cold chain infrastructure includes back-up chiller capacity as well as back-up power generators to ensure seamless operations in the event of power interruptions. 2. Materials Management Division (MMD) is the DOH's office responsible for the storage and distribution of drugs and commodities. The MMD has two warehouses with each having 625 square meters storage and warehouse space for drugs and non-health items located within the DOH compound and in Quirino Memorial Medical Hospital. The space for drug storage is fully air-conditioned and monitored by the MMD staff. The MMD also utilizes its warehouse at the Research			

Institute for Tropical Medicine for cold storage with an estimated 200 cubic meter floor space. This has also been used for vaccine storage for many years.

3. Center for Health Development (CHD) Warehouses of the different regions have been in charge of the storage and distribution of the drugs and commodities including first line anti-TB drugs. These warehouses are equipped with their respective staff and cold chain requirements. The CHDs ensure that the drugs are stored properly and securely. The regional warehouses is about 144 square meters floor space. The drugs and commodities delivered from the MMD warehouse are stored in these facilities prior its distribution to the local health service delivery points.

(d) Describe each organization's **current distribution capacity** for medicines and other related health products. In your response, indicate how any increased responsibility for distribution of medicines and other health products under this proposal will be managed, and potential challenges addressed. In addition, provide an indicative estimate of the percentage of the country and/or population covered by procurement and supply management services under this proposal, and the relative percentage increase (if any) this represents on existing distribution arrangements for the nominated distribution partners.

The distribution of procured drugs and commodities is the responsibility of the Sub-Recipients. The increased responsibility for distribution of medicines under this proposal will clearly require in a corresponding additional manpower hence, the plan for mainstreaming the TB drug distribution system to the DOH. The TDFI will however put in place the ACCPAC inventory module system to assist in the integration of procurement and distribution reports with the Finance and Accounting Departments and for monitoring purposes at the PR level.

The MMD-DOH will be responsible for the distribution of the drugs to the 16 CHD Regional warehouses including 14 new under the GF TB RCC proposal and the 2 existing under GFTB Round 5. For the distribution of the drugs to the 16 Regional warehouses, courier services will be contracted to the CBL Courier Express International. The CBL provides domestic courier through land, air and sea services. The CBL Courier Express International has 12 motorized riders and 4 company drivers in their Makati main office. CBL as well retains 3 branches across the country and employs an additional 11 domestic couriers as outsources with a total working force of around 130 all over Visayas and Mindanao. The domestic couriers have their own courier resources such as ships, trucks and planes that facilitate the speedy delivery and pickup of cargoes, documents all over the country. The distribution to the CHD Regional Warehouses will be done bi-annually.

The CHD Regional Offices – all 16 - CHD Regional warehouses under this proposal will be provided with delivery vans for drug distribution purposes to the 35 new treatment centers. Each region will have 2-3 treatment centers.

The percentage increase of enrolled patients has increased to 379%, from 2,500 patients in TB Round 5 to 9,485 to be enrolled under this proposal.

4.10.5 Pharmaceutical products selection

Do you plan to utilize national standard treatment guidelines ('STG') that comply with the World Health Organization's ('WHO') STG during the proposal term? **If not**, describe below the STG that are planned to be utilized, and the rationale for their use.

In section 5.4.1, Applicants are requested to complete '**Attachment B**' **to this Proposal Form** on a per disease component basis to provide more detail on the STG, and also the expected prices for medicines.

Yes. The management of TB is according to the standard guidelines as provided by the World Health Organization. In the management of MDR-TB, the international standard as prescribed by the Guidelines in the Programmatic Management of Drug-Resistant Tuberculosis is used for patients enrolled for treatment at the Programmatic Management of Drug resistant –TB under the Global Fund –TB projects.

5 Proposal Budget

5. Proposal Budget - Overview and general guidance

In this Section 5 Applicants must provide specific information on their funding request (as summarized in table 1.2).

Applicants should prepare their budget information in the following order:

1. **prepare a detailed proposal budget** (section 5.1);
2. from that detailed budget, **prepare a summary by Service Delivery Area** (section 5.2);
3. from that detailed budget, **prepare a summary by cost category** (section 5.3); and
4. **then** provide details about key budget assumptions (section 5.4).

