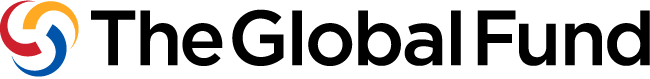
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| |  | | --- | | Funding Request Form  Allocation Period 2021-2023 |   Full Review |

*Refer to the “Full Review” Instructions to complete this form.*

Summary Information

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| --- | --- |
| **Country(s)** | Philippines |
| **Component(s)** | Tuberculosis |
| **Planned grant(s) start date(s)** | 01 January 2021 |
| **Planned grant(s) end date(s)** | 31 December 2023 |
| **Principal Recipient(s)** | Philippine Business for Social Progress, Inc. (PBSP) |
| **Currency** | USD |
| **Allocation Funding Request Amount** | 119,096,167 |
| **Prioritized Above Allocation Request (PAAR) Amount[[1]](#footnote-2)** | 59,718,547 |
| **Matching Funds Request Amount[[2]](#footnote-3)**  (if applicable) | 10,000,000 |



# Section 1: Context Related to the Funding Request

To respond to the questions below, refer to the *Instructions* and **Essential Data Table(s).**

## Key References on Country Context

List key reference documents referred to in this funding request that provide the country’s contextual cross-cutting and disease-specific information. A list of which types of documents can be used is included in the *Instructions*.

|  |  |  |
| --- | --- | --- |
| **Reference Document** | **Link/Attachment reference** | **Relevant section(s) and/or page(s)** |
| 1. UHC Law and IRR |  | Full document |
| 1. Philippine Health Agenda (2017-2022) |  | Full document |
| 1. National Objectives for Health (2017-2022) |  | Full document |
| 1. Philippine Health Systems Review (2018) |  | Full document |
| 1. Stigma Assessment Study 2019 |  | Slide 16-29 |
| 1. Human Rights Baseline Assessment 2018 |  | Page 13-19 |
| 1. TB Gender Analysis 2019 |  | Page 17 |
| 1. TB Catastrophic Cost Study 2017 |  | Page 29 |
| 1. Philippine TB Law |  | Full document |
| 1. Updated Philippine Strategic TB Elimination Plan Phase 1 (2020-2023) |  | Full document |
| 1. Philippine TB Laboratory Network Strategic Plan (2018-2022) |  | Full document |
| 1. NTP Manual of Procedures, 6th Edition 2019 |  | Full document |
| 1. National TB Prevalence Survey 2016 |  | Page 5-10 |
| 1. Joint Program Review and Epidemiologic Analysis 2019 |  | Full Document |
| 1. Quality of TB Service Assessment 2019 |  | Page 11-14 |
| 1. Regional GLC Mission Report on Social Protection 2018 |  | Page 3-5 |
| 1. AuTuMN Modelling 2017 |  | Page 4-5 |
| 1. VALUE TB 2019 |  | Slide 33-95 |
| 1. PPM Action Plan 2017 |  | Full document |
| 1. WHO Report/Country Profile 2019 |  | Full document |
| 1. WHO Report/TB SDG Monitoring |  | Full document |
| 1. WHO Report/TB Financing 2017 |  | Full document |

**SEE ANNEXES VIA THIS LINK:**

**https://www.dropbox.com/sh/m030phe06egjwz6/AADyCsTEpVge0SZuWUtuX-1ga?dl=0**

## Summary of Country Context

Explain critical elements of the **country context** that informed the development of this funding request.

The following points should be addressed in the response:

* The epidemiological context and other relevant disease-specific information;
* Information on disease-specific and the overall health systems, along with the linkages between them;
* Relevant key and/or vulnerable populations;
* Human rights, gender and age-related barriers and inequities in access to services;
* Socio-economic, geographic, and other barriers and inequities in access to health services;
* Community responses and engagement; and
* The role of the private sector.

