Investing for impact against HIV, tuberculosis or malaria

A concept note outlines the reasons for Global Fund investment. Each concept note should describe a strategy, supported by technical data that shows why this approach will be effective. Guided by a national health strategy and a national disease strategic plan, it prioritizes a country's needs within a broader context. Further, it describes how implementation of the resulting grants can maximize the impact of the investment, by reaching the greatest number of people and by achieving the greatest possible effect on their health.

A concept note is divided into the following sections:

Section 1: A description of the country's epidemiological situation, including health systems and barriers to access, as well as the national response.

Section 2: Information on the national funding landscape and sustainability.

Section 3: A funding request to the Global Fund, including a programmatic gap analysis, rationale and description, and modular template.

Section 4: Implementation arrangements and risk assessment.

SUMMARY INFORMATION			
Applicant Information			
Country	**Philippines**	**Component**	**Malaria**
Funding Request Start Date	**2015**	**Funding Request End Date**	**2017**
Principal Recipient(s)	**Pilipinas Shell Foundation, Inc**		

Funding Request Summary Table

- A funding request summary table will be automatically generated in the online grant management platform based on the information presented in the programmatic gap table and modular templates.

SECTION 1: COUNTRY CONTEXT

This section requests information on the country context, including the disease epidemiology, the health systems and community systems setting, and the human rights situation. This description is critical for justifying the choice of appropriate interventions.

1.1 Country Disease, Health and Community Systems Context

With reference to the latest available epidemiological information, in addition to the portfolio analysis provided by the Global Fund, highlight:

a. The current and evolving epidemiology of the disease(s) and any significant geographic variations in disease risk or prevalence.

b. Key populations that may have disproportionately low access to prevention and treatment services (and for HIV and TB, the availability of care and support services), and the contributing factors to this inequality.

c. Key human rights barriers and gender inequalities that may impede access to health services.

d. The health systems and community systems context in the country, including any constraints.

a) Epidemiology

The Philippines has 80 provinces comprising 1,634 municipalities. These municipalities are further subdivided into barangays (villages) which is the smallest administrative unit.

Malaria has historically been one of the 10 leading causes of morbidity and mortality in the Philippines. Over an 8-year period, and in particular, the recent years of 2010-2013 – there has been a significant reduction in malaria cases, annual parasite incidence (API) and mortality rates throughout most of the country (Malaria Program Review 2013).

At the start of 2003, malaria was endemic in 66 provinces in the Philippines. The population at risk, defined at that time, as the entire population of the province where malaria cases were found, was estimated to be 70,687,400.

By 2010, malaria was endemic in 57 provinces and 843 municipalities in the Philippines. The population at most risk was 6,387,734, or 12.5% of the total national population. At this time, the population at risk was defined as the people living in barangays with stable, unstable and sporadic transmission based on the most recent stratification system of the National Program.

Figures 1a-e show the reduction in reported malaria incidence by year since 2005. Cases were reduced by 83% over the 8-year period, while deaths due to malaria declined by 92%.

The 49% reduction in case numbers and incidence rates from 2010 to 2011 shown in Figures 1a, 1c and 1e mainly reflects a reduction in reported cases from Palawan following a scale-up in case finding and preventive measures since 2009.

Figure 1a. Annual Number of Malaria Cases in the Philippines, 2003-2013

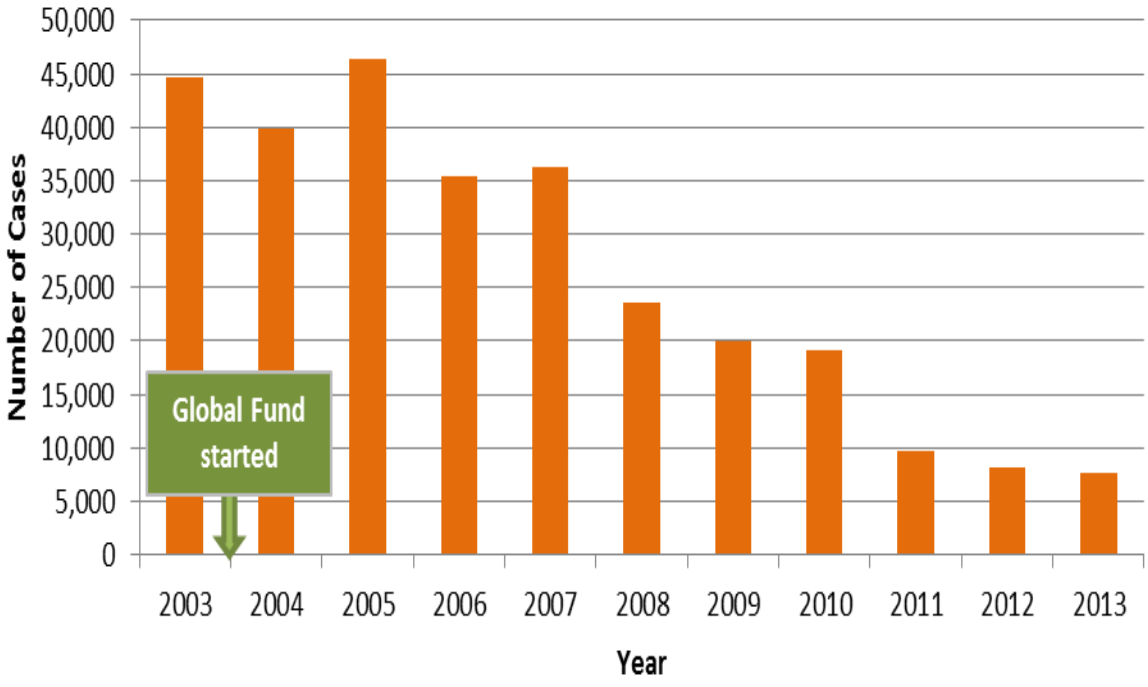


Figure 1b. Annual Number of Malaria Deaths in the Philippines, 2003-2013

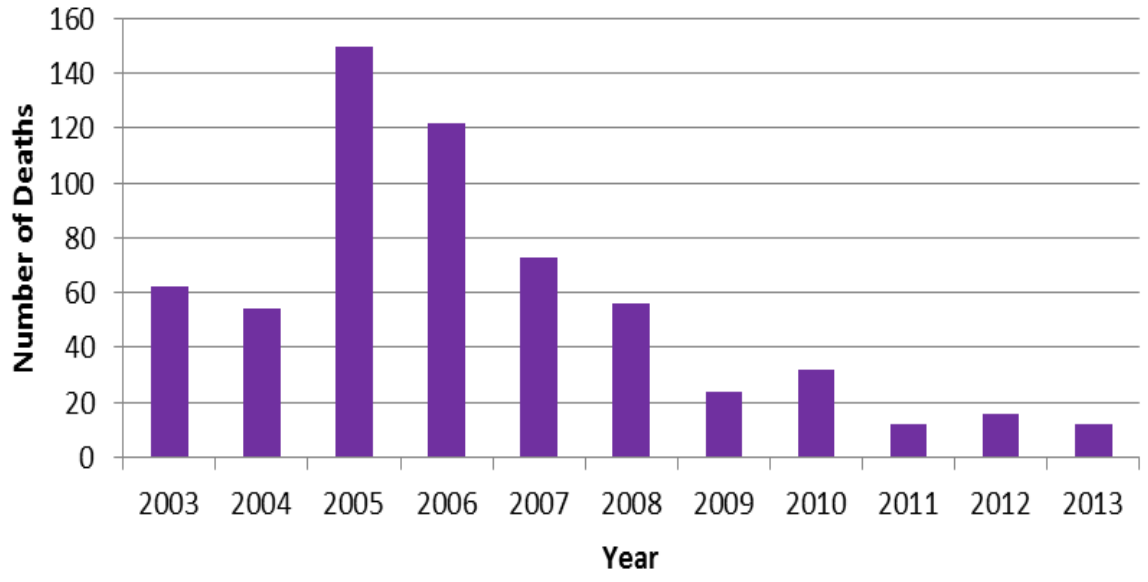


Figure 1c. Trend of Annual Malaria Morbidity Rates in the Philippines, 2003-2013

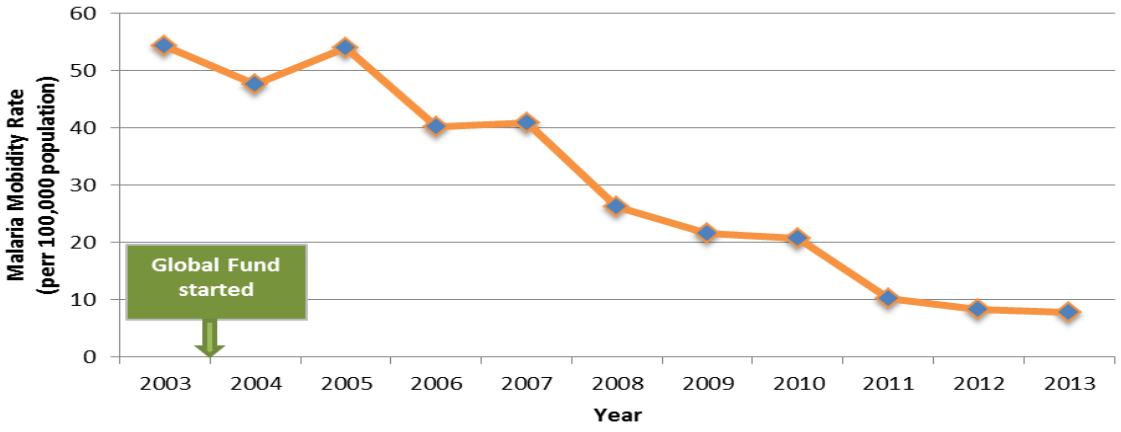


Figure 1d. Trend of Annual Malaria Mortality Rates in the Philippines, 2003 - 2013

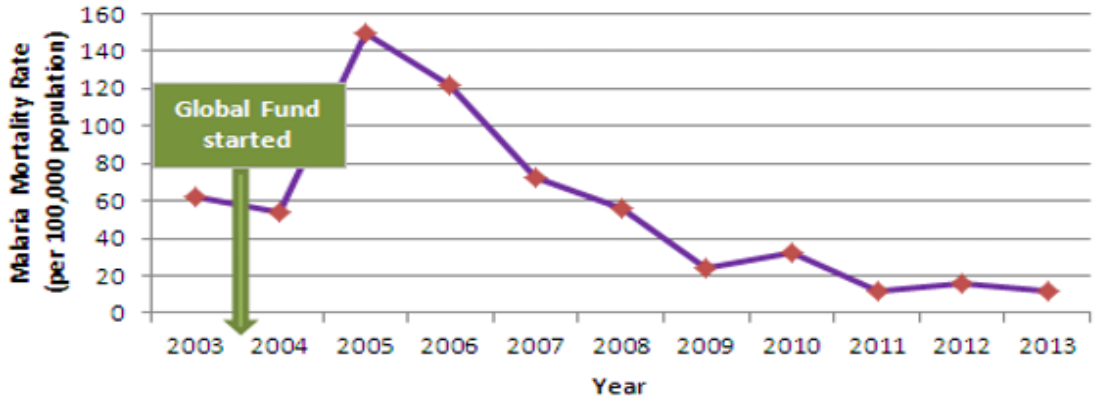
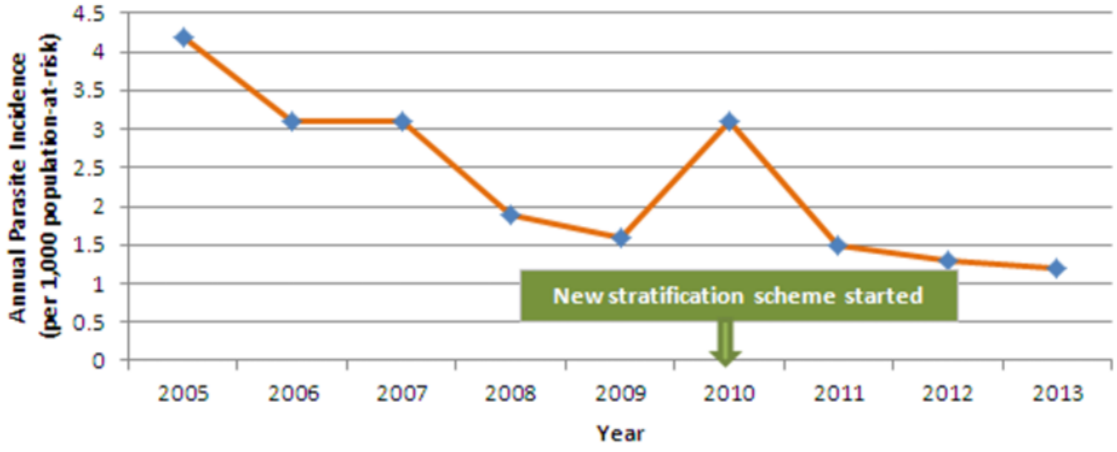


Figure 1e. Annual Malaria Parasite Incidence in the Philippines, 2005-2013



Criteria for stratification of malaria transmission risk in the Philippines are summarized in the box below. The stratification unit is the barangay level.

Stratification - the process of classifying malaria endemic areas that share similar epidemiological characteristics into groups or strata for the purpose of (i) prioritizing areas to be assisted; (ii) identifying the appropriate interventions; and (iii) allocation and prioritization of resources *(Malaria Manual of Procedures, 2009).*

Areas are stratified as:

a. Stable Transmission (ST): continuous presence of at least one indigenous malaria case in a month for 6 months or more at any time during the past three years;

b. Unstable Transmission (UT): continuous presence of at least one indigenous malaria case in a month for less than 6 months at any time during the past three years;

c. Sporadic Transmission (SpT): presence of at least one indigenous malaria case at any time in the past 5 years;

d. Malaria Prone Area (MPA): absence of indigenous malaria case for 5 past years even in the presence of malaria vector;

By 2013, there was further reduction in the number of malaria endemic provinces to 53. Just 47 higher-incidence municipalities in 13 provinces contributed about 97% of the total malaria cases reported in 2011-2013 (discussed further at *Section 1.2* under *National Strategic Plan*). Among these, 6 municipalities (three from Tawi-Tawi, two from Palawan and one from Sulu) had an API above 10 per 1,000 in 2013; 9 municipalities (5 from Palawan, three from Tawi-Tawi and one from Sulu) had an API of 5-10 per 1,000; and 32 municipalities had an API from 1-5 per 1,000.

By the end of 2013, among the 53 endemic provinces, three have not had any indigenous malaria cases for 5 consecutive years (2009-2013) and are awaiting assessment and certification as malaria-free during 2014. Four provinces have not had an indigenous malaria case for four consecutive years (2010-2013), eight have been malaria-free for three consecutive years (2011-2013) and eight more provinces have not had an indigenous case since 2012. (For sub-national certification of malaria-free status, a province must have had 5 consecutive years of zero locally acquired malaria cases and a surveillance system assessed as having sound quality and sensitivity — AO 2011-19 " Guidelines in Evaluation of Low Endemic Provinces for Declaration as Malaria-free).