Funding to be contributed through a common funding mechanism
If part or all of the funding requested is to be contributed through a common funding mechanism *(relevant for Applicants who completed section 4.3.3)*, **Applicants must:**

(a) compile the Budget information in sections 5.1 to 5.3 on the basis of the anticipated use, attribution, or allocation of the requested funds only within the common funding mechanism (that is, not the total combined funds in the common funding mechanism); **and**

(b) provide, **as an annex to your proposal**, the available annual operational plans/projections for the common funding mechanism and explain the link between that plan and this funding request in a covering page to that plan.

5.1 Detailed Proposal Budget

A detailed budget covering the proposal period must be attached as an annex to your proposal.

The detailed budget should also be integrated with the Work Plan referred to in section 4.6.

The Detailed Proposal Budget *should meet the following criteria. (Please refer to the Guidelines for Proposals, section 5.1):*

*(a) It should be **structured along the same lines as the Proposal Strategy**—i.e., reflect the same goals, objectives, service delivery areas and activities which can build towards impact on the disease.*

(b) It should cover the full term of the proposal, and:
- *(i) be **detailed for year 1, year 2 and year 3**, with financial information broken down by **quarters for the first year, and at least half yearly for the second and third years**; and*
- *(ii) provide summarized information and assumptions for the balance term of the proposal period (years 4, 5 and 6).*

*(c) It should state all key assumptions, including those relating to **units and unit costs** **(avoid using lump-sum amounts)**, and should be consistent with the assumptions and explanations included in section 5.4.*

*(d) It should be integrated with the detailed **Work Plan** for year 1 and indicative Work Plan for year 2 and 3 (please refer to section 4.6).*

(e) Details and costs of HSS Strategic Actions should be clearly identified.

*(f) It should be **consistent** with other budget analysis provided elsewhere in the proposal, including those in this section 5.*

5 Proposal Budget

For tuberculosis and HIVAIDS components only:

Multi-drug-resistant tuberculosis	
Does the proposal request funding for the treatment of multi-drug-resistant tuberculosis?	☒ Yes ☐ No
If yes, Applicants are reminded that all procurement of medicines to treat multi-drug-resistant tuberculosis financed by the Global Fund must be conducted through the Green Light Committee (GLC) of the Stop TB Partnership. Thus ➔ Applicants should also ensure that for each year of the proposal term, an amount equivalent to US$ 50,000 should be transparently budgeted for in the Detailed Proposal Budget (this section 5.1) for contribution towards fees incurred by the Green Light Committee. *Applicants should note that this money must be reserved for the Green Light Committee and can not be transferred for other implementation activities.*	

5 Proposal Budget

5.2 Summary of Detailed Proposal Budget by objective and service delivery area

Table 5.2: Budget breakdown by objective and service delivery area

		Budget breakdown by SDA *(same currency as in section 1.1 of the Proposal Form)*						
Objective Number	**Service delivery area** *By reference to your 'Targets and Indicators Table' (Attachment A to Proposal Form)*	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
1.1	TB: Timely detection and quality treatment of cases	417,354	650,252	753,151	623,346	519,459	369,130	3,332,692
1.2	Supportive environment: Laboratory	1,902,478	1,014,299	1,223,574	1,506,955	1,887,014	2,187,117	9,721,437
1.3	TB: Public Private Mix (PPM)	1,185,179	2,167,281	1,814,560	1,820,870	1,605,904	1,602,479	10,196,273
1.4	Supportive environment: Community TB care	657,283	1,507,658	1,907,786	1,601,132	1,265,354	635,428	7,574,641
1.5	Monitoring and Evaluation	1,159,503	1,555,004	1,540,125	847,105	1,428,565	1,731,257	8,261,559
1.6	Supportive environment: Human resources	82,874	88,156	93,967	100,359	107,390	115,124	587,870
2.1	TB: MDR-TB	4,851,517	8,803,406	12,228,561	12,531,610	11,744,430	7,609,568	57,769,092
2.2	Supportive environment: Human resources	584,151	1,225,395	1,987,665	2,530,443	2,783,487	3,059,911	12,171,052
	Supportive Environment: Coordination and partnership development	631,246	544,146	1,006,544	975,955	1,000,455	1,118,135	5,276,481
Total requested from the Global Fund:		11,471,585	17,555,597	22,555,933	22,537,775	22,342,058	18,428,149	114,891,092