Refer to information provided in the key reference documents listed in **Section 1.1**.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Philippine Health System**  The Philippines is an archipelago of more than 7400 islands in South East Asia located in the Western Pacific Region. The World Bank categorized the Philippines as a low middle-income country with annual increase of gross domestic product at an average of 6.3% between 2010 and 2017. The population is estimated to be over 106 million in 2018 and has been growing at a rate of about 1.72% annually (2010-2015).  The Philippines’ health service delivery system is decentralized since 1991 and introduced a national health insurance program (PhilHealth) in 1995. The delivery of healthcare is managed by the Department of Health (DOH) and the Local Government Units (LGU). The DOH oversees government corporate hospitals, specialty hospitals, and regional hospitals, while LGUs are responsible for the delivery of health care through provincial hospitals, district hospitals, health centers (HC), and barangay health stations (BHS). The public primary care facilities comprise of 2,587 RHUs and 20,216 HCs and BHS. There is also a strong private/for-profit sector providing health services. Currently, there are 1, 263 hospitals in the Philippines of which 63% are privately owned. There are also an estimated 19,379 private physicians registered.  Government financing for health is channeled through the DOH, LGUs, and PhilHealth. Total Health Expenditure in the Philippines has been rising (from USD 14.5 billion in 2017 to USD 15.7 billion in 2018, an increase of 8.3%. Total Health Expenditure was 4.6% of the GDP[[3]](#footnote-4) in 2017. The per capita health expenditure at current prices was USD 146). Of the Current Health Expenditure (CHE), government schemes and compulsory contributory health financing schemes contributed USD 5.1 billion (34%), and voluntary health care payment schemes contributed USD 1.83 billion ( 12.2%) with the rest, equivalent to USD 8 billion (or 53.9% of CHE) being household out of pocket health expenditure(OOP). The private pharmacy (USD 4 billion) and the private general hospital (USD 2.9 billion) were the major beneficiaries of OOP. The fiscal space for health is also increasing because of excise taxes on tobacco and alcohol, showing a three-fold increase in the combined budget of the DOH and PhilHealth from the baseline of USD 1 billion in 2013 to USD 3 billion in 2019.  Specific goals and strategies for health systems strengthening is embodied in Republic Act 11223, otherwise known as the Philippine Universal Health Care Act signed into law on February 2019. The law seeks to ensure that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services and protected against financial risk. The major policy reforms include strategic purchasing, integration of local health systems at province/city level, and the establishment of health care provider networks. The operationalization of the UHC Law, as it attempts to overhaul the health system, is a long way ahead. Full implementation of technical, managerial and financial integration in delivery of care services for the Filipinos is expected in the next 10-15 years. Efforts in the first five years are focused on developing policies and guidelines, and testing/modelling of service delivery models that can be adopted and scaled-up at the local levels in the long term.  The National TB Program (NTP) is lodged under the Department of Health-Disease Prevention and Control Bureau (DOH-DCPB). The NTP’s mandate is on policy development, national coordination, procurement of TB commodities, and management of sub-allocations to Regional Health Centers and DOH-maintained hospitals. The NTP implementation and TB care service delivery is through RHU and HCs overseen by city/municipality health officers and district/provincial hospitals overseen by the provincial health office. Relative to the UHC implementation, the DOH-NTP maintains a status quo, pending finalization of guidelines and mechanisms for TB integration with other disease programs would have been finalized.  **Philippine TB Situation**  Republic Act 10767, otherwise known as the Philippine “Comprehensive Tuberculosis Elimination Plan Act” was signed into law on April 2016. It highlights working towards increasing investments for prevention, treatment, control, and adopting a multi-stakeholder approach in responding to the disease. It details the need for multi-sectoral involvement for the national and local responses, empowerment of communities to participate and access care, development of socio-economic development policies to reduce catastrophic cost, focusing on vulnerable population groups (poor, PLHIV, children, elderly, contacts of TB cases, diabetics, and smokers), and continuous performance and quality improvement. RA 10767 and its implementing rules and regulations serve as the anchor of the Philippine Strategic TB Elimination Plan, or PhilSTEP. The national strategic plan for TB will be in 3 phases (2017-2023, 2024-2030, 2031-37).  TB remains to be a major public health threat in the Philippines. The National TB Prevalence Survey carried out in 2016 employing Xpert MTB/Rif assay revealed an extremely high prevalence rate at 1, 159 (95% confidence interval: 1, 016 -1, 301) per 100, 000 population which translates to more than 1% of the Filipino population having TB. The survey revealed a higher rate of TB in males compared to females (1,713/100, 000 for males versus 627/100, 000 in females). Prevalence of TB increased with age and was highest in those aged 45-54 years at 1, 714 per 100, 000 population. The major risk factors for active TB were identified as previous TB ( adjusted odds ratio (aOR), 2.3(95% CI 1.1 -2.6), age over 65 years (aOR 2.8 (95% CI 1.8-4.4), diabetes (aOR 1.7(95% CI 1.1 -2.6), urban residency (aOR 1.6 95% CI: 1.2 -2.0), smoking for more than 5 years in men (aOR 3.3 (95% CI 2.7 -4.4) or 1-5 pack years in females (aOR 1.9 (95% CI 1.3-2.7) and indicators of poverty such as being enrolled in the 4Ps conditional cash transfer program (aOR 1.6 (95% CI 1.2 -2.1).  Based on adjusted WHO estimations for 2018, there were 594, 000 ( 95% CI 332-924) incident cases of TB in the Philippines ( rate 554 (95% CI 311-866) per 100, 000 population) of whom 371, 668 were notified, representing a TB treatment coverage of 63%. For MDR TB, incidence rate is at 18,000 (CI 7-32) at 17,000 per 100,000 population of whom only 7,328 were notified. In the same year it was estimated that 26, 600 people died of TB who comprised 26,000 (95% 22, 000 -30,000) people not infected with HIV and 600 (95% CI 0-4, 200) persons who were co-infected with HIV. Among all notified, only 37% were bacteriologically confirmed (BC) and 12% were children. Low BC resulted from the introduction of mandatory TB case notification which contributed 10% to total notifications, but 95% was clinically diagnosed. Of the total notified cases (excluding mandatory case notifications), 47% came from public facilities, 22% from other public facilities such as prison, jails, and hospitals, 17% from private health care facilities and 15% from community engagements/referral. The catastrophic cost study in 2017 revealed that about 35% of patients experience catastrophic cost.    In 2018, TB Treatment Success Rate (TSR) among drug-susceptible TB cases (DSTB) is at 90% (290,400/320,587 successfully treated, 2018 cohort) and among drug-resistant TB cases (DRTB) at 69% (3815/5549) for 2018 cohort using standard shorter treatment regimen and 33% (233/703) for 2018 cohort using conventional treatment regimen. DS TB services are available in all RHUs (about 2600) nationwide, while DR TB services are available only in 199 facilities. As of March 2020, there are 488 operational Xpert MTB/Rif machines. This is expected to increase to 944 by end of December 2020. Current DR TB enrollment rate is at 95% and drug sensitivity testing using LPA has been applied to 98% of all DR TB notified cases.  For the management of latent TB infections, about 65% of PLHIV registered in HIV hubs reporting to the Epidemiology Bureau were provided TPT. TB contact under age five (9,611) have been provided TB preventive therapy in 2018. With the ongoing TGF Grant for TB, TB-HIV co-management has been operationalized in 1,376 TB facilities, 199 PMDT facilities and 118 HIV Treatment Hubs nationwide.  The 2019 JPR identified key issues and recommendations:   1. **The primary challenge is finding the missing TB cases.** In 2018, the estimated missing cases is at 35% for DS TB and 65% for MDR TB. The various innovative case finding interventions currently being implemented are showing significant success in finding the missing cases and it is required to operate at a larger scale for impact. There is also a need to scale-up availability and access to Rapid Diagnostic Tests and at the interim, enhance specimen transport systems to find missing TB cases. Furthermore, with high notification gap for DR TB (greater than 60%) and low TSR (less than 60%), rapid enhancement of clinical and programmatic capacity to detect, treat and care for patients with MDR TB is required. 2. **High proportion of clinical diagnosis[[4]](#footnote-5)**. There is a need to identify and address issues surrounding clinical diagnosis for TB. 3. To support TB elimination, there is a need to **strengthen contact management and treatment of latent TB infections**. 4. Pro-actively **engage private care providers** to be part of the NTP, i.e. to comply with mandatory case notification, reporting on treatment outcome, and align their practices to national policies on TB diagnosis and treatment. 5. **Mitigate occurrence of stock-outs** of TB medicines and products. There is a need to improve the Procurement and Supply Chain Management (PSCM) system of DOH, including considering alternative procurement modalities and enable rapid registration of TB formulations. 6. Match the ambition to end TB by 2035 with the **right level of domestic financial investment**. There is a need to advocate for national and local financial investments, including from the private sector to support the NTP implementation. 7. Identify and address bottlenecks to **ensure enough health human resources are available** at all levels of the health care delivery system.   In 2018, The Philippine Human Rights Baseline Assessment to reduce barriers to accessing HIV and TB Services was conducted. Specific for TB, there is no organization or program dedicated to addressing rights-related issues faced by people with and/or affected by TB in the Philippines. The NTP and implementation partners have traditionally followed a medical, formalized approach with community involvement limited to supporting awareness raising, case finding and case holding. Community-based or home-based TB care delivery has not been formally adopted in the country, especially for DRTB. Key recommended priorities for immediate action included strengthening TB patient and community groups to support NTP program not just in service delivery implementation but in governance and advocacy, and enhance patient enabler packages to mitigate incidence of catastrophic cost. Other actions being recommended for consideration included increasing patient access to legal services, establishing community monitoring/feedback mechanisms, empowering TB patients on their rights, capacitating Health Care Workers on human rights and ethics related concerns, mobilizing and empowering patient & community groups as advocates, and strengthening programs in prisons to include sensitization of law makers, judicial officials and law enforcement agents. Furthermore, the TB Gender Analysis conducted in 2019 highlighted that there is a strong focus on the science of TB rather than social dynamics, thus gender is generally overlooked. This is contradictory to the TB Law where social determinants are prioritized. The analysis recommendation pointed out the need to enhance TB-related policies and practice to align with the Gender and Development Agenda and address social determinants for TB. In addition, there is a strong recommendation to engage the Department of Labor and Employment to support development of gender sensitive workplace TB policies for both the formal and informal sector taking gender roles and cultural norms into consideration.  In 2017 the NTP and partners developed a “National Action Plan for Public-Private Mix on Private Sector Participation in TB Care and Prevention, 2018-2022”. Given the important role of private healthcare in the Philippines health system, PPM has never received the budgetary and management priority that it deserves. PPM initiatives have been small, time-bound and externally funded. Currently, only 677 private providers are registered in ITIS but in the first 6 months of 2019 only 81 provided program-supported treatment and 285 referred patients, while 311 (46%) were inactive. There are only 146 private program-supported DOTS facilities, and only 108 are accredited with PhilHealth.    Private providers lack access to (and potentially awareness of and confidence in) affordable molecular testing for TB; they rely too much on chest x-rays and clinical diagnosis. As a result, many TB cases may be missed, and many of those treated for TB in the private sector may not have TB. A recently  established consortium of 15 private laboratories will soon avail Xpert cartridges and equipment at reduced prices. However, the expected consumer price will still be about USD 42, which will likely be unaffordable for most patients, especially given that private doctors are evidently willing to prescribe TB drugs based on clinical signs and CxR findings.  **Advancing the TB Response**  PhilSTEP 1 (2017-2023) has been recently updated guided by recommendations from various studies and assessments conducted particularly the NTP Joint Program Review in October 2019. Between 2020 to 2023, the Updated PhilSTEP 1 targets about 50M Filipinos to be screened for TB using chest X-ray and 12.8M presumptive TB cases will be tested with a bacteriologic test. About 1.9M TB cases will be enrolled for treatment (including 39000 DRTB) with 90% and 85% TSR for DSTB and DRTB cases respectively. Shorter term TB preventive therapy will also be introduced to reach at least 685,000 patients from active case finding efforts, including PLHIV, close contacts, and specific risk groups.  To achieve these targets, the Updated PhilSTEP 1 identifies 14 key strategies:   |  |  | | --- | --- | | **TB Care Cascade** | **Key Strategies** | | Screening | 1. Active Case Finding [[5]](#footnote-6)via community based mobile CxR and diagnostics 2. Intensified Case Finding [[6]](#footnote-7)in Health Facilities 3. Enhanced Case Finding [[7]](#footnote-8)through community mobilization 4. Contact investigation | | Testing & Diagnosis | 1. Push compliance to mandatory case notification 2. TB MOLECULAR TEST expansion and utilization 3. LPA/DST Optimization 4. Improve quality of diagnosis | | Treatment | 1. Establishment of province/citywide HCPN offering full TB care continuum 2. Adoption of people-centered care 3. Strengthen active Drug Safety Monitoring and Management 4. TB-HIV Collaboration | | Prevention | 1. Adoption of innovative TB Preventive Treatment 2. Infection prevention and control |   Further to the Global Fund, the United States Agency for International Development (USAID) is providing significant support to the Philippines for Tuberculosis and specific health systems strengthening concerns. The USAID/TB Innovations and Health Systems Strengthening (TB IHSS) and USAID/TB Platforms for Sustainable Detection, Care, and Treatment (TB Platforms) is supporting the NTP in improving the various elements in the delivery of the TB care continuum. The USAID/Medicines, Technologies, and Pharmaceutical Services Program (MTaPS)provides technical assistance to DOH, specifically the Procurement Service and the Supply Chain Management Service, Food and Drug Administration, and Pharmaceutical Division in strengthening the country’s pharmaceutical systems to ensure sustainable access to and appropriate use of safe, effective, quality-assured, and affordable essential medicines and medicine-related pharmaceutical services. USAID/Health Equity and Financial Protection Platform (ProtectHealth) is working with DOH and PhilHealth to strengthen the country’s health financing system to improve financial protection and equitable access to health services to improve TB and Family Planning outcomes. USAID/Human Resources for Health 2030 (HRH2030) is working with the DOH Health Human Resources Bureau to build its capacity in development, deployment, training, and management of health workforce to improve equity, access, and quality health services. USAID/Institutionalization of the Health Leadership and Governance Program (IHLGP) is providing technical assistance to DOH regional offices and selected local chief executives by strengthening health leadership and governance. USAID Washington through its Technical Assistance Support to Countries (TASC) and Sustaining Technical Analytic Research (STAR) mechanisms seconded two specialists to support NTP Management Office in strategic decision making and in operations.  Furthermore, the World Health Organization (WHO) has been continuously providing technical assistance to NTP through a Medical Officer providing strategic-level TA at the national level and one Technical Officer providing operational-level TA at the subnational level. Specific for health systems strengthening, WHO has deployed one coordinator, and three technical focal points: one for health policy and financing, one for essential medicines and technologies, and one for health information systems and human resources.  The NTP maintains close coordination and collaboration among its various implementers through regular conduct of TB Technical Working Group meetings and sub-TWG meetings where both USAID Activities and GF AccessTB Project are always represented. The NTP also reports regularly to the National Coordinating Committee (NCC) as mandated by the TB Law. |

## Lessons Learned from Global Fund and Other Partner Investments

Describe how Global Fund and domestic investments, as well as those of other partners, supported national health targets during the current allocation period. Include the main **lessons learned** that are relevant to this funding request (for example, innovations or bottlenecks in service delivery).