From 2010 to 2013, less than 0.1% of the annual total number of confirmed malaria cases was classified as severe. There were 32 deaths in 2010, 12 in 2011, 16 in 2012 and 12 in 2013, with case fatality rates of 0.16%, 0.13%, 0.20% and 0.16% respectively. The majority of deaths and the highest case fatality rates are reported from Tawi-Tawi, Palawan, Sulu and Mindoro Occidental.

The 20 municipalities with the highest reported number of cases report a biphasic annual occurrence of malaria: the first from May to July and the second from September to November. In 2010, 40 municipalities in 18 provinces showed a stable pattern of transmission lasting 6 months or more but, by 2013, this had fallen to 25 municipalities in 7 provinces. The proportion of cases due to *Plasmodium falciparum* is consistently between 69% and 73% (suggesting active transmission in most areas), with most of the rest due to *P vivax* and a small proportion of *P malariae* and mixed infections. In municipalities with an

API of less than 1 per 1,000, the proportion of *P vivax* cases generally increases relative to *P falciparum*.

Over the past four years, during which there was substantial overall reduction in malaria incidence, several malaria outbreaks have occurred. 5 major epidemics were reported from 2010 to 2013 and involved 11 municipalities (out of 644) amounting to close to 500 cases spread out over 4 years. These were the outbreaks which showed significant clustering of places in time and place. The factors which the outbreaks had in common were the introduction of the index case by travelers. It was also noted that the delay in routine intervention such as IRS resulted to the occurrence of secondary transmission. The most significant outbreaks were in Davao del Sur in 2011 (85 cases and 1 death reported from 3 barangays in 2 adjacent municipalities), and in Ginoog City in Misamis Oriental in 2010 (almost 100 cases, zero deaths). Smaller outbreaks occurred in 2011 in Nueva Ecija (40 cases) and in Rizal Province (30 cases). The latest, most significant increases in incidence occurred in Isabela and Cagayan, which saw increases in case loads from 35 to 132 and from 42 to 146, respectively, between 2012 and 2013.

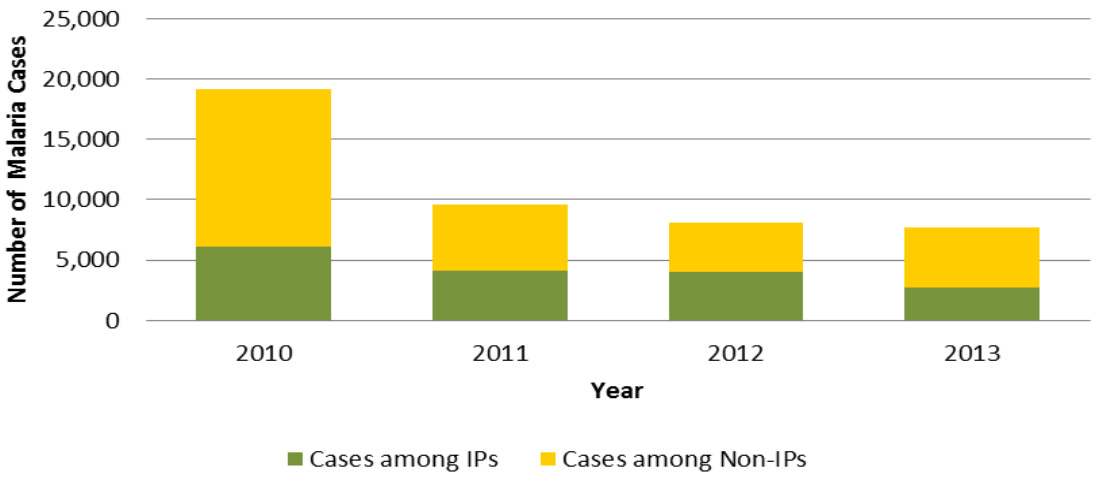
b) Key populations

The NSPCEM identifies indigenous peoples (IPs) as the principal group that is most at-risk of malaria and therefore targeted for specific interventions.

Indigenous peoples account for approximately 14% of the Philippine population (i.e. approaching 20 million people; IGWIA, 2010) and 24 % of the overall population in the 53 endemic provinces. IPs generally live in geographically isolated areas with a lack of access to basic social services and little opportunities for mainstream economic activities. The remoteness of their areas of residence also poses challenges in providing preventive, diagnostic and curative services. Their means of livelihood -- gathering forest products, swidden farming, and hunting – increase their exposure to the malaria vector. Their social determinants of health status (housing, educational participation, access to clean water, gender equity, and cultural beliefs) contribute further to poor health status and vulnerability to malaria

Indigenous populations residing in remote areas of the 13 highly endemic provinces comprise 16% of the overall population but contribute 35% of all malaria cases. Figure 2 summarises recent trends in the number and proportion of malaria cases among IPs.

Figure 2. Malaria Cases among Indigenous People, as Proportion of Total Malaria Cases by Year, 2010-2013



Recent reductions in the annual caseload in the wider population may have contributed to the apparent rise in the proportion of malaria cases among IPs, who have historically been more difficult to reach with health services (see 1.1 *c) Access, equity and health service utilisation*). The decline in the proportion of cases in IPs in 2013 may reflect some early successes in improved access. For example, in Palawan, the proportion of malaria cases among IPs declined from 34% of cases in 2011 to 14% in 2013.

The remaining six identified groups are targeted by the national program for implementation of appropriate interventions. Due to the lack of data on these groups, the first step would be to profile them through coordination with the relevant government agency responsible for attending to their needs.

i) Forest and agricultural workers and other informal occupational groups (non-IP) working in malaria endemic areas;

ii) The military, while on field operations (and, by implication, the insurgent groups that they are tasked to seek out);

iii) Overseas Filipino Workers (OFWs) working in highly malaria-endemic countries;

iv) Tourists or frequent travelers to or from malaria-endemic areas (local and international);

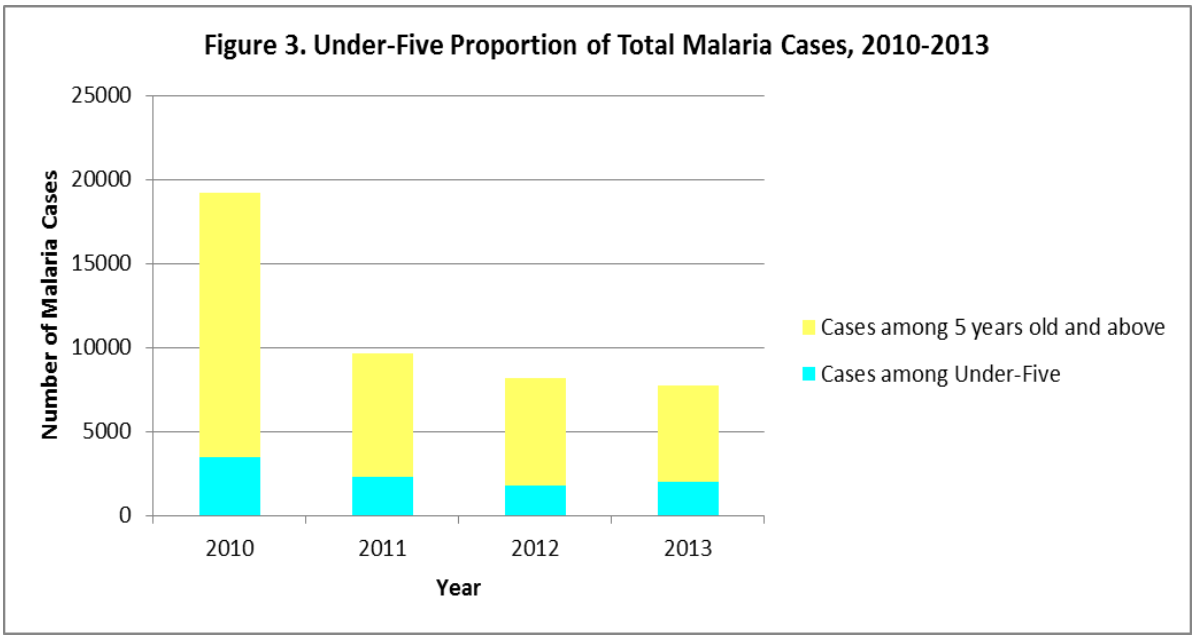
v) Internally displaced populations (IDPs), as a result of conflict or natural disasters;

vi) Communities in development project areas that see the inward migration of workers from malaria endemic areas.

Males consistently account for 57-58% of cases, in all provinces with very little variation from year to year. This may reflect occupational exposure.

Children under 5 years of age comprise 23-25% of the total number of malaria cases, with very little deviation from year to year.

Figure 3 shows the proportion of malaria cases among children under five years old from 2010 to 2013.



In Palawan, Tawi-Tawi, Sulu and Mindoro Occidental the proportion is higher with up to 40% or more of malaria cases reported in children under 5 years; the proportion is higher in municipalities showing higher rates of malaria transmission. Despite reductions in the actual number of cases over the years, the overall age distribution has remained essentially unchanged. The trends may be attributed to exposure of these children during the biting hours when their parents/adults take them along for recreational activities outside the house (and therefore outside their bednets) in the evening (Malaria Program Review, 2013; Assessment and Response Plan for Enhanced Malaria Control in Palawan, 2012).

c) Health service access, equity, utilisation and community factors

Studies by De la Cruz *et al.* in 2005 and Wong and Vergara in 2009 assessed the knowledge, attitudes and practices in relation to malaria among IPs. Both studies showed that the symptoms of malaria (i.e. chills, fever and headache) were well recognized by IP respondents, and that knowledge of its transmission through mosquito bites is also well known.

Access to health services was affected by poor socio-economic conditions, difficult geographical terrain and lack of public infrastructure and transportation; low levels of formal education, traditional beliefs about disease causation and progression, and continued reliance on self-diagnosis and treatment using herbal medicines all contributed to lower utilisation of malaria treatment and preventive services among IPs; the 2009 study suggested that IPs were more likely that non-IPs to complete a course of anti-malaria treatment, once commenced. Distance from a health facility was the major factor affecting care-seeking behaviour for malaria symptoms.

Similar factors are believed to be relevant among other residents of geographically isolated and economically depressed areas.

Gender equality issues are not thought to impact prominently on access to malaria services, since these are available and accessible to both males and females. Concerning gender

equality in health coverage of the population, there is no significant difference in the health insurance coverage between men and women (Friedrich-Ebert-Stiftung, 2013).

Universal Health Care (UHC; *Kalusugan Pangkalahatan*) is the current Philippines administration's organising principle for the health sector, and works to limit any bias based on gender or socio-economic or cultural characteristics. The aim of UHC is to provide every Filipino with quality health care that is accessible, efficient, equitably distributed, adequately funded, fairly financed and appropriately used by an informed and empowered public (AO 2010-0036). The UHC strategy is built around: 1) Financial risk protection through expanded coverage under the national social health insurance program (*PhilHealth*); 2) Improved access to quality hospital and health care facilities; and 3) Attainment of the health-related Millennium Development Goals (including to halt and reverse the incidence of malaria by 2015 – already achieved in 2008).

d) Health system factors

The Philippines health system was decentralized under the *Republic Act 7160* (also known as the *Local Government Code*) of 1991. The *Code* defines the role of the Department of Health (DOH) as the development of policies, standards and technical guidelines and their oversight, and the provision of national level tertiary and specialised clinical care. Responsibility for the provision of health services to communities rests with local government units (LGU) at three levels: 1) barangay, 2) municipal or city, and 3) provincial (Figure 3). LGUs have the power and autonomy to make decisions on the planning, financing and implementation of public health programs (including malaria) and primary and secondary services in their jurisdictions, while receiving technical assistance from the DOH through its Regional Offices. Diagnostic and treatment services for malaria are currently provided at 276 hospitals (mostly government-managed), 408 principal health centers (at the municipal level), 452 barangay malaria microscopy centers and 926 rapid diagnostic testing (RDT) delivery points. Of these, 99 hospitals (35%), 173 municipal level microscopy centers (42%), 344 barangay malaria microscopy centers (76%) and 456 RDT sites (49%) are found in the 13 high burden provinces.

The purpose of decentralization was to make health services more responsive to local level needs. However, it may disadvantage malaria control and elimination when LGU political and financial commitment lapses in the face of competing priorities and demands (e.g. for other sectors or, within health, other high-burden or elimination-targeted diseases); resource allocation may also be influenced by political priorities. The resulting challenges for the Malaria Program may include: a) infrastructure (lack of and/or inequitable distribution of health facilities, which may become concentrated in urban areas); b) human resources (lack of health care providers, underpaid and overworked staff, inadequately trained, migration to other countries); c) financing (underfunded public health services); and d) higher out-of-pocket transaction costs and lower population coverage, especially where there is limited uptake of *PhilHealth* enrolment and access to benefits.

Other potential health system barriers include: regulatory capacity (e.g. drug regulation, regulation of private providers); coordination of service delivery (e.g. referral linkages between public-public and public-private health facilities, harmonisation across geographic and jurisdictional boundaries, awareness of and compliance with treatment protocols among health care providers); and coordination of other health system functions (e.g. alignment of technical standards and health commodities, communication and information sharing, health planning and cost-sharing).

Another response has been the establishment of Inter-Local Health Zones (ILHZ) to address issues in coordination of health care delivery between jurisdictions, the referral system and harmonisation of public health program operations across LGU boundaries.

The Malaria Program has persistently advocated for sustained political commitment and financial support by LGUs for malaria control and elimination. This has resulted in a pledge of commitment by the provincial governors of all 80 provinces, signed on World Malaria Day 2012, to achieve malaria elimination in their respective provinces through continued earmarking of local funds for malaria activities guided by local annual operational plans for malaria.

These efforts have reduced the negative impact of decentralization to malaria program implementation and have actually turned the decentralized system's weaknesses into opportunities to strengthen program implementation.**Summary**

In conclusion, analysis of the epidemiological, health system and population setting indicates:

1. Despite achieving the MDG 2015 target in 2008 and continued falling incidence, malaria transmission remains a significant public health priority for the Philippines.
2. Malaria transmission risk is almost entirely focused on 47 municipalities in 13 provinces of Palawan, the Sulu Archipelago, western Mindanao and northern and western Luzon.
3. Although other areas are naturally focusing on malaria elimination, they remain receptive to malaria and vulnerable to outbreaks.
4. There is a need to strengthen the quality and implementation of Program interventions among indigenous populations living in remote areas, and 6 other at-risk groups.
5. Population movement remains the main threat to resurgence and re-establishment of malaria transmission in areas which have reached pre-elimination and elimination status.
6. Despite the challenges of a decentralized health system, the Program has forged effective partnerships and commitment at national and sub-national level.