5 Proposal Budget

5.3 Summary of Detailed Proposal Budget by Cost Category

In table 5.3 ***on the following page***, provide a breakdown of the annual budget by cost category *derived from your Detailed Proposal Budget (section 5.1).*

Please note:

(a) Guidance on the budget categories and the expenses falling within each category is provided in the **Guidelines for Proposal** section 5.3.

(b) The total requested for each year, and for the proposal term as a whole, must be consistent with the totals provided in section 5.2 (breakdown by 'service delivery area').

(The "Total funds requested from the Global Fund" must also be consistent with the amounts entered in table 1.2 relating to this component.)

5 Proposal Budget

Table 5.3 – Budget breakdown by cost category

	Breakdown by cost category *(same currency indicated in section 1.1 of the Proposal Form)*						
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Total**
Human resources	1,401,935	2,604,906	3,885,453	3,884,429	4,255,021	4,660,614	20,692,358
Technical Assistance	304,315	219,787	264,400	254,892	256,106	334,189	1,633,689
Training	2,576,006	3,662,737	3,219,722	2,868,346	2,597,043	2,711,058	17,634,912
Health products and health equipment	1,198,571	880,748	1,444,685	1,964,750	2,238,042	2,443,204	10,170,000
Medicines and pharmaceutical products	2,323,949	5,060,978	7,716,738	7,106,087	6,353,250	2,543,000	31,104,002
Procurement and supply management costs	421,566	911,586	1,348,476	1,226,583	1,085,465	406,706	5,400,382
Infrastructure and other equipment	1,644,585	944,788	657,387	959,509	719,430	677,841	5,603,540
Communication materials	272,156	807,260	1,024,179	1,027,121	996,153	353,515	4,480,384
Monitoring & Evaluation	768,182	1,076,678	1,159,781	1,024,618	1,610,643	2,055,503	7,695,405
Living Support to clients/target populations	163,731	679,741	1,099,109	1,511,105	1,537,839	1,541,163	6,532,688
Planning and administration	220,207	475,016	477,782	444,403	417,597	418,851	2,453,856
Overheads	176,380	231,373	258,221	265,931	275,469	282,503	1,489,877
Other: *(To be further defined to meet national budget planning categories)*							
Total funds requested from Global Fund	11,471,583	17,555,598	22,555,933	22,537,774	22,342,058	18,428,147	114,891,092

5 Proposal Budget

5.4 Key budget assumptions

The Detailed Proposal Budget (section 5.1) should contain all key budget assumptions. Below, Applicants are requested to highlight their budget assumptions for years 1, 2 and 3 in relation to three key areas.

5.4.1 Medicines and other health products and equipment

Applicants must complete Attachment B to this Proposal Form *(Preliminary List of Pharmaceuticals and other Health Products)* ***to provide details of the budget assumptions for years 1, 2 and 3 in respect of health products (including consumables), medicines, health equipment and services directly tied to procurement and supply management of health products.***
Please note that unit costs and volumes must be consistent with the information reflected in the detailed component budget. If prices from sources other than those specified below are used, a rationale must be included.

(a) **Provide a list (by generic product name) of medicines** to be used in years 1, 2 and 3-, and identify which essential medicines list those medicines are included, and whether WHO's standard treatment guidelines are being followed. **See also section 4.10.5 above**.
(Please complete table B.1 in Attachment B to the Proposal Form.)

(b) **Identify the average cost per person per year (or average cost per treatment course) for these medicines**. *If available, provide the cost per patient including all other costs, beyond the cost of medicines.*
(Please complete table B.2 in Attachment B to the Proposal Form.)

(c) Provide **the total cost** of medicines by therapeutic category for all other medicines to be used over years 1, 2 and 3. It is not necessary to itemize each product in the category.
(Please complete table B.2 in Attachment B to the Proposal Form.)