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| The Philippines is currently implementing the AccessTB Project supported by TGF covering 2018-2020. It is focused on improving the service delivery system for MDR TB and TB-HIV collaboration, finding missing TB cases through ACF and supporting operationalization of the Integrated TB Information System (ITIS). Key insights ad learning from this ongoing GF TB grant (and other ongoing TB initiatives) supported prioritization of interventions included in this funding request.   1. **On finding missing TB cases.** The conduct of systematic screening through active case finding among high risk groups [[8]](#footnote-9)in communities and closed settings using mobile CxR and intensified case finding through symptomatic screening + free CxR voucher system positively resulted in 3-6% increase in case notification in the project areas. However, limited access to TB molecular RTD contributed to initial loss to follow-up of identified presumptive TB for testing and high clinical diagnosis. It is recommended that these innovative case finding initiatives should be scaled-up (a) through active engagement of local government units, civil society organizations, & community volunteers – to augment the already burdened primary care facilities; and (b) with design modifications to include on-site CxR reading and immediate TB molecular RDT (one-stop-same-day approach). Key insight learned also included the need to strengthen linkage of ACF initiatives to HIV testing and provision of TPT among eligible groups. 2. **On mandatory case notification.** Both the 2019 JPR and the 2020 TGF-CT TB Portfolio Analysis recognized the significant contribution in TB case notification (10% of all cases notified in 2018) resulting from the deployment of TB Notification Officers to engage stand-alone physicians and sub-clinics in hospitals. However, it was noted that more than 95% of those cases notified were clinical diagnosis and treatment outcome is not reported. Key insight in advancing this intervention is expanding the role of TB notification officers to build the capacity of private health care providers to comply with the NTP TB diagnostic and treatment algorithms, including utilization of the Integrated TB Information System that is linked to the mandatory TB case notification platform. Furthermore, there is a need to incentivize the private health care providers by providing access to TB MOLECULAR TESTs, free medicines, and financial incentives through optimizing PhilHealth. 3. **On making TB molecular RDT as primary diagnostic tool.** While the NTP MOP identifies molecular TB molecular RTD as primary diagnostic tool for TB, access to TB molecular RTD machines and commodities remain limited. With the high number of missing cases and the limited domestic investment for TB molecular RTD now, optimizing systematic screening and prioritizing most at risk population groups (PLHIV, contacts, and PDL) is critical. Furthermore, the engagement of sputum transport riders (STRiders) showed success in increasing access to TB molecular RTD and reducing turnaround time, as such was recommended to be continued until enough TB molecular RTD facilities have been established for the country. In addition, health promotion efforts are necessary to increase awareness and acceptance of medical doctors of TB molecular RTD for TB diagnosis and reinforce understanding to limit the use of CxR for screening purposes only. On a related note, the Xpert MTB/Rif should be leveraged to support improving access of PLHIVs for viral load testing.      1. **On TB Preventive Treatment.** The coverage of TPT (among all eligible) in the Philippines in 2018 is estimated to be at 1%. Without scaling up efforts to increase coverage of managing latent TB infections and TPT, TB cannot be eliminated by 2035. Furthermore, there is a need to introduce innovative TPT technologies that are more patient friendly. 2. **On implementing MDR-TB.** The combination of decentralizing MDR TB treatment in iDOTS facilities with home-based care options, adopting an all-oral standard treatment regimen, and patient enabler package resulted in better health outcomes. It was also noted that all-oral regimen yielded better treatment outcomes versus the conventional treatment regimen—TSR among DR TB case was 69% (3815/5549) for 2018 cohort using standard shorter treatment regimen and 33% (233/703) for 2018 cohort using conventional treatment regimen. Furthermore, discussions with key affected populations provided key insights in improving the patient enabler package to consider livelihood support to mitigate catastrophic cost to patients and their families. Furthermore, the DS and DR TB case management capabilities should be expanded to include the private sector for a more comprehensive TB Health Care Provider Network (HCPN)- as envisaged under the UHC Law. Vital to private sector engagement however, is their compliance with the NTP protocols to ensure provision of quality clinical care, while the public sector can provide their patients with essential public health care (e.g., contact tracing, home visits), as evident in all high-quality TB care settings like Japan and Taiwan. 3. **On TB-HIV Collaboration.**  HIV testing among TB patients in facilities capacitated by the current TGF TB grant is around 80% HIV testing among TB patients. It is recommended that nationwide coverage to support all TB facilities and HIV hubs would improve national performance. Furthermore, there is recognition on the need to leverage active TB case finding initiatives among most at risk populations by strengthening link to HIV testing. 4. **On TB Information Management.** The Integrated TB Information System (ITIS) is the official source of TB information in the Philippines. While designed as a real time data recording and reporting system, users still do not use it on real time. This is probably due to parallel implementation of paper and electronic recording. As such, there is a need to stop the paper-based system and fully support real time data recording in IT IS and manage program performance using the data. In addition, there is low utilization of the ITIS laboratory module which should be enhanced to mimic business process flow of laboratory personnel. Furthermore, the 2019 JPR also recommended the need to integrate the TB case notification platform into the ITIS and make it interoperable with other information systems (HOMIS, eHARP, FHSIS, eLMIS, SSS, GSIS, PhilHealth, FDA, etc.) 5. **On building resilient and sustainable systems for Health.** Immediate and long-term solutions are needed for health system elements that currently encumber program implementation for TB, HIV/AIDS and Malaria: (1) Increase the capacity for procurement at both the national and local levels to prevent/mitigate stock outs of medicines and commodities; (2) Reinforce data-driven decision making by maintaining information systems on logistics, laboratory, and human resources and establishing routines for data to drive operations; (3) Support advocacy initiatives to improve domestic sub-national resource mobilization to ensure sustainability of efforts currently augmented by donor funding; (4) increase capacity for service level performance management and continuous improvement of care pathways; and (5) address bottlenecks in ensuring adequate and competent human resource for health across all levels of the health care delivery system. 6. **On supporting UHC implementation.** The road to full implementation of UHC in the Philippines, as provided by the UHC Act and its implementing rules and regulations is very challenging and will take a substantial amount of time. Critical in the process is identifying evidence-based implementation models that will feed policy development and implementation. A critical insight from consultations with key stakeholders is to leverage the FR and other donor projects to optimize the NTP as a tracer program in testing approaches towards technical, managerial and financial integration under UHC.   AuTuMN (Australian Tuberculosis Modelling Network) team conducted an epidemiological and economic analysis for the DOH-NTP in 2017 through TGF Special Initiative of Optimizing Value for Money and Financial Sustainability. Optimization revealed that systematic screening in all risk groups including prisoners, urban poor, rural poor, PLHIV and diabetes is the most impactful intervention. Engagement of providers not compliant with NTP protocol and molecular TB MOLECULAR TESTs replacing smear microscopy as primary diagnostic are the second and third most impactful interventions, respectively. |

# Section 2: Funding Request and Prioritization

To respond to the questions below, refer to the *Instructions,* as well as national strategy documents, **Programmatic Gap Table(s), Funding Landscape Table(s), Performance Framework, Budget and Essential Data Table(s)**.

## 2.1 Overview of Funding Priorities

Summarize the **approach used for prioritization** of modules and interventions (or in the case of Payment for Results, the performance indicators and/or milestones). The response should include:

* How these prioritized modules ensure the highest possible impact with a view to ending the epidemics of HIV, TB and malaria; and
* How challenges, barriers and inequities, including those related to human rights and gender, are being addressed through the modules prioritized within this funding request.

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| Over-all, the funding request (FR) directly contributes to priority commitments targeted by the Updated PhilSTEP Phase 1. These commitments are anchored on the cascade of care approach to find and successfully treat the missing TB cases and to increase coverage of TB Preventive Treatment. The FR strongly aligns with the (1) application focus requirements detailed in the allocation letter received by the Philippines for TB, (2) TGF Country Portfolio Analysis, (3) recommendations from the 2019 Joint Program Review, (4) recommendations from key affected population during the various stakeholder consultation sessions in updating the PhilSTEP Phase 1 and the Joint Philippine Country Dialogue conducted in February 2020.  In addition, the FR leverages on key learning and accomplishments of successful interventions from the current TGF TB grant ( as detailed in Section 1.3) and strategically placing TGF investment for 2020-2023 to advance UHC implementation, by using the National TB Program as a tracer program to demonstrate operational elements of technical, managerial, and financial integration of systems at the province/city-wide level, including their health care provider networks with public and private providers.  The country adopted a multi-stakeholder and participatory approach in prioritizing interventions to be included in the FR, ensuring that key affected population, public and private health care providers, civil society organizations, government leaders, and other interest groups were given a voice in the entire prioritization & allocation process.  As a guiding principle, the FR was allocated to cost items that complements the current limitations in the use of government funds & other donor investments. Critically, evidence-based key interventions were selected to directly contribute to national targets. RSSH initiatives were also selected to support creation of an enabling environment to sustain the effort in the medium and long term.  The approach used for prioritization followed this process:   * NTP Joint Program Review, October 2019 * PhilSTEP 1 Updating Workshop by core group/experts, November 27-29, 2019 * Consultation session with KAP on the draft updated PhilSTEP 1, Dec 2019 * Consultation with CSO on the draft updated PhilSTEP 1, Dec 2019 * Consultation with Providers on the draft updated PhilSTEP 1, January 2020 * Consultation with the National Coordinating Council, February 2020 * Consultation with DOH Regional Coordinators, February/March 2020 * Joint Philippine Country Dialogue, January 13-16, 2020 * FR for TB targeting session, January 23, 2020 * FR for TB technical writing workshop, February 26-28, 2020 * FR review by TB TWG (WHO, USAID, NTP), PCOC, and TGF CT, March 6-13, 2020 * FR revision to final version, March 16-17, 2020 * PCCM presentation and endorsement of FR for TB, 18 March 2020 * Packaging and submission of FR for TB to TGF, 20 March 2020   In a nutshell,   * **About 58% (USD 74,291,746)** of the FR will support MDR TB case detection and management. This is critical as the government maintains 100% cost coverage for DSTB case detection and management, while setting up its systems to increasing resources for DRTB case management. * **About 24% (USD 30,575,894)** of the FR will be used to support finding the missing TB cases through (1) active, intensified, and enhanced case finding interventions among high risk groups (PLHIV, patient contacts, PDL, and urban poor), (2) engaging private health providers to comply with the mandatory case notification, outcome reporting, and compliance to the NTP Diagnostics and treatment protocols, and (3) introducing & scaling up adoption of innovative TB preventive therapy among PLHIV and patient contacts. * **About 4% (USD 4,527,759)** of the FR will be allocated to ensuring TB-HIV co-management is delivered in all TB care facilities and HIV treatment hubs nationwide. * **About 6% (USD 9,337,690)** of the FR will be allocated to cross cutting interventions to support RSSH interventions relative to improving procurement & supply chain management systems, improving public health financial management systems, improving interoperable management information systems, and addressing specific human rights and gender related concerns.   + - HMIS & ME: 2,608,394     - HPMS: 985,895     - HSGP: 1,478,843     - Lab Strengthening: 3,240,000     - HR: 1,024,558 * **About 8% (USD 10,363,079)** will be used by the Principal Recipient to ensure the grant is managed efficiently and surrounding risks are mitigated, if not eliminated. |

## Funding Priorities

1. Based on the Global Fund Modular Framework, use the table below to detail **each** **prioritized module** proposed for Global Fund investment for the relevant disease component(s) and/or Resilient and Sustainable Systems for Health (RSSH).

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| **COMPONENT:** *Tuberculosis* |

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| **Module # 1** | MDR TB |
| **Intervention(s) & Key Activities** | 1. Full adoption of the all oral shorter treatment regimen for MDR TB treatment and implementation research on the use of BPAL for XDR TB treatment. 2. Full adoption of TB molecular RDT as primary diagnostic tool. 3. Establishment of two additional LPA Centers 4. Provision of quality assured laboratory tests necessary for baseline and treatment progress monitoring, particularly for TB molecular RDT, DST, sputum microscopy, and culture. 5. Set up two additional LPA centers (currently with 3) for full country coverage. 6. Testing and adaptation of digital technologies as part of the end-to-end digital solution. 7. Expansion of the patient enabler package to include options to learn technical-vocational skills that can support livelihood and reintegration into the community after treatment completion. The current package includes transport/treatment allowance, food provision, ancillary medicines, hospitalization, special diagnostics, special medical services, and post treatment laboratory follow-up up to 1 year. 8. Development of job aids and continuing the engagement of community volunteers linked to iDOTS and PMDT satellite treatment centers that support contact tracing activities in finding cases and supporting community/home-based care. 9. Continuing the engagement of STRiders in transporting specimens to increase access to TB molecular test, reduce turnaround time, and prevent initial loss to follow-up by prompt initiation of treatment. 10. Decentralization of MDR TB case management in at least 2,600 primary care facilities by integrating a comprehensive TB care services into the Health Care Provider Network (HCPN) as envisaged in the UHC Act (iDOTS Phase 2). 11. Strengthening supportive supervision for continuous provision of people-centered clinical care management of DRTB patients, including supporting patient treatment literacy, aDSM, and treatment adherence monitoring. |
| **Priority Population(s)** | DR TB patients, contacts of DR TB patients, retreatment cases, PLHIV |
| **Barriers and Inequities** | * There is a need for the adoption of TB molecular RDT for better diagnosis and increase in capacity for DST. * MDR TB TSR is low and can be improved with the adoption of all oral shorter treatment regimen. * High loss to follow-up and poor treatment adherence can be addressed by decentralizing MDR TB case detection and management and integrating it in the primary care facilities and providing options for community/home-based care supports reducing the TB stigma and risk of discrimination among the patients, their families, health care providers, and the general public. |
| **Rationale** | This module was prioritized for this FR considering that the case notification gap for DR TB cases in 2018 is more than 60% and TSR is less than 70%. Furthermore, government requires time to prepare its systems and resources to fully finance MDR TB case detection and management. All interventions listed above are based on WHO guidelines, recommendations from the 2019 JPR, effective AccessTB project interventions, and key affected population recommendations during the NSP development and country dialogue. |
| **Expected Outcome** | * The FR investment will directly contribute to the Updated PhilSTEP Phase 1 targets as presented below:  |  |  |  |  | | --- | --- | --- | --- | | **Indicators** | **2021** | **2022** | **2023** | | MDR TB notified cases  *(Proportion vs total estimated cases)* | 9,288  (53%) | 10,655  (58%) | 11,713  (62%) | | MDR TB enrolled for treatment | 8,360  (90%) | 10,122  (95%) | 11,127  (95%) | | MDR TB patients tested with LPA  *(Proportion versus eligible pop)* | 8,360 | 10,122 | 11,127 | | MDR TB Treatment Success Rate | 75% | 85% | 85% |  * Scale up in use of TB molecular diagnosis for both public and private health care facilities. * Establishment of functional TB HCPN for all 2600 iDOTS facilities. * Establishment of EQA protocols for LPA and Xpert |
| **Expected Investment** | **USD 74,291,746**  Specific to procurement of SLDs and Ancillary Medicines, DOH will procure the following requirements: 2021: 12%; 2022: 17%; and 2023: 22%$4,806,522 |