1.2 National Disease Strategic Plans

With clear references to the current **national disease strategic plan(s)** and supporting documentation (include the name of the document and specific page reference), briefly summarize:

a. The key goals, objectives and priority program areas.

b. Implementation to date, including the main outcomes and impact achieved.

c. Limitations to implementation and any lessons learned that will inform future implementation. In particular, highlight how the inequalities and key constraints described in question 1.1 are being addressed.

d. The main areas of linkage to the national health strategy, including how implementation of this strategy impacts relevant disease outcomes.

e. For standard HIV or TB funding requests[1], describe existing TB/HIV collaborative activities, including linkages between the respective national TB and HIV programs in areas such as: diagnostics, service delivery, information systems and monitoring and evaluation, capacity building, policy development and coordination processes.

f. Country processes for reviewing and revising the national disease strategic plan(s) and results of these assessments. Explain the process and timeline for the development of a new plan (if current one is valid for 18 months or less from funding request start date), including how key populations will be meaningfully engaged.

a) Key goals, objectives and priority Program areas

The Philippines *Malaria Medium Term Development Plan 2011-16* (MTDP) has guided the implementation of the Malaria Program from 2011 until early 2014. The MTDP has now been revised as the *National Strategic Plan for the Control and Elimination of Malaria 2014-2020* (NSPCEM)[2]. The revised *Strategic Plan* responds to the DOH vision of a malaria-free Philippines by 2030 (page 22). The Goal of the NSPCEM is: *by 2020, to reduce the malaria incidence rate in the Philippines by 80% relative to a 2013 baseline and to increase the number of malaria free provinces from 27 to 50*. At the same time, malaria deaths will be brought to very low levels (close to zero) nationally.

The NSPCEM takes a health systems approach to malaria control and elimination, aligned with the goals of the Philippine health sector reforms. Its four strategic objectives are:

1) To ensure universal access to reliable diagnosis, highly effective and appropriate treatment and preventive measures;

2) To strengthen governance and human resources capacity at all levels in support of malaria elimination;

3) To secure government and non-government financing to sustain malaria control and elimination at all levels;

4) To ensure quality malaria services, timely detection of infection and immediate response, and information and evidence to guide malaria elimination

In 13 provinces and 5 chartered cities with significant ongoing malaria transmission, Objective 1 guides the Program to work closely with DOH Regional Offices, LGUs and non-government partners and communities to prioritise universal access to accelerated control phase interventions: health promotion, prevention with long-lasting insecticidal bed nets (LLIN) and quality-assured diagnosis and treatment. Strong inter-sectoral collaborations will provide important support for accelerated malaria control in the identified vulnerable groups.

In areas entering the elimination phase, maintaining measures to respond to identified cases and prevent reintroduction (Objective 1, Strategy 1.2) and the health system aspects of the Program (Objectives 2, 3 and 4) assume greater priority for: (1) establishing

[1] Countries with high co-infection rates of HIV and TB must submit a TB and HIV concept note. Countries with high burden of TB/HIV are considered to have a high estimated TB/HIV incidence (in numbers) as well as high HIV positivity rate among people infected with TB.

[2] Page numbers in this section refer to the NSPCEM 2014-2020 unless otherwise specified.

an elimination-oriented surveillance system; and (2) strengthening local health systems, with promotion of Program ownership and resource mobilization at the LGU level.

A critical strategic need -- to be addressed as a priority -- is the drafting of a detailed malaria elimination guideline and standard operating procedures for inclusion in the updated Malaria Program Manual of Operations (MOP).

b) Achievements to date

A comprehensive Malaria Program Review (MPR) was conducted in 2013.

To the end of 2013, there has been an 83% reduction in malaria burden since 2005 (when reported cases peaked at 46,342), and a 64% reduction relative to the 2009 MTDP baseline. As shown in Table A, the epidemiological impact is well ahead of the 2013 mid-term targets of the MTDP (2013 Malaria Program Review, Table 4).

From 2011 to 2013, 13 out of the 80 provinces contributed to 97% of all reported malaria cases. Among these, in 2013, Palawan contributed 60% of cases and Tawi-Tawi 25% (of 7,720 cases). An additional 40 provinces are stratified as moderate to low endemic, while 27 are free of malaria.

Table A: Achievement of targets for core impact indicators, Malaria Medium Term Development Plan, 2011-2014

Indicator	2009 baseline	Mid-term (2013) target	End-term (2016) target	Accomplishment by end of 2013	Actual % change
Malaria morbidity rate	22 per 100,000	14.3 per 100,000 (35% reduction)	6.6 per 100,000 (70% reduction)	7.89 per 100,000 population	↓64%
Malaria mortality rate	0.03 per 100,000	0.015 per 100,000 (45% reduction)	0.003 per 100,000 (90% reduction)	0.01 per 100,000	↓66%
Annual parasite incidence	1.7 per 1,000 population-at-risk	1.2 per 1,000 population-at-risk (29% reduction)	0.8 per 1,000 population-at-risk (53% reduction)	1.2 per 1,000 population-at-risk	↓29%
Number of Provinces Certified Malaria Free	23	27	35 (actual declaration is in 2017)	27	↑17.4%

(Reference: Malaria Program Review 2013, page 17; updated 2013 data)

The MPR found that the observed reductions in malaria incidence are the result of targeted malaria control interventions implemented by the National Program in partnership with LGUs and the Global Fund, and not due to incidental contextual determinants or surveillance system irregularities. Between 2010 and 2013, the Program distributed more than 3.9 million long lasting insecticidal bed nets (LLIN) – more than enough to cover the

population at-risk at a ratio of one net per two persons and, according to the most recent bed net utilisation surveys (BUS 2012), reaching the ideal coverage of one net per sleeping space in many communities. The BUS indicates a utilization rate ranging from 68% to 95%. The survey also showed that up to one-third of the population at risk (including children and pregnant women) engaged in some evening activities outdoors and hence outside the net, e.g. watching television or movies, visiting friends.

In 2010, 92% (17,647/19,182) of the cases were diagnosed using microscopy; by 2013, this percentage had fallen to 76% (5,868/7,720), reflecting the expanding role of RDTs in the parasitological confirmation of cases. The overall Annual Blood Examination Rate (ABER) was 6.09% in 2010, 5.29% in 2011, 5.45% in 2012 and 5.87% in 2013 – still below the nominal target of 10%.

In 2013, 98% of diagnosed cases were treated in compliance with the national treatment protocol (first-line or second-line treatment; Philippine Malaria Information System, 2013).

c) Limitations, lessons learned, key constraints and how they will be addressed

The 2013 MPR thoroughly explored limitations, constraints and lessons learned over recent years of Malaria Program implementation. Principal among them are:

1) **Workforce and central DOH leadership –** The current number and balance of positions in the Malaria Program Team at the DOH and its Regional Offices may not be sufficient to address the challenge of elimination. Working within the impending 'rationalization' of health sector human resources, the Program will ensure that a Deputy Program Manager and a full-time Entomologist/Vector Control Specialist are in place; an Epidemiologist/Surveillance Officer, Data Management and Information Technology (IT) staff will be recruited to work with the National Epidemiology Center in addressing issues of data fragmentation between routine surveillance systems at multiple levels, and to manage a national elimination data base; a Logistics Management Officer will be recruited to ensure sound resource management and tracking. An Administrative staff will also be recruited to provide support in coordinating activities within the DOH and across levels of the health system, and to ensure efficient tracking of expenditures at the national and sub-national DOH.

2) **Maintaining political commitment in the face of falling malaria incidence** – Advocacy by the Program to ensure ongoing LGU political and financial commitment to malaria elimination in accordance with national policy will be maintained (as described above). At the national level, malaria remains one of the conditions of public health importance to which the DOH is committed to eliminating; the Government-funded proportion of the total malaria budget increased from 32% in 2011 to 39% in 2014, and improved reporting and analytical capacity within the national Program will help to guide and maintain this national level commitment.

3) **Reaching mobile and disadvantaged populations –** The NSPCEM has identified geographic areas with high malaria transmission and will guide investment in high impact interventions. In these and other areas, residents of remote locations and members of culturally or occupationally mobile groups are at increased risk; this includes IP communities living in and near forested areas in southern Palawan, where children and pregnant women are at particular risk. The

Program will engage strongly with municipal LGUs, local level non-government organizations (NGO) and employer groups (including the military and OFW organizations) to implement specialized and innovative strategies to reach these identified vulnerable groups.

4) **Developing a comprehensive elimination strategy and elimination oriented systems –** In areas with zero (or close to zer) reported malaria cases, provincial or regional elimination hubs will be established to strengthen and maintain excellent surveillance in potential foci of transmission in order to achieve elimination and the prevention of reintroduction. Regional Health offices will support LGUs to maintain prevention in areas with ongoing transmission risk, and to respond immediately to any identified cases to prevent the re-establishment of malaria transmission. (Also refer to NSPCEM, pages 34-35 and to the DOH Administrative Order 2013-0007: Guidelines on the Establishment of malaria Elimination Hubs). Although operational guidelines supporting elimination have been developed under current Global Fund support, the national Malaria Manual of Operations does not yet have a formal section on malaria elimination. A detailed malaria Elimination Strategy will be developed as a matter of priority to guide the establishment and activities of malaria elimination hubs at provincial level. The Program will establish elimination oriented surveillance systems (sensitive enough to detect individual cases and prevent the reintroduction of malaria) and a national elimination database to guide decision-making and epidemiological analysis. Guided by the Elimination Strategy, the capacity of elimination hubs for intensified passive and active case detection, comprehensive investigation of cases and foci of transmission, review and re/classification of foci, and outbreak detection and rapid response will be reviewed and strengthened.

5) **Improved efficiency –** While the extensive barangay malaria microscopy network has been crucial to improved case detection, it is becoming less cost-effective and less sustainable as provinces become “malaria-free” and the number of slides examined falls. In accordance with WHO technical guidance, capacity of microscopy referral centres will be maintained. However, where the number of cases seen and slides examined at a particular service delivery point is insufficient to maintain proficiency, diagnostic reach will be maintained and where necessary extended through trained RDT volunteers. The experience of the Principal Recipient (PR) and private sector partners will be enlisted to strengthen procurement and logistics management systems.

6) **Engagement with private providers –** The Program, through its DOH Regional Office and LGU partners – will engage the private medical sector more actively to facilitate quality management of malaria and efficient reporting through private facilities.

7) **Strategies in politically unstable areas –** Efforts will be exerted to orientate the key officials from politically unstable areas of Mindanao and the Sulu Archipelago to the strategic priorities of the NSPCEM. A detailed epidemiological and program analysis will be undertaken and discussed at a series of consultative meetings planned for the second half of 2014; these will inform the development of an implementation strategy specific to conflict-affected areas, including where there is population displacement. Expertise from adjacent Regional DOH offices will

provide ongoing technical support.

8) **Strengthening DOH procurement and logistics management system** – The 2013 MPR noted some patchy stock-outs of malaria commodities and lack of integration between the Government and GF procurement and supply management systems. This will be improved through the adoption of the Logistics Management and Information System (LMIS) established through Global Fund support, which has been in use in provinces under the current grant. The system is designed to track commodities from procurement to distribution to end- user. The National Program will coordinate with the relevant offices at the DOH to facilitate the adoption of the system.

   Another project-initiated system is the Malaria Text Report System (MTRS) which is a SMS-based reporting system that facilitates the relaying of stock levels of malaria commodities (drugs, RDTs) at the peripheral health facilities by the health workers. The national program will also adopt this system as the project phases out.

d) Linkage to the national health strategy and achievement of key outcomes

The pro-poor orientation of the *Philippine Development Plan 2011-16* (PDP) and the national health strategic plan – the *National Objectives for Health 2011-2016* (NOH) -- align well with the populations and geographic areas most at risk of malaria.

The NSPCEM 2014-2020 is structured to align with the priority areas and goals of the health sector reforms. Objective 1 aligns with the service delivery priority area; Objective 2 aligns with the governance and human resources pillars; Objective 3 with the health financing pillar; and Objective 4 with the health information and regulatory pillars. Individual activities under each Objective will contribute to the relevant NOH outcomes.

It is noted that both the PDP and NOH will be revised and updated during the period of the NSPCEM. However, current priorities for the health sector have been stable through two cycles of NOH and are not expected to change significantly under a new administration after 2016. (This issue is addressed in the Risk Management Matrix – Annex 4)

e) TB/HIV collaborative activities

Not applicable to this Grant

f) Country processes for reviewing and revising the NSPCEM

The MPR of 2013 was conducted in two phases: a thematic desk review by program component, conducted in June and July by local experts, followed by a comprehensive review by a team of external consultants and evaluators. The MPR included consultations with regional Malaria Program Coordinators, Program partners and stakeholders and a number of site visits. Interim results were presented to the Program and stakeholders on 22 August 2009, and the team's final report was released on October 2013. This was the first comprehensive review of the Philippines Malaria Program undertaken since 1993.

Revision of the MTDP was led by a local consultant – with the participation of the national team, regional program coordinators and key technical partners – from October 2013 to March 2014. The strategy development process included a series of workshops to discuss and align the new NSPCEM with the health sector priorities and the findings and

recommendations of the MPR. The draft, costed NSPCEM underwent internal review by the Technical Working Group (TWG) and peer review by three external reviewers.

Key DOH Regional Office and LGU stakeholders and affected populations have been engaged through various discussions on the specific interventions to be prioritized in this strategic plan. The key person for the health component of the National Commission on Indigenous Peoples (NCIP) is a member of the CCM and has been involved in the discussion on the needs and interventions for the indigenous people—one of the key affected population groups identified by the national program (See Annex 1: Documentation of Meeting on Interventions for IPs).

The NSPCEM was reviewed by a mock Technical Review Panel (TRP) and adopted by the CCM prior to finalization of this Concept Note. Based on the estimated NSPCEM costs and the currently available funding, financial gaps were identified, which serve as basis for this Concept Note.

SECTION 2: FUNDING LANDSCAPE, ADDITIONALITY AND SUSTAINABILITY

To achieve lasting impact against the three diseases, financial commitments from domestic sources must play a key role in a national strategy. Global Fund allocates resources which are far from sufficient to address the full cost of a technically sound program. It is therefore critical to assess how the funding requested fits within the overall funding landscape and how the national government plans to commit increased resources to the national disease program and health sector each year.

2.1 Overall Funding Landscape for Upcoming Implementation Period

In order to understand the overall funding landscape of the national program and how this funding request fits within this, briefly describe:

a. The availability of funds for each program area and the source of such funding (government and/or donor). Highlight any program areas that are adequately resourced (and are therefore not included in the request to the Global Fund).

b. How the proposed Global Fund investment has leveraged other donor resources.

c. For program areas that have significant funding gaps, planned actions to address these gaps.

a. Funding for Program Areas

From 2015 onwards, the only available source of funds identified for the NSPCEM is national government revenues allocated to the DOH — at the national, sub-national (regional) and local government level.