(d) Provide a list of other health products (e.g., condoms, diagnostics, hospital and medical supplies), health and non-health equipment, and services directly tied to procurement and supply management. Unit costs are requested for Health Products (i.e., consumables).
(Please complete tables B.3 and B.4 in Attachment B to the Proposal Form.)

Information on appropriate unit costs is available in the Guidelines for Proposals, section 5.4.1.

Provide any additional information on unit costs below.

The unit costs used in this proposal were based on the last procurement in 2007 with incremental 10% per year increase except for certain items. With currency fluctuations/inflation, these assumptions may not be reflect the actual costs at the time of procurement.

5.4.2 Human resources costs

In cases where human resources represent an important share of the budget, explain how these amounts have been budgeted in respect of the first three years, to what extent human resources spending will strengthen health systems' capacity at the client/target population level, and how these salaries will be sustained after the proposal period is over. ***(Maximum of half a page.)***

(Useful information to support the budget includes: a diagram/organigram of the PR; a list of proposed positions showing title, function and planned annual salary; and proportion (in percentage terms) of time that will be allocated to the work under this proposal. Please attach such information as an annex to your proposal and indicate the appropriate annex number.)

The Principal Recipient is the Tropical Disease Foundation, a non-government organization that is a non-stock, non-profit corporation. The implementing sub-recipients include the NTP, the PhilCAT for the engagement of all care providers through PPM strategy, the World Vision Development Foundation for ACSM and community-based TB care and TDF for the Programmatic Management of Drug-Resistant TB (PMDT). In addition, one other unit of the DOH is also sub-recipient: the National Epidemiology Center (NEC) for the scale up of TB services to ensure universal access, human resource development including recruitment and training at the PR and the SR level is required to increase absorptive capacity, amounting to 18% of the total RCC budget.

The organigram of the PR is shown as Appendix 18 and indicates that there will be a total of 35 people in the PMU, but only 10 (including 8 new hires) of these will derive their full salary from the RCC and the rest will derive only a fraction of their salary from RCC in the first year. When the relative proportion of salaries are taken into consideration, the RCC Human resource budget will fund a total of 16 person-years based on cumulative per cent of salaries derived from the RCC. The subsequent year support is as shown in the table

below:

Year of RCC	1	2	3	4	5	6
Person-year support	16	14	29	27	27	27
FULL salary from RCC	10	10	25	22	22	22
PARTIAL salary from RCC	18	19	7	2	2	2

At the sub-recipient level, GF funding will assure the recruitment of 7 additional staff at various levels of the NTP who will be assigned to augment the NTP central office in the areas of information technology, logistics management, technical assistance in TB in children, and monitoring and evaluation at 3 zonal levels in the principal islands of the country. These newly recruited staff will be appointed to vacancies within the DOH within the first three years to ensure continuity of their services without GF support. Their implementing sub-recipient, Christian Action for Relief and Empowerment (CARE) will request support for 10 staff from the RCC. With health financing through PhilHealth packages to be developed for TB care in addition to the TB Outpatient Package, the retention of these new staff can be planned to be sustained from PhilHealth revenues.

For scaling up of the Programmatic Management of Drug-Resistant TB, recruitment of staff at each of the 14 regions to provide monitoring, supervision, and technical assistance to implementing units will be for the purpose of building capacity in existing regional NTP staff. These will act as project consultants on a part-time basis with project-based honorarium and they do not need to continue the service which will have been passed on to the Regional NTP offices. Two full-time and two part-time (existing staff in the PPMD units) will be supported by the project to implement the PMDT services at the 35 treatment centers. After the first three years, their salaries will be sustained through health financing through PhilHealth insurance package for drug resistant TB which has still to be advocated for. Alternately, the private institutions in which the PPMD treatment centers were established could absorb the two new hires and sustain support through a memorandum of understanding at the start of engagement.
For scaling up of ACSM and community-based TB care, recruitment of 1 new staff in each of the 14 sites for ACSM and compensating one local staff per site who will spend 50% working hours for ACSM. The total 212 Health Education and Promotion officers existing in 131 cities and 81 provinces will be capacitated without additional compensation. Advocacy to the local government executives to provide a position for the new hired staff in the 14 sites will be done so that after the first three years, all of these staff will be retained supported by the local government to continue ACSM services.