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| **Module # 2** | TB Care and Prevention |
| **Intervention(s) & Key Activities** | 1. **Active/Intensified/Enhanced Case Finding among most at risk and vulnerable population groups.** This will be done by scaling-up four ACF (guided by the 6th edition of the NTP-Manual of Procedures) activities currently being done under the AccessTB Project and TB Innovations Project that yielded promising results:    1. *PR will optimize use of four existing mobile clinics as a one-stop-shop facility for TB diagnosis, being equipped with Digital Xray with AI and Xpert MTB/Rif to find missing cases among poor communities in the NCR, Region 3, and Region 4A. This will be guided by a presumptive masterlist generated by the TB facilities and link to HIV testing and TPT will be an integral part of the service.*    2. *Approach is like that of (a) but ACF will be managed by twenty NGOs contracted by the PR to cover the rest of the regions. Furthermore, it will include TB & HIV education sessions and outsourcing of CxR mobile vans.*    3. *Intensified case finding in high-volume facilities. Following a selection criterion, PR in consultation with DOH will identify high-volume facilities (public and private hospitals and diagnostic facilities) nationwide where ICF using CxR voucher system will be arranged. Protocol will be consistent with the guidelines for ACF in facilities as outlined in the NTP MOP.*    4. *PR to engage the Bureau of Jails Management and Penology (BJMP) for the conduct of ACF among PDLs nationwide, following the guidelines outlined in the NTP manual of procedures. A new element in the approach is including HIV testing as part of the service offering.* 2. **Construction of isolation facilities in two (2) highly congested prisons**. AccessTB supported BUCOR in setting up an isolation facility in Taguig (Camp Bagong Diwa), which proved to help in better TB care management among inmates. This will be replicated as port of this FR in Visayas and Mindanao. Sites will be selected with BUCOR/BJMP, following the previous criterion and arrangements. Note that isolation facilities also become a referral point for nearby jails and prisons. 3. **Introduction of shorter regimen for TPT and scale-up coverage.** The FR will support procurement of shorter regimen for TPT, including support NTP and other implementing partners in conducting large-scale demand generation initiatives to increase uptake among eligible population groups. Part of the ensuring TPT as part of contact tracing of all TB patients more specifically bacteriologically confirmed cases. LTBI management is also part of the various ACF activities planned under the FR. 4. **Case Finding through Private Health Care Provider Engagement.** PR will engage a sub-recipient to oversee this intervention in close coordination with the regional DOH offices and the selected local government units, preferably aligned to the UHC implementation sites. The over-all approach is to develop and roll-out a capacity building package to support stand-alone physicians to comply with (1) mandatory case notification, (2) NTP TB diagnosis and treatment protocols, and (3) record and report TB data using the ITIS. The intervention will be implemented in the big three regions and 14 highly urbanized cities nationwide. This intervention will engage the TB Notification Officers currently engaged by AccessTB Project with expanded roles. Furthermore, incentives for private sector will be developed to include: (a) providing RDTs and/or TB medicines for free or at reduced cost; and (b) include the compliance with protocols and reporting as part of requirements for accreditation or license renewal. 5. **Health Promotion** campaign among health care providers to correct practices on use of CxR, promote effectiveness of TB molecular tests, innovative case management protocols for both DS and DR TB cases, and use of innovative TPT for LTBI case management. |
| **Priority Population(s)** | Contacts of TB patients, People Deprived of Liberty, Urban Poor, Elderly, poor/malnourished, smokers, diabetics, alcoholics, PLHIV |
| **Barriers and Inequities** | * Innovative ACF interventions provides free TB care services among the poor communities in urban slum areas and among the elderly with limited mobility. Furthermore, it provides opportunity for working men and women to access TB diagnostics during weekends/ off-work hours. * Information-education campaigns that accompany ACF increases awareness of people on their rights and benefits in accessing quality TB care. * ACF in jails and prisons, including establishment of isolation facilities and training of judicial officers aims to address inadequate conditions and services provided to people deprived of liberty. |
| **Rationale** | The top priority of the NTP is finding the missing TB cases and as recommended during the 2019 JPR, there is a need to scale up effective active case finding initiatives and increase uptake of innovative TPT to rationally move closer to TB elimination by 2035. In 2018, mandatory case notification among private healthcare providers contributes to 18% of all notified cases. However, 95% of these cases were clinically diagnosed TB cases and treatment outcomes were not reported. This information prompts the need to actively engage private healthcare providers to become part of the comprehensive TB care services integrated in the HCPN.—i.e. aligning their TB care delivery practices with the NTP diagnosis and treatment algorithms, including recording and reporting of TB data. The approach to engaging private care providers in this FR is scaling up the utilization of TB notification officers, which proved successful in the current TGF TB grant – AccessTB Project.  Important to note that 2016 NTPS found out that among Filipinos showing TB symptoms that consult a medical professional, 31.8% go to the private provider. This is higher than in 2007 (21.7%) NTPS finding. |
| **Expected Outcome** | * The FR investment will directly contribute to the Updated PhilSTEP Phase 1 target on TB case notification as presented below:  |  |  |  |  | | --- | --- | --- | --- | | **Intervention** | **Notified TB Cases** | | | | **2021** | **2022** | **2023** | | Systematic Screening via ACF/ICF/ECF among Vulnerable Population Groups | 18,456 | 22,456 | 26,456 | | ACF for PDL | 5,400 | 5,130 | 4,874 | | Private Sector Engagement | 75,750 | 92,925 | 97,615 | | **Total** | **99,606**  **(20%)** | **120,511**  **(22%)** | **128,945**  **(22%)** |  * It is expected that increased awareness among judicial officers will create an enabling environment for PDLs to access TB and HIV care more easily and the setting up of isolation facilities will mitigate TB transmission in prisons. * The FR investment will also directly result to enrollment in TPT among contacts of TB patients from ACF interventions estimated to about 9,228 patients in 2021, 16,169 patients in 2022 and 25,927 patients in 2023. * Improved market access to innovative TPT would have been achieved in the country. * About 10,103 stand-alone physicians will be engaged *(8,703 MDs from the big three regions currently complying with mandatory case notification in the current grant plus 1,400 MDs from 14 highly urbanized cities to be engaged through this FR)* to be part of the TB health care provider network. |
| **Expected Investment** | **USD 30,575,894**  Specific to the procurement of Xpert cartridges needed in ACF activities mentioned above, the share by year is estimated at:  DOH 2021: 400,000; 2022: 500,000; and 2023: 600,000 | Total: 1.5 million  TGF-FR 2021: 182,133; 2022: 154,912; and 2023: 115,542 | Total: 452,588 |

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| **Module # 3** | TB-HIV Collaboration |
| **Intervention(s) & Key Activities** | 1. Build capacity of 1,885 TB facilities for PICT & HIV proficiency and strnegthne collaboration of 118 HIV hubs to TB care facilities. 2. Use of all TB Xpert machines for HIV viral load testing. 3. Provision of free HIV testing among TB patients and baseline laboratory testing required for ART initiation among those tested positive for HIV. 4. Support EQA for TB laboratories providing HIV testing. 5. Production of job aids for TB care providers in conducting PICT. 6. Advocacy among HIV care providers on adopting innovative TPT. 7. Provision of B6 supplementation to prevent peripheral neuropathy among INH users. |
| **Priority Population(s)** | TB patients, PLHIV,118 TB-HIV patients |
| **Barriers and Inequities** | * Building the capacity of TB facilities and HIV treatment hubs on TB-HIV co-management reduces stigma and discrimination among patients. * Optimization of available Xpert machines in TB facilities for HIV viral load testing improves access to the service among economically challenged PLHIVs. * Capacity building on PICT among TB care providers and TB care protocols among HIV care providers reduces provider stigma and discrimination and support people-centered care delivery. |
| **Rationale** | TB disease as a leading cause of mortality among PLHIV and recognizing the stigma attached to both diseases and relative risk of discrimination, it is critical to create an enabling environment for collaboration. Furthermore, there is a need to increase HIV testing coverage for TB patients as recommended by WHO guidelines. Collaboration between the TB and HIV program has efficiency gains in finding missing cases for both diseases and improving TPT coverage. |
| **Expected Outcome** | * The FR investment will directly contribute to the Updated PhilSTEP Phase 1 targets as presented below:  |  |  |  |  | | --- | --- | --- | --- | | **Indicators** | **2021** | **2022** | **2023** | | *Percentage of registered new and relapse TB patients with documented HIV status* | 60%  198,783/331,305 | 80%  260,475/325,594 | 90%  281,252/312,502 | | Percentage of HIV-positive new and relapse TB patients on ART during TB treatment | 100%  2,982 | 100%  3,907 | 100%  4,219 | | *Percentage of PLHIV on ART who initiated TB preventive therapy among those eligible during the reporting period.* | 75%  5,573/7,430 | 80%  8,920/11,150 | 85%  11,140/13,106 |  * 100% of all TB facilities and HIV hubs will have capacity to provide TB-HIV collaborative services. * 100% of all Xpert sites to cater to HIV viral load testing |
| **Expected Investment** | **USD 4,527,759** |