Variable levels of counterpart funding are available from local government revenues, and mostly used for salary costs. This varies enormously between provinces according to malaria endemicity (and hence both the political commitment and the proportion of an individual officer's workload allocated to malaria).

The NSPCEM (2014-2020) requires an estimated USD **73,811,889**.

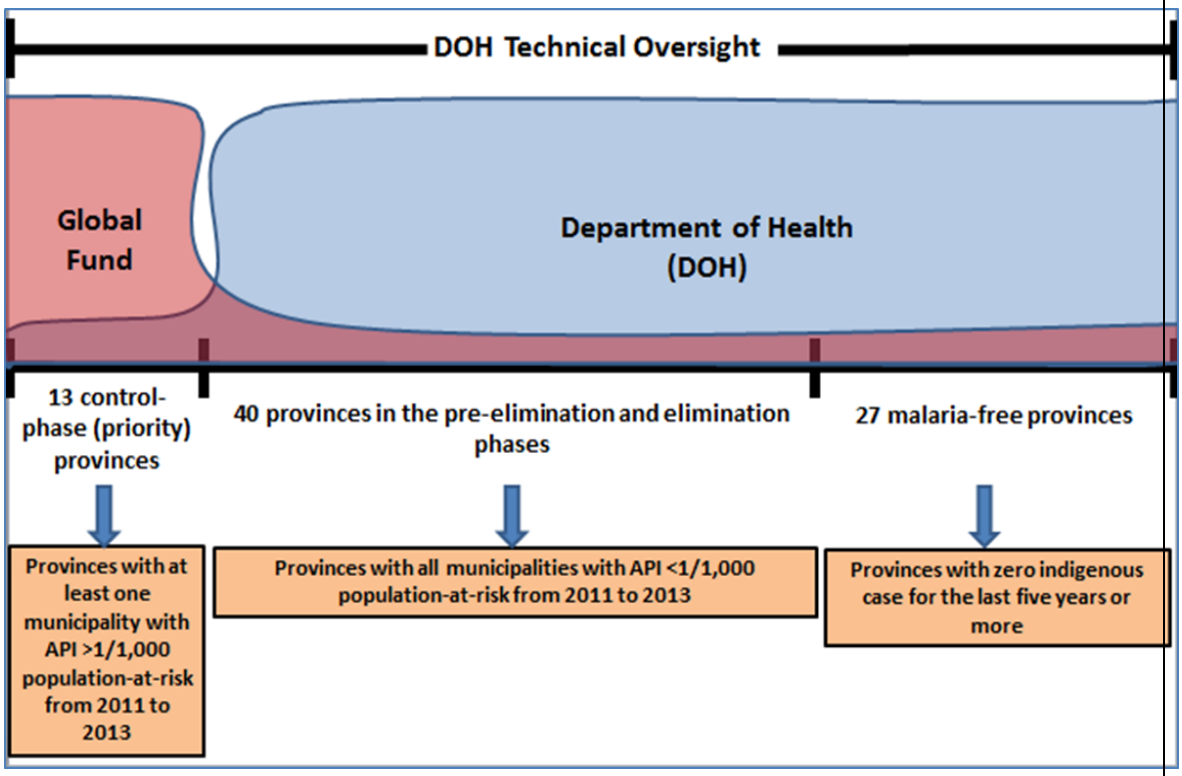
For the three-year implementation period 2015 to 2017, the national Program requires an estimated USD 38,743,4360 (annual average USD 12,914,479.

Costs peak in 2017(USD 13,660,376. This is the year whereinnets distributed in latter part of 2013 and 2014 will be replaced in order to maintain high levels of LLIN coverage.

Government resources available for the same period are currently projected to be USD 22,221,964.

Domestic resources will be used to cover control and elimination interventions in all 53 endemic provinces. Figure 4 shows the schematic representation of the balance between domestic and external resources as they will be applied to the 13 priority (control phase) provinces and the 40 other endemic (pre-elimination and elimination phase) provinces.

Figure 4 Schematic Diagram of Proposed Balance between National Government and Global Fund Resources for Malaria across all Provinces, 2015-2017



All program areas require a blend of domestic and external funding sources. The blue-shaded cells in the table above (Table B) indicate those program areas that are predominantly supported by domestic funding guiding the transition from control to elimination phase interventions in the 40 provinces; the red-shaded cells represent high priority activities in the 13 more highly endemic provinces that require additional external support to maximize impact. Further particulars are provided in the detailed budget (NSPCEM Annex 5)

Table B.Balance between Government and (proposed) Global Fund Investment In Malaria for 2015 to 2017, by Strategic Activity

Strategy	13 priority provinces	40 provinces in the pre-elimination and elimination phases	27 malaria-free provinces
Maintenance of microscopy centers in public health facilities (provision of laboratory supplies)			
Procurement of new microscopes			
Periodic refresher training for microscopists			
Provision of RDT kits for maintenance of existing RDT sites and expansion into public and private health facilities, including among vulnerable groups			
Training for use of RDT			
Training of private and public hospital physicians on severe malaria management			
Procurement of anti-malarial drugs (first to third line) year 2015 &2016			
Procurement of anti-malarial drugs (first to third line) year from 2017 +			
Monitoring of compliance to treatment guidelines			
Procurement and distribution of LLINs			
Procurement of insecticides, spray cans, PPEs			
Training of spray men			
Payment of spray men's fees			
Support to surveillance operations			
Quality Assurance For Diagnosis: Microscopy			
Quality Assurance For Diagnosis: RDT			
Quality Assurance For Treatment			
Quality Assurance For Vector Control			
Periodic M & E supervisory visits			
Program Implementation Reviews			
Conduct of Knowledge, Attitudes and Behavioural Practices Survey			
Development of health promotion and communication plan			
Production and dissemination of IEC materials			
Development of quad-media messages (TV< radio, print, web)			
Integration of malaria into the school curriculum			
Monitoring of malaria into the school curriculum			
Hiring of regional and provincial officers for surveillance and elimination program management			
Training on Malaria Diagnosis (RDT), Treatment and Health Promotion/Advocacy			
Operations Research to Profile Groups and Test Strategies			
Conduct of partnership forum, networking and advocacy activities to mobilize private sector and other NGOs			

National government resources allocated for the DOH regional offices will be used mainly to support personnel costs of key staff designated to implement program activities at the sub-national and local level (provincial/municipal). In addition to this direct funding, a variable proportion of National Program funds (called the sub-allotment) is allocated and released each year to the DOH regional offices to augment their budget for malaria program needs; during the period 2010 to 2013, the annual sub-allotment proportion ranged from 11% to 33% of the National Malaria Program budget (DOH Malaria Program Work and Financial Plan 2010-2013, Department Orders 2010-0068/2011-0153/2012-0063/2013-0017).

The local government units (provincial/municipal) have the autonomy to plan for the implementation of priority health programs and to fund these from their own revenues. For the Malaria Program, local government funds are principally used to cover personnel

costs of key staff designated for program management and clinical service delivery.

b. Other Resources

Since 2013, the Global Fund has been the only available external funding support for the needs of the program. The only recent non-Global Fund, non-government funding source -- the WHO-implemented Roll Back Malaria Project, funded by the Government of Australia – concluded at the end of 2012.

Technical (non-financial) support remains available and funded through the WHO Representative Office in the Philippines. This will be integral to the implementation of the NSPCEM and the proposed Grant.

Shell companies in the Philippines (SciP) will also continue to support the project. No rental is currently being charged in both offices in Makati and in Palawan. Electricity charges being consumed by the PR are also shouldered by SciP. Legal advice is also being offered at no corresponding cost. Support from different departments (transport, procurement, communications, etc) of SciP is also available. Starting in 2015, part of the salaries of the Executive Director and Program Manager will be shouldered by SciP.

The proposed trust fund linked to the Asia-Pacific Leaders for Malaria Alliance (APLMA) and managed by the Asian Development Bank (ADB) is a potential source of future support for Program costs that would not be adequately covered by domestic resources or the Global Fund allocation. At the present time, it is not clear when these funds might become available or how they would be accessed.

Efforts will be exerted to mobilize additional funding support from bilateral donors even before the end of grant implementation to ensure that funding gaps will be kept at a minimum.

Domestically, the Sin Tax law (Republic Act No. 10351, passed into legislation in 2012) is an act restructuring the excise tax on alcohol and tobacco products. These additional resources are intended to support social sector improvement, including the expansion of public health programs to help achieve (and maintain) the country's commitment to the Millennium Development Goals 4, 5, and 6. This has already resulted in a 58% increase in the DOH budget allocation, from PHP 53 billion (USD 1.19 billion) in 2013 to PHP 84 billion (USD 1.89 billion) in 2014 (see Section 2.2 item 3).

c. Actions to address funding gaps

The principle behind fund allocation for the NSPCEM is shown in Figure 4 and the related strategy table above. We propose that the national Global Fund allocation will be used to support high impact, evidence-based interventions to achieve rapid reduction in malaria transmission in the 13 priority provinces.

Should a funding gap emerge (e.g. due to the non-availability of external funds), the Program will: 1) undertake a prioritization exercise to identify those areas that must continue in order to maximize control efforts and, at the same time, not sacrifice the remarkable gains that have been made over the last 5 years (Figures 1 a-e); 2) refocus available resources on those high priority areas and activities; 3) identify efficiency gains within Program implementation, including opportunities for cost-sharing with other health programs and negotiating increased roles and responsibilities for LGUs and civil society partners; 4) identify more cost-effective procurement options for commodities if possible; 5) identify alternative sources of national funding (e.g. increased Sin Tax or other national government allocation); and 6) identify and engage in dialogue with other bilateral and multilateral donors.

2.2 Counterpart Financing Requirements

Complete the Financial Gap Analysis and Counterpart Financing Table (Table 1). The counterpart financing requirements are set forth in the Global Fund Eligibility and Counterpart Financing Policy.

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

Counterpart Financing Requirements	Compliant?	If not, provide a brief justification and planned actions
i. Availability of reliable data to assess compliance	☑ Yes ☐ No	The DOH has an existing Expenditure Tracking System (ETS). It will be enhanced and guidelines developed during the implementation period of the NSPCEM to ensure that all expenses of the National Program, including disbursements to the DOH Regional Office level (sub-allotment), can be even more accurately tracked and reported.
ii. Minimum threshold government contribution to disease program (low income-5%, lower lower-middle income-20%, upper lower-middle income-40%, upper middle income-60%)	☑Yes ☐ No	The yearly average of government resources allocated to the National Strategic Plan in current and previous years is USD 6,389,273; this represents 55% of the combined government and Global Fund allocations. (Refer to Line N of the Financial Gap and CPF Table).
iii. Increasing government contribution to disease program	☑ Yes ☐ No	The following figures represent the annual DOH appropriation for Malaria since 2010 (and percent change over the previous year): 2010: USD 4,864,794 2011: USD 4,276,404 2012: USD 5,627,297 2013: USD 6,279,393 2014: USD 7,261,128 The following estimates for

		2015 and 2016 adopted a very conservative estimate of a nominal increase of 1% in the annual Program budget after 2014. 2015: USD 7,333,739 2016: USD 7,407,077 Realistically, we expect a larger upward trend to be maintained.

b. Compared to previous years, what additional government investments are committed to the national programs (TB and HIV) in the next implementation period that counts towards accessing the willingness-to-pay allocation from the Global Fund. Clearly specify the interventions or activities that are expected to be financed by the additional government resources and indicate how realization of these commitments will be tracked and reported.

c. Provide an assessment of the completeness and reliability of financial data reported, including any assumptions and caveats associated with the figures.

b. Increasing Government Investment

Except for a decrease in 2011, the Malaria Program has been allocated an increasing share of the total annual budget for diseases for elimination from 2010 to 2013.

The percentage of the budget allocated to malaria is expected to increase steadily in the medium term, as the program is a priority for the Government of the Philippines and the PDP for the attainment of relevant MDG 6 targets and the achievement of malaria elimination by 2030.

Table C shows the proportion of disease elimination funding allocated to malaria since 2010.

Table C: Total Annual Budget (in USD) for diseases earmarked for elimination, and amount allocated to the Malaria Program, 2010-2013

Year	2010	2011	2012	2013	2014
Total budget for four elimination diseases (malaria, filariasis, leprosy, schistosomiasis)	USD 13,369,124	USD 13,369,124	USD 13,369,124	USD 12,818,944	USD 18,590,067
Budget for Malaria	USD 4,864,794	USD 4,276,404	USD 5,627,297	USD 6,279,393	USD 7,261,128

(Reference: General Appropriations Act, 2010-2014, DOH Malaria Program Work and Financial Plan 2010-2013, Department Orders 2010-0068/2011-0153/2012-0063/2013-0017)

The increasing government investment will be used in the development and implementation of a sound elimination strategy within the MOP, strengthening Program

management (human resources and governance functions) at the national and regional levels, and maintaining support for the quality of the program through effective information management and the implementation of quality standards for case management. Specifically, the highest priority activities and interventions that government resources will support include the following:

1) Case Management – Diagnosis

   a) expansion of RDT sites to strengthen access to ready diagnosis in the 28 provinces that are in the pre-elimination phase and among private sector providers and vulnerable groups (includes training and provision of laboratory supplies)

   b) maintenance of microscopy facilities in all endemic provinces – provision of laboratory supplies

2) Case Management – Treatment

   a) training of private sector physicians and public hospital physicians in all endemic provinces on the management of severe malaria

   b) procurement of drugs for 80 provinces from 2017.

3) Vector Control – LLIN: Procurement of LLINs to maintain stockpiles at the Regional Offices and elimination hubs for outbreak response and preparedness for events that may result in population displacement e.g. natural disasters

4) Vector Control – IRS: Procurement of insecticides, spray cans and PPEs as well as training for the spraymen prior to operations and their allowances during actual spraying. This will be used as a transitional strategy in communities with high APIs (greater than 5 per 1,000) in areas with stable and unstable transmission. The strategy will be phased out quickly as very high bednet coverage is achieved. There will also be provision for stockpiles of spray equipment and insecticides at selected regional health offices to ensure readiness for outbreak response or events resulting in population displacement.

5) Health promotion and advocacy – a national health promotion and communication plan will be developed to disseminate key messages to specific target audiences with the objective of influencing health-seeking behavior, ensuring consistent LLIN use (for the health promotion strategies) and mobilizing support from local government, key agencies and private sector partners (for the advocacy activities).