Six new staff will be hired for the strategy on engaging all care givers including private physicians and other providers out of the NTP system planned for the PPM activities.

5.4.3 Other key expenditure items

Explain the rationale for how other expenditure categories which form an important share of the budget (e.g., infrastructure and other equipment; communication materials; or planning and administration), have been budgeted for the first three years.
(Maximum of half a page. Please attach an annex and indicate the appropriate annex number.)

A cumulative 39% of the budget comprise of 15% for training, 9% for health products and health equipment, 7% for information systems, 5% for infrastructure and other equipment, 2% for planning and administration and 1% for technical assistance. These budgetary items are required for health systems strengthening" to improve **health services,** which deliver effective, safe, good quality personal and non-personal health interventions to those that need them, a well-performing **health workforce** that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, a well-functioning **health information** system that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status, an equitable access to essential **medical products and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use, a. good **health financing** system that raises adequate funds for health, to ensure people can use needed services, and are protected from financial catastrophe or impoverishment, and le**adership and governance** ensuring strategic policy frameworks that combine with effective oversight, coalition building, regulatoin, transparency and accountability." (WHO's Framework for action:: Everybody's business: Strengthening health systems to improve health outcomes).

5.4.4 Financial Support for Coordinating Mechanism operations	
Does the applicant intend to apply for funding of CCM, RCM, Sub-CCM operations? *Details on the availability of such funding are provided in section 5.4.4 of the Guidelines for Proposals, and Applicants should refer to these before completing this section*.	☐ Yes *provide details below* ☒ No *Go to the checklist for annexes to your proposal*
If yes, please specify the amount requested and describe how the amount complies with the **time limitation** and **funding categories available**, as explained in section 5.4.4 of the Guidelines for Proposals. **Applicants must ensure that the amount requested is included in the Detailed Proposal Budget** (section 5.1) **in a separate identifiable budget line**.	

CHECKLIST OF ANNEXES TO BE ATTACHED TO YOUR PROPOSAL

The table below provides a list of the various annexes that should be attached to the proposal after completing sections 4 and 5. Please complete this checklist to ensure that everything has been included. Please also indicate the applicable annex numbers on the right hand side of the table.

Sections 2: Income level eligibility questions		**Annex Number to your proposal**
2.3	TWG Minutes of the Meeting dated September 20, 2007 regarding identification of sub-sub implementers to adverse vulnerable population.	Appendix 1
Sections 3A and 3B: Applicant eligibility information and proposal endorsement		
3A.2	Country Coordinating Mechanism minutes of the meeting dated September 11, 2007 regarding concept proposal was presented and result of the CCM election.	Appendix 2
3A.4.1	Documentation relevant to the minimum requirements for eligibility and changes in the Coordinating Mechanism and the proposal's scale and/or scope from the expiring grant. Call for Proposals The Philippine Star ClassiFINDER – Call for proposals for the Rolling Continuation Channel dated May 27, 2007	Appendix 3
3A.4.1	Call for Proposals: Response letters from interested organizations Christian Action Relief and Empowerment Organization (CARE) National Telehealth Center/National Institutes of Health (NIH) Cordillera Coalition Against Tuberculosis (CorCAT) Catholic Relief Services (CRS)	Appendix 4
3A.4.1	Country Coordinating Mechanism minutes of the meeting dated November 21, 2007 regarding initial presentation of RCC proposal Malaria and TB. TDF approved as Principal Recipient (PR)	Appendix 5
3A.4.1	Country Coordinating Mechanism minutes of the meeting dated December 19, 2007 regarding RCC proposal Malaria and TB endorsement.	Appendix 6
3A.4.2	TWG Minutes of the meeting dated September 14, 2007 regarding directions of RCC per component were presented	Appendix 7
3A.4.2	Mission Report on the Assessment of Programmatic Management of Multi-Drug Resistant TB	Appendix 8
3B.1.3	List of members of the Country Coordinating Mechanism as signed by those members to confirm endorsement of the proposal	Attachment C
Section 4: Proposal Strategy		**Annex Number to your proposal**
4.4.1	Mission Report on the Assessment of Programmatic Management of multi-drug Resistant TB	Appendix 8