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| **Module #4** | Resilient and Sustainable Systems for Health |
| **Intervention(s) & Key Activities** | **Health Products Management and Systems Strengthening (HPMSS)**   * Improve regulatory and quality assurance by supporting the building of an enterprise solution/enterprise resource planning (ERP) for the Food and Drug Administration (FDA), to include the automation of business processes leading to the registration of health products including second-line drugs for TB, new preparations for HIV (e.g., DTG) and malaria (e.g., artesunate-pyronaridine) with provisions for improved reporting and monitoring of adverse events and drug resistance, where appropriate. * Provision of two (2) High Performance Liquid Chromatography (HPLC) machines to hasten quality testing of government procured drugs as prioritized/requested by FDA to improve their turnaround time. * Temporary deployment of PSCM Officers in the 17 DOH Regional Offices to support PSCM activities and initiate testing and adoption of PSCM-related policies and protocols downloaded from DOH. This is included in the FR while DOH is developing its HR masterplan. * Develop and help implement guidance on the use of pooled procurement agreements/instruments, infrastructure and services at regional level, build the capacity of the selected provinces for pooled procurement, including the use of metrics to monitor procurement efficiency and supplier's performance. * Support building local government staff capacity in electronic inventory management and distribution medicines and related health products at LGU level and develop performance monitoring mechanisms and indicators, as well as electronic dashboards and stock security monitoring reports; build subnational contracts management capacity in these province/city-wide health systems. * Support the operationalization of the electronic Logistics Management Information System (eLMIS) of the DOH at the national and local levels.     **Health Sector Governance & Planning (HSGP)**   * Support review and integration of the PhilHealth TB, HIV/AIDS and malaria benefit packages in the context of a comprehensive primary care benefit package, to improve efficiencies and to integrate mental health interventions to promote adherence to treatment and minimize losses to follow-up (LTFU). * Support establishment of mechanisms to maximize complementation between health maintenance organization (HMO) services and the PhilHealth comprehensive primary care benefit package. * Build capacity of local government units in domestic resource mobilization, pooled procurement, strategic contracting of health care providers and patient navigators as part of the health care provider network (HCPN). * Capacitate LGUs in better operational planning and budgeting, and technical support to develop operational plans and annual budgets. * Support multisectoral engagement in the preparation and approval of local health investments plans. * Strengthen local health system capacity in financial management (systems for budgeting, accounting, reporting and assurance). * Capacitate LGUs in recording, reporting, analyzing and using financing data in decision making for better health outcomes.   **Health Management Information Systems and M&E (HMIS&ME)**   * Support PhilHealth and the DOH Knowledge Management Information and Technology Systems (KMITS) in the review, updating, design and testing of the National Health Information System (NHIS). * Ensure integration of the TB ITIS, HIV/AIDS eHARP and malaria OLMIS in the NHIS. * Build capacity in using the NHIS and other information systems for program performance management at the national level up the primary care facility level. * Support activities to prepare and advocate for a multisectoral, community-driven, integrated and systems-cognizant health policy brief/transition plan using TB, HIV/AIDS and malaria indicators for the incoming national policymakers and local chief executives in 2022. * Optimize the functionality of ITIS to support national and local NTP implementation for better health outcomes.   **Laboratory Systems**   * Develop a routine laboratory specimen transport system that can link different types and levels of service providers to centralized laboratories, regardless of disease. * Support in building regional capacity on strategic contracting for laboratory supply chain management, which includes mapping and optimizing lab networks and improve placements of multi-disease equipment in an integrated laboratory network. * Support creation of EQA protocols for RDTs |
| **Priority Population(s)** | Key Affected Population for TB, HIV/AIDS and Malaria |
| **Barriers and Inequities** | * HPMSS support will address the delay caused by long turnaround time of FDA in conducting quality check of procured medicines. Deployment of additional human resource ensures that national policies and guidelines are rolled out and the necessary additional support in navigating the eLMIS is available. * HSGP interventions aims to improve national health sector financing by supporting the creation of better PhilHealth care packages that can mitigate or prevent patients from experiencing catastrophic cost by optimizing available resource and facilitating new funding streams through domestic resource mobilization. * HMIS & ME interventions will focus on ensuring disease data is collected and analyzed to support evidence-based decision making on resource allocation and identification of appropriate strategies and interventions to address bottlenecks and contribute to better health outcomes. * Laboratory strengthening interventions will reduce initial loss to follow up by reducing turnaround time between diagnosis and treatment initiation. This guarantees prompt treatment and reduce risk of infection, complication, or death. |
| **Rationale** | The major health system barriers affecting the full implementation of the Philippine NTP are (1) the weak PSCM system of DOH which is at very high risk of causing stock out of medicines and health products; (2) lack of sufficient domestic financial investment commensurate with the necessary level of investment to fully implement the strategies and approaches identified in the Updated PhilSTEP Phase 1, and (3) inadequate permanent positions for human resources for health across the various levels of the health care delivery network.  While technical assistance requirements to enhance policies and protocols to address the abovementioned major health systems challenges are being provided by various USAID Projects (MTaPS, Protech Health, and HRH 2030) for TB, it is understood that the HIV/AIDS and malaria programs are also encountering similar challenges. An integrated, cross-cutting approach to RSSH as detailed above will benefit TB KAPs as well as those in HIV/AIDS and malaria; it will also extend benefits to health programs such as maternal and child health, NCDs, and others. Activities included in this FR are both immediate action requirements that can produce results within 2020 to 2023, and health system interventions that can have demonstrable effects in the UHC sites within the same timeframe. |
| **Expected Outcome** | * No occurrence of stock-outs of TB, HIV, Malaria, and other health program medicines and health products * Increased domestic investment to support the National TB, HIV, Malaria, and other health programs * Real time recording and reporting of TB, HIV and Malaria data to support quality care and service delivery, decision making, and performance management. * Faster turnaround time between TB diagnosis using TB MOLECULAR TESTs and TB treatment initiation |
| **Expected Investment** | **USD 8,313,132** |

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| **Module #5** | Removing Human Rights and Gender related barriers to TB services |
| **Intervention(s) & Key Activities** | * Mobilizing and empowering key affected populations by establishing a Patient Champions Pool that will be capacitated to advocate for improved health systems at the national and local government and among private groups to support the TB program. The champions pool will be comprised of selected TB patients and health care workers that can serve as the human face & voice of the TB disease. * Reducing stigma and discrimination and providing support services to TB patients by establishing a patient hotline and multi-media platforms that will serve as help desk for TB patient concerns. This platform will aid to patients in navigating their care pathway (for detection up to completed treatment), including promotion of TB-related rights, provision of legal assistance support and link to social risk protection options (Department of Social Welfare and Development, Social Security System, etc.) * Reducing stigma and discrimination in workplaces by engaging PBSP’s private sector network to comply with the Department of Labor and Employment – Occupational Safety and Health Center’s (DOLE-OSHC) Department Order for the establishment of TB & HIV Programs in Workplaces. This initiative will focus on building capacity of the private sector in designing and implementing TB workplace policies that will not discriminate applicants (during recruitment process) and provide support services to their existing workforce affected by TB disease. Furthermore, this initiative will support inclusion of the company health care provider to be part of the National TB Program and comply with TB mandatory notification and the diagnosis and treatment guidelines. * **Eliminating discrimination in health care settings by supporting an in-depth study** that will assess current practices of TB care providers at the primary care levels relating to stigma and discrimination. The end goal of the study is developing model programs/ technologies (aside from training) that can be adopted to improve the skills, attitude, and practices of health care workers in preventing HCW-initiated stigma and discrimination behaviors. Concomitant to this is investing in motivating HCWs to provide better care by institutionalizing a patient feedback portal for patients to evaluate HCW performance. This will serve as a basis for the program to identify model HCWs monthly (like employee of the month) and enable recognition and provision of tokens of appreciation. * **Training of Judicial Officers to streamline care delivery of PDL with TB.** In cooperation with DOJ, BUCOR, BJMP and courts, DOH-NTP will conduct learning sessions on the on the basics of Tuberculosis, the Philippine TB Law, related stigma and discrimination concerns and patient’s rights. Part of the support is mainstreaming their policies to enable a people-centered approach to TB-HIV care delivery among PDLs. |
| **Priority Population(s)** | TB Patients, Contacts of TB patients, urban poor, elderly, PDL, health workers, PDL |
| **Barriers and Inequities** | Stigma attached to TB is evident and there is anecdotal evidence of discrimination. No legal cases are documented, probably due to low awareness of patient rights (for both KAP and the legal aid providers), low patient literacy, and lack of access to legal aid. Creating a champions pool will provide a strong human face to TB to represent the NTP in advocacy initiatives. Also, TB Champions can serve as motivators and empower patients to address self-stigma. The TB Patient Hotline provides KAP access to information and services to resolve various needs surrounding their illness. This aims to increase knowledge on patient’s rights and identify access points for quality TB care delivery and social risk protection benefits. Furthermore, stigma and discrimination among health care workers happens but is not well understood. An in-depth study will answer various knowledge gaps to help NTP design measures to remove these barriers and genuinely adopt people-centered care across all levels of the TB care delivery system. |
| **Rationale** | The high burden of TB unconsciously prompted the DOH to be more clinical in its approach in implementing the national TB program and ensuring that human rights and gender related concerns and issues specific to vulnerable populations are addressed.  Furthermore, the high burden of TB promoted the DOH to be more clinical in its approach in implementing the national TB program and ensuring that human rights and gender related concerns and issues specific to vulnerable populations. For this FR, several interventions are being proposed to emphasize the value of managing the TB epidemic more holistically. |
| **Expected Outcome** | * Functional TB speaker’s bureau to advocate for the NTP * Functional TB patient hotline with satisfactory client satisfaction results * Scaled-up implementation of TB in the Workplace * More TB patients receive social protection from existing mechanism contributing reducing catastrophic cost * More health care providers adopting people-centered approaches in delivering the TB care continuum. * Comprehensive TB program for PDL |
| **Expected Investment** | **USD 1,024,558** |

1. Does any aspect of this funding request use a **Payment for Results** modality?

Yes  No

**If yes**, in the table below, indicate the relevant performance indicators and rationale for the choice of performance indicators and/or milestones.

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| --- | --- | --- | --- | --- | --- | --- |
| **Performance indicator or milestone** | **Target** | | | | **Rationale for the indicator/milestone selection for Global Fund funding** | |
| **Baseline** | **Y1** | **Y2** | **Y3** |
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|  |  |  |  |  |  | |
| Add rows if necessary |  |  |  |  |  | |
| **Total amount requested from the Global Fund** | | | | | |  |

Specify how the accuracy and reliability of the reported results will be ensured.

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| N/A |

1. **Opportunities for integration:** Explain how the proposed investments take into consideration:

* Needs across the three diseases and other related health programs;
* Links with the broader health systems to improve disease outcomes, efficiency and program sustainability.

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| The operationalization of the UHC Act is underway. One of the first interventions to be carried out is the provision by DOH of technical and financial support to selected LGUs that commit to province- or city-wide integration of local health systems. The DOH identified an initial thirty-three (33) such UHC Integration Sites (UIS) – 15 in Luzon (including 2 in NCR), 10 in Mindanao (including 1 in BARMM), and 8 in Visayas. The 33 UIS will be demonstrating financial integration, managerial integration, and technical integration, all of which will influence how TB, HIV/AIDS and malaria services are to be delivered. The FR will work on these sites and support its realization.  Included in the RSSH Module are health systems improvement concerns that will be addressed to support all three disease components:   * **[PSCM]** Providing support to DOH and LGUs in adopting procurement mechanisms will mitigate the occurrence of stock-outs, with features that will harness the advantages of economies of scale, in addition to ensuring high quality of the commodities, standardized processes, and uniform monitoring. * **[PSCM]** Providing FDA additional HPLC machines used to test drug quality will reduce waiting time between procurement and utilization of medicines. * **[PSCM]** Deployment of PSCM Officers in the DOH regional offices will ensure all medicines and health products for the three diseases are managed. * **[IS/M&E]** Supporting the interoperability of the various health information management systems for the three diseases with DOH enterprise architecture (HOMIS) will support data-driven decision making at both the national and local levels. * **[Financing]** Supporting the development of the PhilHealth Primary Care Package will support increasing domestic resources to support the three diseases. * **[Laboratory]** Optimization of specimen transport riders to reduce time between diagnosis and treatment initiation for all diseases.   Within the FR for TB, integration will be pursued to include:   * All Active TB Case Finding activities will include linkage to HIV testing and treatment among eligible population groups. * All Xpert sites of the NTP will be optimized to provide HIV Viral Load testing. * TB and HIV tests will be provided during TB ACF activities * ITIS will be enhanced to be interoperable with other health information systems |

1. Summarize how the funding request complies with the **application focus requirements** specified in the allocation letter.