6) Policy, planning, management and coordination

   a) revision of MOP (including detailed elimination guidelines, stratification guidelines)

   b) assessment and certification of low endemic provinces as malaria-free

   c) establishment of collaborating centers

   d) conducting provincial and municipal strategic planning

   e) establishment of logistics management system

7) Surveillance

   a) Strengthening of passive and active case detection and response in areas with stable and unstable transmission,

   b) Development and training for an elimination-oriented surveillance system (active management of foci and response to suspected cases), overseen by elimination hubs

8) Health systems strengthening (HSS)

a) Human resource costs to ensure the required expertise and number of personnel for pursuing elimination at the national, regional and local levels to ensure high quality surveillance and management of the elimination program.

b) Harmonization of the existing information systems to facilitate effective surveillance, monitoring and reporting of malaria incidence and trends.

c) Maintenance of quality assurance systems for diagnosis (microscopy and RDT), treatment (including drug efficacy, drug quality and compliance to treatment guidelines) and vector control

To track the realization of government commitments, the program will enhance and maintain the Expense Tracking System that is currently in use. An Administrative assistant will be employed and assigned to record all disbursements and expenses and to develop regular financial reports. The National Program Manager will submit a regular report to the Office of the Secretary on the status of both program implementation and financial management.

c. Financial data reporting

Data on the budget of the DOH for the national Program have been obtained from the General Appropriations Act issued by the Philippine Department of Budget and Management (DBM) for the periods 2010 to 2014. These budgets have been signed into law by President of the Philippines.

Projections for the succeeding years were based on the pronouncements of the current administration of the priority to be given to the elimination of specific diseases (including malaria) and the achievement of the MDG targets within the National Objectives for Health.

SECTION 3: FUNDING REQUEST TO THE GLOBAL FUND

This section details the request for funding and how the investment is strategically targeted to achieve greater impact on the disease and health systems**.** It requests an analysis of the key programmatic gaps, which forms the basis upon which the request is prioritized. The modular template (Table 3) organizes the request to clearly link the selected modules of interventions to the goals and objectives of the program, and associates these with indicators, targets, and costs.

3.1 Programmatic Gap Analysis

A programmatic gap analysis needs to be conducted for the three to six priority modules within the applicant's funding request.

Complete a programmatic gap table (Table 2) detailing the quantifiable priority modules within the applicant's funding request. Ensure that the coverage levels for the priority modules selected are consistent with the coverage targets in section D of the modular template (Table 3).

For any selected priority modules that are difficult to quantify (i.e. not service delivery modules), explain the gaps, the types of activities in place, the populations or groups involved, and the current funding sources and gaps.

The NSPCEM has a detailed implementation plan which has been fully costed, both within and outside the proposed Global Fund allocation (NSPCEM Annex 5), prior to release of the NFM programmatic gap analysis tables. Costing in NSPCEM Annex 5 is based on the NSPCEM's detailed annual targets for 2014 and for each year of the 3-year period 2015 to 2017.

NSPCEM Annex 5 also includes cost assumptions and quantification for all commodities, personnel, and implementation requirements – again, within and outside the proposed Global Fund allocation. We have completed (retrospectively) the programmatic gap analysis tables for LLIN requirements and for overall drug requirements for the Program for 2014 and 2015 to 2017. However, we found the format and content used for NSPCEM Annex 5 a more precise and relevant way of analyzing and costing the requirements of the other priority interventions. In particular, we had difficulty using the tables to reflect the programmatic gaps for the interventions and commodities described below. NSPCEM Annex 5 includes details of types of activities, target populations, programmatic and cost assumptions, current funding sources and gaps under each of the 4 objectives and 11 strategies of the NSPCEM. These are further elaborated in the detailed PR Cost Schedule (Annex 2 to this Concept Note).

The following comments identify areas of the programmatic gap module that we found difficult to quantify.

NSPCEM Objective 1 (Service Delivery)

Diagnosis and Treatment

Quantification of RDT requirements and microscopy consumables -- coverage estimates in the programmatic gap tables are based on overall population, and do not allow programmatic targets (e.g. ABER) or the configuration of service delivery points to be reflected in the calculation.

Quantification of drug requirements – commodity estimates in the programmatic gap table appear to be based on total cases treated and aggregate needs for treatment courses (all drugs). The Program ensures first, second and third-line treatment for up to four species of malaria (*P. falciparum*, *vivax*, *malariae*, and probably *knowlesi*). The large number of service delivery points and facilities in the Philippines also require minimum quantities of all first-line drugs in the National Malaria Treatment Guidelines (Manual of Operations) to be in place at each point-of-care. The gap table and the RBM tool both over-simplify these programmatic realities. The detailed Program requirements in NSPCEM Annex 5 are therefore calculated on the basis of both the number of facilities and the estimated caseload stratified by type and severity of infection.

NSPCEM Objectives 2, 3 and 4 (other health system pillars)

The NSPCEM, like strategic plans for other public health programs in the Philippines, is aligned to the overall health system priority areas under the NOH: i.e. Governance and Human Resources (Objective 2), Financing (Objective 3) and Regulations, Quality Assurance and Information Management (Objective 4).

The programmatic gap tables do not appear to allow the necessary inputs to develop capacity in these areas to be derived. In particular, the requirements for strengthening elimination hubs to provide support for provinces in the pre-elimination and elimination phase are difficult to quantify using the format of the tables. These requirements are quantified in detail in the NSPCEM Annex 5.

In relation to specific health system elements, we highlight the following gaps and how the proposed funding will be used to address them:

Human Resources Support to the National Malaria Program

At the national level DOH, there is a lack of personnel to support the malaria program manager. The 2013 Malaria Program Review made a strong recommendation to augment national capacity; this is reflected clearly in the NSPCEM. To address this gap, this funding request proposes that key national program staff positions be

supported as an interim measure. However, there will be a gradual reduction in the number of field personnel hired by the Project. By 2018, the position of field personnel is expected to be fully absorbed into the DOH structure and fully supported by government resources. In the interim, capacity building activities will be provided for the DOH to absorb the functions provided by the PR.

Health Information System

The PhilMIS and Malaria Text Report system have been maintained in the 40 provinces supported by the current Grant. These systems facilitate collection of data on diagnosis and treatment of malaria cases (distribution of LLINs, stock levels of antimalarial drugs and RDTs, and transmission of these data to the appropriate levels that need to take action. It is proposed that maintenance of these information and reporting systems be supported under the proposed Grant. Effective information systems ensure the availability of quality data that will guide program management. These systems will eventually be adopted by the National Program and fully funded by government resources by 2018.

Other health system functions, e.g. quality assurance for diagnosis and treatment services and vector control, are managed and funded using government resources and do not constitute gaps to be funded by this funding request.

3.2 Applicant Funding Request

Provide a strategic overview of the applicant's funding request to the Global Fund, including both the proposed investment of the allocation amount and the request above this amount. Describe how it addresses the gaps and constraints described in questions 1, 2 and 3.1. If the Global Fund is supporting existing programs, explain how they will be adapted to maximize impact.

For the implementation period of 2015 to 2017, the National Program requires an estimated USD 38,743,436.

The government resources that are projected to be available for the same period is USD 22,221,964, resulting in an anticipated gap of USD 16,521,472.

The total funding request to the Global Fund is the total allocation under the NFM: USD 15,719,722.

This amount is proposed to cover interventions that will be focused on 13 priority control phase provinces where the additional resources are likely to result in maximum impact. These are Cagayan, Isabela, Nueva Ecija, Zambales, Bulacan, Quezon, Occidental Mindoro, Palawan, Maguindanao, Zamboanga del Sur, Zamboanga Sibugay, Sulu and Tawi-Tawi; all except Maguindanao currently receive support through the existing Global Fund grant.

Specifically, the focus of the new grant in these provinces will be on: universal access to high quality diagnosis and treatment; malaria-oriented pregnancy care; comprehensive scale-up of vector control through the achievement of very high levels of LLIN coverage; interventions for key affected populations (predominantly Indigenous People in remote underserviced areas, but also developing more effective strategies in potentially conflict-affected communities in Mindanao, Zamboanga Peninsula and Sulu Archipelago); and monitoring, evaluation and program performance reviews .

The funding request will also support the National Program in the remaining 41 endemic provinces through the provision of anti-malarial drugs for public health facilities and provision of microscopes for microscopy centers of excellence in elimination hubs and

collaborating centers.

Investment of funds within allocation

It is proposed that the Global Fund allocation will be funding 35.7% of interventions under Objective 1 (Service Delivery), predominantly vector control through bednet procurement and distribution; 23.7% of Objective 2 (Governance and Human Resources), particularly human resource costs for some central level functions and the salaries of provincially-based project officers; 6% of Objective 3 (Financing) predominantly grant management and central Principal Recipient (PR) costs; and 50.3% of Objective 4, predominantly on monitoring, evaluation and information management, and program analytic work on key affected populations and in the more challenging provinces and municipalities.

Further details for each priority intervention are:

Case Management - Diagnosis

In the 13 priority provinces, the requested amount will support the maintenance of microscopy centers in public health facilities (RHU), hospital and village microscopy center) and community- and facility-based RDT sites (primarily through the procurement of RDT kits sufficient to meet the projected demand under scale-up for universal access; NSPCEM Strategy 1.1). Village microscopy centers in areas with caseloads that are low enough to compromise the proficiency of the microscopist or the cost-effectiveness of maintaining their skills will be converted to RDT sites; the criteria and process for this policy shift will be detailed in the revised Manual of Procedures (2015; NSPCEM Strategies 1.1 and 2.2). These inputs will ensure continued access to quality diagnosis in these high burden areas, which will facilitate case finding and prompt treatment.

In support of the elimination strategy of ensuring availability of quality-assured microscopic confirmation of all cases (regardless of whether the primary point-of-care diagnosis was by RDT or microscopy), the allocation amount will also cover the procurement of microscopes for provincial centers of excellence and elimination hubs in the elimination phase areas (NSPCEM Strategies 1.1 and 4.3),

Case Management – Treatment

The allocation amount will cover procurement of quality-assured antimalarial drugs to fill the national requirement for first, second and third line drugs (NSPCEM Strategy 1.1) for year 2015 and 2016. The National Program will take advantage of the efficient procurement system developed during the previous and current Global Fund grant implementation (NSPCEM Strategy 2.1) to avoid delays in delivery of the drugs and to avoid stock outs. However, the government will cover for all drug requirement from 2017 onwards Continuous availability of drugs will facilitate prompt and effective management of confirmed indigenous and imported malaria cases in all 53 endemic areas (NSPCEM Strategies 1.1 and 1.2).

The grant will fund a Pregnancy Package consisting of bednets, iron supplements, deworming tablets (Albendazole) and information materials on malaria, pregnancy and child care for all pregnant women in the 13 high priority provinces and adjacent border areas. These will be distributed at their first antenatal visit or as soon as possible afterwards (NSPCEM Strategy 1.3). This is an initiative which has been supported and funded by the Global Fund since Round 5. The provision of pregnancy has been a best practice to address one of the most vulnerable group in preventing anemia that may be aggravated by a malaria infection. It also looks into equity in services. It allows for the integration of malaria into a comprehensive healthcare package for pregnant women.

Vector Control – Procurement and Distribution of LLINs

Universal LLIN coverage and high levels of correct utilization continue to be cornerstone strategies of the National Program in both control and elimination phase areas (NSPCEM

Strategies 1.1 and 1.2). LLINs will be procured for the 13 high priority provinces and border areas with adjacent provinces using the proposed allocation amount, targeting particularly 100% of the population living in barangays with stable and unstable transmission and adjacent populations living in sporadic transmission barangays (estimated at 50% of those populations). Of the total barangays with sporadic transmission in the 13 provinces in 2013, 30% have not shown change or improvement in their stratification as compared to their 2010 status. In these barangays with no change in status, LLIN coverage was noted to be, on the average, 22% of the population. However, among the total sporadic transmission barangays in the 13 provinces, 11% used to have stable transmission in 2010 but have improved to becoming sporadic in 2013. In these areas, LLIN coverage was noted to be, on the average, 41%. From these observations, an assumed coverage of 50% of the population could produce the improvement in transmission desired.

The basis or point of reference for selection of areas to be covered will still be the occurrence/ presence of cases (foci of transmission). Households in these foci transmission areas, and areas proximate to it, will be provided the LLINs. Likewise, there are also areas that were once with stable and unstable transmission and were provided with LLINs but were later re-classified as sporadic transmission in 2013. In these areas, replacement will still continue until the 3-year life expectancy of the LLINs is met.

The five additional provinces bordering high-burden provinces in Mindanao and Bangsamoro / Autonomous Region of Muslim Mindanao (ARMM) that have been selected for supplementary bed net distribution are: Bukidnon, North Cotabato and Sultan Kudarat (bordering Maguindanao), Davao del Sur, and Basilan (an island province situated between Sulu and the Zamboanga Peninsula). This is due to frequent cross-border, conflict-related population displacement or due to population movement for occupational reasons; the distances travelled are relatively short. In these provinces, as in the adjacent high priority provinces, bed nets will be procured through the grant for all barangays with stable or unstable transmission and 50% of those with sporadic transmission.

By 2017, the Program expects LLIN coverage in these areas to have increased progressively to very close to 100% (aided by DOH- and partner-funded health promotion to achieve utilization levels of 90% or more).

Interventions specific for key affected populations

Interventions specific for key affected populations, such as the Indigenous Peoples (IPs), will also be funded using the allocation amount. Diagnostic and treatment services will be made more accessible to these vulnerable groups who represent a significant and often majority proportion of the population in the 13 priority provinces (Section 1.1 of this Concept Note). Representatives from the IP communities will be trained on RDT use and on appropriate and culturally sensitive methods of communicating key messages on malaria control and prevention. High LLIN coverage and utilization (NSPCEM Strategy 1.1) will also be promoted by key leaders and health workers from among the IPs and civil society organizations working with them (NSPCEM Strategy 1.3).

Operations research will carried out to profile the IP communities and test appropriate strategies to ensure access to diagnostic and treatment services as well as promote preventive measures. Results of the implementation study will inform the refinement of these strategies (NSPCEM Strategy 1.3).

The 13 priority provinces include areas with ongoing political instability and risk of population displacement. Program objectives and interventions in these areas will be similar to those in politically stable provinces but strategies and methods may need to be adopted (NSPCEM Strategy 1.3). The allocation under the Grant will fund a careful

review of the Program, its operating context and potential community level partnership in these areas in order to develop feasible implementation strategies. Grant funding may also be used to undertake Program Implementation Reviews in neighboring regions (Region 9, Zamboanga; Region 10, Davao; and Region 12, SOCSKSARGEN), which share a similar ethnic and cultural background with the less stable provinces in order to promote mutual learning and cross-border technical partnerships (NSPCEM Strategy 4.4).

Human Resource Support for the National Program

In compliance to the recommendation of the 2013 Program Review regarding strengthening of program management and governance (Section 1.2 c of this Concept Note), key staff will be engaged to support the Program Manager. Additional roles and skills on the national team that will be funded through the allocation include: malaria program management (Deputy Program Manager), data management and analysis, and logistics management (NSPCEM Strategies 2.1 and 2.2).