CHECKLIST OF ANNEXES TO BE ATTACHED TO YOUR PROPOSAL

4.2	Public-Private Mix for DOTS (PPMD) in the Philippines: A Strategy to engage all health care providers in TB Control and to significantly increase access of the population to DOTS services.	Appendix 9
4.3.2	NTP Strategic Plan to Stop TB in the Philippines 2006-2010	Appendix 10
4.4.1	Mission Report on the Assessment of Programmatic Management of multi-drug resistant TB in the Philippines	Appendix 11
4.4.1	Operational Guidelines for PPMD in the Philippines	Appendix 12
4.6.2	External Evaluation of Social Mobilization on TB (SMT) Project	Appendix 13
4.6.2	Economic Analysis of Programmatic Management of Drug resistant TB on an out patient setting (Feasibility and Cost-Effectiveness of Treating MDRTB)	Appendix 14
4.6.9	Department of Health Administrative Order No. 2006-0023 Re: Implementing Guidelines on Financing Fourmula One for Health (F1) Investments and Budget Reforms	Appendix 15
4.8.1	IUATLD Evaluation on Tropical Disease Foundation's Monitoring and Evaluation System	Appendix 16
4.8.1	IUATLD Evaluation on Tropical Disease Foundation's Human Resource Development	Appendix 17
4.6	**A completed 'Targets and Indicators Table'** **Refer to the M&E Toolkit for help in completing this table**.	**Attachment A**
Section 5: Component Budget		**Annex Number to your proposal**
5.4.2	Human Resources Organigram of the Principal Recipient	Appendix 18
5.4.1 *(and section 4.10.5)*	Preliminary List of Pharmaceuticals and Other Health Products (tables B1 – B3).	**Attachment B**
Other relevant documents attached by Applicant (including for Annex A if applicable to the Applicant's CCM eligibility status/application history, s.3A.1)**:**		**Annex Number to your proposal**

***Please note that the following sections follow the order set out in the document entitled 'Clarifications on CCM Minimum Requirements at**:* http://www.theglobalfund.org/en/apply/rcc/

Principle of broad and inclusive membership

Requirement 1 ➔ Selection of non-governmental sector representatives

(a) Provide evidence of how the Coordinating Mechanism members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, or religious and faith-based organizations),* have been selected by their own sector(s) based on a **documented**, **transparent** process **developed within their own sector**.

*Please indicate below (via the check-box below) which documents are relied on to support the Applicant's statement of compliance with this requirement **AND** attach as an annex the documents showing **each sector's transparent process** for Coordinating Mechanism representative selection, and **each sector's** meeting minutes or other documentation recording the selection of their current representative.*

Documentation relied on to support compliance with Requirement 1	Identify which annex to this proposal contains these documents
☒ Selection criteria for each sector developed by each respective sector	Appendix 19: Guidelines for Nomination for Membership to the Philippine Country Coordinating Mechanism
☒ Minutes of meeting(s) at which the sector transparently determined its representative	Appendix 2: September 11, 2007 CCM Meeting Appendix 20: Minutes of the CCM election committee meeting
☐ Rules of procedure, constitution or other governance documents of a sector representative body identifying the process for selection of their member	
☒ Letters and other correspondence from a sector describing the transparent process for election and the outcome of the selection process	Appendix 21: Correspondence from the SLB (a patient organization) Adviser to the CCM Secretariat
☒ Newspaper advertisements or other publicly circulated calls for members of each sector to select a representative of that sector for membership on the Coordinating Mechanism	Appendix 22: Email from the CCM Secretariat Chair
☐ Other: *(please specify):*	

(b) Please briefly summarize how the information provided within the annexes listed above satisfies Requirement 1.

CCM Membership: The Philippine Country Coordinating Mechanism is a multi-sectoral membership fostering partnership among all stake holders including those from the government sector, academia, non-government organizations and community-based organizations, the private sector, religious and faith-based organizations, and multi-lateral and bi-lateral development partners in country.