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| This FR is anchored in the PhilSTEP Phase 1, which was recently updated to align with WHO and StopTB Partnership Program guidelines and the recommendations from the 2019 Joint Program Review. By and large, key strategies and approaches detailed in the Updated PhilSTEP 1 is consistent with the application focus requirements set by The Global Fund.  This FR focuses almost entirely on TGF investment to support vulnerable population groups.  This FR will support continuation of all essential programming funded by the Global fund in the 2017-2019 allocation period (AccessTB Project 2018-2020). This includes among others, finding the missing TB cases through evidence-based active case finding initiatives, scale-up on the use of molecular TB molecular RDT, full adoption of the all-oral shorter treatment regimen for MDR TB, DST for 1st and 2nd line drugs, provision of expanded enabler support for patients, expansion of TB-HIV collaboration on co-management, and enhancement & utilization of the Integrated TB Information System (IT IS). A new inclusion in this funding request is the introduction of innovative TPT and implementation research on the use of BPAL for XDR TB case management.  Private health care provider engagement is a significant inclusion in this FR. The approach aims to expand available human resources for health by engaging private health care providers to be part of the TB Health Care Provider Network. Doing this contributes to improving quality TB diagnosis by providing the access to TB molecular RDT, thereby reducing clinical diagnosis. Furthermore, private HCP engagement enhances the country’s TB data necessary for data-driven planning and implementation by maintaining a common case notification system and treatment outcome reporting through ITIS.  This FR also puts premium on various interventions that will address human rights and gender concerns surrounding TB, particularly reducing stigma and discrimination (self-stigma, health care worker stigma, and general public) by creating a TB champions pool that will lead health promotion and advocacy initiatives for the NTP, establishing a TB patient hotline to help advance patient literacy and access to medical and non-medical services (legal and financial assistance from various social protection platforms) and scaling up adoption of TB Programs in workplaces. Furthermore, enhancing the TB care package provided in jails and prisons to include HIV testing, construction of isolation facilities, and engaging judicial workers to adopt people-centered care measures for PDLs.  Civil society organizations, TB champions, and patient groups will be also actively engaged and equipped to support national and local advocacy initiatives for improved health systems and direct TB care delivery at the primary care facilities. Details on this are included in Section 3b.  The FR also includes investments for cross-cutting issues, thereby moving towards building a more resilient and sustainable health system. This covers immediate support for actions relating to (1) health products management and systems strengthening, (2) improving financial management systems, (3) enhancing health management information systems and M&E, and (4) improving laboratory systems. Details on the proposed actions can be seen in Section 2.2, Module 4. |

1. Explain how this funding request reflects **value for money**, including examples of improvement in value for money compared to the current allocation period. To respond, refer to the *Instructions* for the aspects of value for money that should be considered.

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| Considering that the Philippine CCM endorsed the current principal recipient to be maintained in the next grant cycle, start-up cost for this FR is almost null and reasonable cost references have already been established for all related international and financial transactions.  Procurement is guided by the PR’s Finance and Procurement Policy Manual, which is anchored on “value of money” and has been reviewed and accepted by TGF.  Major procurement items to include SLDs and Xpert cartridges are procured directly from the Global Drug Facility and Cepheid, respectively leveraging on reduced pricing guidelines already established by TGF.  The compensation and benefits packages provided to grant supported human resources for health is anchored on the DOH-recommended pay scale for donor-funded projects and adopts the PR’s pay scale for non-health positions. All positions are supported by detailed task descriptions with a list of competency requirements. Hiring is though competitive selection following the PR’s Human Resources Policy Manual.  In the preparation of this FR, allocative efficiency has been considered by determining the extent to which committed domestic funding can be optimized, followed by other donor commitments (particularly that of USAID), before the determination of where TGF investment will be allocated more efficiently.  Based on prioritization, 60% of the FR investment will support the MDR TB module followed by the TCP module (25%), TB-HIV (4%), RSSH & Human Rights (4%), and Program Management (7%). Based on the TGF cost categories, the FR cost driver remains to be support to various health products and PSCM at 43% share followed by human resources augmentation at 20% and 14% for living support to clients. About 11% are planned for accessing external professional services, 8% for travel related costs and 2% overhead cost in managing the grant.  The costing landscape of the Updated PhilSTEP 1 was prepared with much consideration of possible technical efficiencies. Part of the exercise was determining the allowable/unallowable costs items and funding priorities for each funding stream (NTP budget, PHIC budget, LGU Budget, USAID funds, WHO, etc.) vis-à-vis GF funding priorities and limitations. Some of the key demonstrations showing technical efficiencies adopted includes, but not limited to the following: (1) FR will support decentralization of MDR TB detection and case management at the primary care facilities. (2) Active case finding initiatives for TB has integrated HIV testing options. (3) FR investments on TB-HIV collaboration strengthens the capacities of both TB facilities and HIV hubs for co-management. (4) Xpert MTB/Rif which were initially procured to support TB diagnosis has been shared with the HIV program to support HIV viral load testing.  As previously highlighted, this FR focuses almost the entirety of TGF investment to support addressing barriers preventing equitable access of quality TB diagnostics and treatment, including preventive therapy for vulnerable population groups.  As the Philippines gear up to the full implementation of the UHC law, this FR is designed to use the TB Program as a tracer program in setting up Health Care Provider Networks, test alternative mechanism for procurement, modelling service contracting & payment mechanisms, and advocating for increase domestic resource mobilization. Learning and insights gained from interventions included in the FR will be used to support further enhancement of UHC policies, guidelines, and procedures towards a comprehensive and unified health system (technical, managerial, and financial) integration form the primary care to the national level. |

## Matching Funds (if applicable)

This question should only be answered by applicants with designated matching funds, as indicated in the allocation letter.

Describe how the **programmatic and financial conditions**, as outlined in the allocation letter, have been met.

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| The Philippines is eligible for additional catalytic matching fund for the TB portfolio amounting to USD 10M that will be accessed to find missing people with TB.  The FR reflects at least USD 20M for finding missing TB cases through systematic screening under the TBCP module. The additional USD 10M is being optimized to find missing TB cases through private health care sector engagement as detailed below. For the ongoing AccessTB Grant, roughly USD 14.4 M is allocated for TBCP – finding missing TB cases.  Between 2021 to 2023, engaging private providers will directly contribute to TB case notification as follows: 2021: 75,750, 2022: 92,925, and 2023: 97,615. Substantially, at least 10 103 private physicians in highly urbanized cities nationwide will be part of the comprehensive TB care network integrated in the HCPN.    In 2017 the NTP and partners developed a “National Action Plan for Public-Private Mix on Private Sector Participation in TB Care and Prevention, 2018-2022”. Given the important role of private healthcare in the Philippines health system, PPM has never received the budgetary and management priority that it deserves. PPM initiatives have been small, time-bound and externally funded. Currently, only a tiny proportion of private healthcare providers are engaged by the program: 677 providers are registered in ITIS but in the first 6 months of 2019 only 81 provided program-supported treatment and 285 referred patients, while 311 (46%) were inactive. There are only 146 private program-supported DOTS facilities, and only 108 are accredited with PhilHealth.    Private providers lack access to (and potentially awareness of and confidence in) affordable molecular testing for TB; they rely too much on chest x-rays and clinical diagnosis. As a result, many TB cases may be missed, and many of those treated for TB in the private sector may not have TB. A recently  established consortium of 15 private laboratories will soon avail Xpert cartridges and equipment at reduced prices. However, the expected consumer price will still be about USD 42, which will likely be unaffordable for most patients, especially given that private doctors are evidently willing to prescribe TB drugs based on clinical signs and CxR findings.  As part of the ongoing TGF Grant for TB in the Philippines (AccessTB Project), an assessment will be conducted in 2020 to review the progress of the country vis-à-vis the Public-Private Mix National Action Plan to better support the private sector engagement strategy being proposed under this FR.  In 2018, AccessTB Project introduced TB Notification Officers to promote mandatory case notification among private physicians in hospitals located in the big three regions. The intervention contributed to about 18% of total TB case notifications from 8,703 engaged private physicians. The matching fund will be earmarked to scale-up this innovative approach, with additional elements to optimize private health care provider engagement to also contribute to better diagnosis and treatment outcome results.  The new element to be added in scaling up this intervention is building capacity of engaged private physicians to become part of the TB Health Care Provider Network, beyond just simply engaging them to comply with mandatory case notification. Being part of the TB care network means engaged private physicians comply to NTP diagnostic and treatment algorithms and use ITIS for TB data real time recording and reporting. Furthermore, engaging private providers more sustainably increase human resources for TB and paves the way to better market access to TB molecular RDT and innovative medicines (SLD and TPT). Moreover, engaging the private providers will greatly improve quality of TB care delivery which will support a reduction in clinically diagnosed TB cases. It is important to note that in 2018, about 98% of all notified cases from mandatory case notification (from private providers) were clinically diagnosed. |

# Section 3: Operationalization and Implementation Arrangements

To respond to the questions below, refer to the *Instructions* and an updated**Implementation Arrangement Map**[[9]](#footnote-10).

1. Describe how the proposed **implementation arrangements** will ensure efficient program delivery.

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| The Philippine CCM endorsed the Philippine Business for Social Progress, Inc. (PBSP) as the principal recipient (PR) for TGF TB grant cycle 2021-2023. PBSP is the current PR for TGF TB grant cycle 2018-2020.  PBSP will directly administer the grant and implementation will be though the DOH national and regional centers, in coordination with the health facilities at the various LGUs.  For both MDR TB and TB-HIV Collaboration modules, PBSP will continue to operate following the current implementation arrangement for the AccessTB Project. For the RSSH module, PBSP will engage consultants/institutions through professional service agreements to deliver grant support requirements to target groups.  For TCP module, PBSP will continue to directly implement the ACF using four AccessTB mobile vans. PBSP will also directly manage service contracting of high-volume facilities for ICF using CxR voucher system. ACF in communities to reach the vulnerable population will be implemented through service contract engagement of at least 20 CSOs nationwide. These CSOs would have been selected to support in 2021-2023 based on their performance in the current grant performing the same function. The Philippine Coalition against Tuberculosis (PhilCAT) will be engaged as sub-recipient to manage and implement the intervention package in engaging private health care providers to be part of the comprehensive TB care network integrated in the HCPN.  The NTP TWG continues to provide technical oversight for the grant, and will regularly report to the PCOC and the PCCM.  Learning from the previous and current project operating structure, PBSP will move from a vertical structure (by module) to a horizontal structure - whereby teams will be organized by geographical coverage. This will allow more integrated management of the grant which proved to be more efficient considering the scale of operations.  Provisions within the grant agreement and the PBSP procurement policy will guide all procurement related activities of this funding request. The PBSP procurement manual details all policies and procedures related to procurement and supply chain management of PBSP, which is applied to all its programs and projects. Noteworthy is the presence of Bids and Awards Committee, PBSP Levels of Authority Manual, and a Fixed Assets Registry. Procurement of SLDs will remain to be via the GDF. |

1. Describe the role that **community-based organizations** will play under the implementation arrangements.

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| PBSP will engage PhilCAT, an NGO, as Sub-recipient for private health care provider engagement in finding missing TB cases.  About 20 NGOs will be engaged to support ACF in communities to find missing TB cases among most at risk population groups. Community Health Volunteers (CHV) from CBOs and patient groups will also be engaged to support contact investigation and case holding (for both DS and DR TB cases) in high-volume iDOTS facilities in the 33 highly urbanized cities. Selection of STRiders will also prioritize hiring of qualified individuals from the key affected population (KAP) groups.  As part of patient empowerment and reducing stigma and discrimination, PBSP through the NTP will organize a TB Champions Pool to be capacitated to serve as advocacy champions at the national and local levels. The pool will be selected among the key affected population groups, including health care workers and community leaders, local chief executives, and/or key personalities/influencers. They will be capacitated on public speaking and will be supported to participate in national and local advocacy initiatives.    The membership of the NTP TWG includes permanent representation from CSOs and KAP. As practiced, all ad hoc committees established to support implementation and evaluation of NTP interventions consciously includes representation from CSOs and KAP. |

1. Does the funding request envisage a **joint investment platform** with other institutions?

Yes  No

If **yes**, describe specific arrangements and modalities.