Throughout the implementation period, the DOH will gradually take over the support for some of these posts and by 2018, all will be funded using government resources.

Monitoring, Evaluation and Information Management

Sound information management will be essential to monitoring progress in the 13 priority provinces and 41 other endemic provinces. It is proposed that the Grant will cover the development of an enhanced version of the Philippine Malaria Information System (PhilMIS 3.1), which will be rolled out to end-users at the national, regional and local level (provincial and municipal) (NSPCEM Strategy 4.4). There will be a subsequent turn-over of the system to full DOH management and funding (through the National Epidemiology Center – NEC) by the end of 2017, as a synchronized version of the PHILMIS and the PIDSR.

Evaluation studies such as Bednet Utilization Survey, Facility and Client Survey on compliance to diagnosis and treatment protocols, LLIN Durability and Attrition Rate Study and other studies that would be identified in the National Program's research agenda are also proposed to be funded by this request (NSPCEM Strategy 4.4). Results of these studies will inform program management and technical decisions on key strategies in both the intensified control and elimination program (see Detailed Costing of the NSPCEM, Objective 4, Lines 203-208).

3.3 Modular Template

Complete the modular template (Table 3). To accompany the modular template, for both the allocation amount and the request above this amount, briefly:

a. Explain the rationale for the selection and prioritization of modules and interventions.

Describe the expected impact and outcomes, referring to evidence of effectiveness of the interventions being proposed. Highlight the additional gains expected from the funding requested above the allocation amount.

The NSPCEM is structured using a health systems approach which reflects the same pillars and structure as the National Objectives for Health (refer to Section 1.2 of this Concept Note). Funding of the national malaria strategy (NSPCEM Annex 5) represents a co-investment by Government and external partners across all objectives of this strategy.

Most of the direct malaria prevention and control activities proposed in this Concept Note will be addressed through the allocation for NSPCEM Objective 1, i.e. Service Delivery. This includes Case Management (Diagnosis, Treatment and Referral Systems), Vector Control, and Health Promotion, with a particular emphasis on vulnerable groups. These priorities are aligned with the Government's overarching policy of achieving universal access to quality health care (*Kalusugang Pangkalahatan*).

Health systems interventions (i.e. NSPCEM Objectives 2, 3 and 4) which provide critical support for these service delivery functions are also allocated against the respective service delivery modules in the Modular Template (i.e. Case Management, Vector Control) and the Health Information Systems and Monitoring and Evaluation module.

Specific high incidence geographic areas have also been prioritized for the funding request to the Global Fund. The basis for this geographic prioritization was the average annual parasite incidence by municipality for the 3-year period 2011-2013, validated against total caseload and cross-referenced against the micro-stratified local level transmission risk in the included barangays. Using this method, we were able to identify 47 highest incidence municipalities (refer to Section 3.2 of this Concept Note), which account for 95% of all reported cases nationally and 96% of all reported cases in the 13 priority provinces over this 3-year period.

The Global Fund investment will focus primarily on these 13 priority provinces and 47 highest incidence municipalities, and adjacent border areas. Where it is technically and operationally relevant (e.g. taking advantage of a single procurement system), Global Fund resources will also be used to support service delivery and relevant health systems interventions in the other 28 endemic provinces.

The four modules included in the Modular Template for this Concept Note are:

1) Case Management
2) Vector Control
3) Health Information System and Monitoring and Evaluation
4) Program Management

The selection and prioritization of these modules and interventions are based on:

a. The demonstrated impact of these strategies on malaria transmission and incidence in the Philippines (refer to Section 1.2 of this Concept Note and Malaria Program Review 2013).

b. The consistency of these strategies with the WHO–RBM Global Malaria Action Plan (GMAP) 2012 to 2015,

We note that the Philippines has achieved a more rapid rate of reduction in cases and

deaths than that targeted in the GMAP and the previous MDTP.

Case Management Module

This module is selected because the included interventions contribute strongly to the achievement of universal access to quality assured diagnosis and treatment among vulnerable populations and in high priority geographic areas (NSPCEM Objective 1). This will be achieved through a focus on facility-based treatment and facility-supervised points of care.

Activities proposed for funding by the Global Fund under the allocation include:

1) procurement of antimalarial drugs and RDTs across the entire Program,

2) training for selected members of IP communities as malaria RDT and treatment volunteers.

3) quality assurance for pharmaceuticals and RDTs procured under the Grant,

4) distribution costs of diagnostic and treatment commodities

5) Refresher Training on malaria microscopy for Medical Technologists and Barangay Microscopists,

6) procurement of microscopes for diagnostic and treatment facilities to ensure quality diagnosis in the pre-elimination and elimination phase provinces,

7) health promotion activities to stimulate demand for malaria services, particularly among vulnerable populations; these will integrate messages on malaria prevention (e.g. via primary and secondary school curricula).

This will contribute to the achievement of the following outcomes and higher order outputs:

1) increasing the proportion of suspected malaria cases that receive a parasitological diagnosis, including in IP communities and other identified high risk population groups

2) among these, maintaining a very high proportion of cases that are managed correctly with highly effective treatment (ACT for first-line treatment of *falciparum* malaria) according to national treatment guidelines

3) strengthening the confirmation of cases, especially those with low parasitemia in elimination areas

At the impact level, this will contribute to the Program goal of reducing the overall national malaria mortality rate from 0.012 per 100,000 (2013 baseline) to 0.006 per 100,000 by 2017. In the 13 high priority provinces, malaria mortality will be monitored using absolute (numerator) data due to the small numbers involved; deaths in these provinces are expected to at least halve by 2017 (reducing from 12 deaths in 2013 to no more than 6 deaths in 2017).

Accurate diagnosis and prompt effective treatment will also reduce the parasite burden of affected populations, contributing to the overall Program goal of reduction in malaria incidence rate and the prevention of reintroduction in elimination areas (Table A section 1 of this Concept Note).

Vector Control Module (Long-lasting Insecticidal Nets)

This module is selected because vector control, particularly LLINs, is one of the major strategies of the NSPCEM (and the GMAP). Continued support for the procurement, distribution and promotion of regular use of LLINs is a major gap to be addressed through this funding request. Scale-up of LLIN coverage will also contribute to the achievement of universal access to malaria preventive measures (NSPCEM Objective 1).

Activities proposed for funding by the Global Fund under the allocation include the procurement and distribution of LLINs using the strategy described in Section 3.2 of this Concept Note. LLINs will also be distributed to pregnant women as part of the Malaria

Pregnancy Package (which contains malaria information materials along with a LLIN and ferrous sulfate and deworming tablets).

By 2017, the Program expects LLIN coverage in all endemic areas to have increased progressively to between 95% and 100% (population-based coverage calculated at 1 net per 1.8 persons), aided by DOH- and partner-funded health promotion to achieve utilization levels of 90% or more. This will contribute to the achievement of the following utilization and coverage outcomes:

1) increasing the proportion of the population that use their bednet correctly and consistently, including in IP communities and other identified high risk population groups
2) specifically, increasing the proportion of at-risk groups, such as children under-five and pregnant women, that use their bednet correctly and consistently

At the impact level, this will contribute to interruption of transmission and the Program goal of reducing the overall national malaria incidence rate from 7.89 per 100,000 (2013 baseline) to 4.28 per 100,000 by 2017.

In the 13 high priority provinces, it is expected that the annual parasite incidence rate will be reduced from 2.32 per 1,000 (2013 baseline) to 1.19 per 1,000 by 2017. Please note that the apparent slowing in the rate of API reduction in 2016-2017 is due to an expected contraction in population-at-risk following re-stratification in 2016; notwithstanding, this rate of progression will still be on track to push the 13 provinces, collectively, into the elimination phase by 2020.

Health Information System and Monitoring and Evaluation Module

This module is selected because accurate and timely data are crucial to the achievement of the goals of the NSPCEM. A strong monitoring and evaluation system will help the performance of the Program by assessing the extent to which implementation has followed the operational plan and how successfully it has achieved the intended results.

In the 13 high burden provinces, enhancement of surveillance, monitoring, and reporting systems at the facility level will help the Program and the Grant Management Unit to closely monitor the impact of intensified interventions and their coverage in key populations. At the regional and national level, they will ensure availability of information to guide effective program planning, program and grant management, and staff competencies to undertake relevant analysis and reporting.

Activities proposed for funding by the Global Fund under the allocation include:

1) enhancement of the PhilMIS system (to version 3.1) and its roll out to municipalities, provinces, and regions in the 13 high priority areas and another 28 endemic provinces
2) enhancement of the Malaria Text Report System as support and complement to PhilMIS, the DOH's events-based surveillance and response (ESR) system and malaria reporting through routine population-based surveillance channels (e.g. PIDSR)
3) on-site monitoring visits, meeting with implementers, and assessment and planning activities with stakeholders (particularly in difficult implementation areas, e.g. remote mountainous areas of Southern Palawan, potentially conflict-affected island municipalities of Sulu and Tawi-Tawi)
4) implementation research and special focused studies such as LLIN bioassay and insecticide susceptibility studies, KAP and Bednet Utilization Surveys, Facility Surveys, LLIN Attrition and Survival Studies, and other studies to be specified in the National Program research agenda

The above will enable the National Program to track achievement of outcomes and impact in endemic areas – both supported as Grant priorities and in the other 41 endemic

provinces. Results of specific research studies will help program management to apply new knowledge in both the intensified control and elimination programs.

In parallel with this investment, Government will be funding the National Program team to establish a complementary system for the elimination areas, using a combination of case-based and focus-based surveillance and investigation. Government will also fund TES, and co-fund vector control quality assurance and operations research.

Program Management Module

Activities proposed for funding by the Global Fund under the allocation include:

a) Policy development and program management support for the National Program in the form of human resource, overhead costs, and office renovation and refurbishments

b) Grant management which consists of five elements:

- PR human resource costs,
- PR administrative and overhead costs,
- procurement of PR equipment,
- PR staff development,
- funding technical assistance services delivered through WHO, and
- technical assistance to Sub-recipients

3.4 Focus on Key Populations and/or Highest-impact Interventions

This question is <u>not</u> applicable for low-income countries.

Describe whether the focus of the funding request meets the Global Fund's Eligibility and Counterpart Financing Policy requirements as listed below:

a. If the applicant is a lower-middle-income country, describe how the funding request focuses at least 50 percent of the budget on underserved and key populations and/or highest-impact interventions.

b. If the applicant is an upper-middle-income country, describe how the funding request focuses 100 percent of the budget on underserved and key populations and/or highest-impact interventions.

The Philippines is classified by the World Bank as a lower-middle-income country. The funding request is therefore required to focus at least 50% of the budget on high impact interventions and key populations.

The request will cover targeted priority communities within the 13 high priority provinces with intensified interventions to reduce malaria transmission. The aim is to contribute strongly to the national goal of an 80% reduction in incidence rate by using evidence-based interventions in those provinces and areas that have proven to be most challenging to the Program and which continue to contribute the majority of the national burden of disease.

Approximately 71.4% (USD 11.2 million) of the total requested amount is allocated to high impact activities and interventions focused on key populations – predominantly Indigenous People (or municipalities with a high proportion of IPs in their population) and pregnant women. Within this portion of the budget, 65.6% is allocated to high impact interventions (which may also be targeting key populations), and 5.8% is allocated to additional activities specifically focused on IPs and vulnerable groups only.

Over half of the USD 11 million (USD 6.11 million) is allocated to LLIN procurement. As noted above, this is a key strategy of the NSPCEM, geared towards maintaining very high coverage and promoting very high utilization rates among IP communities and other vulnerable populations.

Other high impact interventions include: universal access to quality assured diagnosis and treatment (RDTs and ACTs), consultations with key affected communities to identify innovative strategies for the Program to pursue in those areas, and costs associated with monitoring the impact of these pilot interventions and specific community-based studies (e.g. on bednet utilization, treatment compliance, etc.).

SECTION 4: IMPLEMENTATION ARRANGEMENTS AND RISK ASSESSMENT

4.1 Overview of Implementation Arrangements

Provide an overview of the proposed implementation arrangements for the funding request. In the response, describe:

a. If applicable, the reason why the proposed implementation arrangement does not reflect a dual-track financing arrangement (i.e. both government and non-government sector Principal Recipient(s).
b. If more than one Principal Recipient is nominated, how coordination will occur between Principal Recipients.
c. The type of sub-recipient management arrangements likely to be put into place and whether sub-recipients have been identified.
d. How coordination will occur between each nominated Principal Recipient and its respective sub-recipients.
e. How representatives of women's organizations, people living with the three diseases, and other key populations will actively participate in the implementation of this funding request.

The Government allocation to DOH — and therefore the annual Malaria Program budget -- continues to increase (refer to Section 2.2 a and b of this Concept Note). DOH has a medium-term view to being the sole manager and principal funder of the Program – potentially as soon as during the implementation period of the NSPCEM 2014-2020. However, the 2013 Malaria Program Review identified critical resources gaps (financial, human resources and organizational) that need to be addressed before this can happen.

During the period of the proposed Grant, DOH prefers to focus on the development of its relevant capacities to enable it to take on this enhanced management role, in partnership with the PR, LGUs and other stakeholders. The proposed NFM grant will therefore not have a dual-track financing arrangement, and a single non-government PR has been nominated.

As with the current Consolidated Malaria Grant, Pilipinas Shell Foundation Inc. (PSFI) has been nominated as the sole Principal Recipient (PR). PSFI will continue to use the existing structure of the DOH and its LGU partners as the implementing framework at all levels – from the national and Regional Offices of the DOH to the LGU and community: Provincial Health Offices (PHOs), Rural Health Units, health facilities (hospitals, clinics, Barangay Microscopy Centers) and community service delivery points (Barangay Health Centers, RDT sites). Except for a representative of the PR at the provincial level, there will be no duplication of structure or function between the Program and the PR (as strongly recommended by the 2013 MPR). The PR will complement, build on and enhance existing governmental systems and resources; some PR functions from the present Grant will transfer to Government under the proposed new Grant as DOH absorptive capacity improves.

The attached Implementation maps (Annex 3) show the following key players and the way they interact for the following functions: a) governance and coordination, b) financial flows, c) asset and commodity flow, and d) data and information flows.

National and Sub-national Level Stakeholders

The **Department of Health** spearheads the implementation of the Malaria Program in the country and has technical oversight of both the government-funded interventions and any externally funded programs supporting it. At the sub-national and implementation level, DOH provides policy direction, technical guidance and quality assurance to LGU and non-government partners.