The current CCM membership is made up of 30 members with two post to expire this December 2007 and 6 additional members to sit starting January 2008, making the total membership count 34. Ten representatives are from the government sector, 7 coming from bilateral and multi-lateral development partners and the rest (50%) are representations from the non-governmental sectors.

Selection Process: Nomination for membership is open for all interested organizations within each sector. During the 2nd Partnership Forum held last March 2007, attendees were divided into groups according to their sectoral representation. Each group identified possible representative organizations for the CCM. All nominees for membership were required to send in confirmation by way of submitting a document detailing orgnization's profile, track record in implementing collaborative projects/activities with DOH and other partners addressing AIDS, TB and malaria. All of those who confirmed their nomination were considered as official nominees are were voted upon/selected by each sector groups during the August 16, 2007 CCM election (Appendix 19 & 20).

Principle of involvement of persons living with and/or affected by the disease(s)

Requirement 2 ➔ People living with and/or affected by the disease(s).

Describe the involvement of people living with and/or affected by the disease(s) in the Coordinating Mechanism. *(Importantly, Applicants submitting HIV/AIDS and/or tuberculosis components must clearly demonstrate representation of this important group. Please carefully review the Global Fund's 'Clarifications on CCM Minimum Requirements – Round 7' document before you complete this section.)*

There are 2 representations from the sector people living with and/or affected by the diseases. Please refer to Table 3B.1.2

Principle of transparent and documented proposal development processes (Requirements 3, 4 and 5).

As part of the eligibility screening process for proposals, the Global Fund will review supporting documentation setting out the Coordinating Mechanism's proposal development process, the submission and review process, the nomination process for Principal Recipient(s), as well as the minutes of the meeting(s) where the Coordinating Mechanism decided on the elements to be included in the proposal and made the decision about the Principal Recipient(s) for this proposal. We will also review how, during the program term, the Coordinating Mechanism will oversee implementation.

Please describe and provide evidence of the applicant's documented, transparent and established processes to respond to each of the 'Requirements' set out below:

Requirement 3(a) ➔ Process to solicit submissions for possible integration into this proposal.

Call for concept proposal was made public twice through a daily nationwide circulation newspaper (Appendix 3). In addition, an email was circulated to member organizations of the Philippine Coalition Against Tuberculosis, inviting all members to submit a proposal for the TB control program for possible support from the RCC (Appendix 23). Copies of the letters of intent received by the CCM Secretariat together with a brief description of the organizations'/agencies' proposed participation is attached as Appendix 4.

Requirement 3(b) ➔ Process to review submissions received by the Coordinating Mechanism for possible integration into this proposal.

A Technical Working Group meeting was convened to review and evaluate the merits of all concept proposals submitted. All parties were requested to present their plans to the group. Minutes of this meeting is attached as Appendix 24. All proponents were informed of the decision reached and the proposal deemed in line with the NTP direction was invited for a technical meeting with NTP-DOH (Appendix 1) for further deliberation.

Requirement 4(a) ➔ Process to nominate the Principal Recipient(s) for proposals.

The TB TWG proposed that the same Principal Recipient will continue to administer and coordinate the implementation of the RCC. This was approved by the CCM during the November 21, 2007 meeting (Appendix 5).

Requirement 4(b) ➔ Process to oversee/review program implementation by the Principal Recipient(s) during the proposal term.

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

Requirement 5(a) ➔ **Process to ensure the input** of a broad range of stakeholders, including Coordinating Mechanism members **and non-CCM members**, in the proposal development process.
Series of meetings with the TB Technical Working Group were done discussing primarily the RCC. Other meetings were also conducted involving stakeholders outside the TWG and CCM, particularly those working with the vulnerable populations (Appendix 1). In addition to these, at least 3 official CCM meetings were done with the purpose of soliciting inputs from partner members.
Requirement 5(b) ➔ **Process to ensure the input** of a broad range of stakeholders, including Coordinating Mechanism members **and non-CCM members**, in grant oversight processes.
Progress update of projects being implemented gets reported to the TWG monthly and to the CCM quarterly. Reports include both the programmatic accomplishments and financial utilization. During CCM meetings called specifically for the purpose, members deliberates on the issues and areas for strengthening by means of recommendations. From time to time, CCM and TWG members conduct monitoring activities to be able to obtain first hand experience/exposure in field implementation. Regular updates through electronic newsletters is also being done to provide a wide coverage of information dissemination. In addition to the TWG and CCM oversight, quarterly meetings is conducted by Provincial and Regional Committees together with stakeholders to assess performance and identify challenges for improvement. All inputs, including recommendations and actions taken by these committees are relayed back to the NTP for consideration and feedback to the CCM.