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| N/A |

1. Describe key, **anticipated implementation risks** that might negatively affect **(i)** the delivery of the program objectives supported by the Global Fund, and/or **(ii)** the broader health system. Then, describe the mitigation measures that address these risks, and which entity would be responsible for these mitigation measures.

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| **Key Implementation Risks** | **Corresponding Mitigation Measures** | **Entity Responsible** |
| **[Program Quality]** High initial loss to follow-up in ACF activities | For ACF mobile vans, to include CxR and Xpert for a one-stop-shop approach.  For ACF in communities to optimize STRiders to ensure linkage to Xpert sites and fast turnaround time for diagnosis to treatment initiation | PR |
| **[M&E]** Breakdown of ITIS that will make TB data inaccessible. | Conduct regular maintenance checks for the IT IS and maintain data backup (on/off-site). | DOH-KMITS |
| **[Procurement]** Stock out of anti-TB Medicines and TB products/ commodities | For FLDs, to maintain buffer stock. For SLDs and Xpert cartridges to be routinely monitored. | NTP |
| **[In-country supply chain]** Delayed release by Bureau of Customs due to delayed DOH concurrence to consignments and related tax charging. | For GF procured goods, to be monitored closely and provide support to DOH to process immediate release | NTP, PR |
| **[Grant Related Fraud & Fiduciary]** Misuse of grant funds | Conduct of routine and special financial monitoring activities to all PR personnel, SRs and service contractors involved in financial and procurement transactions. Ensure that the Enterprise Risk Management System is in place and operational. | PR/PBSP |
| **[Grant Related Fraud & Fiduciary]** Loss, theft of non-financial assets | Ensure fixed assets registry is up to date and assets are covered by insurance. Ensure FAR is reconciled with expenditure reports. Ensure safety and security checks are made in all facilities with GF properties. | PR |
| **[Quality of Health Products]** Delay in distribution of procured medicines due to delay in FDA drug test quality feedback | Provide HPLC machine to FDA to support faster testing of drug quality | PR |
| **[Macroeconomic]** Potential foreign exchange loss | Use of USD as grant currency and conduct of close monitoring of forex movement and maximizing strength of peso by timely conversion to mitigate forex loss. | PR |
| **[Disaster Risk]** Delay in program implementation due to natural or man-made disasters, including epidemics. | Ensure all TB and HIV Care facilities have business continuity plans or facility emergency protocols.  Insurance for fixed assets put in place and coverage of medical/accident and life insurance of personnel supporting the grant | NTP, PR, |

# Section 4: Co-Financing, Sustainability and Transition

To respond to the questions below, refer to the *Instructions*, the domestic financing section of the **allocation letter**, **the** [Sustainability, Transition and Co-Financing Guidance Note](about:blank)**, Funding Landscape Table(s), Programmatic Gap Tables(s)**, **and a sustainability plan and/or transition work-plan**, if available[[10]](#footnote-11).

## Co-Financing

1. Have **co-financing commitments** for the **current** allocation period been realized?

Yes  No

If **yes**, attach supporting documentation demonstrating the extent to which co-financing commitments have been met.

If **no**, explain why and outline the impact of this situation on the program.

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| N/A |

1. Do **co-financing commitments** for the **next** allocation period meet minimum requirements to fully access the co-financing incentive?

Yes  No

If details on commitments are available, attach supporting documentation demonstrating the extent to which co-financing commitments have been made.

If co-financing commitments do not meet minimum requirements, explain why.

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| N/A |

1. Summarize the **programmatic areas** to be supported by domestic co-financing in the next allocation period. In particular:
   * 1. The financing of key program costs of national disease plans and/or health systems.
     2. The planned uptake of interventions currently funded by the Global Fund.

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| Domestic investment for active **case finding** is increasing, whereby grant funds (primarily from TGF) have been leveraged by DOH-NTP allocations to the DOH regional offices and LGU resources to conduct active case finding among poor communities nationwide. The grant is also leverage with the Bureau of Corrections (BUCOR) and Bureau of Jails Management and Penology (BUCOR) to institutional TB case finding in jails and prisons nationwide. The grant has also been leveraged for TB case finding and preventive therapy in all HIV hubs nationwide, through expansion of TB-HIV Collaboration.    TB **case detection** through DSSM is free in all public facilities. While uptake is low, reforms in the Philhealth benefit package related to UHC aims to make CxR a primary benefit for all members (under the “Konsulta” package). As the country moves to using TB molecular RDT as primary diagnostic tool for TB, DOH-NTP will procure at least 1.5 million Xpert MTB/Rif cartridges between 2021-2023. In 2020, DOH approved procurement of 191 XPert MTB/Rif machines.  For TB treatment, all medicines to manage DS TB cases in adults and children are funded by DOH and LGUs (usually for pediatric formulations and TB medicines for adults during stock-outs). While MDR TB treatment is currently almost fully covered by the AccessTB project, DOH has committed to procure SLD and ancillary medicines for MDR TB patients, reflecting increasing share to target 1003 patients in 2021 (12%), 1721 patients in 2022 (17%) and 2448 patients in 20203 (22%). Specific for LGUs, a recent policy change in government budgeting (i.e., Mandanas ruling) will increase the fiscal space of LGUs by up to 30% which will be an opportunity to increase allocation for TB-related commodities.  For management of LTBI, INH therapy is free for PLHIV and children under 5. Beginning 2020, short term TPT regimen will be introduced. Part of the NTP plan for 2021 budget planning is to include procurement of innovative TPT at limited scale until evidence is established and local policies have been passed to allow full adoption of innovative TPT.  Based on the National Expenditure Program for 2020, the Department of Budget Management (DBM) has earmarked P7 billion for the HRH deployment program under the DOH Miscellaneous Personnel Benefits Fund. DBM has authorized the creation of 26,035 contractual positions under the HRH program. Contractual positions enjoy employer-employee relationship and are covered by civil service rules and regulations.  The Department of Labor and Employment – Occupational Safety and Health Center has invested in an online platform for workplaces to annually submit medical reports that will include TB Data. This will be linked to support compliance to establishment of TB in the Workplace Programs and CxR reporting among the private health care provider network. |

1. Specify how co-financing commitments will be **tracked and reported**. If public financial management systems and/or expenditure tracking mechanisms require strengthening and/or institutionalization, indicate how this funding request will address these needs.

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| USAID/Protech Health is currently working with DOH and PhilHealth to establish better mechanisms for financial planning and expenditure tracking.  At the DOH-NTP level, NTP-PMO will be tracking expenditure of NTP allocations to DOH regional offices and will be shared semi-annually as part of the NTP National Consultative Sessions.  At the level of the grant, PBSP will routinely track co-financing commitments and will be reported as part of the PUDR. However, official supporting documents showing co-financing will be provided after official release of DOH audited financial reports or similar document. |

## Sustainability and Transition

1. Based on the analysis in the **Funding Landscape Table(s)**, describe the funding need and anticipated funding, highlighting gaps for major program areas in the next allocation period.

Also, describe how (i) national authorities will work to secure additional funding or new sources of funding, and/or (ii) pursue efficiencies to ensure enough support for key interventions, particularly those currently funded by the Global Fund.

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| The total funding requirement of the updated PhilSTEP 2021-2023 is USD 1.1B. The major cost driver are pharmaceutical and non-pharmaceutical commodities which constitutes 83% of the requirement. This includes CxR, cartridges, FLD, SLD, and TPT regimens.  Multiyear commitments were obtained from DOH as well as USAID. The GF share reflected here is based on current Funding Request proposal, reflected here jointly with USAID as FAPS. LGU and Philhealth share were estimated using a 10% annual increase in LGU budget (mainly on HRH cost and 10% of annual FLD cost) and a 5-percentage point annual increase in percentage of patients supported by Philhealth reimbursements (from baseline of 10% in 2018). In addition, 25% of cartridge cost was attributed to LGU commitment for years 2022-2023 based on reforms in government budgeting that will increase LGU budget allocation (i.e., Mandanas ruling) and CxR cost for health facility screening was attributed to Philhealth beginning 4th quarter of 2020 based on implementation of the revised Philhealth “Konsulta” package as initial reform related to the UHC. Considering all these, the funding gap is 52% (597 million USD).   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Updated PhilSTEP1**  **(in USD million)** | **2020** | **2021** | **2022** | **2023** | **TOTAL** | | **National Government** | 18 | 27 | 32 | 37 | **113** | | **Foreign Assisted Projects** | 24 | 29 | 29 | 31 | **113** | | **Local Government Unit** | 7 | 7 | 9 | 10 | **34** | | **PhilHealth** | 13 | 51 | 67 | 86 | **217** | | **Out-of-Pocket** | 10 | 14 | 18 | 22 | **64** | | **Total Commitments** | 72 | 128 | 156 | 186 | **542** | | **Funding Requirements** | 209 | 278 | 294 | 359 | **1139** | | **Funding Gap** | **137** | **149** | **138** | **173** | **597** | | **%** | **66%** | **54%** | **47%** | **48%** | **52%** |   This funding request will focus on investments where there is currently limited resources and fiscal flexibility in using domestic/government funds, particularly in MDR TB treatment, active case finding among most at risk population groups, TB-HIV collaboration and addressing stigma and discrimination though human rights and gender initiatives. Furthermore, to invest on specific interventions to support initial work in UHC implementation by building RSSH in health product management, information management, public health financial management and laboratory management.    The full implementation of the UHC Law will revolutionize the Philippine health care service delivery system. Details on the UHC and related funding streams are described in Section 4.2b.  While the UHC implementation guidelines to support technical, managerial integration is being developed and tested, immediate action to address current health system bottlenecks will be undertaken. Some initiatives to increase domestic resource mobilization to reduce the funding gap include:   * **Strengthening the National Coordinating Council (NCC).** The NCC for TB (as provided in the TB Law) is being provided technical assistance to be strengthened to champion the NTP by advocating for higher TB investments at the executive and legislative levels. This also includes advocating for the members of the NCC (CHED, DepEd, DSWD, DOLE, DILG, etc.) to optimize their agency budgets to allocate for TB care. * **Optimization of DOH-NTP budget.** Technical assistance is being provided to improve DOH Financial Management System. Specific for NTP, TA is focused on improving financial planning and utilization. This includes creating a mechanism to better track expenditures and optimize available funds. * **Working with PhilHealth for better TB Benefit Packages.** The NTP and its implementing partners have ongoing efforts to ensure CxR is included in the Primary Care Package and for all government agencies to encourage their employees to optimize their free access annual physical examinations in government health facilities, which includes CxR. Efforts are also underway to revise the TB outpatient benefit package to be more complementary to the current DOH investment for TB and to create an MDR TB care package. * **Improving financial risk protection.** NTP and its partners are working towards optimizing available financial risk protection platforms to prevent catastrophic cost due to TB. This includes working with SSS, GSIS, DSWD 4Ps Program, ECC, OWWA, National Insurance Commission, etc. * **Advocating for increased LGU investments.** Local TB coordinating councils are being mobilized to advocate among local chief executives to increase investments in Health. Technical assistance is also being provided to ensure a TB budget is integrated in the local investment plans for health. * **Increasing private sector investments.** Private health care providers (Hospitals, stand-alone clinics, Health Maintenance Organizations, cooperatives, diagnostic facilities, drug stores, pharmacies, etc.) are being engaged to augment the TB Health Care Service Delivery Network. They are provided access to procure negotiated cost rates for TB molecular RDT and related commodities. Furthermore, NTP and its implementing partners are working with DOLE-OSHC to capture data on CxR screening provided to formally employed personnel and to motivate employees to access the free service. * **Leveraging Civil Society Organizations to support TB Care.** NTP and its implementing partners are also pursuing work with CSOs to include in their institutional mandates or areas of work TB related activities by leveraging their resources to support TB care delivery. |