The **DOH-Regional Offices (ROs)** provide field technical assistance for all devolved health programs, including malaria. The Regional Malaria Coordinator (RMC) is the point person for malaria in the RO. The RMCs orient the Provincial Health Offices and Municipal Health Offices to the national policy context and provide technical guidance for

implementation of the Program in accordance with national strategies and the MOP. The Provincial Health Teams are out-posted representatives of the DOH-RO at the provincial level; they provide implementation support for all health programs, including malaria (under the technical supervision of the RMC).

The **Technical Working Group for Malaria** is chaired by the Director of the DOH-Infectious Disease Office. Through its sub-committees, the TWG analyzes and provides technical recommendations for the different aspects of operational implementation, oversees program monitoring and evaluation and review activities, and manages the application of local and international research to enhance the Program.

A memorandum of agreement (MOA) with the **WHO Representative Office in the Philippines** has been established under the current Global Fund grant to support various technical assistance functions: monitoring and evaluation (including periodic external assessments of the project and its impact relative to National Malaria Program goals and objectives); quality assurance (QA) for diagnosis and treatment; and collation and analysis of all malaria reports from all provinces for the *World Malaria Report* (including the provinces not covered by the Global Fund malaria grant).

Global Fund Mechanisms

PSFI has been **Principal Recipient** for Global Fund grants in Philippines since 2006. As PR for the new Grant, it will be responsible for general and financial management, including quality procurement processes aligned with international standards, and submitting regular progress reports to the DOH, Global Fund and Country Coordinating Mechanism (CCM). It will also liaise with the Global Fund's Local Fund Agent (LFA) as necessary.

The Philippines **Country Coordinating Mechanism** has oversight functions for the Global Fund Grant, PR performance and capacity for resources management in support of effective and efficient achievement of Program objectives. In carrying out this role, the CCM ensures that Global Fund principles of partnerships, community engagement, inclusiveness, transparency and accountability are adhered to.

The **Local Fund Agent** is responsible for auditing the PR's financial and program management. PriceWaterhouse Coopers (PwC) has been selected as the LFA for the proposed Grant.

Local Level Stakeholders

The **Provincial Health Office** is responsible for planning and overall implementation of the Malaria Program within the jurisdiction of the Provincial Government. The PHO coordinates closely with the DOH-RO and DOH central office. In the ARMM, the PHOs report directly to the ARMM Secretary of Health, who has equivalent responsibilities to a DOH Regional Director.

The **Municipal Health Office** is responsible for planning and implementation of the Malaria Program at the municipal and community level. The MHO oversees service delivery, health promotion, community organizing and social mobilization, and logistics management at the grassroots level.

Representatives of Vulnerable Groups

The NSPCEM identifies indigenous populations residing in and/or moving through remote areas of the 13 high priority provinces as the principal vulnerable group to be assisted under the proposed Grant. The 2013 MPR noted many of the challenges inherent in reaching these groups, and the need for specific, focused interventions. The **National Commission on Indigenous Peoples** has been closely engaged in the development of the NSPCEM and continues to advise on possible approaches; the NCIP is also a member of the CCM and the TWG.

The PR will engage at least one **Sub-Recipient (SR)** – selected from among community- or faith-based organizations with a good track record in developing innovative programs in

partnership with IP communities -- to develop and facilitate implementation of appropriate malaria strategies for IP groups. IP organizations will be particularly encouraged to engage in discussion with the PR for this role. The terms of engagement will be finalized once the SR(s) is/are selected.

The military, Department of Foreign Affairs, Department of Labor and Department of Social Welfare have been engaged to explore issues and appropriate interventions for other vulnerable groups falling under their jurisdiction.

4.2 Ensuring Implementation Efficiencies
Complete this question only if the Country Coordinating Mechanism (CCM) is overseeing other Global Fund grants.
Describe how the funding requested links to existing Global Fund grants or other funding requests being submitted by the CCM. In particular, from a program management perspective, explain how this request complements (and does not duplicate) any human resources, training, monitoring and evaluation, and supervision activities.
The current Consolidated Global Fund Malaria Grant is due to conclude on December 31, 2014. The proposed Malaria Grant under the New Funding Model is expected to commence in January 2015 (subject to satisfactory assessment and timely conclusion of grant negotiations). There is therefore no overlap between the two Malaria Grants. Where there is continuity of staff between the two Grants, project-specific salaries will be allocated only against the new Grant from January 2015. There will be no overlap with Global Fund proposals for Tuberculosis (submitted already) or HIV (expected to be submitted later in the year). The proposed Malaria Grant will not share human resources, training, monitoring and evaluation or supervision activities with either of these Grants, should they be successful.

4.3 Minimum Standards for Principal Recipients and Program Delivery			
Complete this table for each nominated Principal Recipient. For more information on minimum standards, please refer to the concept note instructions.			
PR 1 Name	**Pilipinas Shell Foundation, Inc**	**Sector**	**Private**
Does this Principal Recipient currently manage a Global Fund grant(s) for this disease component or a cross-cutting health system strengthening grant(s)?		☑ Yes ☐No	
Minimum Standards		**CCM assessment**	
1. The Principal Recipient demonstrates effective management structures and		Based on previous Global Fund Grant Performance Reports, PSFI was assessed as having an effective and strong management structure and an effective	

planning	planning mechanism. In the External Evaluations done by the WHO, the effective organizational leadership, responsive management, and transparent decision-making processes of PSFI have been repeatedly cited as key factors contributing to the successful implementation of both the Round 5 and Consolidated Malaria Grants. The current Consolidated Grant engages 96 personnel at national level and across 40 provinces; these staff underwent a rigid hiring process that included a careful and thorough assessment of qualifications and relevant training. On transition to the new Grant, disease burden (API, number of cases) and the need for staff to complement existing Government systems and resources in the 13 priority provinces will be used as the basis for decisions on staff requirements for project management. PSFI's Executive Director will continue to take the helm in over-all Grant management, with policy direction from the Board of Trustees. The Executive Director will continue to oversee the financial, data management and procurement units for the Grant. PSFI's current Finance Manager will continue to solely manage and handle Global Fund accounts. She will be supported by one Senior Finance Officer and 6 Finance Officers, all of whom are Certified Public Accountants. The Procurement Unit is headed by a Procurement Officer supported by four logistics staff. Most of the Procurement staff have had several trainings including Inventory Management and Warehousing and Pharmaceutical Management and Quantification. The Data Management Unit is composed of one Data Manager and 7 M and E Officers. The Program Manager, reporting directly to the Executive Director, will continue to head the implementation of the Grant and to supervise its Management Team. The Team is composed of a Finance and Administration Manager, two Deputy Program Managers (both of whom are experts in the field of Health Sciences), one Logistics and Procurement Officer, and one Data Manager. One of the Deputy Program Managers will be out-posted at DOH to supervise field operations; the other will supervise project management and administration from within the core Grant Management Team. The PR's Program Manager and Deputy Program Managers will coordinate closely with the DOH National Malaria Program Manager. At the provincial level, Project Officers will continue to work closely with the Provincial Health Offices of the 13 priority provinces to ensure planned activities are carried out on time as funds, commodities, and other logistical support are provided. The Cluster Heads will maintain the existing links with the DOH Regional

	Offices. All activities carried out on the ground will continue to undergo careful planning, endorsement and approval of Management to achieve optimal efficiency and alignment with NSPCEM and Grant goals and targets. The advice of the TWG will be sought as necessary. Except for its fiduciary role in relation to the NFM Grant, the PR will be directly under the technical and implementing supervision of the DOH National Malaria Program Manager. No programmatic activity will be undertaken without the approval of the DOH (communicated through the out-posted Deputy Program Manager for field operations).
2. The Principal Recipient has the capacity and systems for effective management and oversight of sub-recipients (and relevant sub-sub-recipients)	A Sub Recipient arrangement will be confirmed with a relevant NGO(s) involved with tribal communities to be able to enhance the reach of the proposed Grant to vulnerable IP populations. An SR assessment will be done to determine if the SR has the minimum qualifications to implement the required component of the Grant. Disbursement of funds to the SR(s) will be on a quarterly basis (including a one-month buffer), and will be synchronized to the disbursement schedule of the PR. Programmatic and Financial Reports will be submitted to the PR on a monthly basis. The policies and procedures employed by the PR in its financial transactions will also be used in verifying the acceptability and correctness of the SR's expenditures. Validation will ensure that the SRs have followed agreed financial arrangements and processes. An annual external audit will be undertaken by the PR's external auditor to ensure compliance with applicable laws and policies. A point person will be assigned to monitor the progress of the achievement of the work plan of the SR. Meetings will be held regularly to discuss challenges and highlight the progress of the SR towards achieving their agreed targets. Issues, if any, will be brought to the attention of the Program Manager or during monthly Project Management Meetings. The MOA with the WHO Philippines Office will be renegotiated for the new Grant; this arrangement has been discussed previously (Section 4.1) An annual report of WHO's accomplishment is required in relation to Global Fund Grant funds disbursed annually by the PR under the terms of this SR MOA.
3. The internal control system of the Principal Recipient is effective to prevent and detect misuse or fraud	PSFI is the social arm of the Shell companies in the Philippines and as such, its governance structure has adopted the Shell General Business Principles that instill to all staff the principles of honesty, integrity and respect for others as part of the dictum for doing business. Also, a clear manual on financial and administration management is in place, which defines

	the punitive actions that may arise should staff offend against these policies. Such punitive action may include termination of staff from service. From the commencement of its first Global Fund Grant under management, the PR made enhancements and improvements to address possible risks that might occur with both an increase in staff and their out-posting to provinces. Structures and policies were reviewed, procedures enhanced, and new forms designed to vouch and capture the reasonableness of expenses that either staff or partners might incur. The PR, while promoting financial accountability, ensures that controls in place are being followed and any deviation from the policies is being monitored. Variance analyses on funds released to staff are now undertaken on a per activity basis. Field Officers are aware that expenses should be within budget and that liquidation of any excess in variance will be put on hold until such time that it is justified and fully documented. PSFI management is informed of any material change in activity that will result in additional costs. The PR's Finance Unit ensures that moneys held by field staff are kept to a minimum, with continuous monitoring of cash advances and prompt liquidation. Ageing of advances is done on a daily basis. Release of additional funds is not allowed unless field staff has liquidated earlier cash advances received. Cash counts are done during on-site data validation and audits. The PR also regularly renews its insurance coverage, which covers cash advances to staff against theft, robbery and loss through fraud. PSFI continues to comply with audit requirements of the Global Fund, having had the services of SGV and Co. as PSFI's external auditor. SGV and Co.'s services also include an annual program audit that complies with Terms of Reference specified by the Global Fund; principal among these is to ensure that GF funds are spent in conformity with the approved budget and work plan.
4. The financial management system of the Principal Recipient is effective and accurate	Consistent with the Business Control Guidelines of the Shell companies in the Philippines (SciP), PSFI has established a Financial Accounting and Management System that correctly records all business transactions, enabling periodic and accurate preparation of financial reports for the use of management, donors, government agencies, and the general public. The system has appropriate checks and balances to safeguard the Foundation's assets and to provide an information flow that is efficient and informative to management and end users. As evidenced by high financial management ratings and lack of adverse findings during previous assessments by the LFA, PSFI has demonstrated that it has an effective, accurate financial management

	system. PSFI's Accounting System supports the production of financial reports in a timely and relevant manner. As to the grant requirements, PSFI has been able to submit Enhanced Financial Reporting (EFR) forms and the PUDR on time. During assessments by the LFA, PSFI's good filing system and reliable Accounting System make validation and verification of entries and reports straightforward. Actual expenditures, both on a per allocation code basis and on a per line item basis, can easily be downloaded and subsequently traced to the source documents. To date, all EFRs and PUDRs submitted were found to be accurate and complete. All funds have been properly accounted for.
5. Central warehousing and regional warehouse have capacity, and are aligned with good storage practices to ensure adequate condition, integrity and security of health products	As in the current grant, arrangements have been made for the use of the central and regional warehouses of the DOH which have personnel trained in Logistics Management. The Material Management Division (MMD) of the DOH leads the implementation of the National Online Stocks Inventory Reporting Systems (NOSIRS). Records and reports related to stock management are in place for all warehouses from central to regional level. The Procurement and Supply Management (PSM) unit of the PR is composed of 5 staff based at DOH Central for easy coordination with the MMD. All staff of the PR have been trained on PSM and each have their own role in the implementation of the Logistics Management: • The two staff assigned in the warehouse are tasked to accept deliveries from the supplier; prepare goods for dispatch from central warehouse to the provincial warehouse; maintain records of inventory at the central warehouse; monitor the goods in the warehouse, especially those that need special handling; conduct regular inventory counts at the warehouse; and maintain records of assets procured by the project. • The Procurement Officer is in charge of procurement of goods (both health and non-health) in accordance with GF standards and procedure. • Another staff member is in charge of collecting reports from the field; consolidating them and submitting them to the supervisor for review and analysis. The Procurement and Logistics Officer supervises the unit.
6. The distribution systems and transportation arrangements are efficient to ensure	Distribution is an important component in the supply chain management of pharmaceutical products. To ensure that the original quality of goods is maintained,

continued and secured supply of health products to end users to avoid treatment/program disruptions	every activity in the distribution of pharmaceutical products should be carried out according to the principles of Good Manufacturing Practice, (GMP), Good Storage Practice (GSP) and Good Distribution Practice (GDP). The PR is responsible for ensuring that practices and controls are in place and conform to GMP, GSP and GDP. This is done through proper allocation to target beneficiaries; on-time delivery of goods to the destination; ensuring proper rotation and handling of goods (FIFO, FEFO for dispatching); temperature monitoring for sensitive goods; and selection of appropriate third party freight forwarder. As in the current grant, the PR will subcontract a third party freight forwarder. Bidding for this service will be conducted every first quarter of the year. 1. The PSM unit ensures that the products being dispatched should have at least six months of shelf life remaining. For remote facilities (i.e. those with limited transportation), goods with longer shelf life are provided. Products with less than six months shelf life will be sent to health facilities where the goods will be likely to be used before expiry (nearby facilities or facilities with high turnover of cases). 2. The receiving facility is notified prior to dispatch to ensure that someone at the facility will be available to receive the delivery and that ample storage space is available. 3. The third party freight forwarder hired by the PR will have sufficient trucks to ensure timely delivery of the goods. Before leaving the warehouse, the goods are covered by the insurance of the freight forwarder. This is to ensure that in case of loss or damage, the PR can claim reimbursement. 4. Records for the dispatch of pharmaceutical products should include at least the following information: • Date of dispatch • Name and address of the entity responsible for transportation • Name, address and status of addressee (PHO, RHU, BM, hospital, etc) • Description of product, e.g. name, dosage form and strength (if applicable) • Quantity of products, i.e. number of boxes, quantity per box; • Assigned batch and expiry date; • Applicable transport and storage conditions; and • A unique number to allow identification of the

	delivery order. All the above information is encoded in the LMIS. If, for some reason, delays in delivery of pharmaceutical procurements are experienced, the previous experience of the PR is to move stocks from facilities with less demand to those with higher demand; the same principle is also applied for drugs approaching their expiry date.
7. Data-collection capacity and tools are in place to monitor program performance	Under the present Grant, the 7-person Data Management Unit (DMU) leads the collection and consolidation of all reports from all 40 project sites. The members of the DMU team are holders of bachelor of science degrees and are experienced in data collection. Data collection starts at peripheral facilities (RDT and BMC) located at the *sitio* and barangay level. All barangay reports are collated at the Rural Health Unit (RHU) for submission to the PHO, which forwards a consolidated Provincial Report to the PR monthly. Collection of reports to support program performance is facilitated by regular monthly or quarterly meetings and validated during bi-annual Project Implementation Reviews at the provincial level, led by the PHO. The project utilizes PhilMIS 3.0 in consolidating major accomplishment reports, e.g. bednet distribution, IRS, malaria cases and deaths; these are collated digitally into a monthly provincial report. With the release of PhilMIS 3.0 in 2013, selected municipalities were supported to encode their own data, which are then forwarded electronically for collation at provincial level; other municipalities continue to forward manual records to the provincial level for encoding. The central DMU combines all provincial files into a consolidated national database. Reports on commodity stock outs use LMIS. See Section 4.3 item 6. The DMU maintains a tabular monitoring sheet which is updated on the last Friday of every month to estimate program achievements for the month. Data quality is also checked during internal on-site data validation, which is conducted in project sites with the highest disease burden and/or with the greatest number of deliverables. During these visits, reports that have been submitted to the DMU are verified against primary source documents.
8. A functional routine reporting system with reasonable coverage is in place to report program performance timely and accurately	The current Grant adheres to agreed, feasible reporting timelines. The PR's Project Officers, together with the municipal or provincial malaria point persons, facilitate meetings and collection of reports while, at the same time enhancing counterpart capacity in support of sustainability.