3A.4.6 Principle of effective management of actual and potential conflicts of interest	
Requirement 6 ➔ Are the Chair **and/or** Vice Chair of the Coordinating Mechanism from the same entity as the nominated Principal Recipient(s) in this proposal?	☐ Yes ☒ No
If yes, summarize below the main elements of the Applicant's documented conflict of interest policy to mitigate any actual or potential conflicts of interest **and attach a copy of the Conflict of Interest policy/plan to this proposal as an annex**.	

TB Attachment A to the Proposal Form

Program Details

Country:	PHILIPPINES
Disease:	TUBERCULOSIS
Proposal ID:	

Program Goal, impact and ouctome indicators

	Goals
1	Achieve universal access to high quality care of people with TB
2	Address vulnerable groups and other special challenges in TB management including TB in prisons, TB in children TB in urban and rural poor including the labor force and the scaling up of Programmatic Management of Drug Resistant -TB (PMDT) nationwide
3	

Impact and outcome Indicators	Indicator formulation	initial Baseline (baseline as in expiring grant)			new Baseline for this RCC proposal (i.e. latest available information)			Targets						Comments*
outcome	Case detection													
outcome	Treatment success rate													
impact	TB prevalence rate													
impact	TB mortality rate													
please select…	Please Select…													
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please select…	Please Select…													
please select…	Please Select…													

* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

	Objective description	
	To achieve universal access to high quality care of people with TB	
	To scale-up the Programmatic Management of DR-TB beyond Metro Manila and provide nationwide coverage and universal access	

TB Attachment A to the Proposal Form

Program Details

Country:	PHILIPPINES
Disease:	TUBERCULOSIS
Proposal ID:	

Objective / Indicator Number	Service Delivery Area	Indicator formulation	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4, 5 and 6				Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5	Year 6				
1a	HSS (beyond TB)	Number of reporting units with at least 1 staff trained in ME3 and implementing the ME3 system	N/A	N/A	please select…	18	18	18	96	96	96	96	96	Y	Y	Y - over program term	Quarterly
1.b	PPM / ISTC (Public-Public, Public-Private Mix (PPM) approaches and International standards for TB care)	Provincial Coordinating Committee for PPM supported	N/A	N/A	please select…	22	22	22	44	44	44	44	44	Y	Y	Y - over program term	Quarterly
1.c	ACSM (Advocacy, communication and social mobilization)	Number of provinces and cities with ordinances for the implementation of local ACSM activities	N/A	N/A	please select…	0	0	0	0	0	(32/212) 15%	(42/212) 20%	(53/212) 25%	Y	N	Y - over program term	Annual
2.	MDR-TB	Number and percent of drug-resistant TB cases detected	47%	2007 (2005 cohort)	R&R TB system, yearly management report	205 (56%)	205 (56%)	750 (60%)	750 (60%)	2192 (65%)	3142 (70%)	3153 (75%)	2956 (80%)	Y	N	Y - over program term	Organization in charge: NTRL; Quarterly reporting
2.	MDR-TB	No. of drug-resistant TB cases enrolled for treatment	858	2007 Oct	TB patient register	0	230	680	1130	2555	4755	7120	9485	Y	N	Y - over program term	Quarterly
	MDR-TB	% of MDR TB cases with negative sputum culture on the 6th month of treatment over patients enrolled in the cohort	81%	2007	TB patient register	N/A	N/A	N/A	82%	83%	84%	85%	85%	Y	N	Y - over program term	Quarterly
2.	MDR-TB	No. and % of DR TB cases successfully treated	73%	2007 (2004 cohort)	TB patient register	N/A	N/A	N/A	N/A	N/A	75%	77%	78%	Y	N	Y - over program term	Quarterly
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