1. Highlight challenges related to sustainability (see indicative list in *Instructions*). Explain how these challenges will be addressed either through this funding request or other means. If already described in the national strategy, sustainability and/or transition plan, and/or other documentation submitted with the funding request, refer to relevant sections of those documents.

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| The sustainability challenges and recommended action for the National TB Program is detailed in the JPR 2019 report and the recently Updated PhilSTEP Phase 1 identifies the NTP strategies and approaches to address and ensure better health systems are in place and sustained in the short and medium term. The UHC Law is the Philippines’ long-term plan for RSSH.  The Universal Health Care (UHC) Act was [signed in February 20, 2019](https://www.who.int/philippines/news/detail/20-02-2019-new-uhc-act-a-critical-step-towards-health-for-all-filipinos). It calls for a “systemic approach” to universal health care in the Philippines. The act was put in place to “ensure that all Filipinos are guaranteed equitable access to quality and affordable health care goods and services.”  The sustainability roadmap is therefore embedded in the Philippine UHC Act and its full implementation at the national and local levels, whereby it will optimize service delivery as well as the National Health Insurance Program under PhilHealth and other domestic resources from both private and public sectors to meet the necessary financial investments to care for the Filipinos.  Financing for UHC will be sourced from sin tax collections and partly from income generated by the Philippine Amusement and Gaming Corporation (PAGCOR) with 50% share and Philippine Charity Sweepstakes Office (PCSO) with 40% share in view of improving benefit packages. So far, successful implementation of the sin tax reform law has been a boost to programs and projects of the DOH. Based on the agency’s budget brochures, DOH’s budget, including its attached agencies and corporations, increased by 13 percent from PHP151 billion in 2017 to PHP171 billion in 2018. This was due to PHP113-billion six tax revenues, of which PHP48 billion was allocated to PhilHealth’s premium subsidy for the indigent, senior citizens, and sponsored members.  All income from PhilHealth payments will go to the special health fund, which will be allocated by LGUs exclusively for the improvement of local health systems. Premium contributions to PhilHealth pay a rate of 3% of their monthly salaries beginning 2020 from the previous 2.75% rate. The rate is scheduled for a 0.5% increase every year till 2025; by then, it will be at 5%. This rate applies to all direct contributors--those who are self-employed, employed by a company, housekeepers/helpers, practicing professionals, and Overseas Filipino Workers.  However, the Supreme Court, ruling in the case of *Mandanas vs. Ochoa[[11]](#footnote-12)*, resolved the question of whether or not the exclusion of certain national taxes from the base amount for the computation of the ‘just share’ of the LGUs in the national taxes is constitutional. The Court found that the base for reckoning the ‘just share’ of local government units (LGUs) should include all national taxes, with a few justifiable exceptions (such as those accruing to special purpose funds, including 15% of the excise taxes collected on tobacco products). This just share shall then be released to the LGUs without a need for yearly appropriation by Congress, through the respective LGU treasurers on a quarterly basis. The Court also declared that as part of fiscal decentralization, LGUs have the power to allocate their resources in accordance with their own priorities.  As of the fourth quarter of 2019, the Department of Budget and Management (DBM) has been moving to comply with *Mandanas*. The estimated additional amount to be distributed to LGUs nationwide is PHP 270 billion, with an expected average increase of 30% in LGU fiscal space due to their just share in national taxes. For the National Expenditure Program (NEP) of 2021, DBM will be sourcing this from the usual budgets of national government agencies (NGA) that should have devolved functions but are still doing the same. The DOH is one such NGA, and the DBM is looking at the following DOH budgets: health facilities enhancement program (HFEP), human resources for health (HRH) except the doctors to the barrios (DTTB), and amounts intended for the procurement of commodities.  The UHC Act also provides for a special health fund that will be created for province-wide or city-wide health systems and managed by respective local health boards. All resources intended for health services will be pooled to finance population-based and individual-based health services. Such will also be used to cover operating costs, capital investments, and remuneration and incentives for all health workers.  The UHC law aims to address several recurring problems in the health system.   * **Scope and Coverage.** The biggest concrete change it brings is that, under it, all Filipino citizens are [automatically enrolled into the NHIP](https://www.philhealth.gov.ph/news/2019/uhc_act.php). The law also addresses the fragmented and overlapping roles and responsibilities of various health agencies by delineating between population based (DOH & LGU) and individual based (PhilHealth) health services. This will significantly reduce out-of-pocket spending, by covering medicines for outpatients, directly preventing patients and their families from experiencing catastrophic cost. * **Human Resources for Health.** the UHC law ensures the development of the health system’s human resources through the formulation and implementation of the National Health Human Resource Master Plan. It also ensures that all health professionals have permanent employment and competitive salaries. Similarly, the law provides for the creation of a national health workforce support system that will help local public health systems in addressing human resource needs while prioritizing deployment in the Geographically Isolated and Disadvantaged Areas (GIDAs). The law also tasks the Commission on Higher Education (CHED), Technical Education and Skills Development Authority (TESDA), Professional Regulation Commission (PRC) and the DOH to develop existing and new allied and health-related degrees and training programs, and to regulate the number of its enrollees depending on the needs of the population. The law provides scholarship grants for graduate and undergraduate allied and health-related programs. All professional health graduates of government-funded scholarships will be required by law to render at least three years of return service with compensation under the supervision of the DOH. Incentives will be given to those who will render an additional two years of return service. * **Health Technology Assessment.** Another important feature of the law is the creation of the HTAC – a group of health experts who will be responsible for evaluating latest health developments and recommending their use to DOH and PhilHealth. The HTAC will be responsible for assessing the safety and effectiveness of health technology, devices, medicines, vaccines, health procedures, and other health-related advances developed to solve health problems. Reviewing the social, economic, and ethical issues when using these technologies or programs is also required. The HTAC will be attached to the DOH for the first 5 years after the law is implemented. After this, it will become an independent body attached to the Department of Science and Technology. * **Health Information Management.** Under UHC, public and private hospitals and health insurers will be required to maintain a health information system that will contain electronic health records, prescription logs, and “human resource information.” This system will be developed and funded by DOH and PhilHealth. It will also be subject to patient confidentiality rules and data privacy laws. This will critical in decision-making processes for the continuous improvement of the Philippine Health Care Service Delivery System.   Universal Health Coverage reforms also create opportunities to increase PhilHealth engagement of private providers for TB. Similarly, trends towards consolidation of private laboratories and pharmacies and the development of innovative IT applications to create the conditions for efficient engagement of private providers on a much larger scale. |

# Annex 1: Documents Checklist

Use the list below to verify the completeness of your application package.

|  |  |
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|  | Funding Request Form |
|  | Programmatic Gap Table(s) |
|  | Funding Landscape Table(s) |
|  | Performance Framework |
|  | Budget |
|  | Prioritized above allocation request (PAAR) |
|  | Implementation Arrangement Map(s)[[12]](#footnote-13) |
|  | Essential Data Table(s) (updated) |
|  | CCM Endorsement of Funding Request |
|  | CCM Statement of Compliance |
|  | Supporting documentation to confirm meeting co-financing requirements for current allocation period |
|  | Supporting documentation for co-financing commitments for next allocation period |
|  | Transition Readiness Assessment (if available) |
|  | National Strategic Plans (Health Sector and Disease specific) |
|  | All supporting documentation referenced in the funding request |
|  | Health Product Management Tool (if applicable) |
|  | List of Abbreviations and Annexes |

1. PAARs can only be submitted with the Funding Request. To complete a PAAR, fill-in the Excel template that you will receive from the Global Fund Secretariat. [↑](#footnote-ref-2)
2. This is only relevant for applicants with designated matching funds as indicated in the allocation letter. [↑](#footnote-ref-3)
3. <https://psa.gov.ph/pnha-press-release> [↑](#footnote-ref-4)
4. AccessTB Project is supporting a 2020 study on the TB clinical diagnosis practice in the Philippines and the TB Inventory Study. Findings and recommendations from these studies will support the NTP and its implementing partners to enhance strategies and approaches to support quality improvement in the TB patient care pathway. [↑](#footnote-ref-5)
5. Active case finding refers to systematic screening for cases of active tuberculosis and latent infection among high risk groups rather than waiting for people to develop symptoms/signs of active disease and present themselves for medical attention (passive case finding) [↑](#footnote-ref-6)
6. Intensified case finding refers to systematic screening among outpatients in high volume facilities using CxR and referring presumptive cases for TB molecular RDT. [↑](#footnote-ref-7)
7. Enhanced case finding refers to use of specimen transport mechanisms which support access to limited TB moelcualr RDTs [↑](#footnote-ref-8)
8. Estimated TB cases attributable to risk factors: 137 000 for malnourishment, 74 000 for smoking, 68000 for harmful use of alcohol, 18 000 for diabetes, and 10 000 for HIV. [↑](#footnote-ref-9)
9. An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-10)
10. Note that information derived from the supporting documentation provided in response to the questions below, including information on funding landscape or domestic commitments, may be made publicly available by the Global Fund. [↑](#footnote-ref-11)
11. G.R. No. 199802, July 3, 2018 [↑](#footnote-ref-12)
12. An updated implementation arrangement map is mandatory if the program is continuing with the same PR(s). In cases where the PR is changing, the implementation arrangement map may be submitted at the grant-making stage. [↑](#footnote-ref-13)