	Municipal meetings are held on the last working day of the month or the first working day of the succeeding month. Reports are reviewed for completeness and submitted to the MHO, who submits it to the PHO by the fifth day of the month. The DMU expects to receive the monthly reports (print out and digital file) by the 12th day of every month. These are reviewed for accuracy and validity and are collated with other project sites. Clarification on the provincial monthly reports is by email or phone. By the 22nd day of the month, reports are collated and the Project Management Team provided with validated accomplishments on project deliverables. Any amendments or data updates are possible through to the next PIR.
9. Implementers have capacity to comply with quality requirements and to monitor product quality throughout the in-country supply chain	As in the current grant, all anti-malaria drugs and RDTs procured with GF funds are sampled and tested. Testing of pharmaceuticals is done through accredited laboratories that are ISO 17025 certified and are accredited by the WHO. Samples of pharmaceutical products for testing are collected (1) upon delivery, prior to distribution, and (2) from different supply and storage points in the field once distributed. Collection and testing of samples from the field are done at least once for every batch procured. The selection of the site to be sampled considers, but is not limited to the following factors: • burden of disease • feedback or report of suspicion on the effectiveness of the drug, • feedback or report of suspected adverse reactions to the drugs, and • different climatic zone conditions to which drugs are exposed The following tests are performed on products associated with the above reported findings as deemed appropriate or necessary: • Appearance, Identification • Related substances, water content • Assay (quantitative estimation of active ingredients) • Disintegration or dissolution test (for solid dosage forms) • Uniformity of weight (for solid dosage forms) • pH (for solutions) • Microbial limit tests for non-sterile products, sterility test for sterile products and bacterial endotoxin test for large volume parenteral agents. For RDT kits, PR requests the Procurement Agent

	(PA) to send samples per lot for testing prior to delivery in the country. These samples are sent to Research Institute for Tropical Medicine (RITM) for lot testing. On receipt of a positive report from RITM, the PA is authorized to proceed with delivery. Monitoring of drugs and RDT for appearance, good storage and expiration dates is undertaken by the PR's Project Officer and Cluster Head on a monthly basis. Sample collection for QA testing is done annually by the Logistics and Supply Management staff of the PR.

4.4 Current or Anticipated Risks to Program Delivery and Principal Recipient(s) Performance

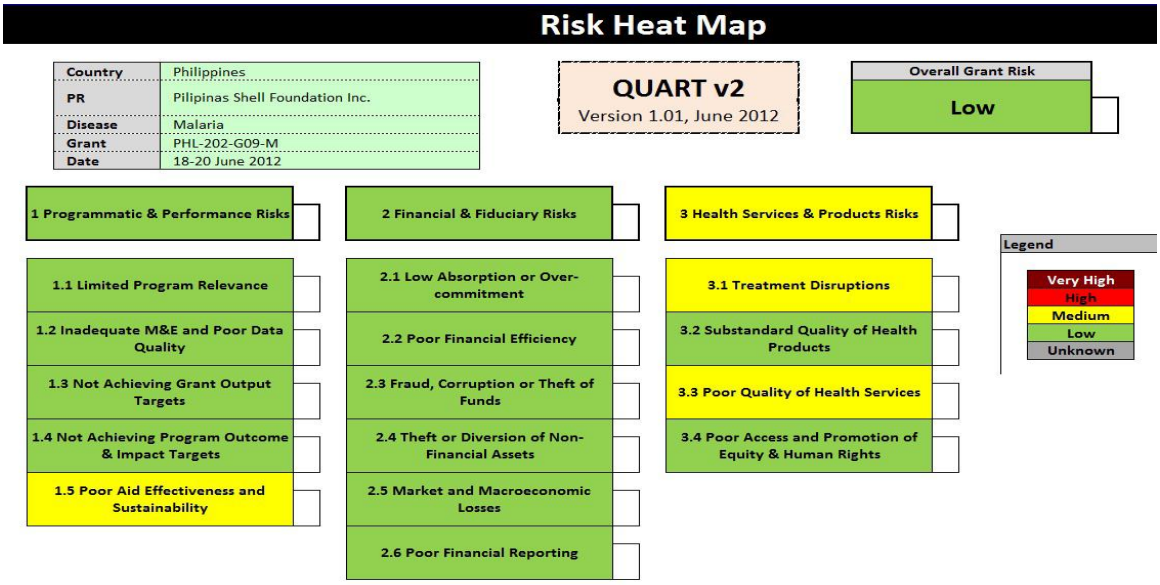
a. With reference to the portfolio analysis, describe any major risks in the country and implementation environment that might negatively affect the performance of the proposed interventions including external risks, Principal Recipient and key implementers' capacity, and past and current performance issues.

b. Describe the proposed risk-mitigation measures (including technical assistance) included in the funding request.

The latest GF risk assessment of the current GF malaria grant showed an overall "low" grant risk. (Please see figure below). The previous assessment of PR's capacity for the current grant has been rated "A", and the same PR has had "A" performance ratings since 2006.

The following diagram summarizes the Global Fund's risk assessment of PSFI during the most recent operational risk management conducted in early 2014.

PHL-202-G09-M – Pilipinas Shell Foundation, Inc. (PSFI)



For the proposed NFM Grant, a comprehensive Risk Assessment and Risk Management Plan has been developed. (See annex 4). Risks identified as "major" in the matrix include:

A. Risks related to Philippines' Policy and Planning Context

1. The ongoing roll-out of the human resources for health (HRH) Rationalization Plan (*plantilla*) of the Government of the Philippines may remove key technical people from the field offices, creating a risk of slippage of implementation targets and reduction in the quality of technical oversight. For the Malaria Program, this may impact on QA for diagnosis (e.g. if national or regional validators are moved to alternative functions), delays reaching coverage targets (e.g. for LLINs, elimination surveillance system enhancements) and delayed recognition and response to outbreaks. Program management at central and peripheral level may need to continue under current staffing restraints. To mitigate possible negative impacts, DOH ROs will be encouraged to re-engage existing core or project-funded staff on a contractual basis (which is permissible under a recent directive in the implementation of the Rationalization Plan); this will ensure continuity of functions for e.g. disease elimination programs. This will enable the Malaria Program not only to minimize risks due to loss of key positions but to enhance its own HR pool in accordance with the recommendations of the 2013 Malaria Program Review. The proposed Global Fund grant will provide transitional support to the Program while DOH assumes responsibility for these positions (starting 2016); the process will be complete by 2018. DOH-IDO will develop specific guidelines for ROs on use of sub-allotments for hiring contractual personnel.
2. Political and/or civil and/or military instability with significant population displacement, especially in the Sulu Archipelago, Zamboanga Peninsula or western Mindanao, although intermittent, could disrupt health services and potentially result in the suspension of some Program activities in affected areas. This will not have any impact in the other areas of the Program. Implementation of the Program will be ensured through detailed contextual assessment, political and civil society engagement, and dialogue with security forces as necessary. It is hoped that the recent Bangsamoro peace pact signed between the MILF in Mindanao and the national government will pave the way for the peace process to be achieved soon. It will also be beneficial for the DOH leaders to continue dialogue through the Bangsamoro framework to determine most effective way of implementing the program in affected areas. Health administrations and malaria programs in adjacent administrations (Regions 9, 10 and 12; Sabah, Malaysia) will be engaged to provide ongoing technical support to Bangsamoro/ARMM.

Other risks of lower priority in this category include:

- Change in health program priorities under a new administration (elections due 2016)
- Perceptions of Local Chief Executives that a falling incidence of malaria indicates that it is already adequately controlled and therefore of lower priority than other health programs

These are discussed further in Annex 4.

B. Programmatic and Performance Risks.

The current grant has been assessed as low risk in most of the programmatic and performance. All activities under the proposed grant are aligned with the NSPCEM and the DOH's goal of Universal Health Care; interventions also aligned with WHO technical guidance, and subject to regular review and evaluation. The PR will maintain its current strong M and E functions within the NFM. For sustainability, the systems of reporting and data validation will be adapted by national Malaria Program, with specialist personnel added to the National team from 2015.

The two principal risks under this category are:

1. Possible slow implementation of programmed activities due to downsizing of GF

supported staff in former Global Fund supported provinces that are no longer prioritized under the NFM Grant. To mitigate this risk, the DOH will hire personnel on a contractual basis as discussed above.

2. Premature or rushed implementation of new WHO technical guidance discouraging overlap of LLIN and IRS as 'dual strategy' vector control interventions. This may result in an increase in transmission and a risk of outbreaks in areas previously implementing the 'dual strategy,' particularly where bed net coverage is sub-optimal. This risk will be mitigated by gradual and well-planned phasing-out of IRS, except in barangays with API greater than 5 per 1,000 and in the context of outbreaks.

Other risks of lower priority in this category include:

- Limited program relevance
- Inadequate M and E and poor data quality
- Insufficient commitment or engagement of PHO and MHO LGU counterparts
- Poor development effectiveness and sustainability

These are discussed in Annex 4.

C. Fiduciary and Financial Risks

The fiduciary and financial risks of the current grant managed by the same PR has been rated "low" by the GF Operational Risk Assessment tool, Qualitative Risk Assessment, Action planning and Tracking Approach and Tool (QUART).

All risks in this category are rated as lower priority; they include:

- Inadequate program budget
- Low absorption or over-commitment of available funds
- Poor financial efficiency
- Negative impact of exchange rate fluctuations
- Theft or diversion of funds or non-financial assets
- Imbalance of DOH focus with NOH due to distortionary effect of malaria resources
- Macro-economic losses
- Poor financial reporting

As in the current grant, the PR will maintain a high level of financial management and fiduciary oversight, and continue to have a good fund absorption rate, high financial efficiency and good financial reporting. Previous fluctuations in exchange rates have been cushioned with good monitoring of currency performance against economic indicators. Risk of theft or diversion of funds or non-financial assets has been minimized as discussed in Annex 15; all assets valued at more than USD300 have been insured against theft and fraud.

D. Risks related to Health Products and Services

The two principal risks under this category are:

1. Poor quality diagnostic services in primary care facilities and hospitals may result in some cases being undetected and therefore untreated, and others being wrongly diagnosed and treated unnecessarily.

2. Poor quality service delivery for treatment in primary care facilities and hospitals. Incorrect treatment carries the risk of clinical non-response and emergence of drug resistance. The Program will support the introduction of updated treatment protocols and develop and strengthen compliance through good quality training and on-the-job supervision. Hospital medical staff will be oriented (or re-oriented) to the management of severe and complicated malaria.

Other risks of lower priority in this category include:

- Disruptions in supply chain for Malaria Program commodities
- Inadequate quality of malaria commodities for case management
- Inadequate quality of LLINs

The Program will continue to procure medicines through WHO-prequalified manufacturers and accredited suppliers. All RDTs procured will be aligned with latest quality assessment through the Foundation for Innovative Diagnostics (FIND), and quality monitored through routine batch-linked QC processes.

LLINs will be procured through WHOPES-prequalified manufacturers and accredited suppliers. Durability, efficacy and physical integrity of nets will be monitored (where possible) through bioassay studies and community surveys.

E. External Risks

The three principal risks under this category are:

1. Emergence or re-emergence of epidemic or pandemic threat could overwhelm health services, result in social and civil disorder and aggravating law and order concerns in conflict-affected areas, potentially leading to diversion of significant Program resources and slowing of Program implementation. A national pandemics and emerging infectious diseases preparedness plan is in place, updated in response to 2009 H1N1 influenza pandemic and current exposure to MERS-CoV importation. Program and DOH will work pro-actively with WHO and other partners to maintain service provision as much as possible while addressing direct consequences of any pandemic effect.
2. Natural disaster, e.g. typhoons, earthquake would have a major impact on the Program: widespread suspension of Program activities, general collapse of health services, and diversion of resources to disaster response. This would carry a high risk of malaria and other VBD outbreaks.
3. Another global recession or financial crisis, or further financial instability could result in reduction in purchasing power of USD-denominated budgets; collapse of GOP and DOH budgets also possible (e.g. with decline in tourism and regional trade), with rise in dependence on donor 'rescue' funding (which may not be forthcoming). Pro-active monitoring of budget position and vulnerability to external shocks should be done. High-level consultations between GOP, donors and global financial institutions should be maintained.

CORE TABLES, CCM ELIGIBILITY AND ENDORSEMENT OF THE CONCEPT NOTE

Before submitting the concept note, ensure that all the core tables, CCM eligibility and endorsement of the concept note shown below have been filled in using the online grant management platform or, in exceptional cases, attached to the application using the offline templates provided. These documents can only be submitted by email if the applicant receives Secretariat permission to do so.

- ☐ Table 1: Financial Gap Analysis and Counterpart Financing Table
- ☐ Table 2: Programmatic Gap Table(s)
- ☐ Table 3: Modular Template
- ☐ Table 4: List of Abbreviations and Annexes
- ☐ CCM Eligibility Requirements
- ☐ CCM Endorsement of Concept Note